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Response to Request for Qualifications
Mississippi Division of Medicaid Coordinated Care

RFQ # 20211210
RFx # 3150003991
Transmittal Letter
Magnolia Health Plan, Inc.

Transforming the health of the community, one person at a time.

111 East Capitol Street
Suite 500
Jackson, MS 39201
1-866-912-6285
TDD/TTY 1-877-725-7753

March 4, 2022

Mississippi Division of Medicaid Coordinated Care Procurement
Office of the Governor, Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201

RE: Response to Section 4.1 Transmittal Letter (Marked) for the Request for Qualifications (RFQ) for the Mississippi Coordinated Access Network (MSCAN) and the Mississippi Children's Health Insurance Program (CHIP) RFQ #20211210, issued by The State of Mississippi, Office of the Governor, Division of Medicaid.

To the Office of Procurement:
Magnolia Health Plan, Inc. is pleased to respond to RFQ #20211210, issued by The State of Mississippi, Office of the Governor, Division of Medicaid.

In accordance with the requirements set forth in Section 4.1 of the RFQ, all statements and /or requirements are listed on the pages that follow:

The Transmittal Letter shall be in the form of a standard business letter on letterhead of the Offeror and shall be signed by an individual authorized to legally bind the Offeror. The transmittal letter should identify all material and enclosures being submitted in response to the RFQ. Failure to include the statements or items listed below may result in rejection of the qualification. The transmittal letter shall include the following:
All Material and enclosures being submitted in response to the RFQ are identified below:

- *Attachment 4.1.3 Mississippi Insurance Department License*
- *Attachment 4.1.18 Subcontractor Scope of Work Statements*
- *Attachment 4.1.19 Certification of Full Authority to Obligate and Bind*
- *Attachment 4.1.23 Appendix D Certifications*
    - *Certifications and Assurances Regarding Contingent Fees and Gratuities*
    - *DHHS Certification Regarding Drug-Free Workplace Requirements (Magnolia and expected Subcontractors)*
    - *DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters for Primary Covered Transactions*
- *RFQ 20211210 Amendment 1 - January 21, 2022 – Enterprise Security Policy*
- *RFQ 20211210 Amendment 2 – January 21, 2022 – RFQ Mandatory Pre-Qualification Question and Answer Document*
- *RFQ 20211210 Amendment 3 – January 21, 2022 – RFQ Appendices D, E, F, G, and H in Word Format*
- *RFQ 20211210 Amendment 4 – February 07, 2022 - Questions and Answers (PDF)*

- *RFQ 20211210 Amendment 5 – February 07, 2022 - RFQ Corrections and Clarifications (PDF)*
- *RFQ 20211210 Amendment 6 – February 07, 2022 – Appendix A: Draft Contract Corrections and Clarifications (PDF)*
- *RFQ 20211210 Amendment 7 – February 07, 2022 – Updates to RFQ Appendix F and H in Word Format (Word)*
- *RFQ 20211210 Amendment 8 – February 07, 2022 – Additional MSCAN and CHIP Rate Information in Excel Format (PDF)*
    - *Amendment 8: SFY 2022 Preliminary MSCAN Capitation Rates (Excel)*
    - *Amendment 8: SFY 2022 Preliminary CHIP Capitation Rates (Excel)*
- *RFQ 20211210 Amendment 9 – February 10, 2022 - Clarification of Amendment 4 Responses-Deadline: Monday, February 14, 2022 12:00 p.m.*
- *RFQ 20211210 Amendment 10 – February 11, 2022 - Summary of Pre-Qualification Conference Held on Friday, January 14, 2022 (PDF)*
- *RFQ 20211210 Amendment 11 – February 11, 2022 - Reporting Manuals (PDF)*
    - *MSCAN Manual (ZIP of Excel Files)*
    - *CHIP Manual (ZIP of Excel Files)*
- *RFQ 20211210-Amendment 12 – February 16, 2022 – Responses Regarding Amendment 9*

1. A statement indicating that the Offeror is a corporation or other legal entity;
Magnolia is a Mississippi licensed corporation.

2. A statement confirming that the Offeror is registered to do business and in "Good Standing" with the State of Mississippi and providing their corporate charter number to work in Mississippi, if applicable;
Magnolia is registered to do business and is in "Good Standing" with the State of Mississippi. Magnolia's corporate charter number is 907018.

3. A statement confirming that the Offeror has been licensed by the Mississippi Insurance Department (MID) accompanied by a copy of the license; or evidence that an application for license in Mississippi has been submitted to the Mississippi DOI at the time of qualification submission. (Note: If selected, the Offeror shall be required to provide evidence that a license has been obtained before offering or providing services to Members);
Magnolia is licensed by the Mississippi Insurance Department. Please see ***Attachment 4.1.3 Mississippi Insurance Department License.***

4. A statement identifying the Offeror's Federal tax identification number;
Magnolia's Federal tax identification number is 20-8570212.

5. A statement confirming that the Offeror has not been sanctioned by a state or federal government within the last ten (10) years;
Magnolia has not been sanctioned by a State or Federal government within the last ten years. Magnolia's affiliate health plans have been subject to State sanctions.

6. A statement confirming that the Offeror is not suspended or debarred under federal law and regulations or any other state's laws or regulations;
Neither Magnolia nor its parent company Centene is suspended or debarred under Federal law and regulations or any other state's laws or regulations.

7. A statement confirming that the Offeror has experience in contractual services providing the type of services described in this RFQ. All experience provided will be considered;
Magnolia has experience providing all services described in this RFQ. Magnolia has operated as a Coordinated Care Organization within the MississippiCAN program since January 2011 and currently

successfully provides Medicaid, Marketplace, and Medicare services in Mississippi. Magnolia proudly serves 192,981 Medicaid Members within TANF, SSI/ABD Non-Dual, and Foster Care.

8. A statement that, if the Offeror is awarded the Contract, the Contractor agrees that any lost or reduced Federal matching money resulting from unacceptable performance of a Contractor task or responsibility, as defined in this RFQ, shall be accompanied by reductions in State payments to the Contractor;
Should Magnolia be awarded the Contract, Magnolia agrees that any lost or reduced Federal matching money resulting from unacceptable performance of a task or responsibility as defined in this RFQ will result in reductions in State payments to Magnolia.

9. A statement identifying any prior project where the Offeror was terminated prior to the end of the Contract period;
Magnolia has never had a project terminated prior to the end of a Contract period. Magnolia's affiliate through Centene Corporation, Oklahoma Complete Health had its contract terminated by the Oklahoma Health Care Authority (OHCA) as did all SoonerSelect managed care organizations in June 2021. The terminations were issued subsequent to Oklahoma Supreme Court decision 2021 OK30, which held that a voter-approved constitutional amendment to expand Medicaid did not authorize the SoonerSelect program and that OHCA did not have legislative approval to proceed with the program.

10. A statement that no attempt has been made or will be made by the Offeror to induce any other person or firm to submit or not to submit a qualification;
Magnolia confirms that no attempt has been made, or will be made by Magnolia, to induce any other person or firm to submit or not submit a proposal.

11. A statement that the Offeror has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set which is guided by the previous provisions of the Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations, a copy of which is available at 501 North West Street, Suite 701E, Jackson, Mississippi 39201 for inspection, or downloadable at http://www.DFA.ms.gov.
Magnolia has not violated, is not currently violating, nor will it violate in the future, the prohibition against gratuities set forth by the Mississippi Public Procurement Review Board.

12. A statement of Affirmative Action, that the Offeror does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, disability or genetic information;
Neither Magnolia nor its parent company, Centene, discriminates in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, disability, or genetic information.

13. A statement that the Offeror agrees to the language of the Division's BAA and DUA without expectation of negotiation;
Magnolia has read, understands, and agrees to the language of the Division's BAA and DUA without expectation of negotiation.

14. A statement identifying by number and date all amendments to this RFQ issued by the Division which have been received by the Offeror. If no amendments have been received, a statement to that effect should be included;
We acknowledge that the Division has issued the amendments listed below.

- RFQ 20211210 Amendment 1 - January 21, 2022 – Enterprise Security Policy
- RFQ 20211210 Amendment 2 – January 21, 2022 – RFQ Mandatory Pre-Qualification Question and Answer Document
- RFQ 20211210 Amendment 3 – January 21, 2022 – RFQ Appendices D, E, F, G, and H in Word Format

- RFQ 20211210 Amendment 4 – February 07, 2022 - Questions and Answers (PDF)
- RFQ 20211210 Amendment 5 – February 07, 2022 - RFQ Corrections and Clarifications (PDF)
- RFQ 20211210 Amendment 6 – February 07, 2022 – Appendix A: Draft Contract Corrections and Clarifications (PDF)
- RFQ 20211210 Amendment 7 – February 07, 2022 – Updates to RFQ Appendix F and H in Word Format (Word)
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- RFQ 20211210 Amendment 11 – February 11, 2022 - Reporting Manuals (PDF)
    - MSCAN Manual (ZIP of Excel Files)
    - CHIP Manual (ZIP of Excel Files)
- RFQ 20211210-Amendment 12 – February 16, 2022 – Responses Regarding Amendment 9

15. A statement that the Offeror has read, understands and agrees to all provisions of this RFQ without reservation and without expectation of negotiation;
Magnolia has read, understands and agrees with all provisions of this RFQ without reservation and without expectation of negotiation.

16. Certification that the Offeror's qualification will be firm and binding for three hundred sixty-five (365) days from the qualification due date;
Magnolia's qualification will be firm and binding for three hundred sixty-five (365) days from the qualification due date.

17. A statement naming any outside firms responsible for writing the qualification;
Assistance in writing the response to the RFQ was provided by Health Management Associates and Guidehouse.

18. If the use of Subcontractor(s) is proposed, a statement from each Subcontractor must be appended to the Transmittal Letter signed by an individual authorized to legally bind the Subcontractor and stating the general scope of work to be performed by the Subcontractor(s);
Magnolia is proposing the use of Subcontractors for the Contract. A signed statement from each Subcontractor is included as ***Attachment 4.1.18 Subcontractor Scope of Work Statements***.

19. All qualifications submitted by corporations must contain certifications by the secretary, or other appropriate corporate official other than the corporate official signing the corporate qualification, that the corporate official signing the corporate qualification has the full authority to obligate and bind the corporation to the terms, conditions, and provisions of the qualification;
Please see ***Attachment 4.1.19 Certification of Full Authority to Obligate and Bind*** for certification by our Secretary, Joel Samson, that Aaron Sisk, Magnolia Health Plan President and Chief Executive Officer, has full authority to obligate and bind Magnolia to the terms, conditions, and provisions of the qualification.

20. All qualifications submitted must include a statement that the Offeror presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of

services under this Contract, and it shall not employ, in the performance of this Contract, any person having such interest;
Magnolia has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services under this Contract, and will not employ, in the performance of this Contract, any person having such interest.

21. A statement that no public disclosure or news release pertaining to this procurement shall be made without prior written approval of the Division; and
No public disclosure or news release pertaining to this procurement shall be made without prior written approval of the Division.

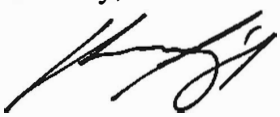
22. A statement that the Offeror's redacted electronic, single-document qualification referenced in 1.4.2, Release of Public Information, does not contain trade secrets or other proprietary information.
Magnolia's redacted electronic, single-document qualification referenced in 1.4.2, Release of Public Information, does not contain trade secrets or other proprietary information.

23. A statement that the Offeror has executed and included with the Transmittal Letter the following Certifications, located in Appendix D:
a. Certifications and Assurances Regarding Contingent Fees and Gratuities;
b. DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals (This document must be executed by the Offeror as well as any expected Subcontractors and submitted with the Offeror's qualification); and
c. DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters
Magnolia has executed the following Certifications which are provided as ***Attachment 4.1.23 Appendix D Certifications***:

a. Certifications and Assurances Regarding Contingent Fees and Gratuities
b. DHHS Certification Regarding Drug-Free Workplace Requirements (Magnolia and expected Subcontractors)
c. DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters for Primary Covered Transactions.

24. Additionally, if the qualification deviates from the detailed specifications and requirements of the RFQ, the transmittal letter shall identify and explain these deviations. The Division reserves the right to reject any qualification containing such deviations or to require modifications before acceptance
Magnolia's proposal does not deviate from the detailed specifications and requirements of the RFQ. We understand that the Division reserves the right to reject any qualification containing such deviations or require modifications before acceptance.

Sincerely,



Aaron Sisk, JD
Plan President and Chief Executive Officer
Magnolia Health Plan, Inc.
asisk@centene.com
Office Phone Number: (601) 863-0822
Cellular Phone Number: (601) 760-9844

Attachment 4.1.23 Appendix D: Certifications

Certifications and Assurances Regarding Contingent Fees and Assurances

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

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APPENDIX D: Certifications

The forms in this Appendix must be used by the Offeror to provide the following Certifications. The Offeror must also include a statement in its Transmittal Letter stating that each have been executed. These Certifications should be included after the last page of the Offeror's Transmittal Letter.

- Certifications and Assurances Regarding Contingent Fees and Gratuities
  - Representation Regarding Contingent Fees
  - Representation Regarding Gratuities
  - Prospective Contractor's Representation Regarding Contingent Fees
- DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals
- DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

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Certifications and Assurances Regarding Contingency Fees and Gratuities

Instructions: Mark the applicable word for each certification provided below. Failure to mark the applicable word or words and/or to sign the qualification form may result in the qualification being rejected as nonresponsive. Modifications or additions to any portion of this qualification document may be cause for rejection of the qualification.

Certifications:
I/We make the following certifications and assurances as a required element of the qualification to which it is attached, of the understanding that the truthfulness of the facts affirmed here and the continued compliance with these requirements are conditions precedent to the award or continuation of the related contract(s) by circling the applicable word or words in each paragraph below:

1. Representation Regarding Contingent Fees

The Offeror represents that it [ ] **has [X] has not** retained a person to solicit or secure a state contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except as disclosed in Contractor's qualification.

2. Representation Regarding Gratuities

The Offeror represents that it [ ] **has [X] has not** violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Public Procurement Review Board Rules and Regulations.

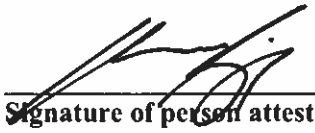
3. Prospective Contractor's Representation Regarding Contingent Fees

The prospective Contractor (Offeror) represents as a part of such Contractor's qualification that such Contractor [ ] **has [X] has not** retained any person or agency on a percentage, commission, or other contingent arrangement to secure this contract.

Magnolia Health Plan, Inc.
Name of Offeror

Aaron Sisk
Printed name of person attesting for Offeror

President and CEO
Title of person attesting for Offeror



Signature of person attesting for Offeror

02/23/2022
Date

[END OF RESPONSE]

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. "Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge

employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraph D(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: Magnolia Health Plan, Inc.				
Line 1 (Street Name and Number): 111 East Capitol Street				
Address Line 2 (Suite, Room, etc.): Suite 500				
City: Jackson	State: MS	Zip Code: 39201	County: Hinds	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

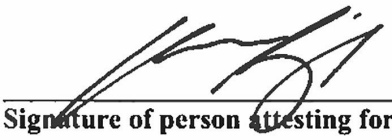
[ ] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Magnolia Health Plan, Inc.
Name of Offeror

Aaron Sisk
Printed name of person attesting for Offeror

President and CEO
Title of person attesting for Offeror


Signature of person attesting for Offeror

02/23/2022
Date

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge

employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraph D(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: Centene Management Company, LLC				
Line 1 (Street Name and Number): 7700 Forsyth Blvd.				
Address Line 2 (Suite, Room, etc.): N/A				
City: St. Louis	State: MO	Zip Code: 63105	County: St. Louis County	
Mailing Address (P.O. Box): N/A	City: N/A	State: N/A	Zip Code: N/A	County: N/A

[ ] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Centene Management Company LLC
Name of Offeror

Christopher A. Koster
Printed name of person attesting for Offeror

Secretary
Title of person attesting for Offeror

Christopher A. Koster
Christopher A. Koster (Feb 24, 2022 08:05 CST)
Signature of person attesting for Offeror

2/24/2022
Date

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge

employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraph D(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: Envolve Dental, Inc.				
Line 1 (Street Name and Number): 8715 Henderson Road				
Address Line 2 (Suite, Room, etc.): Ren 4				
City: Tampa	State: FL	Zip Code: 33634	County: Hillsborough	
Mailing Address (P.O. Box): 8735 Henderson Road, Ren 2	City: Tampa	State: FL	Zip Code: 33634	County: Hillsborough

[ ] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Envolve Dental, Inc.
Name of Offeror

Marlo Williams
Printed name of person attesting for Offeror

VP, Regulatory Affairs
Title of person attesting for Offeror

Marlo Williams
Signature of person attesting for Offeror

2/7/2022
Date

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

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3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge

employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraph D(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: Envolve Vision, Inc.				
Line 1 (Street Name and Number): 1151 Falls Road				
Address Line 2 (Suite, Room, etc.): Suite 2000				
City: Rocky Mount	State: NC	Zip Code: 27804	County: Nash	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

[ ] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Envolve Vision, Inc.
Name of Offeror

Marlo Williams
Printed name of person attesting for Offeror

VP, Regulatory Affairs
Title of person attesting for Offeror

Marlo Williams
Signature of person attesting for Offeror

2/7/2022
Date

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. "Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge

employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

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(1) The dangers of drug abuse in the workplace;

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(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

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G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: Dallas Printing				
Line 1 (Street Name and Number): 315 Carrier Blvd.				
Address Line 2 (Suite, Room, etc.):				
City: Richland		State: MS	Zip Code: 39218	County: Rankin
Mailing Address (P.O. Box): P.O. Box 902	City: Jackson	State: MS	Zip Code: 39205	County: Hinds

[ ] Check if there are workplaces on file that are not identified here.

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Dallas Printing, Inc.
Name of Offeror

David Dallas
Printed name of person attesting for Offeror

Owner
Title of person attesting for Offeror

Signature of person attesting for Offeror

2/2/22
Date

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

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3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. "Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge

employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

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(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

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G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: **All Magellan Health Facilities**				
Line 1 (Street Name and Number):				
Address Line 2 (Suite, Room, etc.):				
City:	State:	Zip Code:	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

[ ] Check if there are workplaces on file that are not identified here.

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National Imaging Associates
Name of Offeror

Theresa Walton
Printed name of person attesting for Offeror

Dir, Employee Engagement Programs & Planning
Title of person attesting for Offeror

Theresa Walton
Signature of person attesting for Offeror

2/9/22
Date

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

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    c. “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;
    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who

are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

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B. Establishing an ongoing drug-free awareness program to inform employees about:
   (1) The dangers of drug abuse in the workplace;
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C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:
   (1) Abide by the terms of the statement; and
   (2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

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   (2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: NCH Management Systems, Inc.				
Line 1 (Street Name and Number): 675 Placentia Avenue				
Address Line 2 (Suite, Room, etc.): Suite 300				
City: Brea	State: CA	Zip Code: 92821	County: Orange	
Mailing Address (P.O. Box): 675 Placentia Avenue	City: Brea	State: CA	Zip Code: 92821	County: Orange

[ ] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

NCH Management Systems, Inc .
Name of Offeror

Scott Pritchard
Printed name of person attesting for Offeror

President
Title of person attesting for Offeror

Scott Pritchard
Signature of person attesting for Offeror

1/28/2022
Date

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraph D(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: See Location Attachment below				
Line 1 (Street Name and Number):				
Address Line 2 (Suite, Room, etc.):				
City:	State:	Zip Code:	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

[ ] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Vigilant Health
Name of Offeror

David Coppeans
Printed name of person attesting for Offeror

Chief Operating Officer
Title of person attesting for Offeror

David Coppeans
Signature of person attesting for Offeror

1/24/2022
Date

Place of Performance				
Name of Location: Biloxi - Vigilant Health Diabetes Care Memorial Physician Clinics at Medical Park Drive				
Line 1 (Street Name and Number): 1759 Medical Park Drive				
Address Line 2 (Suite, Room, etc.): Suite A				
City: Biloxi	State: MS	Zip Code: 39502	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Clarksdale - Vigilant Health Diabetes Care				
Line 1 (Street Name and Number): 580 Friars Point Road				
Address Line 2 (Suite, Room, etc.):				
City: Clarksdale	State: MS	Zip Code: 38614	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Flowood - Vigilant Health Diabetes Care Professional Center				
Line 1 (Street Name and Number): 1040 River Oaks Drive				
Address Line 2 (Suite, Room, etc.): Suite 302				
City: Flowood	State: MS	Zip Code: 39232	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Greenville - Vigilant Health Diabetes Care				
Line 1 (Street Name and Number): 1997 Medical Park Drive				
Address Line 2 (Suite, Room, etc.):				
City: Greenville	State: MS	Zip Code: 38703	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Hattiesburg - Vigilant Health Diabetes Care - Inside Southern Medical Care				
Line 1 (Street Name and Number): 6600 US Hwy 98, Suite B				
Address Line 2 (Suite, Room, etc.): Suite B				
City: Hattiesburg	State: MS	Zip Code: 39402	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Inadianola - Vigilant Health Diabetes Care- inside Delta Surgical Clinic				
Line 1 (Street Name and Number): 110 E. Baker Street				
Address Line 2 (Suite, Room, etc.): Suite A				
City: Indianola	State: MS	Zip Code: 38751	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Jackson - Vigilant Health Diabetes Care Professional Center				
Line 1 (Street Name and Number): 1806 Chadwick				
Address Line 2 (Suite, Room, etc.): Suite 104				
City: Jackson	State: MS	Zip Code: 39204	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Laurel - Vigilant Health Diabetes Care				
Line 1 (Street Name and Number): 1104 W. First Street				
Address Line 2 (Suite, Room, etc.): Suite 4				
City: Laurel	State: MS	Zip Code: 39440	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

Place of Performance				
Name of Location: Vicksburg - Vigilant Health Diabetes Care				
Line 1 (Street Name and Number): One Medical Plaza Drive				
Address Line 2 (Suite, Room, etc.):				
City: Vicksburg	State: MS	Zip Code: 39180	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge

employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraph D(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location: MTM Mississippi Office				
Line 1 (Street Name and Number): 6360 I-55 N				
Address Line 2 (Suite, Room, etc.): Suite 201				
City: Jackson	State: MS	Zip Code: 39211	County: Hinds	
Mailing Address (P.O. Box): Same as above	City:	State:	Zip Code:	County:

[ ] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

Medical Transportation Management, Inc. (MTM)
Name of Offeror

Alaina Maciá
Printed name of person attesting for Offeror

President and CEO
Title of person attesting for Offeror

Alaina Maciá
Signature of person attesting for Offeror

2/9/2022
Date

[END OF RESPONSE]

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below)·

Place of Performance				
Name of Location: TurningPoint Healthcare Solutions, LLC				
Line 1 (Street Name and Number): 1000 Primera Boulevard				
Address Line 2 (Suite, Room, etc.): Suite 3160				
City: Lake Mary	State: FL	Zip Code: 32746	County: Seminole	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

I I Check if there are workplaces on me that are not identined here.

->NOTE: Sections 76.630(c) and (d){2) and 76.63S(a){l) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

TurningPoint Healthcare Solutions, LLC
Name of Offeror

Eric Pezzi
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror

Signature of person attesting for Offeror

3/2/2022
Date

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

1. The prospective primary participant certifies to the best of its knowledge and belief that it and its principals:

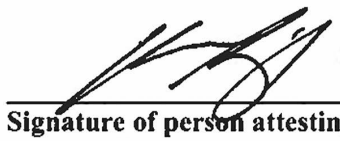
    a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
    b. Have not within a three-year period preceding this qualification been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    c. Are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and
    d. Have not within a three-year period preceding this qualification had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this qualification.

Magnolia Health Plan, Inc.
Name of Offeror

Aaron Sisk
Printed name of person attesting for Offeror

President and CEO
Title of person attesting for Offeror



Signature of person attesting for Offeror

02/23/2022
Date

[END OF RESPONSE]

END OF DOCUMENT

Attachment 4.1.3

Magnolia Health Plan, Inc.'s

Insurance License from Mississippi Insurance Department (MID)

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MISSISSIPPI
CERTIFICATE OF AUTHORITY

I, THE UNDERSIGNED COMMISSIONER OF INSURANCE, OF THE STATE OF MISSISSIPPI, DO HEREBY CERTIFY THAT

MAGNOLIA HEALTH PLAN INC.
111 EAST CAPITOL STREET
SUITE 500
JACKSON, MS 39201

LICENSE NUMBER: 1000006

HAS COMPLIED WITH ALL THE REQUIREMENTS OF THE LAWS OF THIS STATE APPLICABLE TO SAID COMPANY AND IS AUTHORIZED TO TRANSACT THE BUSINESS OF:

HEALTH MAINTENANCE ORGANIZATION

IN ACCORDANCE WITH THE LAWS THEREOF UNTIL: **12/31/2022**

MIKE CHANEY
COMMISSIONER OF INSURANCE

Attachment 4.1.14

Amendments to the RFQ issued by the Division

Signed by Magnolia Health Plan, Inc.

magnolia health™

Amendment #1 to RFQ 20211210: Section 5 – Enterprise Security Policy – Issued January 21, 2022

This Amendment must be signed and submitted as a part of any proposal to be considered for this procurement. The following section of RFP #20211210 is amended to correct Section 5: Authority, References, and Disclaimers in reference to accessing the State of Mississippi's Enterprise Security Policy to read as follows, with removed text stricken through and replacement text added in **RED**:

~~The Enterprise Security Policy is available to third parties on a need-to-know basis and requires the execution of a non-disclosure agreement with the Department of Informatiosn Technology Services (ITS) prior to accessing the policy. The Offeror or Contractor may request individual sections of the Enterprise Security Policy or request the entire document by contacting the Office of Procurement.~~

~~Instructions to acquire a copy of the Enterprise Security Policy can be found at the following link: http://www.its.ms.gov/Services/Pages/ENTERPRISE-SECURITY-POLICY.aspx~~

The Enterprise Security Policy can be found at the following link:
https://www.sos.ms.gov/adminsearch/ACProposed/00020006b.pdf

Receipt of Amendment Acknowledged:

(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

Amendment #2 to RFQ 20211210: RFQ Mandatory Pre-Qualification Question and Answer Document – Issued January 21, 2022

Question #	RFQ Section #	RFQ Page #	Question	DOM Response
1	N/A	N/A	In the mandatory Pre-Qualification Conference, the Division stated that "No branding may be included in any part of the proposal." Can the Division please clarify what is considered branding (logos, colors, etc.) and confirm that this requirement applies across the entire proposal including both the Technical (unmarked) and Management (marked) components?	"Branding" includes company colors, logos, or other symbols or designs adopted by an organization to identify itself, its products, or its corporate parents or siblings. Branding must not appear in the Offeror's Technical (unmarked) proposal. Branding may appear in the Offeror's Management (marked) proposal. However, the Offeror must still use black, Times New Roman 12 pt. font for responses, and black, Times New Roman font no smaller than 9 pt. for any tables, graphics, charts, figures, footnotes, and headers/footers.
2	N/A	N/A	The Clarification of Formatting Requirements slide at the Mandatory Pre-Qualification Conference indicated that "no branding may be included in any part of the proposal." Can the Division please confirm if this is meant to include the marked section of the proposal or if this is only referring to the unmarked submission? If this requirement is inclusive of the marked section, can the Division please expand on what is included under "branding?"	"Branding" includes company colors, logos, or other symbols or designs adopted by an organization to identify itself, its products, or its corporate parents or siblings. Branding must not appear in the Offeror's Technical (unmarked) proposal. Branding may appear in the Offeror's Management (marked) proposal. However, the Offeror must still use black, Times New Roman 12 pt. font for responses, and black, Times New Roman font no smaller than 9 pt. for any tables, graphics, charts, figures, footnotes, and headers/footers.

Receipt of Amendment #2 Acknowledged:

Printed Name: Aaron Sisk

Signature: 

Title: President and CEO

Company: Magnolia Health Plan, Inc.

Amendment #3 to RFQ 20211210: RFQ Appendices D, E, F, G, and H in Word Format – Issued January 21, 2022

Provided herein are Microsoft Word versions of the following Appendices included with RFQ 20211210:

- APPENDIX D: Certifications
- APPENDIX E: Innovation and Commitment
- APPENDIX F: Corporate Background and Experience
- APPENDIX G: Ownership and Financial Disclosure Information
- APPENDIX H: Organization and Staffing

Additionally, the following typographical errors were corrected in the following documents included in this Amendment:

Appendix E
Text in 4.2.3.6: Health Literacy Campaigns has been altered in the following manner, with removed text stricken through and replacement text added in **RED**:

Use the Health Literacy Campaign: Summary Chart on the following page for each ~~PIP~~ Campaign the Offeror is including in its response to this section. The Offeror must include four (4) Health Literacy Campaigns in its response.

Appendix F
Text in the header for 4.3.1.2: Corporate Experience has been altered in the following manner, with removed text stricken through and replacement text added in **RED**:

4.3.1.~~1~~2:Corporate Experience

Appendix H
The form included 4.3.3.5 Subcontractors entitled **Prior Experiences with Subcontractor** has been updated to remove one of the fields requesting Geographic and population coverage requirements. Duplication of this field was an error.

Receipt of Amendment Acknowledged:

(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

APPENDIX D: Certifications

The forms in this Appendix must be used by the Offeror to provide the following Certifications. The Offeror must also include a statement in its Transmittal Letter stating that each have been executed. These Certifications should be included after the last page of the Offeror's Transmittal Letter.

- Certifications and Assurances Regarding Contingent Fees and Gratuities
  - Representation Regarding Contingent Fees
  - Representation Regarding Gratuities
  - Prospective Contractor's Representation Regarding Contingent Fees
- DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals
- DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Certifications and Assurances Regarding Contingency Fees and Gratuities

Instructions: Mark the applicable word for each certification provided below. Failure to mark the applicable word or words and/or to sign the qualification form may result in the qualification being rejected as nonresponsive. Modifications or additions to any portion of this qualification document may be cause for rejection of the qualification.

Certifications:
I/We make the following certifications and assurances as a required element of the qualification to which it is attached, of the understanding that the truthfulness of the facts affirmed here and the continued compliance with these requirements are conditions precedent to the award or continuation of the related contract(s) by circling the applicable word or words in each paragraph below:

1. Representation Regarding Contingent Fees

The Offeror represents that it [ ] **has [ ] has not** retained a person to solicit or secure a state contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except as disclosed in Contractor's qualification.

2. Representation Regarding Gratuities

The Offeror represents that it [ ] **has [ ] has not** violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Public Procurement Review Board Rules and Regulations.

3. Prospective Contractor's Representation Regarding Contingent Fees

The prospective Contractor (Offeror) represents as a part of such Contractor's qualification that such Contractor [ ] **has [ ] has not** retained any person or agency on a percentage, commission, or other contingent arrangement to secure this contract.

_____
Name of Offeror

_____	_____
Printed name of person attesting for Offeror	**Title of person attesting for Offeror**
_____	_____
Signature of person attesting for Offeror	**Date**

[END OF RESPONSE]

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).

4) If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

    a. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

    b. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

    c. “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

    d. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge

employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) the grantee's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

E. Notifying the Division in writing, within ten calendar days after receiving notice under paragraph D(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

F. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

Place of Performance				
Name of Location:				
Line 1 (Street Name and Number):				
Address Line 2 (Suite, Room, etc.):				
City:	State:	Zip Code:	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

[ ] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

_____

Name of Offeror

_____ _____

Printed name of person attesting for Offeror **Title of person attesting for Offeror**

_____ _____

Signature of person attesting for Offeror **Date**

[END OF RESPONSE]

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

Primary Covered Transactions
45 CFR Part 76,

1. The prospective primary participant certifies to the best of its knowledge and belief that it and its principals:

    a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
    b. Have not within a three-year period preceding this qualification been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    c. Are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and
    d. Have not within a three-year period preceding this qualification had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this qualification.

_____
Name of Offeror

_____ _____
Printed name of person attesting for Offeror **Title of person attesting for Offeror**

_____ _____
Signature of person attesting for Offeror **Date**

[END OF RESPONSE]

APPENDIX E: Innovation and Commitment

The forms in this Appendix must be used by the Offeror to respond (either in whole or in part, depending on the instructions in the RFQ) to the following:

- 4.2.3.3: Social Determinants of Health (SDOH) (Unmarked): 20 points available
- 4.2.3.4: Value Added Benefits (Value-Adds) (Unmarked): 10 points available
- 4.2.3.5: Performance Improvement Projects (Unmarked): 10 points available
- 4.2.3.6: Health Literacy Campaigns (Unmarked): 10 points available
- 4.3.2.9: Potential Partnerships (Unmarked): 10 points available

The Offeror must respond to all other portions of the Innovation and Commitment section of the RFQ in the manner and format stated therein. Answers should be presented in the Offeror's qualification in the order and format indicated within the RFQ.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

4.2.3.3: Social Determinants of Health (SDOH) (Unmarked): 20 points available

If additional and/or dedicated staff will be required to execute the Offeror's SDOH proposal, use the chart on the following page to provide that information.

If no additional/dedicated staff will be required to execute the Offeror's SDOH proposal, indicate that by marking the below and submitting this page at the end of the Offeror's SDOH proposal. **This page will not count against the Offeror's SDOH proposal page limit.**

[ ] The Offeror does not expect to require additional and/or dedicated staff to execute its SDOH proposal.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

<table>
<tr><th colspan="2">Social Determinants of Health: Staffing</th></tr>
<tr><td colspan="2">Title of Position:</td></tr>
<tr><td colspan="2">SDOH Component to which Position will be Linked:</td></tr>
<tr><td colspan="2">Description of Position:</td></tr>
<tr><td colspan="2">Number of Staff Expected to Fill this Position/Staffing Need:</td></tr>
<tr><td>Employee(s) filling this position would be:
[ ] Hourly [ ] Salaried</td><td>Employee(s) filling this position would be:
[ ] Full-Time [ ] Part-Time</td></tr>
<tr><td>Expected Wage of Position (Hourly rate or salary):</td><td>Expected Location of Employee:
[ ] Mississippi [ ] Out-of-State</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Title of Position:</td></tr>
<tr><td colspan="2">SDOH Component to which Position will be Linked:</td></tr>
<tr><td colspan="2">Description of Position:</td></tr>
<tr><td colspan="2">Number of Staff Expected to Fill this Position/Staffing Need:</td></tr>
<tr><td>Employee(s) filling this position would be:
[ ] Hourly [ ] Salaried</td><td>Employee(s) filling this position would be:
[ ] Full-Time [ ] Part-Time</td></tr>
<tr><td>Expected Wage of Position (Hourly rate or salary):</td><td>Expected Location of Employee:
[ ] Mississippi [ ] Out-of-State</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Title of Position:</td></tr>
<tr><td colspan="2">SDOH Component to which Position will be Linked:</td></tr>
<tr><td colspan="2">Description of Position:</td></tr>
<tr><td colspan="2">Number of Staff Expected to Fill this Position/Staffing Need:</td></tr>
<tr><td>Employee(s) filling this position would be:
[ ] Hourly [ ] Salaried</td><td>Employee(s) filling this position would be:
[ ] Full-Time [ ] Part-Time</td></tr>
<tr><td>Expected Wage of Position (Hourly rate or salary):</td><td>Expected Location of Employee:
[ ] Mississippi [ ] Out-of-State</td></tr>
<tr><td colspan="2"></td></tr>
</table>

4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked): 10 points available

The Division has provided on the following page a curated set of Value-Added Benefits in which it is interested for the Offeror to review. The Offeror may choose to use any of these Value-Adds as part of its proposal or choose to use none.

Use the Proposed Value-Added Benefit: Summary Chart for each Value-Add the Offeror is including in its response to this section.

If additional and/or dedicated staff will be required to execute a Value-Add, use the Value-Added Benefit: Staffing Chart to provide that information.

If no additional/dedicated staff will be required to execute any of the Offeror's Value-Adds, indicate that by marking the below and submitting this page at the end of the Offeror's Value-Adds proposal.

[ ] The Offeror does not expect to require additional and/or dedicated staff to execute any of its proposed Value-Adds.

If the Offeror has chosen not to offer any Value-Adds in its qualification, indicate that below, and submit this page as the Offeror's response to this request.

[ ] The Offeror is not including Value-Adds as part of its qualification response.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Division-Curated Value-Adds for CCO Contract

The Division has compiled a list of desired Value-Adds for this procurement. If an Offeror chooses to include value-added services in its qualification, the Offeror may choose from this list, propose their own original value-added services, or include a combination of both. To the extent that some or all of the desired value-added services may be covered through the offeror's Care Management strategy, that should be made evident in the Offeror's Care Management answers in its qualification.

Perinatal

1. Full sponsorship, including any materials, fees, transportation, and childcare for Members, and support for providers, of the Centering Pregnancy Model and/or prenatal classes for pregnant members.
2. CPR and Parenting classes for parents/caregivers
3. Dental preventative care during pregnancy and postpartum
4. Wound care management or home health nursing in postpartum for cesarean sections and slow-healing vaginal lacerations

Expanded Services

1. Hearing aids for members over 21
2. Vision benefits for members over 21
3. In-home respite services
4. Home modifications and/or environmental adaptations
5. Over-the-counter (OTC) monthly allowance for non-prescription/commonly used OTC and hygiene items
6. Enhanced dental services

Social Determinants of Health

1. Nutrition Assistance, including but not limited to additional nutrition resources for Members (even those who receive SNAP and/or WIC benefits) and education and training for Members regarding nutritious foods and food preparation
2. Utility payment assistance
3. Pest Control/Bed Bug home treatment
4. Education and employment supports, including but not limited to paying for GED classes, supporting pregnant minors in pursuit of high school diploma, paying for skills training, and supplying Members with a computer and internet in the home

Children

1. A monthly supply of diapers and baby wipes for children until they are potty trained
2. Car seats and booster seats for children, including ensuring that parents/caregivers receive proper installation training
3. Childcare of a Member's sibling(s) during a Well Child or EPSDT visit

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Proposed Value-Added Benefit: Summary Chart	
Benefit Name:	
Target Beneficiary Population(s):	
Benefit description, including any limitations and prior authorization requirements:	
Projected utilization in year one (total units):	**Price per unit:**
Gross value:	**Offsetting costs (provide amount and basis for estimate):**
Net Value (gross value minus offsetting costs):	**Will a staffing investment be made for this Value-Add? [ ] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Staffing	
Title of Position:	
Value-Add to which Position will be Linked:	
Description of Position:	
Number of Staff Expected to Fill this Position/Staffing Need:	
Employee(s) filling this position would be: **[ ] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[ ] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary):	**Expected Location of Employee:** **[ ] Mississippi [ ] Out-of-State**

4.2.3.5: Performance Improvement Projects (Unmarked): 10 points available

Use the Performance Improvement Project (PIP): Summary Chart on the following page for each PIP the Offeror is including in its response to this section. The Offeror must include four (4) PIP proposals in its response.

If additional and/or dedicated staff will be required to execute a PIP, use the Performance Improvement Project (PIP): Staffing Chart to provide that information.

If no additional/dedicated staff will be required to execute any of the Offeror's PIPs, indicate that by marking the below and submitting this page at the end of the Offeror's PIP proposal.

[ ] The Offeror does not expect to require additional and/or dedicated staff to execute any of its proposed PIPs.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Performance Improvement Project (PIP): Summary Chart
PIP Title:
Target Beneficiary Population(s):
Overview of PIP Strategy and Goals:
Reason for choosing this PIP:
Tools for measuring impact:
Will a staffing investment be made for this PIP? [ ] Yes [ ] No **If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.**

Performance Improvement Project: Staffing	
Title of Position:	
PIP to which Position will be Linked:	
Description of Position:	
Number of Staff Expected to Fill this Position/Staffing Need:	
Employee(s) filling this position would be: **[ ] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[ ] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary):	**Expected Location of Employee:** **[ ] Mississippi [ ] Out-of-State**

4.2.3.6: Health Literacy Campaigns (Unmarked): 10 points available

Use the Health Literacy Campaign: Summary Chart on the following page for each Campaign the Offeror is including in its response to this section. The Offeror must include four (4) Health Literacy Campaigns in its response.

If additional and/or dedicated staff will be required to execute a Health Literacy Campaign, use the Health Literacy Campaign: Staffing Chart to provide that information.

If no additional/dedicated staff will be required to execute any of the Offeror's proposed Health Literacy Campaigns, indicate that by marking the below and submitting this page at the end of the Offeror's Health Literacy Campaign proposal.

[ ] The Offeror does not expect to require additional and/or dedicated staff to execute any of its proposed Health Literacy Campaigns.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Health Literacy Campaign: Summary Chart
Campaign Title:
Target Beneficiary Population(s):
Overview of Campaign Strategy and Goals:
Reason for choosing this Campaign:
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.):
Tools for measuring engagement:
Tools for measuring impact:
Will a staffing investment be made for this Campaign? [ ] Yes [ ] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

Health Literacy Campaign: Staffing	
Title of Position:	
Campaign to which Position will be Linked:	
Description of Position:	
Number of Staff Expected to Fill this Position/Staffing Need:	
Employee(s) filling this position would be: **[ ] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[ ] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary):	**Expected Location of Employee:** **[ ] Mississippi [ ] Out-of-State**

4.2.3.9: Potential Partnerships (Unmarked): 10 points available

Use the Potential Partnerships: Summary Chart on the following page for each Potential Partnership the Offeror is including in its response to this section. The Offeror must include four (4) potential partnerships its response.

Additionally, use the Care Management Potential Partnership: Summary Chart for each Care Management Potential Partnership the Offeror is including in its response to this section. The Offeror must include four (4) potential partnerships its response.

The Offeror may not duplicate potential partners in answering either part of the section.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Potential Partnership: Summary Chart	
Name of Organization:	**Type of Organization (community-based organization or government):**
Goal of partnership:	
Expected financial commitment to project/partnership:	
Scale of project (local, statewide):	**Population(s) targeted by the partnership:**

Care Management Potential Partnerships: Summary Chart	
Name of Organization:	**Type of Organization (community-based organization or government):**
Type of Referral(s) to be sent to this partner:	
Population target(s) for referral to this partner:	

APPENDIX F: Corporate Background and Experience

The forms in this Appendix must be used by the Offeror to respond (either in whole or in part, depending on the instructions in the RFQ) to the following:

- 4.3.1.1 Corporate Background
- 4.3.1.2 Corporate Experience

[REST OF PAGE INTENTIONALLY LEFT BLANK]

4.3.1.1: Corporate Background

The Offeror must use the form provided on the next page to detail its corporate background, as required by 4.3.1.2.2, Corporate Background.

Responses to 4.3.1.1.2, Corporate Resources must be provided as described in the RFQ.

[REST OF PAGE INTENTNIONALLY LEFT BLANK]

Biographical Information				
General Background Information				
Date Business was Established:				
Legal Business Name as Reported to the Internal Revenue Service:				
Doing Business As Name (if applicable):	**Tax Identification Number (required):**			
Ownership Type (public company, partnership, subsidiary, etc.):				
Number of Personnel Currently Engaged in Operations:	**Total Number of Employees:**			
Professional accreditations pertinent to the services provided by this RFQ:				
Location of the Principal Place of Business				
Address Line 1 (Street Name and Number):				
Address Line 2 (Suite, Room, etc.):				
City:	**State:**	**Zip Code:**	**County:**	
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Location of place of performance of the proposed Contract				
Address Line 1:				
Address Line 2:				
City:	**State:**	**Zip Code:**	**County:**	
Contractual Termination				
Has the Offeror been a party to any contractual termination within the past five (5) years? [ ] Yes [ ] No **If yes, attach a narrative explanation for each termination including date, market, population covered, circumstances of termination, and contact information for the state entity that was party to the contract.**				

[REST OF PAGE INTENTIONALLY LEFT BLANK]

4.3.1.2: Corporate Experience

Use the following form to provide information for any states that the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.

If the Offeror has no current or recent clients, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support information provided. Acceptance of the explanation provided is at the discretion of the Division.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Corporate Experience: Current and/or Recent Client				
Client's Name:				
Client Location				
Address Line 1:				
Address Line 2:				
City:	**State:**	**Zip Code:**	**County:**	
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name:				
Title:				
Phone Number:	**Email Address:**			
Work Details				
Number of covered lives:				
Time period of contract:				
Total number of staff hours expended during time period of contract:				
Personnel requirements:				
Geographic and population coverage requirements:				
Geographic and population coverage requirements:				
Publicly funded contract cost:				
Description of work performed under this contract				

APPENDIX G: Ownership and Financial Disclosure Information

The forms in this Appendix must be used by the Offeror to respond to the listed RFQ sections:

- 4.3.2.1 Information to Be Disclosed
- 4.3.2.2 When and to Whom Information Will Be Disclosed
- 4.3.2.3 Information Related to Business Transactions
- 4.3.2.4 Change of Ownership
- 4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense

For 4.3.2.6 Audited Financial Statements and Pro Forma Financial Template:

- The Offeror must respond in the manner and format stated within that section of the RFQ.
- The pro forma financial template may be found at the Division's dedicated Coordinated Care Procurement website: https://medicaid.ms.gov/coordinated-care-procurement/. The Offeror must complete the designated fields of the Excel workbook and submit as attachment to the Offeror's Qualification.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Response to 4.3.2.1 Information to Be Disclosed (Marked) – Pass/Fail

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

1. The name and address of any individual or corporation with an ownership or control interest in the Offeror. The address for corporate entities shall include as applicable primary business, every business location, and P.O. Box address;
2. Date of birth and Social Security Number (in the case of an individual);
3. Other tax identification number (in the case of a corporation) with an ownership or control interest in the Offeror or in any subcontractor in which the Offeror has a five percent (5%) or more interest;
4. Whether the individual or corporation with an ownership or control interest in the Offeror is related to another person with ownership or control interest in the Offeror as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or control interest in any subcontractor in which the Offeror 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;
5. The name of any other managed care entity in which an owner of the Offeror has an ownership or control interest; and,
6. The name, address, date of birth, and Social Security Number of any managing employee of the Offeror.

Full disclosure through use of the following forms meets the requirements of completion of this section.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Section 1: Ownership Interest and/or Managing Control Identification Information

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification				
This response applies to an entity with: [ ] Managing Control [ ] 5% or More Ownership Interest (percentage owned: _____%)				
Effective Date of Ownership:				
Legal Business Name as Reported to the Internal Revenue Service:				
Doing Business As Name (if applicable):		Tax Identification Number (required):		
Primary Business Address				
Line 1 (Street Name and Number):				
Address Line 2 (Suite, Room, etc.):				
City:	State:	Zip Code:	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:
Business Location				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
Last Name	First Name	MI	Suffix
Title	Social Security Number (required)	Date of Birth (MM/DD/YYYY)	Gender (M/F)
Home Address Line 1			
Address Line 2			
City	State	Zip Code	County
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner _____	[ ] Partner		
Effective Date (MM/DD/YYYY):			
Ownership Percentage _____%			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date (MM/DD/YYYY		Effective Date (MM/DD/YYYY
[ ] Director/Officer		[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official	[ ] Delegated Official		
Effective Date (MM/DD/YYYY):			

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Section 1(c): Familial Relationships		
Are any individuals listed in Section 1 related to each other as a spouse, parent, child, or sibling? **[ ] Yes [ ] No** If yes, provide additional information below. Duplicate this page as necessary to provide a complete disclosure.		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		

Section 2: Disclosure of Subcontractor Information

Disclosure of Subcontractor Information				
Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5% ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure.				
This response applies to: [ ] The Offeror [ ] An Owner of the Offeror				
If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above):				
The person or entity named as an: [ ] Ownership Interest [ ] Management Control Interest				
If there is an ownership interest, what is the ownership percentage? _____%				
If there is a management control interest, describe that interest:				
Effective Date of Ownership and/or Management Control:				
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service:				
Doing Business As Name (if applicable):	Tax Identification Number (required):			
Primary Business Address				
Line 1 (Street Name and Number):				
Address Line 2 (Suite, Room, etc.):				
City:	State:	Zip Code:	County:	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:
Additional Business Location(s): Duplicate this page to provide all locations if necessary.				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	
Business Location				
Address Line 1:				
Address Line 2:				
City:	State:	Zip Code:	County:	

Disclosure of Subcontractor Information (cont.)		
Are any individuals disclosed in Section 1 or 2 related to the subcontractor or an owner of the subcontractor as a spouse, parent, child, or sibling? [ ] Yes [ ] No **If yes, provide the following information for each.**		
Name of Subcontractor/ Subcontractor's Owner	**Name of Offeror's Owner**	**Relationship**

Section 3: Other Disclosing Entities

Ownership Interests in the Division's Fiscal Agent, Another Managed Care Entity, or other Disclosing Entity under 42 C.F.R § 104(b)			
Do any of the entities or individuals named in Sections 1.a or 1.b have an ownership and/or management control interest in the Division's Fiscal Agent? [ ] Yes [ ] No Do any of the entities or individuals named in Sections 1.a or 1.b have an ownership and/or management control interest in Another Managed Care Entity? [ ] Yes [ ] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [ ] No If yes to any question above, provide additional information below:			
Name of entity/individual named in Section 1.a or 1.b	**Name of Entity in which the entity/individual has an interest**	**Describe the entity/individual's interest (Ownership or Management)**	**If the entity/individual is an owner, give the ownership percentage.**

Response to 4.3.2.2 When and to Whom Information Will Be Disclosed (Marked) – Pass/Fail

The Offeror attests to and affirms the following:

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

1. Upon the Contractor submitting a qualification in accordance with the State's procurement process;
2. Annually, including upon the execution, renewal, and extension of the contract with the State; and,
3. Within thirty-five (35) days after any change in ownership of the Contractor.

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

The Offeror attests that the disclosures made as part of this application are true and correct, and the Offeror will make required disclosures as necessary for this RFQ. If the Offeror is chosen as a Contractor, the Offeror will comply with all disclosure requirements.

_____
Name of Offeror

_____	_____
Printed name of person attesting for Offeror	**Title of person attesting for Offeror**
_____	_____
Signature of person attesting for Offeror	**Date**

[END OF RESPONSE]

Response to 4.3.2.3 Information Related to Business Transactions (Marked) – Pass/Fail

In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about:

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

2. Any significant business transactions between the Offeror 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.

The date of the request is the issue date of the RFQ.

If the Offeror has information responsive to this request, use the forms in the following pages of this Attachment to respond to this request.

If the Offeror does not have information responsive to one or both of these requests, attest to that by signing below and submitting this page as the response to this request. If the Offeror has information responsive to one of these requests and not the other, use the following attestation as applicable as well as the applicable form to respond.

The Offeror does not have:

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

[ ] Any significant business transactions between the Offeror 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.

_____

Name of Offeror

_____ _____

Printed name of person attesting for Offeror **Title of person attesting for Offeror**

_____ _____

Signature of person attesting for Offeror **Date**

Business Transactions with Subcontractors	
Disclose The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request. Use additional pages as necessary.	
Name of Subcontractor:	**TIN/SSN (as applicable):**
Address of Subcontractor:	
Date of Transaction:	**Amount of Transaction:**
Name of Subcontractor:	**TIN/SSN (as applicable):**
Address of Subcontractor:	
Date of Transaction:	**Amount of Transaction:**
Name of Subcontractor:	**TIN/SSN (as applicable):**
Address of Subcontractor:	
Date of Transaction:	**Amount of Transaction:**
Name of Subcontractor:	**TIN/SSN (as applicable):**
Address of Subcontractor:	
Date of Transaction:	**Amount of Transaction:**
Name of Subcontractor:	**TIN/SSN (as applicable):**
Address of Subcontractor:	
Date of Transaction:	**Amount of Transaction:**

Significant Business Transactions	
Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.	
Name of Entity with Whom the Transaction Took Place:	
TIN/SSN (as applicable):	**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor:	
Date of Transaction:	**Amount of Transaction:**
Name of Entity with Whom the Transaction Took Place:	
TIN/SSN (as applicable):	**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor:	
Date of Transaction:	**Amount of Transaction:**
Name of Entity with Whom the Transaction Took Place:	
TIN/SSN (as applicable):	**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor:	
Date of Transaction:	**Amount of Transaction:**
Name of Entity with Whom the Transaction Took Place:	
TIN/SSN (as applicable):	**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor:	
Date of Transaction:	**Amount of Transaction:**

Response to 4.3.2.4 Change of Ownership (Marked) – Pass/Fail

If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract.

If the Offeror does not have a disclosure to make that is responsive to this request, the offeror must sign below, attesting to the following:

- The Offeror does not have a disclosure that is responsive to this request.
- Should the Offeror be chosen as a winning Contractor, the Offeror will comply with the requirement to disclose any and all changes of ownership in the time and manner required by the C.F.R. and the Division.

_____

Name of Offeror

_____	_____
Printed name of person attesting for Offeror	**Title of person attesting for Offeror**
_____	_____
Signature of person attesting for Offeror	**Date**

[END OF RESPONSE]

Response to 4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked) – Pass/Fail

If the Offeror has information responsive to this request, provide that information using the form on the following page. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose make disclosures regarding this issue during the life of the Contract.

If the Offeror does not have a disclosure to make that is responsive to this request, the offeror must sign below, attesting to the following:

- The Offeror does not have a disclosure that is responsive to this request.
- Should the Offeror be chosen as a winning Contractor, the Offeror will comply with the requirement to make disclosures regarding this issue in the time and manner required by the C.F.R. and the Division.

_____

Name of Offeror

_____	_____
Printed name of person attesting for Offeror	**Title of person attesting for Offeror**
_____	_____
Signature of person attesting for Offeror	**Date**

Criminal Convictions and Other Sanctions
Provide the requested information in this section for any person who: (1) Has an ownership or control interest in the Offeror OR is an agent or managing employee of the Offeror AND (2) Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Titles XIX or XXI services since the inception of those programs, OR (3) Has been convicted of a crime referenced in Miss. Code Ann. § 43-13-121(7)(c) – (h), (4) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c-h), (5) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program, (6) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program, (7) Has had his/her/its license or certification revoked, or (8) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.
Identify the person and each conviction/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Provide a copy of any documentation. Include additional copies of this page as necessary.

Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	

APPENDIX H: Organization and Staffing

The forms in this Appendix must be used by the Offeror to respond (either in whole or in part, depending on the instructions in the RFQ) to the following:

- 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked) – 20 points
- 4.3.3.3 Administrative Requirements (Marked) – 10 points
- 4.3.3.5 Subcontractors – 20 points
- 4.3.3.6 Economic Impact – 20 points

The Offeror must respond to all other portions of the Organization and Staffing portion of the RFQ in the manner and format stated therein. Answers should be presented in the Offeror's qualification in the order and format indicated within the RFQ.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked) – 20 points

Use the following form to provide job descriptions and responsibilities for each position included in Section 1.13, Administration Management, Facilities, and Resources, Appendix A, Draft Contract.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Key Position: Job Description
Title of Position:
Description of Position:
Description of Responsibilities of Position:
Minimum Experience Required:
Skills Required:
Are there any educational requirements for this position? **[ ] Yes [ ] No** **If yes, list below:**
Are any professional licenses or certifications required for this position? **[ ] Yes [ ] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [ ] No** **If yes, list below:**
Any additional information relevant to this position:

4.3.3.3 Administrative Requirements (Marked) – 10 points

Offeror attests to the following:

1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.

2. The Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives.

_____

Name of Offeror

_____ _____

Printed name of person attesting for Offeror **Title of person attesting for Offeror**

_____ _____

Signature of person attesting for Offeror **Date**

4.3.3.5 Subcontractors – 20 points

Use the first provided form entitled “Subcontractor” to describe the any subcontractor the Offeror plans to use if chosen as a winning Contractor through this RFQ.

If the Offeror has worked with the subcontractor in the past three (3) years on a managed care contract, use the second form, “Prior Experience with Subcontractor” to give details about that experience.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Subcontractor				
Name of Subcontractor:				
TIN/SSN (as applicable):		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary**		
Address Line 1:				
Address Line 2:				
City:	**State:**	**Zip Code:**		**County:**
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract:				
How will the Offeror monitor and manage this Subcontractor?				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [ ] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name:				
Client Location				
Address Line 1:				
Address Line 2:				
City:	**State:**	**Zip Code:**		**County:**
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name:				
Title:				
Phone Number:		**Email Address:**		
Work Details				
Number of covered lives:				
Time period of contract:				
Total number of staff hours expended during time period of contract:				
Personnel requirements:				
Geographic and population coverage requirements:				
Publicly funded contract cost:				
Description of work performed under this contract				

4.3.3.6 Economic Impact – 20 points

There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be located in Mississippi. Please provide the Offeror's expected wages for each of those positions.

Additionally, include a list of any other positions the Offeror will locate in Mississippi and include expected wages for each of those positions, as well as any other investment that the Offeror plans to make inside the state.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Economic Impact: Wage Chart	
Title of Position:	
If Position is not a Key Position, provide description:	
Number of Staff Expected to Fill this Position/Staffing Need:	**Expected Wage of Position (Hourly rate or salary):**
Employee(s) filling this position would be: **[ ] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[ ] Full-Time [ ] Part-Time**
Title of Position:	
If Position is not a Key Position, provide description:	
Number of Staff Expected to Fill this Position/Staffing Need:	**Expected Wage of Position (Hourly rate or salary):**
Employee(s) filling this position would be: **[ ] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[ ] Full-Time [ ] Part-Time**
Title of Position:	
If Position is not a Key Position, provide description:	
Number of Staff Expected to Fill this Position/Staffing Need:	**Expected Wage of Position (Hourly rate or salary):**
Employee(s) filling this position would be: **[ ] Hourly [ ] Salaried**	**Employee(s) filling this position would be:** **[ ] Full-Time [ ] Part-Time**

END OF DOCUMENT

MISSISSIPPI DIVISION OF MEDICAID

Amendment #4 to RFQ 20211210: RFQ Questions and Answers

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

This document contains all questions submitted by potential offerors by the RFQ Questions Deadline of January 7, 2022. The document is split into two parts:

1. RFQ-Specific Questions and Answers (Blue Table, 120 Questions)
2. Appendix A: Draft Contract-Specific Questions and Answers (Green Table, 56 Questions)

Three additional amendments will be referenced throughout this document that will be published the same day as this Amendment 4 (February 7, 2022):

- Amendment 5: RFQ Corrections and Clarifications
- Amendment 6: Appendix A: Draft Contract Corrections and Clarifications
- Amendment 7: Updates to Certain RFQ forms from Appendix F and H in Word Format
- Amendment 8: Additional MSCAN and CHIP Rate Information in Excel Format

Receipt of Amendment 4 Acknowledged:

(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

Question#	Section #	Page #	RFQ Question	DOM Response
1.	1.2	6	Can DOM provide an estimated Implementation Period start date in order to enable Offerors to submit the most accurate work plans with their RFQ responses?	The requirement to provide Work Plans and Schedules has been removed from the RFQ. (Corrected in Amendment 5.)
2.	1.2	6	Section 1.2 of the RFQ identifies that "information about the Contract operationalization date will be provided to winning Contractors." As the RFQ requires the submission of a detailed "Work Plan and Schedule" for numerous questions, inclusive of start and end dates, will the Division provide more detail on the assumed readiness period start and end dates, and the contract operationalization dates? If not, what date assumptions should Contractors use when preparing these deliverables?	The requirement to provide Work Plans and Schedules has been removed from the RFQ. (Corrected in Amendment 5.)
3.	1.2.3	8	Please clarify the maximum file size for each submission to the designated SharePoint site.	There is no minimum file size
4.	1.2.3	8	Will Electronic Signatures be accepted by the state?	Yes.
5.	1.2.3.2	8	Will font size smaller than 12 be accepted for headers/footers, captions, graphics, figures, tables, and footnotes?	Tables, graphics, charts, figures, footnotes, callouts, and headers/footers may contain font smaller than 12-point. The font may not be smaller than 9-point font. The font must be in black Times New Roman.
6.	1.2.3.2	8	Will DOM please confirm that tables, graphics, and charts can contain a legible font size smaller than 12 pt?	Tables, graphics, charts, figures, footnotes, callouts, and headers/footers may contain font smaller than 12-point. The font may not be smaller than 9-point font. The font must be in black Times New Roman.
7.	1.2.3.2	8	Will DOM please confirm that reiteration of the question will not count toward page limits?	Reiteration of the question will count towards page limits.
8.	1.2.3.2	8	Will DOM permit other than black font in the Marked/not blind responses?	The Offeror must use black, Times New Roman 12 pt. font for responses, and black, Times New Roman font no smaller than 9 pt. for any tables, graphics, charts, figures, footnotes, callouts, and headers/footers.

Question#	Section #	Page #	RFQ Question	DOM Response
9.	1.2.3.2	8	Will DOM allow for company colors and images in the Marked/not blinded responses?	The Offeror must use black, Times New Roman 12 pt. font for responses, and black, Times New Roman font no smaller than 9 pt. for any tables, graphics, charts, figures, footnotes, callouts, and headers/footers. The Offeror may otherwise use company images and company colors in the Marked/not blind responses.
10.	1.2.3.2	8	Do other elements such as tables, callouts, and graphics have to comply with the Times New Roman 12 pt. requirement?	Tables, graphics, charts, figures, footnotes, callouts, and headers/footers may contain font smaller than 12-point. The font may not be smaller than 9-point font. The font must be in black Times New Roman.
11.	1.2.3.2	8	Would the State prefer offerors paginate sections based on page limits to ensure responses are compliant? Using this model section 4.2.2.1 would be paginated 1-55, section 4.2.2.2 would start over at page 1 and continue through to page 45.	No.
12.	1.2.3.2	8	Section 1.2.3: Qualification Submission Requirements, Figure 1.2: Format of Qualification--Font & Margins states we are required to use black Times New Roman font size 12. Can the State please confirm the following: 1) Offerors may use font colors other than black to distinguish headings, emphasized text, and other specialized text within the narrative, so long as they are not colors that would disclose the bidding entity in the unmarked portion. 2) Offerors may use an easily readable, smaller font for exhibits, graphics, tables, callouts, and headers/footers.	1) No. Only black Times New Roman text should be used. 2) Tables, graphics, charts, figures, footnotes, callouts, and headers/footers may contain font smaller than 12-point. The font may not be smaller than 9-point font. The font must be in black Times New Roman.

Question#	Section #	Page #	RFQ Question	DOM Response
13.	1.2.3.2	8	Section 1.2.3: Qualification Submission Requirements, Figure 1.2: Format of Qualification--Font & Margins states that appendices, as well as samples and templates required of the qualification, must comply with font restrictions, which is black Times New Roman font size 12. Some requested items, such as sample reports, may output in a different font/font size than what is required by the State and cannot be changed. Will these documents be acceptable for submission?	No. The Offeror should reformat the document to conform with RFQ requirements.
14.	1.2.3.2	9	Can the State confirm offerors should include their name within the PDF file and cover page for the Technical Qualification?	Yes, the Offeror should include its name in the PDF file and cover page for the Technical Qualification. These elements will not be accessible by the Evaluation Committee and for the sake of the Office of Procurement's ability to properly organize files and keep records. The Offeror's name should not appear anywhere else in the Technical Qualification.
15.	1.2.3.2	8	Will DOM please confirm that Cover Pages may contain graphics, use a font other than black Times New Roman, and a larger font size than 12 pt?	Cover pages may be formatted however the Offeror desires. The Evaluation Committee will not have access to Cover Pages.
16.	1.2.3.2	10	Can the State clarify if the redacted copy should be submitted to the designated SharePoint site? If not submitted to the SharePoint site, how is the redacted copy to be submitted?	An Offeror's redacted copy should be submitted into the designated subfolder in the Offeror's SharePoint submission folder.
17.	1.2.3.2	10	If the Redacted copy is to be emailed, can the State please clarify if an Adobe cloud link will be accepted and if not is the offeror allowed to break the response into parts for proper submission?	The Reacted copy should not be emailed. An Offeror's redacted copy should be submitted into the designated subfolder in the Offeror's SharePoint submission folder.
18.	1.2.3.3.2	11	Regarding Section 1.2.3.3.2 Definition of Identifying information, can the Division please clarify if Offeror-specific branded or named programs or systems that the Division may be aware	Offeror-specific branded or named programs or systems of any kind would be identifying information, no matter the Offeror's perception of the Division's previous exposure and/or knowledge of them.

Question#	Section #	Page #	RFQ Question	DOM Response
			of based on prior interaction or communication would be considered identifying information?	
19.	1.2.3.3.2	11	Regarding Section 1.2.3.3.2 Definition of Identifying information, can the Division please confirm that Offerors may include awards or accomplishments within the unmarked components of their qualifications, even if the award is unique to the organization as long as the award or accomplishment is not discussed as being unique.	Offerors may not include reference to any awards in their unmarked/Technical responses.
20.	1.2.3.3.2	11	Regarding Section 1.2.3.3.2 Definition of Identifying information, in an effort to "describe our direct experience" requested throughout multiple components of the technical unmarked component, please confirm that Offerors may reference experience, including Offeror's parent company and affiliate companies' experience, outcomes, successes, and other relevant information to support solutions for Mississippi, as long as a specific State or Contract is not included in such justification.	The Offeror may respond in general terms to describe experience in service delivery and payment outside of the State of Mississippi. The Offeror must not indicate the geographical locations of the experience, including but not limited to naming the specific State or Contract with which the experience is related. The Offeror may include to the size of the market served. The Offeror may include the experience of parent and affiliate companies, but the Offeror must not use the names of those companies, as that would violate the rules against Identifying Information.
21.	1.2.3.3.2	11	1.2.3.3.2 states, "if the entity is unique in its function, i.e., the entity is the only or one of the only companies known to perform the function the Offeror is describing, the Offeror may not mention that fact." If the Offeror or a related entity has a characteristic that shows their experience and capacity to provide the service in order to address the experience requirement are they permitted to mention that fact? For example, having the largest foster care membership, holding a sole source foster care contract in another state, or years of experience building Medicaid provider networks.	The Offeror may respond in general terms to describe experience in service delivery and payment outside of the State of Mississippi. The Offeror must not indicate the geographical locations of the experience, including but not limited to naming the specific State or Contract with which the experience is related. The Offeror may include to the size of the market served. The Offeror may include the experience of parent and affiliate companies, but the Offeror must not use the names of those companies, as that would violate the rules against Identifying Information.

Question#	Section #	Page #	RFQ Question	DOM Response
22.	1.2.3.3.2	11	1.2.3.3.2 states, "if the entity is unique in its function, i.e., the entity is the only or one of the only companies known to perform the function the Offeror is describing, the Offeror may not mention that fact." Please provide additional clarification on "known to perform the function".	If the Offeror performs a function that only the Offeror performs, or only a few organizations in the Offeror's industry performs, the Offeror may state that it performs the function, but the Offeror may not state that the Offeror is the only or one of the few organizations that performs this function. This also applies to any organizations associated with the Offeror.
23.	1.2.3.3.2	11	Please confirm that incumbents cannot name staff members or cite known in-state programs, local experience, or local partners.	An Offeror, incumbent or otherwise, cannot name staff members, cite known in-state programs associated with that Offeror, identify local experience, or identify local partners and/or partnerships by name. An Offeror should name potential partnerships in 4.2.3.9, Potential Partnerships.
24.	1.2.3.3.2	11	Section 1.2.3.3.2 states, "the Division of Medicaid defines "any other information" as information including but not limited to names of parent or umbrella companies with which the Offeror is currently associated or has been associated with in prior State Medicaid contracts, the names of subsidiaries of the Offeror, the Offeror's company and parent company initials, initials of any of the Offeror's subsidiaries, listing(s) of current and past State Medicaid contracts including dates of service, current or past provider lists in the State of Mississippi." We are concerned that the disclosure of the nature of the organization, such as by referencing that you are a public-private partnership, provider-sponsored, or joint venture, could disclose the identity of the offeror. Please confirm that this information would also be considered identifying information.	The Offeror should not state whether it is a private corporation, publicly-traded corporation, public-private partnership, or make reference to the nature of its corporate structure in the Technical/unmarked proposal.

Question#	Section #	Page #	RFQ Question	DOM Response
25.	1.2.3.3.2	11	1.2.3.3.2 states "When a response requires reference to a subcontractor, subsidiary, or other related entity, all requirements applicable to the Offeror as discussed in the previous paragraph also apply to that entity." Please confirm that an Offeror may name unrelated entities, such as technology and program vendors, that do not have an ownership relationship with the Offeror.	The Offeror should speak to capabilities only and omit the names of tools, technologies, and application names.
26.	1.2.7	12	Please confirm that the Offeror should include their acknowledged, signed amendments as an attachment to the Transmittal Letter in conjunction with item 14 that identifies the received amendments by name and date.	The Offeror should include their acknowledged, signed amendments as an attachment to the Transmittal Letter.
27.	1.2.9	12	Sections 1.2.9 and 1.4.7 of the RFQ identify that Contractors will be paid an "annual capitated rate". However, Section 1.3.5 identifies that payment will be a "monthly capitation payment". Please confirm that capitation rates are developed annually, however, Contractors will be paid a monthly capitation rate for services provided under the contract.	Capitation rates are developed annually, and Contractors will be paid a monthly capitation rate for services provided under the Contract.
28.	1.3.6	16	Section 1.3.6 identifies that "a time limited auto-assignment methodology will be used to ensure that each selected entity reaches a minimum threshold of twenty (percent of the program." Will the Division consider any additional methodologies to support a more financially sustainable membership level for new entrant Contractors such as proactively assigning all membership of an exiting Contractor to a new Contractor (in the event of one exiting Contractor and one new entrant Contractor)?	The Division's current policies are as stated in Appendix A: Draft Contract, Section 3. See also Appendix A: Draft Contract Questions and Answers, Questions 5-10 (in this document) for additional information.
29.	1.3.6	17	Is the 20% minimum threshold described in the first paragraph for both MSCAN and CHIP combined, or is there a separate 20% threshold for MSCAN and 20% threshold for CHIP?	The threshold is for MSCAN and CHIP combined.

Question#	Section #	Page #	RFQ Question	DOM Response
30.	1.3.6	17	If an incumbent is not chosen, are their members distributed using the time-limited auto-assignment process or is that process only used for newly eligible members?	The Division's current policies are as stated in Appendix A: Draft Contract, Section 3. See also Appendix A: Draft Contract Questions and Answers, Questions 5-10 (in this document) for additional information.
31.	1.3.7	17	Based on information in 1.3.7 in the RFQ regarding use of a PBA, in addition to the definition of PBA in 2.1 as well as section 4.4.4.1 in Appendix A, can the Division clarify what "pharmacy services" the MCOs are anticipated to deliver outside of Physician-Administered Drugs and Implantable Drug Systems (4.4.5), which is covered under Physician Services?	Contractors will not conduct retail pharmacy services. Contractors should maintain pharmacy information and data from the PBA for Care Management purposes and for reimbursement of the PBA for claims.
32.	1.3.7	17	Based on information in 1.3.7 in the RFQ regarding use of a PBA, in addition to the definition of PBA in 2.1 as well as section 4.4.4.1 in Appendix A, can the Division please confirm that the reference to pharmacies does not mean retail pharmacies but medical specialty pharmacies?	NCPDP D.0 type claims for both retail and medical specialty pharmacies will be managed by the PBA.
33.	1.3.7	17	Based on information in 1.3.7 in the RFQ regarding use of a PBA, in addition to the definition of PBA in 2.1 as well as section 4.4.4.1 in Appendix A, can the Division confirm the PBA will manage the pharmacy lock in program and also provide additional information as to what pieces of a pharmacy lock in program the Division expects CCOs to fulfill?	The PBA will manage the lock in program.

Question#	Section #	Page #	RFQ Question	DOM Response
34.	1.3.7	18	It is our understanding based on the language in section 1.3.7 of the RFP as well as in section 4.4.4.2 of the draft contract that pharmacy is carved-out of MississippiCAN/CHIP and will be paid by payments received by the Contractor from the Division and passed through to the PBA. However, in the pro forma template "DOM-CCO-Procurement-4.3.2.6-Pro-Forma-Financial-Template-Referenced-in-Appendix-G.xlsx" on the "P&L" tab there is a line for Prescription Drugs. Is it the expectation of the Division that this line be zero or should we project out the pharmacy costs?	The entry should be zero.
35.	1.5	21	Should Section 1.5 be included in the response to Management Qualification, or is it meant to be an outline of all required documents that are responded to throughout the Response?	Items 3, 4, 5, 7, and 8 can only be provided after award of the Contract by a winning Contractor. These items are included to alert Offerors of the requirement should they be awarded the Contract.
36.	1.5	21	Requirements 1, 2, 6, and 9 are included in the transmittal letter. Where would the State like us to respond to requirements 3, 4, 5, 7, and 8?	Items 3, 4, 5, 7, and 8 can only be provided after award of the Contract by a winning Contractor. These items are included to alert Offerors of the requirement should they be awarded the Contract.
37.	2.3.2	27	Can the Division provide clarification on how the Written Qualification Clarifications included in RFQ Section 2.3.2 will be factored into, or impact the scoring of the Offeror's qualifications.	Written clarifications will be used only in circumstances where the Offeror's response is unclear to the Evaluation Committee. The goal of Written Clarifications is to allow the Evaluation Committee the ability to fully understand the Offeror's proposal. It is not an opportunity for the Offeror to amend its proposal. The Offeror is required to respond only to the request for clarification. The Offeror may not change its proposal through a response to a Written Clarification; the Offeror may only respond to the question asked.
38.	2.6	31	In the post-award debriefing section, is "vendor" equivalent to "offeror"?	Yes.

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39.	4.1.9	41	This requires an Offeror/Contractor to state whether it was terminated prior to the end of the project Contract period. Did the Division intend to limit this statement to the termination of a government programs managed care contract? Further, it is common practice within the industry for a health plan to establish a legal entity (the "Contracting Entity") dedicated solely to holding the managed Medicaid contract with a State Medicaid Agency, while a separate legal entity (the "Administrating Entity") actually administers the day-to-day operations of the plan pursuant to an Administrative Services Agreement with the Contracting Entity. Does the Division intend to consider an Administrating Entity's experience for this response?	The Offeror's response should be limited to a government managed Medicaid contract with a state Medicaid agency. This section applies to both Contracting and Administrating entities.
40.	4.2, 4.3	-	We will submit the forms as PDFs; however, are Offerors allowed to replicate these forms in MS Word to allow for a more complete and thorough answer which may extend the length of the response form?	These forms were made available in Word format to all potential Offerors through Amendment 3 to this RFQ.
41.	4.2.2.1	44	Section 4.2.2.1 requiring the member call center to be in one of the 3 mentioned counties was removed by an Amendment 4 to the prior contract and is not included in the Appendix A CCO contract. Was this intended to be removed from the contract to allow hiring across the state or is this still a preference of the state?	The Member Call Center may be located anywhere within the state. RFQ Question 4.2.2.1.B.1.a. is revised to read as follows: Confirming that the location of the operations will be within the State of Mississippi (provide a yes or no answer; do not include address). (Corrected in Amendment 5.)

Question#	Section #	Page #	RFQ Question	DOM Response
42.	4.2.2.1	45	Section 4.2.2.1 allows Offerors to submit sample member marketing materials. Can the State please confirm if these materials should be submitted outside of the Technical (blind) Submission, or if the materials should be redone to remove all identifying information including branded colors? If the marketing materials should be submitted outside of the Technical Submission, please indicate where in the submission they should be included.	Samples should be reformatted to remove identifying information in conformance with RFQ Section 1.2.3.3 and submitted with the Technical/blind submission.
43.	4.2.2.1	45	Section 4.2.2.1: Member Services and Benefits has a response limit of 55 pages plus 2 marketing samples. Based on the extensive information requested in this section which includes more than 50 question prompts, would the State consider raising the page limit to allow Offerors to fully respond to each prompt included in the Section?	The Response Limit for this section is amended to read as follows: Response Limit: 65 pages, plus two (2) marketing samples, not to exceed five (5) pages each. (Corrected in Amendment 5.)
44.	4.2.2.1	46	Can the State please confirm if there is a question or requirement associated with 4.2.2.1 Question A.4.f.?	There is no question associated with this element. This is a typographical error. (Corrected in Amendment 5.)
45.	4.2.2.1	45	Regarding Section 4.2.2.1: Member Services and Benefits--Response Limit: 55 pages, plus two (2) marketing samples: Can the State please confirm that the two marketing samples will not be counted against the limit of 55 pages for this section?	Yes. The Response Limit for this section is amended to read as follows: Response Limit: 65 pages, plus two (2) marketing samples, not to exceed five (5) pages each. (Corrected in Amendment 5.)
46.	4.2.2.1	46	Section 4.2.2.1: Member Services and Benefits, Item A, Question 4: Chronic Conditions has a letter "f," however there is no associated question listed next to it. Can the State please confirm whether there is a question missing, and if so, provide the question text?	There is no question associated with this element. This is a typographical error. (Corrected in Amendment 5.)
47.	4.2.2.1	46	Please confirm A.4.f is intended to be blank.	There is no question associated with this element. This is a typographical error. (Corrected in Amendment 5.)

Question#	Section #	Page #	RFQ Question	DOM Response
48.	4.2.2.1.A.5.a	46	A.5.a reads ""Describe the Offeror's experience or capacity to manage the care of foster children, and your ability to develop a continuum of care responsive to their needs." Please confirm it should read "experience **and**/or capacity"	The Division confirms that this question should read "and/or" (Corrected in Amendment 5.)
49.	4.2.2.1	48	Given the current reading level for member materials is at a 6th grade reading level, it will take time and collaboration to ensure materials are appropriately revised to be at a 3rd grade reading level to meet contract requirements. Would the Division be willing to discuss the transition process and time period allowed to develop these materials?	The Division will discuss development of materials related to this Contract element during the Implementation period with Contractors.
50.	4.2.2.2	52	With question 4.2.2.2 Provider Network and Services on page 52 of the RFQ, there are 2 section "F", one for Provider Payment and one for Provider Grievances and Appeals. Was it the state's intention to label Provider Payment as "E"? If so, should respondents make that correction in their submission?	Provider Payment should be labeled "E," and Provider Grievance and Appeals should be labeled "F." This is a typographical error. (Corrected in Amendment 5.)
51.	4.2.2.2	52	Can the state clarify that Section 4.2.2.2 - Provider Payment should be labeled as "E. Provider Payment" rather than "F. Provider Payment"?	Provider Payment should be labeled "E," and Provider Grievance and Appeals should be labeled "F." This is a typographical error. (Corrected in Amendment 5.)
52.	4.2.2.2	52	In Section 4.2.2.2: Provider Network and Services, there are two items on RFQ pg. 52 labeled with an "F." Can the State please confirm that "F. Provider Payment" should instead be "E. Provider Payment"?	Provider Payment should be labeled "E," and Provider Grievance and Appeals should be labeled "F." This is a typographical error. (Corrected in Amendment 5.)
53.	4.2.2.3	53	Would the state consider accepting documents as part of Readiness Review to be responsive to Section 4.2.2.3.B.1 & 4.2.2.3.B.2 regarding "including questions" for our Health Risk Screening (HRS) and Comprehensive Health Assessment (CHA) due to the length of such documents or can the state confirm that they would allow as an attachment submission excluded from page limits?	These documents should be included with the Offeror's response to this question. They will be required again as part of the Readiness Review. To accommodate the submission of these documents, the Response Limit for this section is amended to read as follows: Response Limit: 45 pages, plus two (2) appendices: one (1) in response to B.1, and one (1) in response to B.2. Each appendix is limited to five (5) pages. (Corrected in Amendment 5.)

Question#	Section #	Page #	RFQ Question	DOM Response
54.	4.2.2.3	54	The questions below appear to be seeking duplicate information/response. Would the state remove the duplicative question or can the state clarify what specific information it is seeking in these questions: -Section 4.2.2.3.C.3.d. asks for information regarding "The Offeror's Care Management processes and specific communication steps with hospital inpatient Providers to ensure post-discharge care is provided to Members. The Offeror's response should address review of potential Member inpatient readmission by diagnosis and the Offeror's plans for readmission reduction through coordination with hospital providers and other relevant parties." -Section 4.2.2.3.D.2.b asks for information regarding "Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff" related to Transition of Care planning. (p. 54 of RFQ)	C.3.d requests, "Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time of Contract implementation." It appears the Offeror's question is about C.3.e, which is focused on the Offeror's processes post-discharge, as well as how those processes related to the reduction of readmissions. D.2.b is more specific, asking about the relationships the Division expects the Offeror to utilize in Transition of Care services.
55.	4.2.2.3.E	54	Please clarify a case load ratio with an associated care management risk level. Does the ratio pertain to the number of high risk members assigned to a single care manager? A case load of 40:1 could represent an intensive risk stratification level. A ratio of 40:1 for all risk levels deviates greatly from industry standard. If a 40:1 ratio is intended for all risk levels, please clarify how this is factored into the rate setting process.	The 40:1 ratio indicates that no Care Manager for a winning Contractor may have a case load of more than 40 Members. A Contractor may assign fewer than 40 Members to a Care Manager as needed to ensure quality Care Management. Offerors are reminded that medium- and high-risk Members are to be assigned a Care Manager per Section 7.5 of Appendix A: Draft Contract. Low-risk Members are to have access to Care Management teams with a point of contact, and therefore, they are not part of the 1:40 Member count. The ratio will be taken into account in the rate setting process in the same manner that care management is usually taken into account in the rate setting process. More details will be available when the rates are set for the base year of this Contract.

Question#	Section #	Page #	RFQ Question	DOM Response
56.	4.2.2.4	56	Section 4.2.2.4: Quality Management has a 40 page response limit plus a 10-page appendix, but two (2) components of the Quality Management Section request additional information with a 10 page limit (A.2 and C.1). Can the Division please confirm that the Annual Program Evaluation and Annual Program Description Work Plan requested in A.2, and the data analytics and informatics capabilities requested in C.1 each have a 10 page limit that does not count towards the section's 40 page response limit?	The Response Limit for this section is amended to read as follows: Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to ten (10) pages. (Corrected in Amendment 5.)
57.	4.2.2.4	56	In Section 4.2.2.4: Quality Management, the page limit is 40 pages, plus a 10-page appendix. A.2 Quality Management Program asks us to provide models in Appendix A, Draft Contract (no more than 10 pages). C.1 Quality Measurement ask to provide up to 10 pages as an appendix to this response of sample reports that the Offeror proposes to use for this Contract. Can the State please confirm that items A.2 and C.1 each have a 10-page limit, bringing the total additional page count to 20 pages (in addition to the 40 pages allotted)? Can the State please confirm if it would like the model documents requested in A.2 to also be submitted as an appendix, as requested in item C.1?	The Response Limit for this section is amended to read as follows: Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to ten (10) pages. (Corrected in Amendment 5.)
58.	4.2.2.4.A.2	56	Does the State want the models of the Annual Program Evaluation and the Annual Program Description as an appendix to question 4.2.2.4.A.2?	Yes. The Response Limit for this section is amended to read as follows: Response Limit: 40 pages, plus two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to ten (10) pages. (Corrected in Amendment 5.)

Question#	Section #	Page #	RFQ Question	DOM Response
59.	4.2.2.5.A.	58	The questions below appear to be seeking duplicate information/response. Would the state remove the duplicative question or can the state clarify what specific information it is seeking in these questions: c. Data sources and processes to determine which services require Prior Authorization and how often these requirements will be re-evaluated; f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need for updates;	c. refers application of Prior Authorization requirements to services; f. refers to how the effectiveness of and need for update(s) to the Prior Authorization requirements will be measured.
60.	4.2.2.5.B	58	Will the Contractor have access to real-time pharmacy claims data?	In answering this question, assume that a winning Contractor will have access to real-time pharmacy claim information for all of its Members.
61.	4.2.2.5.B	58	Will the Contractor have access to the pharmacy prior authorization system to review approvals/denials?	In answering this question, assume that a winning Contractor will have access to the pharmacy prior authorization system to review approvals/denials.
62.	4.2.2.5.B	58	Will DOM provide monthly reports to the Contractor similar to the MMR reports that Contractors submit today?	Yes. The Monthly Management Reports (MMR) are the historical name for the Reporting Manual.
63.	4.2.2.5.B	58	Will the Contractor be responsible for handling member and provider calls pertaining to pharmacy claims issues or pharmacy prior authorizations?	No.
64.	4.2.2.6	60	Do systems diagrams count toward the 25 page limit for this section?	The Response Limit for this section is amended to read as follows: Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages. (Corrected in Amendment 5.)
65.	4.2.2.6	60	For Offeror's claims processing systems in Unmarked section 4.2.2.6, please confirm that Offeror is allowed to use names of industry standard tools, technologies and application names or does the State prefer we speak to capabilities only?	The Offeror should speak to capabilities only and omit the names of tools, technologies, and application names.

Question#	Section #	Page #	RFQ Question	DOM Response
66.	4.2.2.6	60	Can the state confirm that the third item listed under Section 4.2.2.6 - Innovation should be labeled #3 as opposed to #2?	The third question should be labeled with a 3. This is a typographical error. (Corrected in Amendment 5.)
67.	4.2.2.6	60	Section 4.2.2.6: Information Technology, Item C. Innovation has two questions numbered with a "2." Can the State please confirm the third question should be numbered with a "3"?	The third question should be labeled with a 3. This is a typographical error. (Corrected in Amendment 5.)
68.	4.2.2.6	60	Regarding Section 4.2.2.6: Information Technology, Question D.1: Can the State please confirm that the attachment with the Offeror's emergency response continuity of operations plan does not count toward the section limit of 25 pages?	The Response Limit for this section is amended to read as follows: Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages. Question D.1. is amended as follows: "In an appendix no longer than ten (1) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including…." (Corrected in Amendment 5.)
69.	4.2.2.6.D	60	Under D. Continuity of Operations 1b., the RFQ asks the Offeror to address "Essential business functions and responsible key employees." What are the essential business functions as defined by the State of Mississippi?	The essential business functions are the uninterrupted continuity of care of and availability of services to MississippiCAN and CHIP Members.
70.	4.2.2.7.B.1.g	62	Can the state make available a copy of the Annual Quality Management Program report as referenced in section 4.2.2.7.B.1.g.?	The Annual Quality Management Report is a report generated by the Contractor. The Division does not produce this report, and therefore, the Division does not have a copy of the report available for potential Offerors to review.
71.	4.2.2.7.B.1.h	62	The RFQ requires the Offeror/Contractor to describe how it will ensure subcontractor compliance with the Division's policies regarding subcontractor classification of administrative and medical expenses. Will the Division produce such policies?	Subcontractors are required to follow the same polices that apply to the Contractor regarding classification of administrative and medical expenses. It is the Contractor's responsibility to monitor Subcontractors for compliance.

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72.	4.2.2.8	64	Section 4.2.2.8, Financial and Data Reporting, item B, Data Reporting, Question 2, Health Information System Data. In describing our approach to maintaining a health information system that collects, analyzes, integrates, validates, and reports data, please provide further detail on what the Division intends Contractors to describe in the first item, i. Utilization. For example, is this referring to Utilization Management data?	This question is in reference to Utilization Management.
73.	4.2.2.11	68	Regarding Section 4.2.2.11: Eligibility, Enrollment, and Disenrollment, Question A, Item 2.c: Can the State please confirm that the Offeror's draft disenrollment survey does not count toward the 15-page limit for this section?	Yes. The Response Limit for the section is amended to read as follows: Response Limit:15 pages, plus two (2) appendices: one (1) in response to A.2.c, and one (1) in response to C.1.e. (optional). Each appendix is limited to five (5) pages each. (Corrected in Amendment 5.)
74.	4.2.3.1 & 4.2.3.2	70	Considering that a "Patient-Centered Medical Home" ("PCMH") (which is addressed in Section 4.2.3.2) may also be included in the concept of "Value-Based Purchasing" (which addressed in Section 4.2.3.1), should Offerors omit references to PCMHs when responding to Section 4.2.3.1 to avoid redundancy?	No.
75.	4.2.3.3	71	Will a minimum of 0.5% capitation for social determinants of health be provided for in the capitation rates?	No.
76.	4.2.3.3	71	Section 4.2.3.3 of the RFQ identifies that Contractors devote at least 0.5% of their capitation payments to improve SDOH during the contract cycle. Will the Division permit Contractors to categorize these expenses as quality improvement activities for the purposes of calculating medical loss ratio?	The Division will allow Contractors to categorize these expenditures as quality improvements for all expenses meeting the definitions included in Appendix A: Draft Contract, Exhibit C, Section C, Subpart 2.

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77.	4.2.3.3	71	Could DOM provide clarification as to how the required 0.5% of capitated payments for Population Health services will be determined? What costs are included/excluded?	DOM will require that payments for these services be separately identified in the quarterly/annual MLR reporting. The Offeror must refer to 45 C.F.R. § 158.150, as also referred to in Draft Contract Exhibit C, Section C, Subpart 2, to propose services that would conform to this requirement.
78.	4.2.3.4	71	Regarding Section 4.2.3.4: Value-Added Benefits-Prenatal, #3,Dental preventative care during pregnancy and postpartum, as a value add suggestion is the understanding correct this coverage is for pregnant women who are non-EPSDT eligible? Part 200 Chapter 3: Beneficiary Information Rule 3.1: Coverage of Eligibility Groups lists pregnant women as a full coverage category of eligibility.	This is in reference to pregnant women who are non-ESPDT eligible.
79.	4.2.3.4	71	Section 4.2.3.4 of the RFQ identifies that the Division will evaluate any proposed Value Adds as part of the Innovation and Commitment score. It is noted that a list of Division-curated Value-Adds are included with the RFQ. Will the Division please provide additional clarity on the scoring methodology for this section? Are Division-curated Value-Adds scored higher than Contractor-proposed value adds? Is the evaluation based solely on the price per unit, gross value, or net value?	The Division-curated list is provided so that the Offeror has some context for services currently desirable to the Division. Each proposed value-added benefit will be scored based on the information solicited through the form and based on its value, both intrinsic and extrinsic, to the Division, its beneficiaries, and the state. The Division is open to innovative VAB proposals.
80.	4.2.3.4	71	Section 4.2.3.4: Value Added Benefits indicates that Offeror's may describe some of their own value added benefits. Would the State allow Offeror's to include a brief narrative introduction to the value added benefits preceding the requested forms?	No.

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81.	4.2.3.4	71	The state lists in-home respite services in the expanded benefits section of the value-add list. Is there a specific population within MSCAN or CHIP the state wishes to target with this value add? Please define the services and/or codes that the state is asking CCOs to cover as in-home respite services.	As an example, this value-add service could be offered, based on medical necessity, to the following potential participants: • Medically complex children up to age 21 whose caregivers may need additional support • Children up to age 21 with a serious emotional disturbance (SED) whose caregivers may need additional support • Individuals on any of the home and community-based waiver waiting lists whose caregivers may need additional support while waiting for enrollment into a waiver The Division of Medicaid (DOM) recommends adherence to all coding principals and guidelines when determining potential procedure code(s) to use for this value-add which meets the description of the service rendered.
82.	4.2.3.5	71	Section 4.2.3.5: Performance Improvement Projects has a response limit of 4 PIP Proposal Pages. Can the District please clarify if there is a page limit associated with the completed charts required for submission for each proposed PIP?	One (1) page.
83.	4.2.3.5	71	RFQ Section 4.2.3.5 asks for 4 PIP proposals; however, contract section 8.11 - performance improvement plans - indicates the contractor shall perform a minimum of five for MississippiCAN and five for CHIP. Please confirm that Offerors should propose 4 PIPs total in the RFQ response.	This interpretation is correct. Two (2) should be for MSCAN, and two (2) should be for CHIP.
84.	4.2.3.5	71	4.2.3.5 calls for the submission of four (4) Performance Improvement Projects (PIPs). Is the intent to submit (2) MSCAN and two (2) CHIP PIPs?	This interpretation is correct.

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85.	4.2.3.6	71	Section 4.2.3.6 asks Offerors to use the "Health Literacy Campaign Summary Chart on the following page for each PIP the Offeror is including in its response to this section." Can confirmation be provided that the Health Literacy Campaign Summary Chart will be utilized for each Health Literacy Campaign?	This interpretation is correct.
86.	4.2.3.5	72	Please confirm that the response to this section, in its entirety, is to be contained in the forms provided in Appendix E.	Responses to 4.2.3.5 should only be comprised of completed PIP forms included in Appendix E.
87.	4.2.3.6	72	Please confirm that the response to this section, in its entirety, is to be contained in the forms provided in Appendix E.	Responses to 4.2.3.6 should only be comprised of completed Health Literacy Campaign forms included in Appendix E.
88.	4.2.3.9	72	For the summary charts associated with Section 4.2.3.9 Potential Partnerships, please confirm that a total of eight (8) partnerships must be submitted: four (4) community based organization partnerships and four (4) additional care management focused community based organization partnerships.	This interpretation is correct.
89.	4.2.3.9 (Question asked about 4.3.2.9)	72-73	Please confirm that the response to this section, in its entirety, is to be contained in the forms provided in Appendix E.	There is no 4.3.2.9 in the RFQ. This question appears to be in reference to 4.2.3.9. For 4.2.3.9, the response to this section, in its entirety, is to be contained in the forms provided in Appendix E.

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90.	4.2.3.9	73	Please clarify what is meant by "partnerships to be utilized for Care Management closed-loop referrals and warm hand offs." Does DOM intend the Offerors to delegate aspects of Care Management to community based organizations, such as care coordination and disease management?	The Division does not intend for the Contractor to delegate Care Management responsibilities. The Division intends for Contractors to utilize partnerships with community-based organizations to ensure that Members receive holistic Care Management. For example, if a Care Manager becomes aware of a Member who is food insecure, the Care Manager may refer that Member to a food pantry or similar organization local to that Member, and the Care Manager would then be required to ensure that the Member is connected with the food pantry, contacting the food pantry if necessary to ensure an easy process for the Member, and then follow up with the Member to follow-up on whether the Member has utilized the referral.
91.	4.3.1	72	Please confirm that the Offeror is not to provide any narrative for 4.3 and 4.3.1 and that only section 4.3.1.1.2 should be responded to with any narrative.	The Offeror should use the correlating form in Appendix F to reply to 4.3.1.1.1. The Offeror should provide a narrative response to 4.3.1.1.2. The Offeror should provide a narrative response to 4.3.1.2 ONLY if there is no information available that is responsive to the chart provided for 4.3.1.1. (See Question 92, below, for more information.)
92.	4.3.1.2	74	Please confirm that the offerors can provide a narrative response for Section 4.3.1.2 in addition to Appendix F to fully address all components of the requirements.	A narrative response may only be submitted if the Offeror does not have the experience requested through the available form in Appendix F. This narrative should be no longer than three (3) pages. If the Offeror does have the experience requested, submission of the form provided for each applicable experience is the only response the Offeror may submit. Directions for 4.3.1.2 have been updated to clarify the three (3) page narrative limit. (Corrected in Amendment 5.) Directions in Appendix F have also been updated in clarify the three (3) page narrative limit and to remove the requirement for documentation supporting the assertion of unavailability of experience conforming with that requested in 4.3.1.2. (Corrected in Amendment 5.)

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93.	4.3.1.2	74	Section 4.3.1.2 asks Offerors to describe experience from other states. Is the Division asking Offerors to only consider experience from states where an Offeror has served at least 400,000 beneficiaries, or is the Division asking for experience from any state where the total Medicaid enrollment exceeds 400,000 beneficiaries.	The Division is seeking experience for markets totaling 400,000 or more beneficiaries. The Offeror's enrollment in such a market does not have to meet or exceed 400,000 beneficiaries.

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94.	4.3.3	78, 79	The first sentence of 4.3.3 states, in part, that the Organization and Staffing section shall include ... "the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract and what economic impact the execution of the Offeror might have on the state." Per 4.3.3.5 and 4.3.3.6, information about subcontractors and our economic impact is to be submitted on the respective forms in Appendix H. Neither of the applicable forms has a field for describing our hiring and management plan for subcontractors or for the impact that will have on the economy in the State. Can the State please provide additional guidance on where in the RFQ response it would like Offerors to describe these elements?	The directions for 4.3.3 are amended as follows for clarity: "The Organization and Staffing Section shall include team organization, charts of proposed positions, number of FTEs associated with each position for key staff, and job descriptions of key management personnel and care managers listed in Section 1.13, Administration, Management, Facilities, and Resources of Appendix A, Draft Contract, as well as the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract, and what economic impact the selection of the Offeror might have on the state." (Corrected in Amendment 5.) Directions for 4.3.3.5 are amended to allow for a brief narrative explaining the Offeror's overall philosophy and strategy for subcontractor hiring and management. (See Amendment 5 for this addition in the body of the RFQ; see Amendment 7 for this addition in the directions included in Appendix H). Additionally, there is a field on the first Subcontractor form for 4.3.3.5 that asks how the Offeror will monitor and manage that specific subcontractor. Responses to this element of the form are to be used to understand the Offeror's approach to management of specific subcontractors. It was not the Division's intention that the Offeror include information about potential subcontractors' economic impact. Directions for 4.3.3.6 are amended to clarify this point. (Corrected in Amendment 5.)
95.	4.3.3.1	78	Can the state confirm whether the offeror is allowed to list name of staff within the requested org charts requested in Section 4.3.3.1?	The Offeror is not allowed to list the name of staff in its response.

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96.	4.3.3.2	78	Is it the intent of the State for Offerors to provide job descriptions for positions listed in 1.13.2 Additional Staff Requirements in addition to Key Personnel listed in sections 1.13.1.1 Executive Positions and 1.13.1.2 Administrative Positions?	Yes.
97.	4.3.3.4	78	Section 4.3.3.4 requires staffing ratios per enrolled member and/or provider as well as total staffing numbers. For consistency in comparison across responses, what membership assumption should Offeror's use when developing this response?	The Offeror should assume an enrollment of 125,000 Members per Contractor for the purposes of preparing its Qualification.
98.	4.3.3.5	79	The definition of "Subcontract" in the draft contract includes not only direct subcontracts, but also downstream contracts "between a third party and fourth party, or between any subsequent parties". Given how extensive this list may be, please confirm that for the purposes for RFQ responses, including, but not limited to the Subcontractor information required in RFQ Section 4.3.3.5, that Offerors are only required to submit information for direct Subcontractors, and not an exhaustive list of downstream entities.	For the purposes of RFQ responses, the Offeror need only submit first-level subcontractors, i.e., subcontractors with which the Offeror expects to directly subcontract with for services. This does not relieve the Contractor of any responsibilities stated within Exhibit A, Draft Contract, regarding Subcontractors as defined in that document.
99.	4.3.3.5	79	For Section 4.3.3.5 Subcontractors, in the summary table that must be completed for each subcontractor would the Division considering adding an additional category for entity type? Currently the options are "The entity is a: subcontractor or wholly-owned subsidiary". Would the Division consider adding "The entity is a: affiliate under the same common ownership"?	Yes, that addition to the form in Appendix H: Organization and Staffing for 4.3.3.5 Subcontractors is appropriate. (Use updated form included in Amendment 7.)
100.	4.3.3.6	79	Please confirm that Section 4.3.3.6 Economic Impact is intended to be MARKED.	Section 4.3.3.6 Economic Impact is intended to be Marked. (Corrected in Amendment 5.)

Question#	Section #	Page #	RFQ Question	DOM Response
101.	4.3.3.6	79	In Section 4.3.3.6, Economic Impact, are Offerors permitted to also include any positions that they will locate in Mississippi that are not dedicated to the Mississippi Medicaid contract, but would nonetheless provide a positive economic impact to the state (e.g. call center representatives for other state Medicaid programs that would be located in Mississippi if awarded a contract).	The Offeror may include a two (2) page narrative of other investments, if applicable. (Corrected in Amendment 5.)
102.	4.3.3.6	79, 80	This section outlines completion of Wage Charts. The last sentence allows for a "Narrative of other investments." Is this to be submitted as an attachment or part of the Appendix? Is there a page limit for this narrative?	The Offeror may include a two (2) page narrative of other investments, if applicable. (Corrected in Amendment 5.)
103.	Appendix C	15 of Appendix C	This page states, "There are no withholds associated with the CHIP capitation rate." Will this remain the same once CHIP is combined with MSCAN or will the CHIP rate cell be subject to the 1% withhold applied to the MSCAN rate cells?	CHIP will be subject to the 1% withhold as a new Rate Cell in the new Coordinated Care contract.
104.	Appendix C	23 of Appendix C	The CHIP population is currently priced at a statewide level. Once combined with MSCAN will the CHIP capitation rates be developed at a regional level like the MSCAN rates?	Milliman will evaluate the necessity of splitting CHIP rates by region at the time of rate setting under the new contract.
105.	Appendix C, Contract 1.13.1.1	40 of Appendix C	Please confirm that the Chief Medical Director may also serve as the Perinatal Medical Director or Behavioral Health Medical Director if they meet the contractual requirements of those roles.	They may not. These are three separate and distinct roles.
106.	Appendix C	Capitation Rate Exhibit 1-8	PDF tables for rate buildup are not formatted to fit within page and therefore do not contain complete data. Please provide complete data set files.	This information is supplied in Excel format via Amendment 8.
107.	Appendix E		Additionally, Appendix E identifies that "to the extent that some or all of the desired value-added services may be covered through the Offeror's care management strategy, that should be made evident in the Offeror's Care Management answers in its	This interpretation is correct.

Question#	Section #	Page #	RFQ Question	DOM Response
			qualification." Please confirm that even if some value-added services are provided through the Care Management strategy, they should also be incorporated into the Proposed Value Added Benefit: Summary Chart and Proposed Value-Added Benefit: Staffing sections?	
108.	Appendix E, 4.2.3.4	97	Will over-the-counter medications continue to be a PDL managed category?	Yes, OTC medications that fall within therapeutic classes reviewed under PDL.
109.	Appendix E, 4.2.3.4; Contract 8.9	97	Will the state please confirm that any proposed and implemented VABs the state has recommended under the Social Determinants of Health section are allowed to be included in the 0.5% Capitation Payment requirement for SDOH projects.	Expenditures made on Value-Added Benefits will not be allowed to be included in the 0.5% Capitation Payment requirement for SDOH projects.
110.	Appendix E, 4.2.3.6	103	Section 4.2.3.6 instructs the Offeror to "Use the Health Literacy Campaign: Summary Chart on the following page for each ***PIP*** the Offeror is including in its response to this section." Please confirm that the instructions should read "for each ***campaign*** the offeror is including" and not "for each ***PIP***".	This was a typographical error and was corrected in Amendment 3.
111.	Appendix F		Can the State clarify the proper heading in Appendix F form referencing Corporate Experience should be 4.3.1.2 and not 4.3.1.1?	This was a typographical error and was corrected in Amendment 3.
112.	Appendix F, 4.3.1.1	111	The biographical information form asks the Offeror/Contractor to disclose any "Contractual terminations" within the last 5 years. Are these disclosures limited to managed care contracts with government entities?	The Offeror's response should be limited to a government managed Medicaid contract with a state Medicaid agency. This section applies to both Contracting and Administrating entities.
113.	Appendix F, 4.3.1	113	The form titled "Corporate Experience: Current and/or Recent Client" on RFQ page 113 of 140 lists the same line item asking for "Geographic and population coverage requirements:" twice. Please confirm that one of these lines will be removed.	This is a typographical error. This document has been corrected in Amendment 7 to remove the duplicative "Geographic and population coverage requirements:" field.

Question#	Section #	Page #	RFQ Question	DOM Response
114.	Appendix H, 4.3.3.3	132	Question #2 of 4.3.3.3 states "The Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives." Appendix H 4.3.3.3 has the same statement. Does the signature on Appendix H suffice, or do we need a narrative of how we will address the question in #2? If so, is there a page limit or other formatting requirements for this narrative?	Use of the form included Appendix H 4.3.3.3 will satisfy 1. of this section. (See Amendments 5 and 7.) 2. has been amended to allow for a narrative no longer than two (2) pages. (See Amendments 5 and 7.)
115.	Appendix H, 4.3.3.5	135	Form 4.3.3.5 "Prior Experiences with Subcontractor" has two (2) sections titled "Geographic and population coverage requirements." What is the difference between the two sections or will the State confirm this is a duplication?	This was a typographical error and was corrected in Amendment 3.
116.	General		Can the State please confirm that testimonials or quotes from community organizations or other stakeholders may be included in the response to the Technical Qualifications and would not be in violation of the blind/unmarked requirement as long as the quote speaks to future partnerships that will be contemplated for this RFQ?	Quotes may not be included in the Offeror's qualification.
117.	General	N/A	Several questions in the RFQ require a work plan and schedule to be submitted. These work plans and schedules will naturally differentiate a new entrant versus an incumbent. Can the State please provide additional guidance on how Offerors should navigate this work plan and schedule requirement given the "unmarked" requirement for this portion of the RFQ?	The Division is amending the RFQ to remove these subparts from the Methodology Work Questionnaire section. (Corrected in Amendment 5.) Additionally, the following is stricken from 4.2.2.: "For each of the subsections below, responses to Work Plan and Schedule are not subject to the page response limits listed for that section. Work Plans and Schedule response are limited to 15 additional pages for each section." (Corrected in Amendment 5.)
118.	General		The RFQ uses interchangeably "Offeror" and "Contractor," are these considered the same?	Yes.

Question#	Section #	Page #	RFQ Question	DOM Response
119.	Multiple	Multiple	For the staffing attachments for SDOH, Value Added Benefits, PIPs, etc., the instructions seem to indicate that only "additional and/or dedicated" staff should be included. If an Offeror engages other staff member who may not be dedicated or "additional" in its programming for these respective areas, should they be included in this attachment?	No.
120.	Multiple	Multiple	A number of questions within the Unmarked Methodology/Work Statement, such as Question 4.2.2.1.A.2, ask for the Offeror's "direct experience in service delivery and payment". Can DOM confirm that specification of experience and success outside of Mississippi will not be considered in violation of 1.2.3.3.2? If that would be a violation, can DOM provide additional guidance for how to express experience without violating 1.2.3.3.2?	The Offeror may respond in general terms to describe experience in service delivery and payment outside of the State of Mississippi. The Offeror must not indicate the geographical locations of the experience, including but not limited to naming the specific State or Contract with which the experience is related, but it may include to the size of the market served. The Offeror may include the experience of parent and affiliate companies, but the Offeror may not use the names of those companies, as that would violate the rules against Identifying Information

[End of 1. RFQ Questions and Answers]

Question#	Section #	Page #	Draft Contract Question	DOM Response
1.	1.12	39	The 10th item in the data exchange section states, "any files related to pharmacy and/or drug benefits and/or services as directed by and in a timeframe determined by the Division." Is this still a requirement for the CCOs or will this be the responsibility of the PBA?	As the PBA continues to evolve, the Division may need certain data transfers from a Contracted CCO regarding pharmacy and/or drug benefits. DOM will inform Contractors of the specifics of this need if it should arise.
2.	1.12.10	39	The Contract in 4.4.4.1 states that the PBA will share the claims with the Contractor for the purposes of Care Management and payment. Within the Data Exchange Requirements section, 1.12.10, the Contractual Agreement states the Contractor must utilize data extract from the Division and/or its Agents and that data extract files will include any files related to pharmacy and/or drug benefits and/or services. Can the Division provide clarity around the files the MCOs will receive related to pharmacy including file format and frequency?	Contractors will be able to view claims through a web portal application.
3.	1.17.1.4, 11.1.7	46	It appears that Contract Section 11.1.7 - Reinsurance and Section 1.17.1.4 - Financial Insurance have duplicative language. Would the division confirm that the two are the same requirement and that only reinsurance coverage is required. Otherwise, please provide additional detail on Financial insurance requirements as we have not encountered this type of insurance in other Medicaid contracts.	These sections refer to the same requirement. Only one policy is required.
4.	2.1.98	63	To ensure there are clear lines of responsibility between the PBA and the CCOs, what process will be used to decide how a drug will be administered for those that can be administered in either a retail pharmacy setting or a medical setting?	The Division will provide additional information to winning Contractors on this topic.
5.	3	72	Section 3 states, "the Contractor will be responsible for assessing eligibility and conducting enrollment for members of MississippiCAN and CHIP." Please confirm that this is the Division's responsibility and not the Contractor's.	This is the Division's responsibility, not the Contractor's. The sentence is amended to read, "The Division will be responsible for assessing eligibility and conducting enrollment for Members of MississippiCAN and CHIP." (Corrected in Amendment 6.)

6.	3	72	Contract Section 3. Eligibility, Enrollment, and Disenrollment, states, "The Contractor will be responsible for assessing eligibility and conducting enrollment for members of MississippiCAN and CHIP." Can the State please confirm that "Contractor" should instead read "the Division?" If the State is in fact looking for Contractors to take on this function, can the State please provide additional information on what the process and expectation is, so Offerors may adequately address this in their RFQ response?	This is the Division's responsibility, not the Contractor's. The sentence is amended to read, "The Division will be responsible for assessing eligibility and conducting enrollment for Members of MississippiCAN and CHIP." (Corrected in Amendment 6.)
7.	3.2	75	The passive auto enrollment rules under section 3.2 of Contract include - "Special Open Enrollment: If passive auto assignment is needed during that the Special Open Enrollment period, assignment will be made using a random process." Does the 20% minimum threshold referenced in 3.2.2.1 take precedence in order of operations for passive enrollment during the special open enrollment period over the above random process?	Yes.
8.	3.2	75	The passive auto enrollment rules under section 3.2 of the contract include: "Value-Based Purchasing: If multiple Contractors meet the Proximity standard, then assignment will occur based on Value-Based Purchasing (VBP) performance measures as defined by the Division." Please provide additional clarification on how the auto assignments will be made, including a description of the type of VBPs that will be used to determine these assignments. Since VBPs often require at least 1 year of provider experience, please also provide clarification on how this process will be implemented if a new entrant is awarded a contract.	The VBP process will be developed prior to the operationalization of the Contract, based on input from winning Contractors through the RFQ and during the implementation period. There will be a least one measurement year before any VBP-driven auto assignments are made.

9.	3.2.1	75	In section 3.2.1 the contract contains the following language - "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" The language appears to a maximum threshold verse the minimum threshold language of 20% provided under section 3.2.2.1. Please provide if the Division has set a maximum threshold of members who can be enrolled with a single contractor, and the details.	There is no maximum threshold.
10.	3.2.2.1	76	The following language is in Contract Section 3.2.2.1 - "Beneficiaries already enrolled with an incumbent contractor, should one exist, are allowed to continue their enrollment with that entity or change to another entity. Following Special Open enrollment, a time-limited auto-assignment methodology will be used to ensure that each selected entity reaches a minimum threshold of twenty (20) percent of the program. Once such threshold has been reached, the Division will revert to the passive auto enrollment methodology outlined in Section 3.2 of the Contract" The above section addresses beneficiaries enrolled with an incumbent, and how they will continue with that entity unless they make a change. If an incumbent is not awarded would it be correct to assume that those displaced members will go through the following process. First, In the special open enrollment the displaced members will be given a 60 day window to select one of the awarded CCOs. Second, After the special open enrollment any displaced members that have not made a selection will be assigned to the new entrant(s) until they reach 20% of the program. Third, if any additional members are remaining from step 2 they will be equally distributed among the awarded CCOs. If the above assumption is not correct please provide how the division intends to handle beneficiaries that are with an incumbent that is not awarded a contract.	After the 20% threshold is met, the Division will utilize the passive auto enrollment methodology as stated in Section 3.2 of Appendix A, Draft Contract. If no incumbent was awarded a Contract, that process would necessarily start at the third step, Prior Claims History, to ensure continuity of care for the Member. If there is a mix of new and incumbent plans, then the process would start at the first step of Section 3.2, again to prioritize continuity of care for the Member.

11.	4	87	The Contractor must submit reports related to covered services and benefits in accordance with Section 16, Reporting Requirements, of this Contract, and the MississippiCAN and CHIP Reporting Manuals, which are incorporated into this Contract via reference. Can the State please provide these Reporting Manuals or a link to the manuals referenced here and also throughout Appendix A.	Downloadable links for both Reporting Manuals will be provided on the dedicated DOM CCO Procurement Website no later than Friday, February 11, 2022.
12.	4.3.1.1	102	Will DOM consider reviewing/approving pre-emptive policies prior to FDA approval for new drug therapies (j codes) to allow the Contractor to have policies in place when drugs receive FDA approval?	The Division will not review/approve policies prior to FDA approval for new drug therapies (j codes). In accordance with Administrative Code, Part 200, Chapter 2: Benefits, Rule 2.2 Non-Covered Services, A.6., DOM does not cover "Procedures, products and services for conditions and indications not approved by the Federal Drug Administration (FDA) and/or that do not follow 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)…"
13.	4.3.1.6	103	Please confirm that a Mississippi license is not needed for all authorization reviews. Section 4.3.1.6 states, "nurses, physicians, and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty shall be currently licensed or certified by the Mississippi state licensing agency or hold a multi-state license with Mississippi privilege." We received previous clarification from DOM that this was only applicable to authorizations resulting in the reviewer making the denial, in compliance with 42 C.F.R. § 438.210 (b)(3).	Section 4.3.1.6 refers to Denials. Denial of authorization must be made in compliance with Miss. Code Ann. § 41-83-31.

14.	4.4.4	113	Section 4.4.4 of the draft contracts identifies that the Pharmacy Benefits Administrator (PBA) will be responsible for claims management and payment and prior authorization for all covered outpatient drugs for Members. It goes on to identify that the PBA will "share all Member claims with the Contractor for the purposes of Care Management and payment". Please confirm that the Contractors are expected to reimburse the PBA for claims paid? As pharmacy expenses can represent a significant portion of a Member's medical expense (for which the Contractor is at risk for), will Contractors have input into the PBA's prior authorization policies and processes?	The Contractor will reimburse the PBA for claims as described in Section 4.4.4.2 of exhibit A, Draft Contract. The Contractor will serve as a pass-through payer to the PBA; funds for PBA claims will be transferred to the Contractor by the Divisions. The PBA and the Division will develop Prior Authorization policies and processes.
15.	4.4.4.1	114	Question in regards to section 4.4.4.1 "The Contractor is expected to cooperate with the PBA fully in all aspects of pharmacy administration. The PBA will share all Member claims with the Contractor for the purposes of Care Management and payment." For care coordination and clinical interventions, will pharmacy claims files be provided on a daily basis and in an industry standard format? Will there also be access to a PBA reporting portal/system for MCO access?	Contractors will be able to view claims through a web portal application.
16.	4.4.4.2	114	Will the Contractor be required to pay additional funds, outside of the funds the Division provides, to the PBA?	No.
17.	4.4.4.2	114	Contract Section 4.4.4.2 states "The PBA will submit a weekly invoice to the Contractor that the Contractor will pay with funds provided by the Division. The Contractor must make payments as directed by the Division to the PBA. The Contractor will establish a dedicated bank account for the purpose of receiving the funds and managing the payment of PBA invoices." Can the Division provide more detail on how they will be paying the CCO for the PBA invoices?	Like the Contractors, the Division will receive weekly invoices from the PBA. The Division will allocate the funds necessary to pay those invoices to the Contractors, directing those funds to each Contractor's dedicated PBA bank accounts. Each Contractor must then use those funds to pay their invoice from the PBA.

18.	4.4.4.2	114	Regarding the weekly invoice mentioned in Section 4.4.4.2: a. Will this be a pass thru item? b. Will all pharmacy payments be outside the capitation payment? c. Will there be administrative costs included in the rates for processing these payments?	a. Yes. b. Yes. c. Milliman will evaluate the expected administration costs associated with the pharmacy services under the new contract and build it into the capitation rates, as appropriate.
19.	4.4.4.3	114	How will the capitation rates be adjusted to account for the administration? Currently rates have an admin percent applied to the total expected medical/rx dollars. If Rx dollars are removed from the rate, the admin dollars needed for administering the pharmacy benefit will not be accounted for in the rates according to the current methodology.	Milliman will evaluate the administration costs associated with the pharmacy services under the new contract and build that into the capitation rates, as appropriate.
20.	5.1	116	Regarding Contract Section 5.1, can the state confirm that when you speak to a toll-free dedicated Member services call center, that it is the toll-free line that needs to be dedicated to this contract?	Yes.
21.	5.1.6	119	The requirement in Contract Section 5.1.6 that "the average monthly speed to answer after the initial automatic voice response is forty (40) seconds or less" appears to conflict with the requirement in 5.1.1 that "the average hold time for a member before speaking with a live representative must not exceed 2 minutes". This 2 minute requirement is also specified for the provider calls. Can you confirm that the 40 second requirement should be removed and both member and provider should operate under the 2 minute requirement?	The second item in the list of 5.1.6 should read, "The average monthly speed to answer after the initial automatic voice response is one hundred and twenty (120) seconds or less;". (Corrected in Amendment 6.)
22.	6.1	155	Will pharmacy network contracts be the responsibility of the PBA?	Yes.
23.	6.2.5	158	In order to broaden member access to highly qualified PCMH programs, will DOM permit PCMH recognition / certification from other respected organizations such as URAC and Joint Commission?	The Division prefers NCQA certification. The Division may discuss other strategies for certification with winning Contractors.

24.	6.5	169	Will Centralized Credentialing be in place upon award? If not, is the state willing to deem active, Medicaid enrolled providers state credentialed, so CCOs can contract with them/include them in CCO network without direct credentialing?	Centralized Credentialing is scheduled to be in place upon reward.
25.	6.9.3.2	184	Section 6.9.3.2 states "In order to effectively train Providers, the Contractor shall have a working knowledge of the Contractor tool and web portal and be able to communicate about the basic functionality of the tool and how it can be used to meet Provider Clinical Transformation goals." Can the Division provide further definition of "Contractor tool" in this context?	This is in reference to the Provider Portal, as described in Draft Contract, Section 5.8.4.
26.	6.9.3.3	185	Please define "Provider Network Representatives" in the context of the requirement to have at least 30 Representatives.	The Draft Contract states, "The Contractor shall implement policies to monitor and ensure compliance of Providers with the requirements of this Contract. The Contractor shall retain a proportional number of Provider Representatives to assist Providers. This number shall not be fewer than thirty (30), including Subcontractors. These Provider Representatives shall have appropriate training by the Contractor. These Provider Representatives shall assist Providers with claims, enrollment, credentialing, and all areas required for assistance. Provider Representatives are required to develop relationships with Providers located in their coverage area through regular contact. The Division shall reserve the right to modify or change the provider representative requirements during the term of the Contract." The Division expects the Contractor to have Provider Representatives adequately staffed across the state and dedicated proportionately to each provider population (MSCAN v. CHIP, higher percentage of representatives for PCPs v. practice types with fewer members, etc.).

27.	7.3	190	Section 7.3 states, "the number of Care Managers hired must equal at least a 40:1 ratio of Members for each Care Manager." If the intent is for each CCO to have a CM ratio of 1 CM for every 40 members enrolled with the CCO, that would result in a need for 3,000-4,000 case managers per CCO. a. If this is correct, can you please clarify how this will be accounted for in the rates? b. If this is incorrect, can more clarity be provided on how this ratio should be calculated? c. Please confirm that "care manager" is inclusive of non-clinical member-facing staff such as community health workers and care coordinators.	a. The ratio will be taken into account in the rate setting process in the same manner that care management is usually taken into account in the rate setting process. More details will be available when the rates are set for the base year of this Contract. b. The 40:1 ratio indicates that no Care Manager for a winning Contractor may have a case load of more than 40 Members. There may be fewer than 40 Members assigned to a Care Manager as needed due to stratification of Members and to ensure that Members are receiving the best Care Management. Offerors are reminded that medium- and high-risk Members are to be assigned a Care Manager per Section 7.5 of Appendix A: Draft Contract. Low-risk Members are to have access to Care Management teams with a point of contact, and therefore, they are not part of the 1:40 Member count. c. As stated in Draft Contract, Section 7.3, "Care Managers must have appropriate skills and training to engage with Members of different acuity levels, including training and experience in healthcare delivery, health education and coaching, supporting access to needed resources, and assisting in adherence to treatment plans. Care Managers must additionally receive Cultural Competency training. Additionally, the Contractor must hire at least one Care Manager with special training and knowledge of Care Management practices relevant to Mississippi's Native American community." The Offeror may hire qualified individuals who fit this definition. Clinicians are not required.

28.	7.3	190	Contract Section 7.3: Care Managers states that the "number of Care Managers hired must equal at least a 40:1 ratio of Members for each Care Manager." Is the 40:1 ratio applicable when Care Manager caseloads include a mix of acuity/risk levels (i.e., Low, Medium, High)? For example, is the 40:1 ratio the same for a Care Manager with a case mix of 60% medium-risk and 40% high-risk members and a Care Manager with a case mix of 70% high-risk or 30% medium-risk members?	Members assigned may be stratified across risk levels or not; that is at the Offeror's discretion in its qualification. 40:1 is the highest ratio the Division expects; Contractors can assign fewer Members per Care Manager as appropriate.
29.	7.4.1	191	Can the state clarify what constitutes a "Closed-loop Referrals and Warm Handoff" as indicated in Contract Section 7.4.1? For example, if a referral is made by an individual members or provider, is the expectation that Care Managers follow-up on these referrals or is the requirement limited to referrals that the Contractor makes?	The requirement applies to referrals made by a provider and referrals made by the Care Manager.
30.	7.4.2, 6.2.5, 3.2.4, RFQ 4.2.3.2	191, 158, 77	Can the state clarify what the intention is regarding mandatory enrollment of medium and high risk members with a PCMH. Section 7.4.2 states "the Contractor is required to utilize a PCMH as the PCP for higher acuity (medium- and high-risk) Members" and 6.2.5 states that we are to "develop an NCQA-recognized Patient-Centered Medical Home (PCMH).... for each medium- and high-risk Member." The RFQ Question 4.2.3.2 includes the language "PCMHs should be made available to all medium- and high-risk Members." Understanding that while PCMHs are available in MS currently, there is limitations of the network at present. Is the intent for the respondent to build this network and to offer or make available a PCMH to all medium and high risk members (retaining their choice of providers per Section 3.2.4)? Also, should PCMHs be made available to all members, including low risk members?	The Contractor should work to build a robust PCMH network within the state. PCMHs are required for medium- and high-risk Members; PCMHs are desirable for low-risk Members but are not required.

31.	7.4.1, 7.5.1, 7.8.4	191, 199, 204	Can the state please clarify the appropriate time frames for closed-loop referral follow-up once a CM has made a referral to an external entity or provider: Section 7.5.1 and Table 7.1 of the contract references a 30 day time frame, Section 7.4.1 references a 7 day time frame, and 7.8.4 references a 48 hour time frame.	Table 7.1 and Section 7.5.1 should include a 7-day time frame as stated in Section 7.4.1, not a 30-day time frame. (Corrected in Amendment 6.) Section 7.8.4 is in reference to Transitions of Care only, and in this circumstance, a 48-hour time frame is required.
32.	7.4.3.3	194	Contract Section 7.4.3.3, Risk-level Assignment identifies multiple subpopulations to be assigned to a medium- or high-risk care management category, while 7.4.3.3.1, Mandatory Assignment, includes a list of those same subpopulations as required to be automatically enrolled into a high-risk category. Can the State please confirm that the requirement for those subpopulations to be enrolled into a medium- or a high-risk category, as indicated in 7.4.3.3, is the accurate one? For example, if a member with diabetes or SPMI has completed the CHA and is determined to be at medium risk, is this allowable?	7.4.3.3.1 speaks to automatic assignment at the time of a Member's enrollment and/or at the time the condition is first detected. The language referring to medium- or high-risk care management assignment in 7.4.3.3 is indicating that if, during the life of the Member's enrollment with the Contractor, after a follow-up assessment is conducted, the Contractor has information about the Member that placement in medium-risk care management is more appropriate, then the Member may be reassigned.
33.	7.4.3.3	194	Will the state provide guidance on how it defines "Serious SDOH challenges" referenced in contract section 7.4.3.3.	Serious SDOH challenges are SDOH issues identified by the Contractor through its Assignment of Risk Levels process. Given the nature of SDOH, these determinations are based on a holistic view of the Member and may change on a case-by-case basis. In making answers about its Care Management strategy, the Offeror is encouraged to highlight SDOH challenges it believes may be applicable to the MississippiCAN and CHIP populations in Mississippi.

34.	7.4.3.3.1	194	Contract Section 7.4.3.3.1 of the draft contract identifies that "all members identified as having one of the following conditions" should be enrolled into the "high-risk" Care Management category. The conditions listed include: pregnancy, diabetes, asthma, cardiovascular diseases, and/or chronic kidney disease, substance use disorder, and Foster Children. Section 7.4.3.4 identifies that the "Contractor will provide Medium- or High-Risk care Management to all Members identified with the following conditions: diabetes, pre diabetes, asthma, hypertension, obesity, attention deficit disorder, congestive heart disease, organ transplants, behavioral health conditions, foster children, substance use disorders, perinatal conditions." Please confirm that the reference in 7.4.3.4 is correct, and that members in these categories may be assigned to Medium or High Risk care management depending on their full Comprehensive Health Assessment, and do not all automatically default to High Risk care management.	7.4.3.3.1 speaks to automatic assignment at the time of a Member's enrollment and/or at the time the condition is first detected. The language referring to medium- or high-risk care management assignment in 7.4.3.3 is indicating that if, during the life of the Member's enrollment with the contractor, after a follow-up assessment is conducted, the Contractor has information about the Member that placement in medium-risk care management is more appropriate, then the Member may be reassigned.

35.	7.4.3.3, 7.4.3.4	194-195	Can the state please clarify the mandatory populations for medium and high risk assignment as there appears to be some discrepancy across contract sections. Contract Section 7.4.3.3 states that 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, Members with serious SDOH challenges, foster children, and infants and toddlers with established risk for developmental delays, shall be assigned to the medium or high risk level. Members being discharged from an acute inpatient psychiatric stay or PRTF shall be assigned to the high-risk level and receive Care Management services. *Subsequently, Section 7.4.3.3.1 states that many of the conditions or situations addressed above should enroll in high risk (vs. medium and high) including ALL pregnant members (vs. high risk pregnant members and pregnant members under 21). *Subsequent section 7.4.3.4 states that "the Contractor will provide Medium- or High-Risk Care Management services to all Members identified with the following conditions: diabetes, prediabetes, asthma, hypertension, obesity, attention deficit disorder, congestive heart disease, organ transplants, behavioral health conditions, foster children, substance use disorders, perinatal conditions." This language seems to revert to the CCOs capability to assign members to one of two risk levels (medium or high) based on their needs despite the fact that many conditions (diabetes, asthma, cardiovascular disease, etc.) are included in the mandatory high enrollment conditions.	7.4.3.3.1 speaks to automatic assignment at the time of a Member's enrollment and/or at the time the condition is first detected. The language referring to medium- or high-risk care management assignment in 7.4.3.3 is indicating that if, during the life of the Member's enrollment with the contractor, after a follow-up assessment is conducted, the Contractor has information about the Member that placement in medium-risk care management is more appropriate, then the Member may be reassigned. 7.4.3.4 refers again to a Contractor's ability to reassign as stated in 7.4.3.3.
36.	7.8.8	206, 207	Please clarify how the PPHR described in this section will be used.	The PPHR will be used as one quality metric for measuring each Contractor's efforts to improve the quality of care for Members. This quality metric may be used in association with the Contractor's annual incentive withhold.

37.	8.5	213	Please provide a copy of the Mississippi Division of Medicaid Value-Based Payment Work Plan.	This document is under development and will be further developed based on responses from Offerors and with winning Contractors during implementation.
38.	8.9	215	Contract Section 8.9 states the Division reserves the right to raise the 0.5% SDOH capitation payment rate during the life of the contract. Will the state provide a threshold or range for any potential increase?	The Division will not require more than 1% of the capitation payment to be devoted to SDOH projects.
39.	8.9	215	The contract (section 8.9) specifies that 0.5% of Capitation Payments received be devoted to Social Determinants of Health projects with community-based organizations. Will the state please confirm that Contractors may implement SDOH projects (upon state review and approval) that partner with entities, subcontractors, or vendors in lieu of or in addition to projects with community-based organizations. If so, will the state also confirm these projects (upon state review and approval) may be included in the 0.5% Capitation Payment.	Contractors may partner with other entities in projects designed with community-based organization. Contractors may not partner with other entities in lieu of partnership with community-based organization. The 0.5% must be devoted to SDOH projects and initiatives built in partnership with community-based organizations. As stated in Exhibit A, Draft Contract, projects are subject to Division approval.
40.	8.9	215	Regarding the commitment of at least 0.5% of Capitation Payments to Social Determinants of Health: a. How should these costs be shown in the Pro Forma? b. Please confirm that these expenses will count in the numerator of the MLR for minimum MLR calculation purposes. c. Please clarify if this is for both the MSCAN and CHIP programs.	a. Show these costs separately so the Division can track these expenditures. b. Yes, these expenses will count in the numerator of the MLR for minimum MLR calculation purposes. c. Yes, because under the new procurement/contract, CHIP will be combined into MSCAN as a separate Rate Cell.

41.	8.20	226, 227	Please confirm that table 8.1 contains the rate targets we must meet. Also in Table 8.1 EPSDT Screening Rates, the second measure is immunizations and the rate targets show 85% of enrolled members under age one (1) had required immunizations; and 75% of enrolled members between the ages of one (1) and 21 had screenings. Should the 85% measure for members between ages of one and 21 be for immunizations instead of screenings?	Section 8.20 should reference Table 8.1 in the second paragraph of the section. Table 8.1 contains the rate targets a Contractor must meet for EPSDT Screening and Immunization Rates. Table 8.1 should be named "Table 8.1 EPSDT Screening and Immunization Rates." Under the Measure "Immunizations" in Table 8.1, the requirement should read as follows: "Eighty-five percent (85%) of enrolled Members under age one (1) had required immunizations; Seventy-five percent (75%) of enrolled Members between the ages of one (1) and twenty-one (21) had required immunizations." (Corrected in Amendment 6.)
42.	8.21	227	Table 8.2 Well-Care Child Assessments and Immunization Screening Rates follows this statement. Please clarify that the Screening rates requirement for 8.21 are contained in Table 8.2.	8.21 should reference Table 8.2 in the second paragraph of the section. Table 8.3 does not exist. Table 8.2 contains the rate targets a Contractor must meet for CHIP Well-Care Child Assessments and Screening Rates, in compliance with Section 8.21. (Corrected in Amendment 6.)
43.	9.1.6	231	Section 9.1.6 states "the Contractor shall not employ off-system adjustments when processing corrections to payment errors unless it requests and receives prior written authorization from the Division." Can the Division define and provide more information about "off-system adjustments?"	Off-system adjustments are defined as any payments or adjustments that the Contractor would expect to include in its financial template but would not be included in Encounter reporting.
44.	11.1.2	250, 251	In Section 11.1.2 Payment in Full of Appendix A - CCO Contract, the contract contains the following language: • Failure to provide Care Management services as required under Section 7, Care Management will result in Capitation Payment reduction. • Failure to enroll the Members identified in Section 7.4.3.3.1, Care Management: Assignment of Risk Levels: Mandatory Assignments into the Contractor will result in Capitation Payment reduction. Please provide additional clarification on the process to	The Division will evaluate the level and quality of care management provided by each CCO against standards of care for each beneficiary level as described in Appendix A, Draft Contract. The determination that either a pattern of inappropriate provision of care management or delays in the provision of care management exist is at the sole discretion of the Division. A corrective action plan (CAP) will be required from the Contractor upon the Division's finding of a failure to meet requirements as appropriate. The timing and amount of any associated Capitation Payment reduction will be dependent upon the failure found by the Division, the ability

			determine a failure on the part of a Coordinated Care Organization to meet these requirements and how the Division will assess the reduction in capitation payment, including the timing and amount.	of the Contractor to resolve the issue, and the impact on the Member community. At all times, the well-being of the Member community will be tantamount in the Division's application of the Capitation Payment reduction.
45.	16	302	Please provide a copy of the MississippiCAN and CHIP Reporting Manuals.	Downloadable links for both Reporting Manuals will be provided on the dedicated DOM CCO Procurement Website no later than Friday, February 11, 2022.
46.	16.2.4	305	The numbered list of claims denials by category in Section 16.2.4 begins at #15, rather than #1. Will the Division please confirm that this list of denials is comprehensive and there are not missing denial types the Contractor is responsible for reporting on?	The list is comprehensive, and there are no missing denial types. This list should begin with 1 and be numbered through 8. This is a typographical error. (Corrected in Amendment 6.)
47.	16.5	311	Section 16.5 states "it is a Division requirement that the Contractor integrates with any future Division Government-to-Constituent (G2C) CIAM with Federation." Can the Division provide more information on any planned or potential G2C CIAM initiatives?	The Division will provide additional information to winning Contractors regarding this requirement as it becomes available during the life of the Contract.
48.	16.7.1	314	Will the PBA be responsible for pharmacy encounter data submissions?	Yes.
49.	16.8	320	This section states, "For any pharmacy and/or drug delivery services and/or benefits the Contractor is directed to deliver by the Division, the Contractor shall report drug (i.e., j-code) utilization data to the Division's Agent." Will the Contractors be required to submit drug data to the Division or will this be the responsibility of the PBA?	For Physician-Administered Drugs and Implantable Devices, this would be the responsibility of the Contractor. For retail pharmaceuticals, this would be the responsibility of the PBA. If the Division requires additional information from the Contractor regarding this issue, the Division reserves the right to make that request during the life of the Contract.
50.	Exhibit C, B.2.b	331	Please confirm that rebates received by the PBA would not be excluded from the minimum MLR calculation.	Rebates will not be included in the MLR calculation.

51.	Exhibit C	331	As a PBA will be utilized for pharmacy claims management, can the Division confirm the PBA will manage "prescription drug rebates received and accrued by the Contractor, as well as rebates available and retained by the pharmacy benefits manager;"? Can the Division also confirm the language relating to "pharmacy benefits manager" should be updated to "pharmacy benefits administrator"?	The PBA will be responsible for management of prescription drug rebates received and accrued, as well as rebates available and retained. (Corrected in Amendment 6.)
52.	Exhibit C	332	Can the Division confirm this requirement will be updated as a PBA will be utilized for pharmacy claims management? Can the Division also confirm the language relating to "pharmacy benefits manager" should be updated to "pharmacy benefits administrator"?	This requirement will be updated to account for PBA claims management. The language relating to "pharmacy benefits manager" should be updated to "pharmacy benefits administrator."
53.	Exhibit C	335	As a PBA will be utilized for pharmacy claims management, can the Division confirm the PBA will perform "Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions"?	Yes. (Corrected in Amendment 6.)
54.	Exhibit C, L.2.a	348	Will MSCAN and CHIP be combined for the minimum MLR requirement, or will they have separate minimum MLR calculations? If separate, will CHIP have an 85% minimum MLR threshold like pg. 14 of Appendix C? The difference between the 87.5% and 85% minimum MLRs are due to the MHAP/MAPs payments being included in the MSCAN calculation, while they are not in the CHIP program because CHIP does not have MHAP/MAPs payments. If combined, will there be an update to minimum MLR amount to blend the two minimum thresholds of 87.5% and 85% for MSCAN and CHIP respectively?	Yes, these will be combined. The Division will calculate a revised Minimum MLR Ratio to be effective with the first reporting year of the Contract.

55.	Exhibit D	352	Please confirm that the intent is for the Contractors to respond within five (5) business days of the receipt of Grievance and Appeals.	The intent is for the Offeror to respond within five (5) calendar days of receipt of the Grievance or Appeal. Inclusion of "business" in this requirement is a typographical error. (Corrected in Amendment 6.) The requirement is reiterated in Table 5.1 Summary of MississippiCAN Member Grievances and Appeals Requirements and Table 5.1 Summary of CHIP Member Grievances and Appeals Requirements.
56.	Exhibit G	404	Is this is reference to the quality withholds referenced in 11.1.1.5 or a separate set of measures? Additionally, is PM#1 duplicative of GEN#1 or a different set of performance measures?	GEN#1 is duplicative of PM #1. GEN #1 will be removed. (Corrected in Amendment 6.) This Liquidated Damage does not apply to the quality withhold described in 11.1.1.5.

[End of 2. Draft Contract Questions and Answers]

[END OF DOCUMENT]

Amendment #5 to RFQ 20211210: RFQ Corrections and Clarifications

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

This document contains corrections and clarifications referenced in Amendment 4: RFQ Questions and Answers as they relate to RFQ-Specific Questions and Answers.

Receipt of Amendment 5 Acknowledged:

(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

4.2.2 Methodology/Work Statement

Page 44 is amended as indicated in red, below:

~~**For each of the subsections below, responses to Work Plan and Schedule are not subject to the page response limits listed for that section. Work Plans and Schedule response are limited to 15 additional pages for each section.**~~

4.2.2.1 Member Services and Benefits

Page 45 is amended as indicated in red, below:

Response Limit: ~~5~~65 pages, plus two (2) marketing samples, not to exceed five (5) pages each.

Page 46 is amended as indicated in red, below:

4. Chronic Conditions

   a. Describe how the Offeror will implement innovative programs to improve the health and well-being of Members diagnosed with diabetes and pre-diabetes.
   b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for services for Members with chronic health conditions generally.
   c. Describe the Offeror's approach to delivery and payment for chronic health conditions services generally.
   d. Describe any innovative methods that Offeror will use to augment its approach.
   e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding Members with chronic conditions?

   ~~f.~~

5. Foster Children

   a. Describe the Offeror's experience and/or capacity to manage the care of foster children, and your ability to develop a continuum of care responsive to their needs.

Page 47 is amended as indicated in red, below, to correct typographical errors found in the course of making other revisions:

7. Vision Services

   a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for vision services.
   b. Describe any innovative methods that Offeror will use to augment its approach.
   c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding visions services?

8. Additional Items

   d. Describe any additional practices the Offeror will use to address racial, ethnic, and geographic disparities in delivery of services.

B. Member Services Call Center

1. Describe the Offeror's Member services call center operations, including:

   a. Confirming that the location of the proposed operations will be within the State of Mississippi ~~Hinds, Madison or Rankin Counties~~ (provide a yes or no answer; do not include address);

Page 49 is amended as indicated in red, below:

~~**H. Work Plan and Schedule**~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Member Services and Benefits, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

1. ~~Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~
2. ~~Effort Needed: Resource-weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
3. ~~Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
4. ~~Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
5. ~~Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
6. ~~Schedule: A schedule for all deliverables.~~

4.2.2.2: Provider Network and Services

Page 52 is amended as indicated in red, below:

~~F~~E. Provider Payment

~~**G. Work Plan and Schedule**~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Provider Network and Services, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

1. ~~Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~

~~2. Effort Needed: Resource-weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
~~3. Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
~~4. Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
~~5. Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
~~6. Schedule: A schedule for all deliverables.~~

4.2.2.3: Care Management

Page 53 is amended as indicated in red, below:

Response Limit: 45 pages, plus two (2) appendices: one (1) in response to B.1, and one (1) in response to B.2. Each appendix is limited to five (5) pages.

Page 55 is amended in red, as follows:

~~**G. Work Plan and Schedule**~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Care Management, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

~~1. Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~
~~2. Effort Needed: Resource-weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
~~3. Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
~~4. Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
~~5. Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
~~6. Schedule: A schedule for all deliverables.~~

4.2.2.4 Quality Management

Page 56 is amended as indicated in red, below:

Response Limit: 40 pages, plus ~~a 10-page appendix~~ two (2) appendices: one (1) in response to A.2, and one (1) in response to C.1. Each appendix is limited to ten (10) pages.

Page 57 is amended as indicated in red, below:

~~D. Work Plan and Schedule~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Quality Management, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

1. ~~Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~
2. ~~Effort Needed: Resource-weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
3. ~~Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
4. ~~Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
5. ~~Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
6. ~~Schedule: A schedule for all deliverables.~~

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4.2.2.5 Utilization Management

Page 58 is amended in red, below:

~~C. Work Plan and Schedule~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Utilization Management, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

1. ~~Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Page 59 is amended as indicated in red, below:

~~2. Effort Needed: Resource-weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
~~3. Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
~~4. Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
~~5. Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
~~6. Schedule: A schedule for all deliverables.~~

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4.2.2.6: Information Technology

Page 60 is amended as indicated in red, below:

Response Limit: 25 pages, plus two (2) appendices: one (1) in response to A.1.a., and one (1) in response to D.1. Each appendix is limited to ten (10) pages.

C. Innovation

~~2~~3. Describe any other innovative technological methods, if any, the Offeror will utilize to render services to the Division.

D. Continuity of Operations

1. In an appendix no longer than ten (10) pages, ~~D~~describe the Offeror's proposed emergency response continuity of operations plan. ~~Attach a copy of the Offeror's plan or summarize how the Offeror's plan a~~Addresses the following aspects of pandemic preparedness and natural disaster recovery, including:

Page 61 is amended in red, as follows below:

~~**E. Work Plan and Schedule**~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Information Technology, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

~~1. Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~
~~2. Effort Needed: Resource-weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
~~3. Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~

~~4. Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
~~5. Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
~~6. Schedule: A schedule for all deliverables.~~

4.2.2.7: Subcontractual Relationships and Delegation

Page 62 is amended as indicated in red, below:

~~**C. Work Plan and Schedule**~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Subcontractual Relationships and Delegation, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

~~1. Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~
~~2. Effort Needed: Resource-weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
~~3. Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
~~4. Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
~~5. Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
~~6. Schedule: A schedule for all deliverables.~~

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Page 63 is amended as indicated red, below:

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4.2.2.8: Financial Data and Reporting

Page 64 is amended as indicated in red, below:

~~**C. Work Plan and Schedule**~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Subcontractual Relationships and Delegation, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual~~

~~deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

1. ~~Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~
2. ~~Effort Needed: Resource weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
3. ~~Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
4. ~~Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Page 65 is amended as indicated in red, below:

5. ~~Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
6. ~~Schedule: A schedule for all deliverables.~~

[~~REST OF~~ PAGE INTENTIONALLY LEFT BLANK]

4.2.2.9: Program Integrity

Page 66 is amended as indicated in red, below:

~~**D. Work Plan and Schedule**~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Program Integrity, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

1. ~~Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~
2. ~~Effort Needed: Resource weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
3. ~~Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
4. ~~Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
5. ~~Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
6. ~~Schedule: A schedule for all deliverables.~~

4.2.2.10: Subrogation and Third-Party Liability

Page 67 is amended as indicated in red, below:

~~**D. Work Plan and Schedule**~~

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Subrogation and Third Party Liability, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

1. ~~Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~
2. ~~Effort Needed: Resource-weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
3. ~~Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
4. ~~Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
5. ~~Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
6. ~~Schedule: A schedule for all deliverables.~~

4.2.2.11: Eligibility, Enrollment, and Disenrollment

Page 68 is amended as indicated in red, below:

Response Limit:15 pages, plus two (2) appendices: one (1) in response to A.2.c, and one (1) in response to C(1)(e) (optional). Each appendix is limited to five (5) pages each.

~~**D. Work Plan and Schedule**~~

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Page 69 is amended as indicated in red, below:

~~The Offeror must create a detailed work plan broken down by tasks and subtasks of the duties required by Appendix A, Draft Contract, regarding Eligibility, Enrollment, and Disenrollment, and a schedule for the performance of each task included in each Contract year. The schedule should allow fifteen (15) working days for the Division approval of each submission or re-submission of each individual deliverable, unless another timeframe has been specified for a particular deliverable in other sections of this RFQ or in Appendix A, Draft Contract. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined in Appendix A, Draft Contract, and this RFQ.~~

~~The Offeror's response must include the following subsections:~~

~~1. Assumptions and Constraints: Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.~~
~~2. Effort Needed: Resource-weeks of effort for each task or subtask, showing the Offeror's resource and the Division's resource efforts separately.~~
~~3. Diagram: A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.~~
~~4. Gantt Chart: A Gantt chart, showing the planned start and end dates of all tasks and subtasks.~~
~~5. Troubleshooting: A discussion of how the work plan provides for handling of potential and actual problems.~~
~~6. Schedule: A schedule for all deliverables.~~

[PAGE INTENTIONALLY LEFT BLANK]

4.3.1.2 Corporate Experience

Page 74 is amended as indicated in red, below:

The Corporate Experience Section must present the details of the Offeror's experience with the type of service to be provided by this RFQ and Medicaid experience. Using the provided form in Appendix F, provide information about states the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.

If the information requested above is not available, the Offeror must provide a~~n~~ narrative explanation, not to exceed three (3) pages. Acceptance of the explanation provided is at the discretion of the Division.

4.3.3 Organization and Staffing
Page 78 is amended as indicated in red, below:

The Organization and Staffing Section shall include team organization, charts of proposed positions, number of FTEs associated with each position for key staff, and job descriptions of key management personnel and care managers listed in Section 1.13, Administration, Management, Facilities, and Resources of Appendix A, Draft Contract, as well as the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract, and what economic impact the ~~execution~~ selection of the Offeror might have on the state.

4.3.3.3 Administrative Requirements
Page 78 is amended as indicated in red, below:
The Offeror will verify and answer the following:

1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.

2. In a narrative no longer than two (2) pages, ~~T~~the Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives.

The Offeror must complete the appropriate attestation in Appendix H as its response to Question 1.

4.3.3.5 Subcontractors

Page 79 is amended as indicated in red, below:

The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management. Additionally, the Offeror must ~~U~~use the forms provided in Appendix H to describe Subcontractors the Offeror expects to utilize for this Contract. If a subcontractor has provided services for the Offeror for a managed care contract in the past three (3) years, use the appropriate form in Appendix H to detail those services.

4.3.3.6 Economic Impact

The heading for 4.3.3.6 is amended as indicated in red, below:
4.3.3.6 Economic Impact (Marked) – 20 points

Page 79 is amended as indicated in red, below:
There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be located in Mississippi. Use the form provided in Appendix H to detail expected wages for those positions as well as any other positions the Offeror will locate in Mississippi. The Offeror should only describe positions that will be directly hired by the Offeror. The Offeror should not include positions to be filled by Subcontractors.

Page 80 is amended as indicated in red, below:
Additionally, include a narrative explanation no longer than two (2) pages of other investments, if any, that the Offeror plans to make in Mississippi.

[END OF DOCUMENT]

Amendment #6 to RFQ 20211210: Appendix A: Draft Contract Corrections and Clarifications

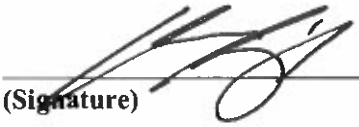
RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

This document contains corrections referenced in Amendment 4: RFQ Questions and Answers as they relate to Appendix A: Draft Contract-Specific Questions and Answers.

Receipt of Amendment 6 Acknowledged:



(Signature)

Aaron Sisk

(Printed)

President and CEO

(Title)

Magnolia Health Plan, Inc.

(Company)

3. Eligibility, Enrollment, and Disenrollment

Page 72 is amended as indicated in red, below:

The Division ~~Contractor~~ will be responsible for assessing eligibility and conducting enrollment for members of MississippiCAN and CHIP. Eligibility and Enrollment guidelines for each program are described in this section.

5.1.6 Additional Call Center Sufficiency Standards

Page 119 is amended as indicated in red, below:

2~~1~~. The average monthly speed to answer after the initial automatic voice response is ~~forty (40)~~ one hundred and twenty (120) seconds or less;

Table 7.1

Page 198 is amended as indicated in red, below:

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 organizations, free care initiatives, and support groups; and follow up with both the Member and any organizations to which the Member has been referred within seven (7) ~~thirty (30)~~ calendar days of referral, with assistance offered to the Member to overcome any barriers to access to the utilization of the referral organization.

7.5.1 Services for All Members/Low Risk Members

Page 199 is amended as indicated in red, below:

6. 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 Mississippi Department of Human Services; Developing, planning and assisting Members with information about community-based organizations, free care initiatives, and support groups; and follow up with both the Member and any organizations to which the Member has been referred within seven (7) ~~thirty (30)~~ calendar days of referral, with assistance offered to the Member to overcome any barriers to access to the utilization of the referral organization;

8.20 MississippiCAN EPSDT Screening and Immunization Rate Validation

Page 226 is amended as indicated in red, below:

The Contractor must achieve the screening rates in Table 8.12 to comply with this Contract. The identified targets may be updated by the Division periodically.

Page 227 is amended as indicated in red, below:

Table 8.1 EPSDT Screening and Immunization 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-five percent (85%) of enrolled Members under age one (1) had required immunizations; Seventy-five percent (75%) of enrolled Members between the ages of one (1) and twenty-one (21) had required immunizations ~~screenings~~.

8.21 CHIP Well-Care Child Assessments and Immunization Rates Validation

Page 227 is amended as indicated in red, below:

The Contractor must achieve the screening rates in Table 8.23 to comply with this Contract. The identified targets are in effect for the first year of operations, and the Division will update these targets annually.

16.2.4 Claims Denial Report

Page 306 is amended as indicated in red, below:

1~~5~~. Prior authorization,

2~~6~~. Claims completion errors,

3~~7~~. Duplicate claims,

4~~8~~. Services not covered,

5~~9~~. Services not rendered because the Member is not eligible,

6~~20~~. Timely filing,

7~~21~~. Coordination of benefits, and

8~~22~~. Any other denial categories utilized by the Contractor.

Exhibit C: Medical Loss Ratio (MLR) Requirements

B. Reimbursement for Clinical Services Provided to Members

Page 331 is amended as indicated in red, below:

1. Amounts that must be deducted from incurred claims include:

   a. Overpayment recoveries received from Network Providers;

   b. If applicable, prescription drug rebates received and accrued by the Contractor~~, as well as rebates available and retained by the pharmacy benefits manager~~;

C.2. Activity Requirements

Page 335 is amended as indicated in red, below:

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;~~

Page 336 is amended as indicated in red, below:

   (d~~e~~)Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and

   (c~~f~~) Health information technology to support these activities.

Exhibit D

Page 352 is amended as indicated in red, below:

B. Grievance

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 the grievant with verbal notice of expected date of resolution. If requested by the Member or the Member's representative, a written resolution will be provided.

Exhibit G: Liquidated Damages

Category 1: General - GEN

Page 388 is amended in red, below:

Reference #	Service/Component	Performance Standard	Measurement Period	Measurement Assessment	Liquidated Damages
~~GEN #1~~	~~General~~	~~Failure by the Contractor to meet the Performance Measure targets established by the Division.~~	~~For the Term of the Contract~~	~~Per measure, per reporting period~~	~~The Division may assess up to a 1% reduction in Capitation Payments for the reporting period of the measure if the Contractor is found out of compliance.~~
GEN #12	General	The Contractor must not engage in misrepresentation or falsification of information to the Division, any governmental entity, any provider, and/or any Member or potential Member.			The Division may assess liquidated damages of up to $25,000 for each failure to comply. Repeated instances may result in grounds for Termination.
GEN #23	Section 16.4, Access to Records and throughout this Contract.	The Contractor must grant timely access to records (as defined by the Secretary in regulations) upon reasonable request to any person (including an organization, agency, or other entity, but excluding a Member) or 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.	For the Term of the Contract	Per incident, per day of noncompliance	In addition to any other penalties that may be prescribed by law, the Division may asses a 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 terminate the Contract.
GEN #34	Section 13.2.1, Subcontracting Conditions	1In the event that the Contractor terminates the Subcontractor or the Subcontractor ends its relationship with the Contractor, the Contractor will give notice to the Division within one (1)	For the Term of the Contract	Each day of noncompliance	The Division may assess up to $5,000 per day of noncompliance.

		business day of termination and include information about the Contractor's plan to ensure continuity of services affected by the loss of the Subcontractor.			
GEN #45	Section 13.2.3, Division Approval Process	The Contractor must obtain written approval from the Division of a Subcontractor prior to initiating a Contract for services from that Subcontractor.	For the Term of the Contract	Per incident	The Division may assess liquidated damages in an amount up to $10,000 for each day that the Subcontractor was in effect without the Division's approval.

Page 389 is amended in red, below:

[~~REST OF~~ PAGE INTENTIONALLY LEFT BLANK]

[END OF DOCUMENT]

Amendment #7 to RFQ 20211210: Updated RFQ Appendices F and H in Word Format

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

Provided herein are amended Microsoft Word versions of the following:

- APPENDIX F: Corporate Background and Experience, form 4.3.1.2: Corporate Experience
- APPENDIX H: Organization and Staffing, Attestation for 4.3.3.3 Administrative Requirements
- APPENDIX H: Organization and Staffing, first form for 4.3.3.5 Subcontractors

Typographical Errors

Additionally, the following typographical errors were corrected in the following documents included in this amendment:

APPENDIX F Amendments

Page 112 is amended in red, below:
4.3.1.2: Corporate Experience
Use the following form to provide information for any states that the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.

If the Offeror has no current or recent clients, the Offeror must provide a narrative explanation, not to exceed three (3) pages. ~~an explanation. Offerors must submit appropriate documentation to support information provided.~~ Acceptance of the explanation provided is at the discretion of the Division.

Page 113 is amended as explained below:
The form for APPENDIX F: Corporate Background and Experience, form 4.3.1.2: Corporate Experience (Page 113) is amended to remove a duplicative field requesting "Geographic and population coverage requirements."

APPENDIX H Amendments

Page 132 is amended as explained below:

The header of the attestation for APPENDIX H: Organization and Staffing, 4.3.3.3 Administrative Requirements is amended to show the correct number of points available for this section as indicated in red below, in conformance with the scoring as stated in the body of the RFQ:

4.3.3.3 Administrative Requirements (Marked) – 510 points

The body of the attestation for APPENDIX H: Organization and Staffing, 4.3.3.3 Administrative Requirements is amended as indicated in red below:

4.3.3.3 Administrative Requirements (Marked) – ~~510~~ points

Offeror attests to the following:

1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.
2. ~~The Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives.~~

Page 133 is amended as indicated in red, below:
4.3.3.5 Subcontractors – 20 points

The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management.

Use the first provided form entitled "Subcontractor" to describe the any subcontractor the Offeror plans to use if chosen as a winning Contractor through this RFQ.

If the Offeror has worked with the subcontractor in the past three (3) years on a managed care contract, use the second form, "Prior Experience with Subcontractor" to give details about that experience.

Page 134 is amended as explained, below:
The first form in APPENDIX H: Organization and Staffing, 4.3.3.5 Subcontractors was amended to include an option for "Affiliate under the same common ownership" as a response to the question, "This entity is a:".

Receipt of Amendment 7 Acknowledged:

(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

Corporate Experience: Current and/or Recent Client				
Client's Name:				
Client Location				
Address Line 1:				
Address Line 2:				
City:	**State:**	**Zip Code:**		**County:**
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name:				
Title:				
Phone Number:		**Email Address:**		
Work Details				
Number of covered lives:				
Time period of contract:				
Total number of staff hours expended during time period of contract:				
Personnel requirements:				
Geographic and population coverage requirements:				
Publicly funded contract cost:				
Description of work performed under this contract				

4.3.3.3 Administrative Requirements (Marked) – 5 points

Offeror attests to the following:

3. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.

_____

Name of Offeror

_____ _____

Printed name of person attesting for Offeror **Title of person attesting for Offeror**

_____ _____

Signature of person attesting for Offeror **Date**

Subcontractor				
Name of Subcontractor:				
TIN/SSN (as applicable):		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1:				
Address Line 2:				
City:	**State:**	**Zip Code:**	**County:**	
Mailing Address (P.O. Box):	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract:				
How will the Offeror monitor and manage this Subcontractor?				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [ ] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Amendment #8 to RFQ 20211210: Additional MSCAN and CHIP Rate Information in Excel Format

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

There was request through RFQ Questions and Answers (see Amendment 4 to this RFQ) for complete tables used for rate development, as referenced in RFQ Appendix C. These tables are now available in Excel Format for both MSCAN and CHIP on the dedicated Division of Medicaid Coordinated Care Procurement website, https://medicaid.ms.gov/coordinated-care-procurement/ with the following names:

- Amendment 8: SFY 2022 Preliminary MSCAN Capitation Rates
- Amendment 8: SFY 2022 Preliminary CHIP Capitation Rates

Receipt of Amendment 8 Acknowledged:

(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

Amendment #9 to RFQ 20211210: Clarification of Amendment 4 Responses

RFQ #: 20211210 / RFx#3150003991

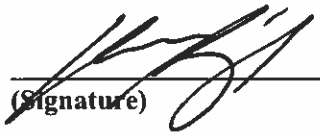
Date: February 10, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

The Division has received requests to clarify certain answers given by the Division in Amendment 4: RFQ Questions and Answers. The Division is not obligated to grant this request. However, in order to ensure that the Division receives the best possible qualifications, the Division has decided to grant this request, with the following requirements:

1. Questions submitted must be about specific answers given in **Amendment 4 ONLY**. No questions outside of that scope will be accepted. The Division has sole discretion as to whether a question submitted complies with this requirement.
2. The Division is not obligated to provide an answer to a question submitted if, in the Division's judgment, there is an answer that has already been given that addresses the submitted question. The Division may respond to such a question with the previously stated answer.
3. All questions must be submitted using Appendix J, Question and Answer template. Potential Offerors should use the "Section" Column to reference the specific question the Potential Offeror is referencing in Amendment 4 and use the "Page" column to reference the page of that question.
4. Potential Offerors must submit questions under this Amendment via Email to MSCAN_CHIP@medicaid.ms.gov by no later than **Monday, February 14, 2022, 12:00 pm Central Time Zone**. Submissions made after this time will not be accepted. The Offeror bears all risk of delivery.
5. The Division will publish answers no later than Wednesday, February 16, 2022, 5:00 pm Central Time Zone.
6. Other than in response to this Amendment, Offerors may not submit any further questions, other than those necessary to ensure that the Offeror has access to the SharePoint submission site. As stated previously, those questions should be submitted to both Christopher.Shontell@medicaid.ms.gov and MSCAN_CHIP@medicaid.ms.gov. Those questions are handled on an ad hoc basis, and technical assistance given is not considered an amendment to this process.

Receipt of Amendment 9 Acknowledged:



(Signature)

Aaron Sisk

(Printed)

President and CEO

(Title)

Magnolia Health Plan, Inc.

(Company)

Amendment #10 to RFQ 20211210: Summary of Pre-Qualification Conference Held on Friday, January 14, 2022

RFQ #: 20211210 / RFx#3150003991

Date: February 11, 2022

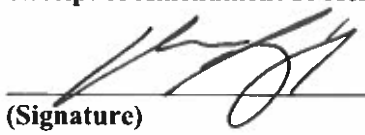
RFQ Name: Mississippi Division of Medicaid Coordinated Care

The Division held a Pre-Qualification Conference on Friday, January 14, 2022. This meeting has been transcribed so that Offerors have a record to reference. Statements made in the meeting have been further clarified by Amendment 2. No part of Amendment 10 supersedes any amendment made after the date of the Pre-Qualification conference. The only additional requirement is included in 1, below.

This document contains the follow:

1. **Attendance Sheet – The Offeror's representative must sign this sheet, certifying that the Offeror attended the pre-qualification conference on Friday, January 14, 2022. This must be submitted with the Receipt of Amendment 10 Acknowledgement when the Offeror submits its qualification.**
2. Transcript of Pre-Qualification Conference
3. Slide Deck presented at the Conference

Receipt of Amendment 10 Acknowledged:



(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

MISSISSIPPI DIVISION OF MEDICAID

ATTENDANCE SHEET

RFQ 20211210: Coordinated Care Procurement
Pre-Qualification Conference
January 14, 2022, at 1:00 P.M.

On January 14, 2022, at 1:00 p.m., the Mississippi Division of Medicaid held a Pre-Qualification Conference via Microsoft Teams. Potential Offerors were required by RFQ 20211210: Section 1.2.2.2, Mandatory Pre-Qualification Conference, to attend the conference. At least one representative had to be present for the entirety of the conference. Attendance was taken at the beginning of the conference for each attendee, and then again at the end of the conference for one representative for each Potential Offeror.

	Representative Name	Organization Name	Required End of Meeting Attendance ✓
1.	Aaron Sisk	Magnolia Health Plan	✓
2.	Brittany Stephenson	Magnolia Health Plan	
3.	Randall Brock	AmeriGroup Mississippi, Inc	
4.	Debby Brutsman	Care Source/TrueCare	
5.	Dana Carbo-Bryant	United HealthCare of MS, Inc.	
6.	Tara Clark	AmeriGroup Mississippi, Inc.	✓
7.	Katelyn Cooper	United HealthCare of MS, Inc.	
8.	Cheryl Crombie	Molina HealthCare of MS, Inc.	
9.	Matthew Dey	AmeriGroup Mississippi, Inc.	
10.	Jennifer Driggs	AmeriGroup Mississippi, Inc.	
11.	Chandler Ewing	United Healthcare of MS, Inc.	
12.	Lauren Fancy	AmeriGroup Mississippi, Inc.	
13.	Bridget Galatas	Molina HealthCare of MS, Inc.	
14.	Erin Gilbert	AmeriGroup Mississippi, Inc	
15.	J. Michael Parnell	United HealthCare of MS, Inc.	✓
16.	Jordan Geolat	Magnolia Health Plan	
17.	Taira Kelley	TrueCare	
18.	Jeremy Ketchum	Molina HealthCare of MS, Inc.	✓
19.	Ian Long	TrueCare	
20.	Karson Luther	AmeriGroup Mississippi, Inc	
21.	Latrina McClenton	United HealthCare of MS, Inc.	

MEDICAID

RFQ 20211210: Amendment 10
February 11, 2022
Attendance Sheet

22.	Sanjoy Musunuri	True Care	
23.	Jason Neerman	True Care	
24.	Nicole Litton	Magnolia Health Plan	
25.	Kristi Plotner	United HealthCare of MS, Inc.	
26.	Dawn Price	True Care	
27.	Jennifer Quittschreiber	Molina HealthCare of MS, Inc.	
28.	Richard Roberson	True Care	✓
29.	Tim Moore	True Care	
30.	Trip Peeples	Magnolia Health Plan	
31.	Mark Voudrie	AmeriGroup Mississippi, Inc	
32.	Khanh Vu	AmeriGroup Mississippi, Inc	
33.	Will Simpson	Magnolia Health Plan	
34.	Dana Yancey	Molina HealthCare of MS, Inc.	
35.	James Sasso	Care Source/True Care	
36.	Maggie Middleton	DOM	
37.	Jeanette Crawford	DOM	
38.	Kate Holland	DOM	
39.	Kayla McKnight	DOM	

Meeting adjourned 1:30 PM.

On behalf of my organization, I attest that a representative for the Organization attended this meeting, in compliance with RFQ 20211210: Section 1.2.2.2, Mandatory Pre-Qualification Conference:

(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

In The Matter Of:

Mississippi Division of Medicaid Office of Procurement
DOM Coordinated Care Procurement

Mandatory Pre-Qualification Conference
January 14, 2022

AW Reporting
Realtime Court Reporters
601-573-0961
amanda@awreporting.net

Min-U-Script® with Word Index

MISSISSIPPI DIVISION OF MEDICAID
OFFICE OF PROCUREMENT

****

DIVISION OF MEDICAID COORDINATED CARE PROCUREMENT
MANDATORY PRE-QUALIFICATION CONFERENCE

****

DATE: FRIDAY, JANUARY 14, 2022
TIME: 1:00 p.m.

TRANSCRIBED BY: AMANDA M. WOOTTON, CSR, RPR

AW Reporting
amanda@awreporting.net
338 Indian Gate Circle
Ridgeland, Mississippi 39157
601.573.0961

* * * * * *

MS. MCKNIGHT: All right. Well, Good afternoon, everyone. And thank you guys for joining the call. I wanted to first start by -- I see that we have quite a few people on the call.

Is there anyone that's waiting on anyone? Do we need to maybe extend the time to 1:05? Does everybody feel like they have their team?

All right.

MR. BROCK: I think everybody is good, yeah.

MS. MCKNIGHT: All right. I guess I'll go that way. AmeriGroup, are you good?

MS. CLARK: We're good.

MS. MCKNIGHT: Good. All right. TrueCare.

I saw you shaking your head. Okay.

MR. DEY: Yes, we are good.

MS. MCKNIGHT: Okay. Magnolia, are you guys good?

MR. SISK: We're good.

MS. MCKNIGHT: All right. And Molina.

MR. KETCHUM: Yes, we're good.

MS. MCKNIGHT: Okay. All right. So this is the Prequalification Conference for the

Coordinated Care Procurement. My name is Kayla McKnight, and I'm the Procurement Director here at the Mississippi Division of Medicaid. I'm going to first start off by taking attendance, and then I'll give you a little instruction on that.

So we will call on you one by one. You just state your name and your organization. At least one member of your organization must be present for the entire meeting. At least one member of your organization must appear on video.

After attendance is taken, please mute your microphones. And then at the end of the presentation, we'll retake attendance but only one person from each of your organizations will have to be present at that point.

All right. So how I'll do this is I'm going to go through our chat, and I will start with the names in the chat and then I will go over to the phone numbers. All right. And again you'll just need to let me know your name, repeat that for us and then the organization.

All right. The first one is Aaron Sisk.

MR. SISK: Hey. Aaron Sisk. Magnolia Health Plan.

MS. MCKNIGHT: Magnolia.

Brittany Stephenson.

MS. STEPHENSON: Brittany Stephenson. Magnolia Health Plan.

MS. MCKNIGHT: All right. Randall Brock.

MR. BROCK: Randall Brock. AmeriGroup.

MS. MCKNIGHT: AmeriGroup. Okay.

Debby Brutsman.

MS. BRUTSMAN: Hi. Debby Brutsman. Care Source, partner with TrueCare.

MS. MCKNIGHT: TrueCare. Okay. Thank you, Debby.

All right. The next one is Dana Carbo-Bryant.

MS. CARBO-BRYANT: Dana Carbo-Bryant. United Healthcare.

MS. MCKNIGHT: All right. Our next one is Tara Clark.

MS. CLARK: Hi. Tara Clark. AmeriGroup Mississippi.

MS. MCKNIGHT: Okay. Katelyn Cooper.

MS. COOPER: Hi. Katelyn Cooper. United Healthcare.

MS. MCKNIGHT: Cheryl Crombie.

MS. CROMBIE: Cheryl Crombie. Molina HealthCare.

MS. MCKNIGHT: Molina.

Matthew Dey.

MR. DEY: Matthew Dey. AmeriGroup Mississippi.

MS. MCKNIGHT: AmeriGroup.

Jennifer Driggs.

MS. DRIGGS: Hi. Jennifer Driggs with AmeriGroup Mississippi.

MS. MCKNIGHT: AmeriGroup.

Chandler Ewing.

MR. EWING: Chandler Ewing with United Healthcare, Mississippi.

MS. MCKNIGHT: Lauren Fancy.

MS. FANCY: Hi. Lauren Fancy. AmeriGroup Mississippi.

MS. MCKNIGHT: Bridget Galatas.

MS. GALATAS: Bridget Galatas. Molina Healthcare of Mississippi.

MS. MCKNIGHT: United.

MS. GALATAS: Molina.

MS. MCKNIGHT: Thank you, Bridget.

All right. Erin Gilbert.

MS. GILBERT: Hi. Erin Gilbert.

AmeriGroup, Mississippi.

MS. MCKNIGHT: All right.

Michael Parnell.

MR. PARNELL: Michael Parnell. United Healthcare of Mississippi.

MS. MCKNIGHT: Okay. Let me make sure I've got your name. Parnell. Okay.

Jordan Geolat.

MS. GEOLAT: Jordan Geolat. Magnolia.

MS. MCKNIGHT: Geolat. Sorry about that. Magnolia.

MS. GEOLAT: No worries. It doesn't pronounce like it's spelled at all.

MS. MCKNIGHT: Hold on, let me see. I have more. All right.

Taira Kelley.

MS. KELLEY: Hi. Taira Kelley. TrueCare.

MS. MCKNIGHT: TrueCare.

All right. Jeremy Ketchum.

MR. KETCHUM: Hi. Jeremy Ketchum. Molina HealthCare of Mississippi.

MS. MCKNIGHT: Molina. All right. Ian Long.

MR. LONG: Ian Long. TrueCare.

MS. MCKNIGHT: TrueCare.
Karson Luther.
MS. LUTHER: Hi, Karson Luther. AmeriGroup Mississippi.
MS. MCKNIGHT: Latrina McClenton.
MS. MCCLENTON: Hello. Latrina McClenton. United Healthcare.
MS. MCKNIGHT: UHC.
Sanjoy Musunuri.
MR. MUSUNURI: Sanjoy Musunuri. TrueCare.
MS. MCKNIGHT: TrueCare.
Jason Neerman.
MR. NEERMAN: Yes, ma'am. Jason Neerman. TrueCare.
MS. MCKNIGHT: TrueCare.
Nicole Litton.
MS. LITTON: Nicole Litton. Magnolia Health Plan.
MS. MCKNIGHT: Kristi Plotner.
MS. PLOTNER: Hi. Kristi Plotner. United Healthcare.
MS. MCKNIGHT: UHC.
Dawn Price.
MS. PRICE: Hi, Dawn Price. TrueCare.

MS. MCKNIGHT: Jennifer Q.

MS. QUITTSCHREIBER: Jennifer Quittschreiber. Molina Healthcare.

MS. MCKNIGHT: Molina. I didn't want to do it.

MS. QUITTSCHREIBER: Oh, it's okay.

MS. MCKNIGHT: All right. Richard Roberson.

MR. ROBERSON: Hey. Richard Roberson with TrueCare.

MS. MCKNIGHT: TrueCare.

Jennifer, I had you down as Molina; is that correct?

MS. QUITTSCHREIBER: That's correct, yeah.

MS. MCKNIGHT: Okay. All right.

Tim Moore.

MR. MOORE: Tim Moore. TrueCare.

MS. MCKNIGHT: TrueCare.

Trip Peeples.

MR. PEEPLES: Hey. Trip Peeples. Magnolia Health Plan.

MS. MCKNIGHT: Mark Voudrie.

MR. VOUDRIE: Mark Voudrie. AmeriGroup Mississippi.

MS. MCKNIGHT: AmeriGroup.

Khanh Vu.

MS. VU: Hi there. It's Khanh Vu. AmeriGroup Mississippi.

MS. MCKNIGHT: AmeriGroup. Sorry about that.

MS. VU: No worries.

MS. MCKNIGHT: All right. Will Simpson.

MR. SIMPSON: Will Simpson. Magnolia Health Plan.

MS. MCKNIGHT: All right. Dana Yancey.

MS. YANCEY: Hi. Danny Yancey. Molina Healthcare.

MS. MCKNIGHT: Molina HealthCare.

Okay. All right. So going back through making sure I didn't miss any names.

All right. So I have two phone numbers here. And what I would like for you guys to do, I'm going to go ahead and get you guys to announce yourselves and your organization, but what I would also like and to provide it on an upcoming slide is if you could e-mail your name and -- or leave your signature block there and we'll have it. But e-mail that to the MSCAN_CHIP@medicaid.ms.gov e-mail address

just so I can get the spelling correct and don't clobber it up too much, but I will ask you to announce yourself on the call.

All right. So the number I see here is, it ends in 1865. Area code 508.

Now, is that a number for someone who's also -- have already announced themselves?

MS. COOPER: That's my number. Katelyn Cooper that ends in 1865.

MS. MCKNIGHT: Okay. Katelyn Cooper. Got you, Katelyn. 1865.

All right. The number ending 2294 with an area code of 618. Is that someone?

MS. STEPHENSON: Hey, that's -- it is. That's Brittany Stephenson with Magnolia.

MS. MCKNIGHT: Brittany. Okay. Hold on just one second. Looks like your name is one of the longer names. Oh, I've got you. At the top. All right.

So again, at the end of the call --

MS. MIDDLETON: Someone else came in. James Sasso.

MR. SASSO: Hi. James Sasso with Care Source.

MS. MCKNIGHT: James. Okay. True

Care/Care Source. All right. Thank you.

All right. Is there anyone else that I missed?

Okay. All right. Again, at the end of the call, we will go back through a quick attendance, again only one person from each organization will have to be -- will have to remain on the call for the entire duration.

So I want to go ahead and introduce the DOM staff. So again, I'm Kayla McKnight, and I'm the Procurement Director, our Director of Procurements and Contracts here at the Division of Medicaid. We have Kate Holland and Jeanette Crawford and they're both Procurement officers on our PPRB side. And then we have our senior attorney Maggie. She's been very instrumental in helping us with this, and she's going to walk you through the slides and discuss everything with you.

Maggie.

MS. MIDDLETON: All right. Hi, y'all. Thank you-all for being here today. I'm not going to take up too much of your time with slides. There are just a few things that we wanted to clarify now that we've gotten in Letters of Intent, and we wanted to give you a heads up about a couple of things.

One thing I'm going to ask all of y'all to do is please mute your microphone. Even if you think it's muted, double check that it's muted. I know we've all been doing this whole, you know, kind of Zoom lifestyle for a long time now and I still mess it up so I would like to remind everybody about that at the beginning of a meeting. Let me go back.

Secondly, this meeting is being recorded. That was on the first slide that you saw when you came in, so I wanted to remind everybody of that. That -- this recording will be released when we release our summary of this as well so you'll be able to come back and see that later on if you need to or if you miss anything. And if you're uncomfortable with it being recorded, you can leave the meeting but we have to record it.

Questions about statements made in this presentation should be sent to the dedicated e-mail for the Procurement. I think y'all are familiar with that by now, but if not it's MSCAN_CHIP@medicaid.ms.gov. Of course that e-mail is a reminder to everybody that this Procurement is for both MSCAN and CHIP. We want to make sure that both of those populations get plenty of your attention in your answers. And submit those questions about just

this presentation no later than next Wednesday at 5 p.m.

We're not taking any more questions about substantive matters of interpretation of the RFQ. That deadline, as y'all are all well aware, was last Friday. We got a bunch of great questions from y'all that we're working through and we are going to -- we're going to have all of those answers back to you and published by February 7th. So that is just kind of the -- setting the stage before we begin. So like I said, this isn't going to take terribly long, but there are some important points that we want to go over with y'all.

So we're already rocking through the agenda. We've already taken attendance and thank you to Kayla for doing that in an orderly manner. I know it's a lot of people who are interested in this. Thank y'all all for following directions very well. We appreciate that because we want to get through it.

First, we're going to talk about the Procurement Timeline. That's laid out in the RFQ and it's not too different. Now that we kind of know the universe of submissions that we might get as limited by the number of Letters of Intent we got, we have sort of a clearer idea of how it's going to all play

out.

Then I'm going to talk with y'all a little about SharePoint. This is the first time that we're using SharePoint to submit RFQs for this purpose. That is -- it has a lot of benefits really to everybody. I think that's going to streamline the process a lot and our IT department is excited about it, and I know PPRB has been supportive of our pursuing this route. Y'all know these files are quite large so hopefully that will streamline a bunch of things.

Then I have a few clarifications on formatting requirements. There were a lot of questions about that so I wanted to go ahead and address some of those. I also want to talk with y'all a little bit about the State Enterprise Security Policy. I think we're going to have to do an amendment about that because we have a faulty link in there. So those are just a few highlights we wanted to get in with y'all today, and then we're going have some closing remarks and Kayla is going to take attendance again.

Okay. So the timeline is as stated in the RFQ, that no later than Monday, February 7th at 5 p.m., the Office of Procurement is going to release

answers to questions submitted last Friday. All of y'all who submitted a Letter of Intent that are here today, you'll receive notice of a posting of that and be able to access those. Then everybody knows the deadline, but to clarify it, to say it, to put it on the record, the deadline to submit your qualification through SharePoint is at 2 p.m. on Friday, March 4th. After 2 p.m., we're going to shut off access and that way nobody can submit after that.

I'm going to have information for y'all about who you can talk to in our IT department. If you're having any problems with that, you're also going to get an e-mail about it later this week and I'll talk to you about that when I get to that slide.

After you make that submission, we're going to do internal vetting of those qualifications for responsiveness and compliance with the RFQ and the PPRB rules. Everybody has access, of course, to the rules in the RFQ. The rules for PPRB are linked in that RFQ. So if you have any questions about interpretation of their rules, you know, reach out to PPRB about that. But we have an entire month set aside to vet those qualifications and to ensure that they are compliant, so we're going to be spending, you know, a lot of time being very thorough about it to be

sure that this process runs as smoothly as they can.

By April 4th, maybe sooner if we get through vetting sooner, but by April 4th, the proposals will make their way to the evaluation committee. And the way that that works is the evaluation committee will get the technical proposal first. That means they'll be, you know, doing the blind scoring section of things first. They will not have access to the identities of what -- what identity goes with what proposal. So they won't be aware of that. They'll just be basing their scores on, you know, what is contained in that proposal, how does that serve the agency's needs, how does that serve the people of Mississippi that we're trying to serve.

So after we -- we have a period for them to evaluate, we will have a consensus scoring session where they'll all get together and they will come up with a consensus score, one score that comes out of the evaluation committee for each part of that technical evaluation. At that point, those scores will be blocked. Those will be put away. They will -- those scores will be, you know, done and can't be changed. And then they will get access to the management proposal. And at that point, it's unblind as explained in the RFQ. So they will have knowledge

of who the proposals are as linked to the identity of the Proposers at that point in that second half.

We're hoping to finish the evaluation and consensus scoring process by the end of June which would mean that in July we're hopeful that we will be releasing award. As y'all know, sometimes these things take a longer period of time, sometimes you get lucky and they take a shorter period of time. But we do suspect that in July we will be making the agency's announcement. Implementation will then begin after award is verified by PPRB.

Y'all know that there can be protests that come up. There can be all kinds of things that can delay award being made. We are mindful of that, and we're going to work with everybody to ensure that this is as smooth of a process as it possibly can be.

The SharePoint Submission Process. I wanted to be sure to get to talk with y'all just a little bit just because it is something new. I think most of the people on this call, at least y'all are familiar with SharePoint or you have someone in your organization who's very familiar with SharePoint.

Your organization on its Letter of Intent, they had to supply the name of someone who would be responsible for submitting your proposal

through SharePoint. That person, that e-mail account that you gave us is going to get an e-mail from our IT department next week that is going to give them that access. We already have folders set up in there. There are five folders. And we've talked about in the RFQ what's supposed to go in each folder. But there's one for the transmittal letter, one for the technical proposal, one for the management proposal, one for your fully redacted proposal which would be your entire proposal redacted in a way that could be released publically and then prior submissions.

And that prior submissions folder is just like if you had submitted a paper proposal and then resubmitted, submitted one that superseded it. We have to keep record of that. So if you do submit something like, let's say on March 1st you submit your whole proposal and then you decide oh, I wanted to tweak the technical proposal. You need to move that original technical proposal into the prior submissions and put your most up-to-date technical proposal in the technical folder.

If you have any questions about that, technical assistance is going to be through Christopher Shontell here at Medicaid. His e-mail is Christopher.Shontell, just as it appears on the

screen, at medicaid.ms.gov, and I believe he's going to be the one who's going to be e-mailing you. But at the very least, his e-mail is going to be in the information that you get next week. And any time you e-mail Chris, please CC the dedicated e-mail that we have just so we know that that communication is going on. That is the only other person in Medicaid you should be communicating with outside of that dedicated Procurement e-mail. And that's just so we can keep everything smooth, make sure that everybody is following all of the rules that they're supposed to follow.

All right. Some clarification on formatting requirements. There have been a few questions about can we use different color fonts, can we use different fonts, that type of thing. All of the text must be black. It must be Times New Roman. It must be 12 pt. in the body of your response. If you have headers, footers, callouts, you can use a smaller font but please don't let it be smaller than 9 pt. font. Y'all, I can't read that. I know people on the evaluation committee can't read that. We want to make sure it's readable. These requirements apply to all aspects of the qualification. We ask that you don't include any branding on any part of the

proposal. We just want our evaluation committee to evaluate the words that you have put on that page and nothing else. We want them to make their decision based solely on, you know, what you've proposed and the services that you've proposed and, you know, the support that you've talked about having -- that you talk about having to make the delivery with those services. And we don't want them distracted by anything else, and that's part of why we've asked for this. Your name should appear on the cover pages for each of your proposals. And in the name of the proposal, we're going to remove those cover pages and that's just for our file keeping purposes.

These details will be included in the questions and answers that come up on -- that we post on February 7th, and I'll also be -- we'll also be addressing other questions y'all have asked about formatting in that as well as obviously all of the other questions.

There's also I think a few questions that we got about the forms that are in the appendices and how to use those, whether you should convert those to Word yourself. We have the Word files, so we're going to go ahead and give those to y'all by the end of next week just so you can use them and everybody is

using the same thing. We want this to be as uniform as possible again just so we can focus on content instead of what it looks like.

All right. The State Enterprise Security Policy. That is located in Section 5 of the RFQ, and we've looked at that and we got notices from some of y'all that that link doesn't work. That is correct. The link does not work. The policy has changed. So what we're going to do is, we're going to amend the RFQ next week and issue an amendment so that we're aware -- everybody is aware of the right policy and has a link to the right thing. So we'll make sure to make you aware of that amendment next week when we make it.

Lastly, like I told y'all, this was short and sweet. There's just a few things we want to make you aware. Again, questions about statements made in this presentation should be submitted to that general MSCAN_CHIP@medicaid.ms.gov e-mail no later than next Wednesday at 5 p.m. No more substantive questions. Time for that has passed and we're working our way through those. And if you have any questions about technical issues, e-mail Christopher Shontell and CC MSCAN-CHIP@medicaid.ms.gov with that communication.

And then, Kayla, I'm going to turn it back to you as Chair of the conference.

MS. MCKNIGHT: Thank you. All right. So just one person so we don't go back through the entire list. One person can speak up for each organization. I'll call each organization out by name and your representative can speak up. All right. Hold on just a second.

So AmeriGroup Mississippi.

MS. CLARK: Hi. Tara Clark still here.

MS. MCKNIGHT: Tara Clark. Thank you.

Magnolia Health Plan.

MR. SISK: Hey, Aaron Sisk.

MS. MCKNIGHT: Aaron Sisk. Thanks Aaron.

All right. TrueCare.

MR. ROBERSON: Hey. Richard Roberson still here.

MS. MCKNIGHT: Richard Roberson. Got you, Richard.

Molina HealthCare of Mississippi.

MR. KETCHUM: Hey. Jeremy Ketchum. Still here.

MS. MCKNIGHT: Got you, Jeremy.

And United Healthcare of Mississippi.

MR. PARNELL: Hi, Kayla. Michael Parnell.

MS. MCKNIGHT: Michael Parnell. All right. Give me just a second. I'm looking for you. All right. I've got everybody. We appreciate you so much for joining the call today.

This adjourns the meeting, and again any questions, please send them to the MSCAN_CHIP@medicaid.ms.gov box before January 19th or at -- by January 19th at 5 o'clock. Any technical to Christopher.Shontell@medicaid.ms.gov.

And no more substantiative questions. We appreciate you guys. Thank you so much. Bye.

(WHEREUPON, THE MEETING WAS CONCLUDED.)

CERTIFICATE OF REPORTER

I, AMANDA WOOTTON, Court Reporter and Notary Public for the State of Mississippi, do hereby certify that the above and foregoing pages contain a full, true and correct transcript of the proceedings had in the aforenamed case at the time and place indicated, which proceedings were recorded.

I certify that I have no interest, monetary or otherwise, in the outcome of this case.

This the 10th day of February 2022.

AMANDA M. WOOTTON

My Commission Expires:
December 15, 2022

Division of Medicaid Coordinated Care Procurement

Mandatory Pre-Qualification Conference

Friday, January 14, 2022, 1:00 p.m.

THIS MEETING IS BEING RECORDED. BY ATTENDING, YOU ARE GIVING YOUR CONSENT TO BEING RECORDED. LEAVE THE MEETING IF YOU DO NOT CONSENT.

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid
Office of Procurement

INTRODUCTION AND TAKING OF ATTENDANCE

Taking of Attendance:

- We will call on you one-by-one. Please state your name and your organization.
- At least one member of your organization must be present for the entire meeting.
- At least one member of your organization must appear on video.
- After attendance is taken, please mute your microphone.
- Attendance will be taken again at the end of the presentation. At least one member of your organization must stay for the entire presentation.

DOM Staff:

- Kayla McKnight, Director of Procurement and Contracts
- Kate Holland, Procurement Officer
- Jeanette Crawford, Procurement Officer
- Maggie Middleton, Senior Attorney

BEFORE WE BEGIN

- This meeting is being recorded. By attending, you are giving your consent for recording.
- Please mute your microphone.
- Questions about statements made **in this presentation** should be submitted in writing to MSCAN_CHIP@medicaid.ms.gov. by no later than Wednesday, January 19, at 5:00 p.m.
- No questions about substantive matters of interpretation of the RFQ should be submitted. The deadline for submission for those questions was January 7, 2022. Any questions submitted pertaining to substantive RFQ matters will not be answered.

MISSISSIPPI DIVISION OF MEDICAID

AGENDA

1. Introductions and Taking of Attendance
2. Procurement Timeline
3. Overview of SharePoint Submission Process
4. Clarification of Formatting Requirements
5. State Enterprise Security
6. Closing Remarks

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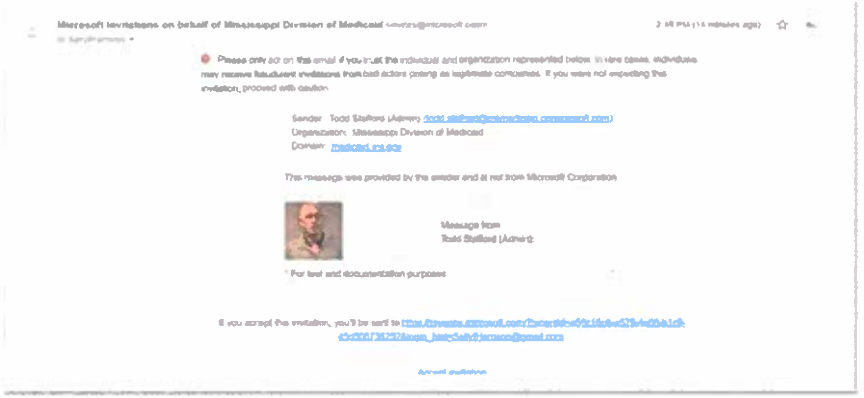
MISSISSIPPI DIVISION OF MEDICAID

TIMELINE

- No later than Monday, February 7, 2022, 5:00 p.m. – Office of Procurement will release Answers to Questions submitted on January 7, 2022. All potential Offerors who submitted a Letter of Intent will receive notice of the posting of the Answers on the DOM CCO Procurement website.
- Friday, March 4, 2022, 2:00 p.m. – Deadline for Offerors to submit qualifications to SharePoint.
- March 2022 – Internal vetting of qualifications for responsiveness and compliance with RFQ and PPRB rules.
- April 4, 2022 – The Evaluation Committee will begin evaluation. Evaluation may begin sooner if vetting is completed earlier. Based on estimated number of submissions, evaluation should be complete by the end of June 2022.
  - There will be two consensus scoring sessions: one for technical requirements, and one for management requirements
- July 2022 – It is estimated that DOM will announce award this month.
- Implementation can begin after award is made by PPRB.

SHAREPOINT SUBMISSION PROCESS

- Your organization included the email that will be used for submission of the qualification via SharePoint. This email will be given guest access to the SharePoint next week.
- That guest access will expire at 2:00 p.m., Friday, March 4, 2022. This ensures that no one can make submission after the deadline has passed.
- There will be five folders set up in each Offeror's account:
  - Transmittal Letter
  - Technical
  - Management
  - Redacted
  - Prior Submissions



- Place the correct file in each folder. The Prior Submissions folder is for files uploaded that the Offeror decides to replace with an updated copy prior to submission. DOM needs to keep these files just as they would with paper submissions that are replaced by later paper submissions.
- Technical Assistance: Christopher.Shontell@medicaid.ms.gov (cc: MSCAN_CHIP@medicaid.ms.gov)

MISSISSIPPI DIVISION OF MEDICAID

CLARIFICATION OF FORMATTING REQUIREMENTS

- Text must be black, Times New Roman, 12 pt.
- For headers, footers, callouts, tables, captions, the text must be black, Times New Roman, but may be 9 pt – 12 pt.
- These requirements apply to all aspects of the qualification: transmittal, technical, and management.
- No branding may be included in any part of the proposal.
- The Offeror's name should be on cover pages and in file names.
- These details, and others, will be included in the February 7 Questions and Answers.
- Word files: DOM will provide potential offerors with Microsoft Word files of relevant appendices by the end of next week.

STATE ENTERPRISE SECURITY

- Section 5 of the RFQ states includes an incorrect link to the State Enterprise Security Policy.
- A non-disclosure agreement is no longer required to access the State Enterprise Security Policy.
- The RFQ will be amended by the end of next week and will include a link directly to the policy.

MISSISSIPPI DIVISION OF MEDICAID

Closing Remarks

- Questions about statements made **in this presentation** should be submitted in writing to MSCAN_CHIP@medicaid.ms.gov. by no later than Wednesday, January 19, at 5:00 p.m.
- No questions about substantive matters of interpretation of the RFQ should be submitted. The deadline for submission for those questions was January 7, 2022. Any questions pertaining to substantive RFQ matters will not be answered.
- If there are questions about the use of the SharePoint portal for submission, email Christopher.Shontell@medicaid.ms.gov and cc MSCAN_CHIP@medicaid.ms.gov with that communication.
- Final taking of attendance.

MISSISSIPPI DIVISION OF MEDICAID

Amendment #11 to RFQ 20211210: Reporting Manuals

RFQ #: 20211210 / RFx#3150003991

Date: February 11, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

As stated in Amendment 4, issued on February 7, 2022, the Division is supplying Offerors with downloadable links for the following:

- MississippiCAN Reporting Manual
- CHIP Reporting Manual

Both are available for download on the Division's dedicated CCO Procurement website: https://medicaid.ms.gov/coordinated-care-procurement/.

Receipt of Amendment 11 Acknowledged:

(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

MISSISSIPPI DIVISION OF MEDICAID

Amendment #12 to RFQ 20211210: Responses Regarding Amendment 9

RFQ #: 20211210 / RFx#3150003991

Date: February 16, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

This document contains all questions submitted by Potential Offerors in response to Amendment #9: Clarification of Amendment 4 Responses, issued on February 10, 2022.

As stated in Amendment #9, Potential Offerors may not submit any further questions, other than those necessary to ensure that the Offeror has access to the SharePoint submission site. Those questions should be submitted to both Christopher.Shontell@medicaid.ms.gov and MSCAN_CHIP@medicaid.ms.gov. Those questions are handled on an ad hoc basis, and technical assistance given is not considered an amendment to this process

As additionally stated in Amendment #9, the Division has sole discretion as to whether a question submitted complies with the requirements stated in Amendment #9. The Division is not obligated to provide an answer to a question submitted if, in the Division's judgment, there is an answer that has already been given through Amendment #4 that addresses the submitted question. The Division may respond to such a question with the previously stated answer.

Receipt of Amendment 12 Acknowledged:

(Signature)

Aaron Sisk
(Printed)

President and CEO
(Title)

Magnolia Health Plan, Inc.
(Company)

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
1.	1	1	"The response to Question #1 in the RFQ-Specific Questions and Answers states the following: "The requirement to provide Work Plans and Schedules has been removed from the RFQ. (Corrected in Amendment 5.)"	"Work plan" in this instance refers to a summary of the Offeror's approach and philosophy in designing a coordinated care solution for the Division. It should not include information that would violate the rule against Identifying Information.
2.	3	1	We understand that there is no minimum file size for SharePoint submission, but is there a maximum file size?	There is not maximum file size.
3.	7	2	In Amendment 4, the State noted that "Reiteration of the question will count towards page limits." With this in mind, would the state consider allowing an Offeror to format question reiterations as 9-point black Times New Roman font?	Offerors may reiterate the question in 9 pt. black Times New Roman font.
4.	9	2	May graphics in the Marked/not blind section contain colors other than black?	The Offeror must use black, Times New Roman 12 pt. font for responses, and black, Times New Roman font no smaller than 9 pt. for any tables, graphics, charts, figures, footnotes, callouts, and headers/footers. The Offeror may otherwise use company images and company colors in the Marked/not blind responses.
5.	12	2	Are the State's Appendix forms that are in table format considered tables for purposes of font size? It appears that the State's Word version of the Appendix tables are in 11pt Times New Roman. May our responses in the State-provided Appendix tables be in 11pt Times New Roman?	The Offeror may submit responses in Word documents provided by the state in 11 pt. black Times New Roman font.
6.	10	3	In Amendment 4, the State noted that "Tables, graphics, charts, figures, footnotes, callouts, and headers/footers may contain font smaller than 12-point. The font may not be smaller than 9-point font. The font must be in black Times New Roman." Some graphics, such as screen-captures, contain content that	Yes. Ancillary materials (such as audits that are created by a third party and reports developed by the Offeror) submitted in response to marked/unblind portions can be submitted in the original format.

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
			the Offeror is incapable of altering the appearance of due to previously-designed system interfaces. Does the requirement for text in graphics to be (at minimum) 9-point black Times New Roman font apply to screen-captures?	**ALL** materials submitted in response to the Technical/blind portion must be submitted in the prescribed format, even if this requires reformatting by the Offeror.
7.	13	3	In response to question #13, the Division indicated that items such as sample reports and templates have to follow RFP format requirements. Please confirm this does not apply to the voluminous audited financial statements which must be submitted in response to 4.3.2.6.	Ancillary materials (such as audits that are created by a third party and reports developed by the Offeror) submitted in response to marked/unblind portions can be submitted in the original format. **ALL** materials submitted in response to the Technical/blind portion must be submitted in the prescribed format, even if this requires reformatting by the Offeror.
8.	13	3	Regarding the Division's answer to question #13, please confirm that Offerors do not need to reformat documents provided by the Division (e.g., red font in amendments, 11pt font in appendices) and are to use the exact version the Division provided?	The Division does not intend for Offerors to reformat the Word documents provided. 11 pt. font is permissible in these documents. The Division does not intend for Offerors to reformat Amendments.
9.	13	3	The response to Question #13 in the list of RFQ-Specific Questions and Answers states the following: "No. The Offeror should reformat the document to conform with RFQ requirements." Requirement 4.3.2.6: Audited Financial Statements and Pro Forma Financial Template requires us to provided our audited financial statements for the past 3 years and documentation of available lines of credit. Given that these are formally audited statements or documents provided by a third party as documentation, we do not believe these items should be manipulated to fit the font restrictions. Can the State please confirm that there is an exception to this requirement for the audited financial statements and documentation of available lines of credit? In an effort to demonstrate our capabilities, Offeror's may want to include non-identifying screenshots of reports and	Ancillary materials (such as audits that are created by a third party and reports developed by the Offeror) submitted in response to marked/unblind portions can be submitted in the original format. **ALL** materials submitted in response to the Technical/blind portion must be submitted in the prescribed format, even if this requires reformatting by the Offeror.

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
			dashboards in their responses (where applicable). It is difficult to conform to the font and size restrictions on screenshots. Is it generally acceptable for Offeror's to provide screenshots of dashboards and like capabilities as long as it's non-identifying? If so, would the State consider an exception to the font restrictions for these types of graphics? Would the State please consider releasing an addendum with more clarity on what documentation is required to be reformatted versus what can be submitted in its original format?	
10.	13	3	Please confirm that the requirement to reformat samples, templates, and appendices does not apply to items produced by a third-party, such as 4.1 Copy of Insurance License and 4.3.2.6 Audited Financial Statements.	Ancillary materials (such as audits that are created by a third party and reports developed by the Offeror) submitted in response to marked/unblind portions can be submitted in the original format. **ALL** materials submitted in response to the Technical/blind portion must be submitted in the prescribed format, even if this requires reformatting by the Offeror.
11.	13	4	Section 1.2.3: Qualification Submission Requirements, Figure 1.2: Format of Qualification-- Font & Margins states that appendices, as well as samples and templates required of the qualification, must comply with font restrictions, which is black Times New Roman font size 12. Some requested items, such as sample reports, may output in a different font/font size than what is required by the State and cannot be changed. Will these documents be acceptable for submission? Do attachments such as Marketing Materials (requested in Section 4.2.2.1 E) require reformatting to meet the mandate of black Times New Roman font - size 12? These marketing materials have been designed using the offeror's existing brand guidelines that differ from the requested specifications and have been previously used for other medicaid programs.	Ancillary materials (such as audits that are created by a third party and reports developed by the Offeror) submitted in response to marked/unblind portions can be submitted in the original format. **ALL** materials submitted in response to the Technical/blind portion must be submitted in the prescribed format, even if this requires reformatting by the Offeror.

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
12.	13	4	Section 1.2.3: Qualification Submission Requirements, Figure 1.2: Format of Qualification-- Font & Margins states that appendices, as well as samples and templates required of the qualification, must comply with font restrictions, which is black Times New Roman font size 12. Some requested items, such as sample reports, may output in a different font/font size than what is required by the State and cannot be changed. Will these documents be acceptable for submission? Do attachments such as Member ID Cards (requested in Section 4.2.2.11) require reformatting to meet the mandate of black Times New Roman font - size 12? These ID cards have been designed using the offeror's existing brand guidelines that differ from the requested specifications and have been previously used for other medicaid programs.	Ancillary materials (such audits that are created by a third party and reports developed by the Offeror) submitted in response to marked/unblind portions can be submitted in the original format. **ALL** materials submitted in response to the Technical/blind portion must be submitted in the prescribed format, even if this requires reformatting by the Offeror.
13.	23	5	In response to question #23 about identifying information, the Division states that "An Offeror, incumbent or otherwise, cannot name staff members, cite known in-state programs associated with that Offeror, identify local experience, or identify local partners and/or partnerships by name." Please clarify if any of the restrictions listed above are intended for the marked/unblinded sections. If restrictions do apply, please clarify if photos of staff or photos of locations in MS are also precluded from being in the marked/unblinded sections.	Section 1.2.3.3.2 of the RFQ states, "When a response requires description of a potential partnership with a community-based organization, the Offeror may name that organization and describe the contemplated partnership. The Offeror must not describe any current or prior relationship with the organization, and the Offeror must not reference any other line of business or any relationship at all that the Offeror or its owner, subcontractors, subsidiaries, or other related entities has had, will have, or desires to have with a named community-based organization, other than the partnership contemplated for this qualification." In response to the Technical/blind portion, the Offeror may discuss partnerships that the Offeror expects to utilize should it be selected in this procurement. The Offeror may not refer to current or past relationships with partners. The Offeror may not describe current relationships with partners. The Offeror may only speak in the future tense regarding partnerships. These restrictions do not apply to the marked/unblind sections.

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
14.	23	5	In response to question #23 about identifying information, the Division states that "An Offeror, incumbent or otherwise, cannot name staff members, cite known in-state programs associated with that Offeror, identify local experience, or identify local partners and/or partnerships by name." Please clarify if bidders are restricted from naming other state agencies, such as the Mississippi Department of Child Protection Services, and national organizations, such as the National Alliance on Mental Illness, that may play a key role to address the question. Please also clarify if bidders are restricted from naming key provider partners that may play a role in the bidder's future solutions. If both are prohibited, please provide guidance on what details related to these types of partnerships will be allowed.	Section 1.2.3.3.2 of the RFQ states, "When a response requires description of a potential partnership with a community-based organization, the Offeror may name that organization and describe the contemplated partnership. The Offeror must not describe any current or prior relationship with the organization, and the Offeror must not reference any other line of business or any relationship at all that the Offeror or its owner, subcontractors, subsidiaries, or other related entities has had, will have, or desires to have with a named community-based organization, other than the partnership contemplated for this qualification." In response to the Technical/blind portion, the Offeror may discuss partnerships that the Offeror expects to utilize should it be selected in this procurement. The Offeror may not refer to current or past relationships with partners. The Offeror may not describe current relationships with partners. The Offeror may only speak in the future tense regarding partnerships. These restrictions do not apply to the marked/unblind sections.
15.	23	5	The response to Question #23 in the RFQ-Specific Questions and Answers states the following: “An Offeror, incumbent or otherwise, cannot name staff members, cite known in-state programs associated with that Offeror, identify local experience, or identify local partners and/or partnerships by name. An Offeror should name potential partnerships in 4.2.3.9, Potential Partnerships.” Incumbents and non-incumbents can and should be contracting with Providers in the State in anticipation of managing these populations. Can the State please confirm Offeror’s are allowed to cite numbers of contracted Providers demonstrating our ability to serve this program? Can the State please also confirm that Offeror’s are allowed to mention significant Providers by name and indicate that we	Section 1.2.3.3.2 of the RFQ states, "When a response requires description of a potential partnership with a community-based organization, the Offeror may name that organization and describe the contemplated partnership. The Offeror must not describe any current or prior relationship with the organization, and the Offeror must not reference any other line of business or any relationship at all that the Offeror or its owner, subcontractors, subsidiaries, or other related entities has had, will have, or desires to have with a named community-based organization, other than the partnership contemplated for this qualification." In response to the Technical/blind portion, the Offeror may discuss partnerships that the Offeror expects to utilize should it be selected in this procurement. The Offeror may not refer to

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
			have already established a contract or letter of intent with specific impactful Providers in the state?	current or past relationships with partners. The Offeror may not describe current relationships with partners. The Offeror may only speak in the future tense regarding partnerships. The Offeror should not cite the number of Providers it has already contracted with, nor should the Offeror supply the Division with contracts or Letters of Intent with providers. These restrictions do not apply to the marked/unblind sections.
16.	23	5	Does this requirement mean that we cannot name any provider or vendor that we will work with in any respect? For example, “We will refer Members to UMMC’s CHAMP program for…”. Can we name UMMC in this example?	Section 1.2.3.3.2 of the RFQ states, "When a response requires description of a potential partnership with a community-based organization, the Offeror may name that organization and describe the contemplated partnership. The Offeror must not describe any current or prior relationship with the organization, and the Offeror must not reference any other line of business or any relationship at all that the Offeror or its owner, subcontractors, subsidiaries, or other related entities has had, will have, or desires to have with a named community-based organization, other than the partnership contemplated for this qualification." In response to the Technical/blind portion, the Offeror may discuss partnerships that the Offeror expects to utilize should it be selected in this procurement. The Offeror may not refer to current or past relationships with partners. The Offeror may not describe current relationships with partners. The Offeror may only speak in the future tense regarding partnerships. The Offeror should not cite the number of Providers it has already contracted with, nor should the Offeror supply the Division with contracts or Letters of Intent with providers. These restrictions do not apply to the marked/unblind sections.

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
17.	23	5	May we name State agencies that we intend to work with, such as the Department of Health and the Mississippi Department of Child Protective Services?	Section 1.2.3.3.2 of the RFQ states, "When a response requires description of a potential partnership with a community-based organization, the Offeror may name that organization and describe the contemplated partnership. The Offeror must not describe any current or prior relationship with the organization, and the Offeror must not reference any other line of business or any relationship at all that the Offeror or its owner, subcontractors, subsidiaries, or other related entities has had, will have, or desires to have with a named community-based organization, other than the partnership contemplated for this qualification." In response to the Technical/blind portion, the Offeror may discuss partnerships that the Offeror expects to utilize should it be selected in this procurement. The Offeror may not refer to current or past relationships with partners. The Offeror may not describe current relationships with partners. The Offeror may only speak in the future tense regarding partnerships. These restrictions do not apply to the marked/unblind sections.
18.	23	5	May we name Providers whom we intend to contract with as part of our Provider network?	Section 1.2.3.3.2 of the RFQ states, "When a response requires description of a potential partnership with a community-based organization, the Offeror may name that organization and describe the contemplated partnership. The Offeror must not describe any current or prior relationship with the organization, and the Offeror must not reference any other line of business or any relationship at all that the Offeror or its owner, subcontractors, subsidiaries, or other related entities has had, will have, or desires to have with a named community-based organization, other than the partnership contemplated for this qualification." In response to the Technical/blind portion, the Offeror may discuss partnerships that the Offeror expects to utilize should it be selected in this procurement. The Offeror may not refer to

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
				current or past relationships with partners. The Offeror may not describe current relationships with partners. The Offeror may only speak in the future tense regarding partnerships. The Offeror should not cite the number of Providers it has already contracted with, nor should the Offeror supply the Division with contracts or Letters of Intent with providers. These restrictions do not apply to the marked/unblind sections.
19.	23	5	May we name entities that we intend to include as part of a stakeholder engagement process (e.g., to develop the PCMH proposal)?	The RFQ states, "When a response requires description of a potential partnership with a community-based organization, the Offeror may name that organization and describe the contemplated partnership. The Offeror must not describe any current or prior relationship with the organization, and the Offeror must not reference any other line of business or any relationship at all that the Offeror or its owner, subcontractors, subsidiaries, or other related entities has had, will have, or desires to have with a named community-based organization, other than the partnership contemplated for this qualification." In response to the Technical/blind portion, the Offeror may discuss partnerships that the Offeror expects to utilize should it be selected in this procurement. The Offeror may not refer to current or past relationships with partners. The Offeror may not describe current relationships with partners. The Offeror may only speak in the future tense regarding partnerships. The Offeror should not cite the number of Providers it has already contracted with, nor should the Offeror supply the Division with contracts or Letters of Intent with providers. These restrictions do not apply to the marked/unblind sections.

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
20.	23	5	To further clarify DOMs response to question #23, can the Offeror identify partnerships (past or future) by category? For example, Community Action Agency, FQHC, Academic Institution etc.?	The RFQ states, "When a response requires description of a potential partnership with a community-based organization, the Offeror may name that organization and describe the contemplated partnership. The Offeror must not describe any current or prior relationship with the organization, and the Offeror must not reference any other line of business or any relationship at all that the Offeror or its owner, subcontractors, subsidiaries, or other related entities has had, will have, or desires to have with a named community-based organization, other than the partnership contemplated for this qualification." In response to the Technical/blind portion, the Offeror may discuss partnerships that the Offeror expects to utilize should it be selected in this procurement. The Offeror may not refer to current or past relationships with partners. The Offeror may not describe current relationships with partners. The Offeror may only speak in the future tense regarding partnerships. The Offeror should not cite the number of Providers it has already contracted with, nor should the Offeror supply the Division with contracts or Letters of Intent with providers. These restrictions do not apply to the marked/unblind sections.
21.	53	11	Can DOM provide additional pages for the HRS and CHA in order to allow Offerors to include the full sample documents as requested?	The page limit of five (5) pages each for responses to 4.2.2.3.B.1. and 4.2.2.3.B.2. are removed so that Offerors may supply complete samples for the HRS and CHA.
22.	55	12	In order to accurately prepare our Pro Forma in response to 4.3.2.5 and organizational charts and FTE counts in response to 4.3.3, can DOM provide additional membership assumptions about the assumed enrollment of 125,000? We will need to know the percentage of Members expected to be categorized as medium- and high-risk (i.e. how many foster children, pregnant women, persons with SED/SMI etc.) in order to accurately estimate how many care management FTEs we will need to maintain a 40:1 ratio.	The Division has provided membership months per rate cell for SFYs 2019 – 2021 at the end of this document to assist Offerors in answering this question. The Offeror may provide additional assumptions made in the Assumptions tab of the template.

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
23.	60, 61	14	In Amendment 4, in response to questions #60 and #61 which asked about a pharmacy data file, the Division responded "assume that a winning Contractor will have access to real-time pharmacy claim information for all of its Members." Can the Division please confirm that in addition to being able to view claims through a web portal application, Contractors will also be able to download the historical and real-time pharmacy claims data file?	The Offeror may assume that they will have that information as well for the purposes of preparing its qualification.
24.	64	14	For ease of review, would the Division prefer that we keep the system diagram in the narrative if the additional space of the appendix granted is not needed?	The Division has no preference. This is at the discretion of the Offeror.
25.	82	18	Amendment 4, Question 82 specifies that the PIP forms are to be limited to 1 page each. Does this same limit apply to the forms for other questions in section 4.2.3, such as Health Literacy Campaigns, VABs, and Potential Partnerships?	Yes.
26.	82-84	18	Should the CCOs submit PIP topics based on the 4 required topics identified by the state for MississippiCAN and CHIP and/or the 4 new proposed topics (Improving Diabetes Through the Lens of Health Equity, Reducing Infant Mortality among Black women living in the Mississippi Delta Region, A Focus on EPSDT: Increase Child and Adolescent Well-Care Visits, Improving Follow-Up Care for Children and Adolescents with Mental Health Providers)	Topics of PIPs are at the discretion of the Offeror.
27.	95	22	In the Division's response to the question #95 regarding the naming of staff in organizational charts in Section 4.3.3.1, the Division states that the "The Offeror is not allowed to list the name of staff in its response." Please clarify if this means that staff names as well as any staff photos should be removed in all other marked/un-blinded sections (including cover pages and tabs) as well. If all names should be removed from all marked/un-blinded sections, please clarify if previous work experience, including roles held in MS and relevant	The Division is seeking information about what the Offeror will require for key positions if the Offeror is chosen. The Offeror is not allowed to list the name of staff in its response. Staff pictures should not be included. Previous work experience and staff education and training should not be submitted. Requirements for work experience, education, training, and special certifications should be submitted.

Question #	RFQ Question #	Page #	RFQ Question	DOM Response
			educational degrees or certifications, would be allowed to describe the qualifications of current or proposed staff.	
28.	96	23	Please clarify what is meant by "sufficient support staff to conduct daily business in an orderly manner". What types of job descriptions would DOM like to see?	The Division expects the Offeror to make its own determination regarding what sufficient support staff would be needed for daily business based on its knowledge of its own needs for operation.
29.	116	26	The Division's response regarding the inclusion of testimonial or quotes from community-based organizations in the Technical Qualifications, question #116, is "Quotes may not be included in the Offeror's qualification." Please clarify if this means that testimonial or quotes from community-based organizations should be removed in marked/un-blinded sections (including cover pages and tabs) as well.	Quotes may appear in the marked/unblind submissions.
30.	116	26	Our interpretation of the State's response to this question is that quotes cannot be used in the blind/unmarked Technical Qualifications portion of our submission, but that they may be included in the marked sections of our response (e.g., 4.3). Is our interpretation correct?	Quotes may appear in the marked/unblind submissions.
31.	117	26	Amendment 4, Question 117 removes the work plan requirements from sections 4.2.2.1 – 4.2.2.11. Does the Division intend to also remove the "work plan" portion of section 4.2.1, Executive Summary?	"Work plan" in this instance refers to the Offeror's approach and philosophy in designing a coordinated care solution for the Division. It should not include information that would violate the rule against Identifying Information.

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Additional Information in response to Question # 22			
Membership Months by Rate Cell SFY 2019 to SFY 2021			
Rate Cell	**SFY 2019**	**SFY 2020**	**SFY 2021**
Non-Newborn SSI / Disabled	766,450	764,512	756,254
Breast and Cervical Cancer	1,150	1,242	1,740
MA Adult	493,333	490,054	575,590
Pregnant Women	136,544	136,424	128,526
SSI / Disabled Newborn	6,432	6,144	5,314
Non-SSI Newborns 0 to 2 Months	75,383	74,514	70,999
Non-SSI Newborns 3 to 12 Months	256,516	251,641	245,587
Foster Care	78,305	82,414	81,077
MYPAC	7,007	8,545	9,909
MA Children	3,066,013	3,053,244	3,440,812
Quasi-CHIP	326,868	339,618	368,721
CHIP	559,365	563,395	577,612
This table provides the total member months for each of the twelve months periods of the state fiscal years ended 2019, 2020 and 2021.			

[END OF DOCUMENT]

Attachment 4.1.18

Subcontractor Scope of Work Statements

magnolia health™

February 24, 2022

Aaron Sisk
President and CEO
Magnolia Health Plan
111 E Capitol Street, Suite 500
Jackson, MS 39201

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ# 20211210

Mr. Sisk,

Centene Management Company LLC confirms our consent to submission as a proposed subcontractor for Magnolia Health Plan in response to RFQ# 20211210 for the Mississippi Division of Medicaid Coordinated Care. Centene Management Company LLC will provide administrative services through a Management Services Agreement, including support for information systems, claims processing, fraud and abuse, provider data management, human resources, BH utilization management, disease management, and language services.

Christopher A. Koster
NAME OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

Secretary
TITLE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

Christopher A. Koster
Christopher A. Koster (Feb 24, 2022 08:05 CST)
SIGNATURE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

2/24/2022
DATE

envolve
Benefit Options

David Lavely
President & CEO
o: 252.544.9251
1151 Falls Road, Suite 2000
Rocky Mount, NC 27804

January 24, 2022

Aaron Sisk
President and CEO
Magnolia Health Plan
111 E Capitol Street, Suite 500
Jackson, MS 39201

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ# 20211210

Mr. Sisk,

Envolve Dental, Inc. confirms our consent to submission as a proposed subcontractor for Magnolia Health Plan in response to RFQ# 20211210 for the Mississippi Division of Medicaid Coordinated Care. Envolve Dental will provide dental benefit management services on behalf of Magnolia, including claims processing and payment, quality improvement, utilization management, and network development and management.

David Lavey
NAME OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

President and CEO
TITLE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

David Lavely
David Lavely (Jan 31, 2022 10:51 EST)
SIGNATURE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

January 31, 2022
DATE

envolve
Benefit Options

David Lavely
President & CEO
o: 252.544.9251
1151 Falls Road, Suite 2000
Rocky Mount, NC 27804

January 24, 2022

Aaron Sisk
President and CEO
Magnolia Health Plan
111 E Capitol Street, Suite 500
Jackson, MS 39201

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ# 20211210

Mr. Sisk,

Envolve Vision, Inc. confirms our consent to submission as a proposed subcontractor for Magnolia Health Plan in response to RFQ# 20211210 for the Mississippi Division of Medicaid Coordinated Care. Envolve Vision, Inc. will provide vision benefit management services on behalf of Magnolia, including claims processing and payment, quality improvement, utilization management, and network development and management.

David Lavely
NAME OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

President and CEO
TITLE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

David Lavely
David Lavely (Jan 31, 2022 10:51 EST)
SIGNATURE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

January 31, 2022
DATE

DALLAS PRINTING INCORPORATED
315 Carrier Boulevard
Richland, MS 39218
p: 601.968.9354
f: 601.968.9357
w: dallasprintingms.com

January 24, 2022

Aaron Sisk
President and CEO
Magnolia Health Plan
111 E Capitol Street, Suite 500
Jackson, MS 39201

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ# 20211210

Mr. Sisk,

Dallas Printing confirms our consent to submission as a proposed subcontractor for Magnolia Health Plan in response to RFQ# 20211210 for the Mississippi Division of Medicaid Coordinated Care. Dallas Printing will provide printing services, such as Member identification cards and other Member materials, on behalf of Magnolia.

David Dallas
NAME OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

Owner
TITLE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

David Dallas
SIGNATURE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

2/2/22
DATE

February 01, 2022

Aaron Sisk
President and CEO
Magnolia Health Plan
111 E Capitol Street, Suite 500
Jackson, MS 39201

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ# 20211210

Mr. Sisk,

National Imaging Associates, Inc. confirms our consent to submission as a proposed subcontractor for Magnolia Health Plan in response to RFQ# 20211210 for the Mississippi Division of Medicaid Coordinated Care. National Imaging Associates, Inc. will provide specialty utilization management for high-tech and cardiac imaging; physical therapy, occupational therapy, and speech therapy; and interventional pain services on behalf of Magnolia through a Management Services Agreement with Centene Management Company.

James Wieland

NAME OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

SVP, GM, Specialty Health

TITLE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

National Imaging Associates, Inc.

By: James Wieland

SIGNATURE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

2/10/2022

DATE

675 Placentia Avenue, Suite 300, Brea, CA 92821
888.999.7713 p | 800.214.9910 f

New Century Health

January 28, 2022

Aaron Sisk
President and CEO
Magnolia Health Plan
111 E Capitol Street, Suite 500
Jackson, MS 39201

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ# 20211210

Mr. Sisk,

NCH Management Systems, Inc. doing business as New Century Health confirms our consent to submission as a proposed subcontractor for Magnolia Health Plan in response to RFQ# 20211210 for the Mississippi Division of Medicaid Coordinated Care. New Century Health will provide utilization management for specialty services such as hematology, oncology, urology, and durable medical equipment on behalf of Magnolia.

Scott Pritchard
NAME OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

President
TITLE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

Scott Pritchard
SIGNATURE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

1/28/2022
DATE

VIGILANT HEALTH

January 24, 2022

Aaron Sisk
President and CEO
Magnolia Health Plan
111 E Capitol Street, Suite 500
Jackson, MS 39201

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ# 20211210

Mr. Sisk,

Vigilant Health confirms our consent to submission as a proposed subcontractor for Magnolia Health Plan in response to RFQ# 20211210 for the Mississippi Division of Medicaid Coordinated Care. Vigilant Health will provide diabetes self-management and education services, and training, medical nutrition therapy; and point-of-care laboratory testing and related services for Members with diabetes or prediabetes and enrolled in the Diabetes Care Group program services on behalf of Magnolia.

David Coppeans
NAME OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

Chief Operating Officer
TITLE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR


SIGNATURE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

1/24/2022
DATE

February 9, 2022

Aaron Sisk
President and CEO
Magnolia Health Plan
111 E Capitol Street, Suite 500
Jackson, MS 39201

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ# 20211210

Mr. Sisk,

Medical Transportation Management, Inc. (MTM) confirms our consent to submission as a proposed subcontractor for Magnolia Health Plan in response to RFQ# 20211210 for the Mississippi Division of Medicaid Coordinated Care. MTM will provide Non-Emergency Medical Transportation services on behalf of Magnolia.

Alaina Maciá

NAME OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

President and CEO

TITLE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

Alaina Maciá

SIGNATURE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

February 9, 2022

DATE

TurningPoint
1000 Primera Blvd, Suite 3160
Lake Mary, FL 32746

January 28, 2022

Aaron Sisk
President and CEO
Magnolia Health Plan
111 E Capitol Street, Suite 500
Jackson, MS 39201

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ# 20211210

Mr. Sisk,

TurningPoint Healthcare Solutions LLC. confirms our consent to submission as a proposed subcontractor for Magnolia Health Plan in response to RFQ# 20211210 for the Mississippi Division of Medicaid Coordinated Care. TurningPoint Healthcare Solutions LLC. will provide utilization management for orthopedic procedures on behalf of Magnolia.

Eric Pezzi

NAME OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

CHIEF EXECUTIVE OFFICER

TITLE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

SIGNATURE OF INDIVIDUAL AUTHORIZED TO LEGALLY BIND THE SUBCONTRACTOR

3/2/2022

DATE

Attachment 4.1.19

Authority to Obligate and Bind

magnolia health™

magnolia health
111 East Capitol Street
Suite 500
Jackson, MS 39201
1-866-912-6285
TDD/TTY 1-877-725-7753

March 4th, 2022

RE: Transmittal Letter Requirement: Certification of Full Authority to Obligate and Bind

As the Secretary of Magnolia Health Plan, Inc., I hereby certify that Aaron Sisk, Plan President and Chief Executive Officer of Magnolia Health Plan, Inc. has full authority to obligate and bind Magnolia Health Plan, Inc. to the terms, conditions and provision of the Qualification submitted in Request for Qualifications (RFQ) for the Mississippi Coordinated Access Network (MississippiCAN or MSCAN) and the Mississippi Children's Health Insurance Program (CHIP) RFQ #20211210, issued by the Mississippi Division of Medicaid.

Signed,

Signature

Joel B. Samson

Printed Name

Secretary, Magnolia Health Plan, Inc.

Title

February 25, 2022

[END OF RESPONSE]

PUBLIC COPY

magnolia health™

Response to Request for Qualifications
Mississippi Division of Medicaid Coordinated Care

RFQ # 20211210
RFx # 3150003991
Technical Qualification (Blind Evaluation)
Magnolia Health Plan, Inc.

Transforming the health of the community, one person at a time.

4.2.1 EXECUTIVE SUMMARY

The Executive Summary shall condense and highlight the contents of the qualification in such a way as to provide a broad understanding of the entire qualification. The Executive Summary shall include a summary of the proposed approach, the staffing structure, and the task schedule, including a brief overview of:

We are pleased to submit this response to the Request for Qualifications (RFQ) for the Mississippi Division of Medicaid (DOM) Coordinated Care, RFQ #20211210. As a longstanding managed care plan with experience serving Medicaid and CHIP plans across the country through our affiliate health plans, we are well equipped to partner with DOM to serve Mississippi Coordinated Access Network (MSCAN) and CHIP beneficiaries as a Coordinated Care Organization (CCO). We have a deep understanding of the needs of and challenges faced by Medicaid and CHIP beneficiaries, and we will bring experiences and best practices learned from serving similar populations in other states to provide high-quality care to MSCAN and CHIP Members.

1. Proposed work plan;

We will base our program and project management methodology on the same successful model we have used to implement programs similar in size and scope to the CCO program.

Project Management Approach

Our proven implementation approach includes the right combination of executive oversight, senior leadership engagement, and technical expertise to ensure a compliant and accurate implementation. Our **Steering Committee**, comprised of our Senior Leadership Team, are responsible for providing strategic oversight for changes required by the project that will impact the overall health plan. The Steering Committee is also the project governance body to which key business decisions and project issues are escalated and resolved, and requires communication on matters which will change the scope of the project and its deliverables. Our **Project Implementation Team** includes our Executive and Senior Leadership Team, Project Lead, Integrated Leads and Subject Matter Experts, including Subcontractor Representatives, responsible for the design and implementation of any new process, program or technology solution required by new Model Contract requirements. Our parent company's **Executive Steering Committee** will function as the corporate oversight body for our CCO implementation. Our Project Management Approach consists of five key elements, described in detail in our response to Section 4.3.4.1 of the RFQ:

1. A consistent **project lifecycle methodology** with defined stages and activities to ensure progress to implement the CCO Contract requirements
2. The deployment of **dedicated, local, and highly specialized professionals** with defined levels of authority to implement CCO Contract requirements
3. A **customized communications plan** that ensures adequate and timely reporting to executive management and department personnel and ensures consistent communication between implementation participants
4. A set of **industry-standard and proprietary tools** to define accountability, track progress, and identify and mitigate risks to implementing the CCO Contract requirements
5. A **proactive systematic review** of implementation progress, issue identification/assessment, alternatives analysis, and resolution

Enterprise Business Implementation Tools and Templates. Leveraged from best practices, our work plan tools and templates have been tailored to specifically meet the needs of Mississippi Medicaid and CHIP managed care projects and encompass the following key areas: Project Scope, Project Communications, Resource Planning, Work Plan and Schedule, Risk Management, Quality Control, and Cost Management.

Work Plan and Task Schedule. Our Implementation Work Plan and Schedule include all responsibilities, milestones, and deliverables necessary for the CCO program. It is a detailed Work Plan broken down by tasks and subtasks and a schedule for the performance of each task. The Work Plan clearly identifies which activities require involvement or participation from DOM. Upon contract award, our Project Lead will review the Work Plan and Schedule to ensure that activities reflect all required work; all work is properly sequenced; durations are reasonable for the nature of the work; and that the correct people are assigned to oversee the performance of each activity. Once all changes are completed, the Project Lead will baseline the Work Plan to provide a reference point against which project performance will be measured. During weekly Project Team meetings, the

Project Lead will review information from the Work Plan including status of deliverable completion, progress of work, work at risk or behind schedule and actions needed to correct the issue, updates on open issues, actions on risks, and activities due in the upcoming period. The Project Lead will make the appropriate changes to the Work Plan and then post the updated Work Plan to our internal project site. As part of our Steering Committee meetings, the Project Lead will review and report information from the Work Plan including status of critical milestones, work at risk or behind schedule (and actions to address the issue), and milestones due in the upcoming period. When appropriate, our Chief Executive Officer (CEO) will escalate identified issues to our parent company's Executive Steering Committee for additional discussion and possible action.

2. Staff organizational structure;

Staff Organizational Structure

We believe that Mississippians are best served by Mississippians. Our local approach will ensure that we supply jobs of all skill levels and bring growth and development opportunities for Mississippians statewide. Our staff will be familiar with the local culture, geography, and health care delivery system, which will contribute to an unparalleled understanding of the needs of our Members. Our local approach will enable us to:

- Provide accessible, high quality, and culturally sensitive health care services to our Members
- Form strong, collaborative relationships with the Provider community
- Be a responsive partner to DOM, undertaking special projects and setting the bar as a CCO
- Create flexibility in our operating model to meet the unique needs of Mississippi

Our organizational structure will have clear lines of authority and an experienced Senior Leadership Team. Our governing body, the Board of Directors, will set forth policy and has overall responsibility for organization of the plan. The local health plan will be responsible for administration and management of all aspects of the Contract. Members of our Senior Leadership Team, all of whom will be Mississippi-based to support implementation and operations of the CCO Contract, will include:

- Chief Executive Officer (CEO)
- Chief Operating Officer (COO)
- Chief Financial Officer (CFO)
- Medical Director
- Perinatal Health Director
- Behavioral Health Director
- Chief Information Officer
- Compliance Officer
- Project Manager

We will employ senior leaders with strong experience and qualifications to position us to offer best-in-class services to MSCAN and CHIP Members. The team will be supported by many other staff overseeing and carrying out tasks to support daily operations in functional areas including but not limited to Member Services, Population Health and Care Management, Quality Management, Provider Services, Provider Network and Contracting, Utilization Management, Grievances and Appeals, Claims, Data and Analytics, and Pharmacy.

Our parent company will offer us the opportunity to take advantage of economies of scale by providing administrative services, such as IT, Finance, and Human Resources support as well as access to national expertise through affiliate health plans. By utilizing the corporate expertise for some administrative tasks, we can focus on important Member and Provider facing positions, such as employing medical and behavioral health care managers to promote the integration of care and numerous field positions within the care management department to provide community outreach and face-to-face visits.

3. Key personnel; and,

Our entire team will be responsible for ensuring we meet all Appendix A, Draft Contract requirements and provide high-quality services to our Members. Qualifications of key personnel, in alignment with Section 1.13.1 of the Draft Contract, are reflected in **Table 4.2.1.3** below.

Table 4.2.1.3 Key Personnel

Key Personnel Title	Required Qualifications and Experience	Location in Organizational Structure
Chief Executive	Extensive experience in contracting and strategic planning and development. At least 5-8 years of experience in a top management position in the government or healthcare	Reports to Board of

Key Personnel Title	Required Qualifications and Experience	Location in Organizational Structure
Officer (CEO)	industry working on contract acquisition and operations management. Excellent managerial and financial skills and the ability to take leadership over any health plan business operations area. Outstanding communication skills. Thorough understanding of management and financial/budgeting practices in all areas and phases of business operations. Bachelor's degree in business, health care administration, public administration, or related field. Master's degree preferred.	Directors
Chief Operating Officer (COO)	Extensive experience in contracting and strategic planning and development. At least 5-8 years of experience in a top management position in the government or healthcare industry working on contract acquisition and operations management. Excellent managerial, financial planning, and strategy planning skills. Thorough understanding of management and financial/budgeting practices in all areas and phases of health plan business operations. Outstanding leadership and communication skills. Deep understanding of advanced business planning and regulatory issues. Understanding of data analysis and performance metrics. Bachelor's degree in business, health care administration, public administration or related field. Master's degree preferred.	Reports to CEO
Chief Financial Officer (CFO)	10+ years in a high level finance role in the healthcare or insurance industry. Master's degree preferred. CPA preferred. 10+ years in a high level finance role in the healthcare or insurance industry. Excellent skills in financial planning and strategy, strategic planning and vision, process improvement, forecasting, corporate finance, budget development and management, and quality management. Outstanding written and verbal communication and leadership skills. Proficient in database and accounting computer application systems.	Reports to CEO
Chief Medical Director	Medical Doctor or Doctor of Osteopathy, board certified in a specialty recognized by the American Board of Medical Specialists. Master's degree in Business Administration, Public Health, Healthcare Administration or related field preferred. Volunteer patient care required. Previous experience as Medical Director is preferred. Knowledge and understanding of managed care principles, industry, provider reimbursement, and human resource management required. Strong communication, interpersonal, and presentation skills. Experience treating or managing care for a culturally diverse population preferred.	Reports to CEO
Perinatal Health Director	Medical Doctor or Doctor of Osteopathy, board certified in obstetrics and gynecology. Must be an actively practicing physician with a specialty in obstetrics and gynecology in Mississippi or have been an actively practicing physician in Mississippi with a specialty in obstetrics and gynecology in the past five (5) years and be located in Mississippi. Knowledge and understanding of managed care principles, industry, provider reimbursement, and human resource management. Strong communication, interpersonal, and presentation skills. Experience treating or managing care for a culturally diverse population preferred.	Reports to Medical Director
Behavioral Health Medical Director	Medical Doctor or Doctor of Osteopathy, board certified preferable in a primary care specialty (Internal Medicine, Family Practice, Pediatrics or Emergency Medicine). The candidate must be an actively practicing physician. Previous experience within a managed care organization is preferred. Course work in the areas of Health Administration, Health Financing, Insurance, and/or Personnel Management is preferred. Experience treating or managing care for a culturally diverse population preferred. Board Certified Psychiatrist. 5+ years of experience in mental health and substance use disorder services. Experience directing behavioral health programs and services for special populations, including individuals with intellectual or developmental disabilities, preferred. Knowledge and understanding of managed care principles, industry, provider reimbursement, and human resource management. Strong communication, interpersonal, and presentation skills. Experience treating or managing care for a culturally diverse population preferred.	Reports to Medical Director
Chief	15+ years of related experience. Previous management experience including	Corporate Support

Key Personnel Title	Required Qualifications and Experience	Location in Organizational Structure
Information Officer	responsibilities for hiring, training, assigning work and managing performance of staff. Excellent analytical and problem-solving skills. Superior leadership skills. Relationship building and team development skills. Thorough understanding of health plan data management and administration. Bachelor's degree in Finance, Accounting, Economics, Business Administration. Bachelor's degree in related field. Master's degree preferred.	with a dotted line reporting structure to CEO
Compliance Officer	8+ years of compliance program management and contract experience. Extensive knowledge of state administrative code and regulations, state insurance laws and regulations including managed care regulations. Experience with state and federal government agencies, accreditation bodies, participating provider agreements, HIPAA and Third Party Administration (TPA) laws, credentialing regulations and prompt pay laws. Excellent organizational and analytical skills. Strong influencing skills and perseverance in investigating. Ability to read, analyze, and interpret technical procedures, governmental regulations, and legal documents. Excellent oral and written communication skills. Ability to write clear, concise reports, business correspondence, and procedures. Ability to effectively present and represent the plan's interests externally with regulators. Ability to effectively present information and respond to inquiries from employees, regulatory agencies, and others, as necessary. Ability to initiate administrative activities as necessary, and institute quality control procedures. Ability to meet deadlines and adjust to changes in company policies, procedures, and priorities. Bachelor's degree in Public Policy, Government Affairs, Business Administration or related field. Master's or Law degree preferred.	Reports to CEO
Project Manager	3+ years of project management experience. Experience working with and leading diverse groups and matrix managed environments. Excellent interpersonal, leadership, and problem-solving skills. Demonstrates flexibility. Proficient with MS Office applications and project management tools. Bachelor's degree in Business Administration, Healthcare Administration, related field, or equivalent experience.	Reports to CEO
Provider Services Manager	3+ years of customer service experience in a call center environment. Previous experience as a lead in a functional area, managing cross-functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff. Bachelor's degree preferred. Strong leadership skills, demonstrated ability to manage cross-functional teams on large scale projects.	Reports to COO
Network/ Contracting Manager	4+ years of provider recruitment, contracting, contract analysis, or provider relations. Bachelor's degree in Health Administration, Business Administration, related field, or equivalent experience. Must be knowledgeable of network development processes, contract language, principles of negotiation, credentialing and call center operations.	Reports to Provider Services Manager
Member Services Manager	3+ years of customer service experience in a call center environment. Previous experience as a lead in a functional area, managing cross-functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff. Bachelor's degree preferred. Strong leadership skills, demonstrated ability to manage cross-functional teams on large scale projects.	Reports to COO
Quality Management Director	Five years clinical experience in an acute care setting. Four years experience in quality management/ improvement in a health care setting. Two years work experience in a managed care environment. Five years management experience in a health care setting. Three years management experience in quality management/ improvement in an HMO setting. Bachelor's degree in Nursing or equivalent is required; Master's degree in health services administration or equivalent is desired. Strong leadership skills, demonstrated ability to manage cross-functional teams on large scale projects. Excellent strategic planning and process improvement skills. Broad understanding of HEDIS and how it is used to drive business growth and efficiencies. Ability to develop, execute and improve clinical programs across large or	Reports to Medical Director

Key Personnel Title	Required Qualifications and Experience	Location in Organizational Structure
	multiple business units.	
Care Management Director	7+ years of nursing, quality improvement, and management experience in a healthcare environment, preferable managed care. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff. Current state's RN or LMSW license. Strong leadership skills, demonstrated ability to manage cross-functional teams on large scale projects. Excellent strategic planning and process improvement skills. Broad understanding of accreditation. Ability to develop, execute and improve clinical programs across large or multiple business units. Strong understanding of health care provider communication strategies.	Reports to Senior Director, Population Health, who Reports to the Population Health Director
Population Health Director	8+ years of clinical experience in the Healthcare industry. Prior experience in an innovation field, long term project, or evidence of driving successful clinical practice innovative solutions. Medical Doctor or Master's degree in Nursing, Therapy, Pharmacy, Public Health/Administration or related field. MBA preferred. 8+ years of clinical experience in the Healthcare industry. Broad understanding of HEDIS and how it is used to drive business growth and efficiencies. Ability to develop, execute and improve clinical programs across large or multiple business units. Ability to identify, create and tracking clinical program opportunities for population health management. Prior experience in an innovation field, long term project, or evidence of driving successful clinical practice innovative solutions.	Reports to CEO
Utilization Management Coordinator	3+ years utilization management and recent nursing experience in an acute care setting particularly in medical/surgical, pediatrics, or obstetrics and management experience. Thorough knowledge of utilization management and clinical nursing. Familiarity with Medicare and Medicaid managed care practices and policies, CHIP and SCHIP. Previous experience as a lead in a functional area, managing cross functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff. Bachelor's degree in nursing preferred. Excellent understanding of and ability to apply clinical guidelines and best practices in utilization management. Strong cross-functional and external communication skills.	Reports to Population Health Director
Grievance and Appeals Coordinators	2+ years of claims, contracting, or related experience in a managed care environment. Excellent understanding of and ability to apply regulations and requirements regarding grievances and appeals. Strong cross-functional and external communication skills.	The two dedicated Grievance Coordinators and two dedicated Clinical Appeals Coordinators report to Supervisor, Clinical G&A, who ultimately reports to the Quality Management Director
Claims Administrator	4+ years of medical surgical claims processing experience, including knowledge of claims processing methodology. Previous experience as a lead in a functional area or managing cross functional teams on large scale projects. Excellent understanding of and ability to apply regulations and requirements regarding claims adjudication and processing. Strong cross-functional and external communication skills.	Reports to COO
Data and Analytics Manager	4+ years of statistical analysis or data analysis experience. Medicare and Medicaid managed care experience a plus. Knowledge of various data mining, reporting, and reconciliation tools and methodologies. Advanced systems and software knowledge in MS Access and Excel, SQL, Business Objects, and data warehousing. Amysis experience preferred. Experience working with diverse business groups within a matrix environment. Project management experience preferred.	Reports to Vice President, Finance, who reports to CFO

Key Personnel Title	Required Qualifications and Experience	Location in Organizational Structure
Clinical Pharmacist	Must have and maintain current, valid and unrestricted Pharmacist license in the state of employment and credentialed by the health plan of employment. One year prior experience in clinical pharmacy. Demonstrated success in managing professional relationships in a managed care system, medical group, hospital, or related organizations. Strong clinical pharmacy background with ability to demonstrate clinical pharmacy skills and knowledge in a care setting. Strong knowledge of managed care; pharmaceutical/healthcare industry dynamics and provider reimbursement; and provider contracting processes and strategies. Demonstrated success in managing professional business relationships in a managed care system, medical group, hospital, or related business in health care delivery industry. Excellent verbal and written communication skills; strong business analytical skills and abilities; strong project management and coordination ability; ability to function effectively as a management team member.	Reports to COO

4. A brief discussion of the Offeror's understanding of the Mississippi environment and MississippiCAN and CHIP requirements.

We understand the Mississippi environment, including the demographics and health indicators within the state, and the MSCAN and CHIP Program requirements which seek to improve access, quality, and overall health outcomes for eligible Mississippians. We understand and are fully aligned with DOM's goals as stated in the RFQ to:

- **Improve quality** through performance improvement projects, value-adds, value-based purchasing, health literacy campaigns, care management, and other mechanisms
- Engage in **collaborative innovation** with DOM, other CCOs, and community partners to achieve quality, leveraging our experience, knowledge, and creativity while providing consistency and ease of administrative burden for both Members and Providers
- **Address barriers to access**, including geographic barriers and those related to social determinants of health (SDOH)
- **Demonstrate a true commitment** to improving the quality of life for Mississippians, both through delivery of care and through investments in communities and human capital

Understanding the Mississippi Environment

We know that Mississippians are a strong and resilient community. At the same time, we understand there are significant disparities in the quality of care and health outcomes throughout the state. For example, we share DOM's commitment and focus on addressing SDOH to attain the highest level of health for all people, no matter who they are or where they live, while lowering unnecessary health care costs. We will hire a local Director of Health Equity to oversee the strategic design, implementation, and evaluation of initiatives that address social and community health, including reducing disparities and increasing cultural sensitivity. Using our SDOH Predictive Analytics Tool, we found that the average risk score for urban census tracts in Mississippi is nearly 23 percentage points higher than rural census tracts. Although rural areas tend to have greater access issues, urban areas in Mississippi present a different set of risk factors that can lead to increased risks for chronic conditions. Infant mortality, asthma, and diabetes are significant issues across the State.

- **Infant Mortality**. Mississippi ranks near the top of all States in infant mortality rates with 8.6 deaths per 1,000 births exceeding the national average of 5.7[1].

[1]America's Health Rankings analysis of CDC WONDER, Linked Birth/Infant Death Files, United Health Foundation, AmericasHealthRankings.org, Accessed 2022.

- **Asthma**. The asthma rates in Mississippi are 9.9%, exceeding the national average of 7.8%[2].
- **Diabetes**. Mississippi has the third highest rate of diabetes in the country at 13.6%[3] with Tippah County having the highest rate of all counties in the nation[4].

We have deep experience synthesizing, analyzing, and acting on physical health, behavioral health, pharmacy, dental, vision, Member demographics, utilization, and Member assessments including SDOH data. We understand that addressing the barriers to access presented by SDOH are primary objectives of DOM to impact overall health more effectively. The primary SDOH issues we have identified in Mississippi include:

Poverty (Below 100% of FPL). Mississippi had the highest percentage of people living in poverty nationally (2017)[5] and ranked the second hungriest State[6]. Approximately 20.75% of individuals live in households with income below the FPL in Mississippi.[7] Nearly 65.5% of Members live in census tracts with a poverty rate greater than 20%, and 86.2% of Members live in tracts with a median family income less than the state average of $45,081. High poverty rates are concentrated in the western, central, and eastern regions of the State, with the highest density in the western parts of the State. Jefferson County has the highest average poverty rate of 45.8%. Counties with low average median income are spread throughout the State with dense areas in the northern, western, and southern regions. Poverty is a critical indicator because it creates barriers to health services, healthy food, and other necessities that contribute to poor health status.

Food Insecurity. On average, 40.7% of the urban population lives in low food access tracts (defined as living more than a mile from the nearest supermarket, supercenter, or grocery store) compared to 12.2% in rural populations. Approximately 40% of urban tracts are classified as ***food deserts*** compared to 22% of rural tracts (1 in 3 Members live in a census tract considered a food desert). Rural areas with less population density also have high SDOH needs. Mississippi has the highest projected food insecurity rate in the country in 2020,[8] with nearly 1 in 5 people and 1 in 4 children facing hunger.[9] ***Food access*** appears to be a significant risk factor, with 4 of 5 Members living in low-food census tracts and 1 in 3 in a census tract designated as food deserts. The Delta Region (DeSoto County, Tallahatchie County, Bolivar County) and Benton County have the highest rates of low food access, and one-third of the region is considered a food desert. Jackson County is predominately urban with outlying high rates of low food access. More than half are estimated to be below the SNAP threshold of 130% poverty level among the food insecure. All tracts in Benton, Issaquena, Tunica, Montgomery, Amite and Wilkinson counties are food deserts. There is a concentration of food deserts in western Mississippi, where low population density likely leads to fewer grocery stores. Furthermore, the Robert Wood Johnson Foundation's project - the State of Childhood Obesity - shows Mississippi continues to have a high obesity rate, which may be in part to poor eating habits and disparities in accessing healthy food.[10]

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[2] "Most Recent Asthma State Data." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 30 Mar. 2021, https://www.cdc.gov/asthma/most_recent_data_states.htm.

[3] "Diabetes Prevention and Control." Diabetes - Mississippi State Department of Health, Mississippi State Department of Health, 28 Mar. 2018, https://msdh.ms.gov/msdhsite/_static/43,0,296.html#:~:text=In%202016%2C%20Mississippi%20ranked%20first,deaths%20in%20Mississippi%20in%202016.

[4] Jaglois, Jessica. "Investigators: Mississippi County Has Highest Rate of Diabetes in the US." Https://Www.actionnews5.Com, Action News 5, 22 Apr. 2021, https://www.actionnews5.com/2021/04/22/investigators-mississippi-county-has-highest-rate-diabetes-us/.

[5] Nave, R.L., and Mississippi Today September 14 R.L. Nave. Mississippi Still Has Worst Poverty, Household Income. Mississippi Today, 10 May 2021, https://mississippitoday.org/2017/09/14/mississippi-still-worst-poverty-household-income-u-s/.

[6] Top 10 Hungriest States in the U.S. Friends Committee On National Legislation, 10 Nov. 2021, https://www.fcnl.org/updates/2021-11/top-10-hungriest-states-us.

[7] Lynch, Victoria, et al. "Improving the Validity of the Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits." Census.gov, Urban Institute, Health Policy Center, 27 Sept. 2011, https://www.census.gov/content/dam/Census/library/working-papers/2011/demo/improving-the-validity-of-the-medicaid-chip-estimates-on-the-acs.pdf.

[8] Norwood, Ashley. Child Hunger Is on the Rise in Mississippi. MPB - Mississippi Public Broadcasting, 21 Nov. 2020, https://www.mpbonline.org/blogs/news/child-hunger-is-on-the-rise-in-mississippi/.

[9] "What Hunger Looks Like in Mississippi." Hunger in America, Feeding America, https://www.feedingamerica.org/hunger-in-america/mississippi.

[10] Prioritizing Children's Health during the Pandemic. Robert Wood Johnson Foundation, Oct. 2020, https://media.stateofobesity.org.

Transportation. The greatest transportation gaps are found in the western and southern regions of the State. Participants of the 2021 Mississippi State Department of Health State Health Assessment session most cited housing as a challenge in their communities, especially for low socio-economic status communities - compromising their accessibility and safety. Forty-one percent of Members live in census tracts with high (over 60) Poor Housing and Lack of Transportation Index (PHLTI) percentiles. Approximately 43.2% of Members live in census tracts where the rate of individuals without vehicle access in the household is above the U.S. average of 8.6%, with Issaquena and Sharkey's counties ranking the lowest. Eight counties have average PHLTI percentiles of 80 or greater (Bolivar, Holmes, Claiborne, Greene, Wilkinson, Sharkey, Tunica, and Issaquena. Seven counties have 14% or more households with no vehicle access (Humphreys, Bolivar, Washington, Sharkey, Noxubee, Leflore, and Issaquena).

Housing. Household Vulnerability, the degree to which a family is at risk of becoming unhoused due to additional financial stressors, is a significant issue in many counties – mostly in the western and eastern parts of the State where nearly three in four Members live. The Mississippi 2020 HUD Point-in-Time Count and Housing Inventory Count accounted for 1,107 homeless persons across the state and were unsheltered (48%), in emergency housing (30%), or transitional housing (22%). Half identified as Black or African-American, and 46% identified as white (by comparison, 38% of the state population is Black, 59% of the population is white).[11] Mississippi has the highest rate of renters in the country (27%).[12] An estimated 61.5 % of parents with incomes at or below 138% of the FPL reported delaying or forgoing health care in the past 12 months because of the cost, difficulties taking time off work, difficulties balancing family or childcare obligations, and transportation challenges.[13] According to the National Low Income Housing Coalition, there is a shortage of rental homes affordable and available to extremely low-income households already severely cost-burdened (spend more 50% of their income on housing) and are more likely than other renters to sacrifice necessities like healthy food and health care to pay rent. One quarter (27%) of Members are cost-burdened, with housing costs exceeding 30% their total household income. Although lower than the national average, most households have a single source of income.[14] Housing costs can cause increased stress levels in adults leading to potential health issues.

Understanding MSCAN and CHIP Requirements

As an established managed care plan with years of experience serving populations similar in size and scope to MSCAN and CHIP, we are fully prepared to comply with all requirements described in Appendix A, Draft Contract. Through our affiliate plans, we have demonstrated success carrying out all CCO requirements including but not limited to:

RFQ Area	Areas of Experience
Member Services and Benefits	• Delivering covered services including children's services (through Medicaid and CHIP), behavioral health services, perinatal and neonatal, chronic conditions, foster children, dental services, vision services, non-emergency transportation (NET) services, value-added benefits, and others • Operating a Member Services call center with fully trained staff that meets and exceeds all key performance measures • Developing and distributing a Member Handbook to inform Members how to access services and programs • Operating a website and mobile application to ensure Members are well-informed about programs and services • Deploying a multi-modal approach to Member education and communication that educates Members on our programs and covered services, Care Management, rights and responsibilities, preventive health care, and others

[11] "Mississippi Homelessness Statistics." Homelessness Statistics, United States Interagency Council on Homelessness, https://www.usich.gov/homelessness-statistics/ms/.
[12] "The State of the Nations Housing 2021." Joint Center for Housing Studies of Harvard University, President and Fellows of Harvard College, 2021, https://www.jchs.harvard.edu/sites/default/files/reports/files/Harvard_JCHS_The_State_of_the_Nations_Housing_2020_Report_Revised_120720.pdf
[13] Haley, Jennifer, et al. Parents with Low Incomes Faced Greater Health Challenges and Problems Accessing and Affording Needed Health Care in Spring 2021. Urban Institute, Jan. 2022, https://www.urban.org/sites/default/files/publication/105304/lowinc1_0.pdf.
[14] "Mississippi." Housing Needs by State, National Low Income Housing Coalition, https://nlihc.org/housing-needs-by-state/mississippi.

RFQ Area	Areas of Experience
	• Developing, implementing, and measuring success of health literacy campaigns • Measuring and continually monitoring Member satisfaction • Operating a fully compliant and effective Grievance and Appeal process
Provider Network and Services	• Developing and maintaining a comprehensive, statewide Provider Network through a robust recruitment and retention strategy, strong monitoring methods, continual evaluation and network improvement, and a transparent communication process with Providers • Operating a Provider Services call center with fully trained staff that meets and exceeds all key performance measures • Developing a strong Provider and education communication program for Primary Care Providers (PCPs)/Patient Centered Medical Homes (PCMHs), specialist Providers, Behavioral Health (BH) Providers, and others that includes individual trainings, workshops, the Provider Manual, and other mechanisms • Collaborating with PCPs/PCMHs to improve care for Members with chronic illnesses and to improve perinatal care • Ensuring timely and accurate payment to Providers through an established claims system and processes • Operating a fully compliant and effective Provider Grievance and Appeal process • Collaborating with Providers and State partners to implement Value-Based Purchasing (VBP) programs to improve health outcomes
Care Management	• Developing, implementing, and maintaining an evidence-based, person-centered, culturally responsive Care Management program • Conducting health assessments and stratifying and assigning Members to appropriate Care Management services based on the results and Member needs and preferences • Ensuring coordination of care across the care continuum, including appropriate communication with Members' Provider(s) and other members of the care team • Implementing and maintaining clearly defined Transition of Care processes to support safe and seamless transitions across care settings • Appropriately and thoroughly training Care Management staff, including ensuring all Care Managers are culturally competent and aware of implicit biases
Quality Management	• Developing, implementing, and maintaining a robust and data-driven Quality Management program with clear lines of accountability • Designing and implementing targeted Performance Improvement Projects • Employing and education Providers and staff on evidence-based clinical guidelines to support the provision of high-quality care • Using advanced data analytics and data informatics capabilities to drive performance improvement and quality management activities • Developing and deploying innovative approaches to ensure Quality Management is accuracy and effective
Utilization Management	• Developing, implementing, and maintaining a fully compliant, effective Utilization Management program with clear lines of accountability • Employing innovative and evidence-based approaches to avoid unnecessary emergency department utilization, avoidable hospitalization, and readmissions • Developing and communicating clear guidance on Utilization Management policies, procedures, and processes across health plan staff and externally with Providers
Information Technology	• Leveraging advanced technology to support effective operations including Care Management, Quality Management, Utilization Management, Population Health, and other areas • Using proven systems and processes to process claims in a timely and accurate manner • Developing and deploying innovative technological methods to optimize delivery of services to Members, including supporting efficient and effective use of telehealth • Developing and deploying a rigorous continuity of operations plan to support rapid and appropriate actions related to pandemics, natural disasters, and other scenarios
Subcontractual Relationships and Delegation	• Contracting with qualified Subcontractors and conducting ongoing oversight to ensure Subcontractors meet all requirements and support the provision of high-quality care
Financial and Data Reporting	• Conducting timely completion and reporting of all data requirements, including Medical Loss Ratio (MLR), encounter data, and health information system data, to State partners
Program Integrity	• Implementing a rigorous Program Integrity structure inclusive of proactive and reactive fraud, waste, and abuse detection and swift and appropriate action • Developing and implementing a formal Denials Review and Reporting program to monitor claims denials and educate Providers accordingly • Complying with Medicaid National Correct Coding Initiative (NCCI) requirements
Subrogation and Third-Party Liability (TPL)	• Developing and implementing fully compliant policies, procedures, and processes for conducting subrogation and TPL activities

RFQ Area	Areas of Experience
Eligibility, Enrollment, and Disenrollment	• Implementing a clearly defined and organized approach to manage eligibility and enrollment data and files • Employing a clear and consistent approach to assign Members to a PCP in a timely and appropriate manner • Providing Members with Welcome Packets and identification cards in a timely manner
Social Determinants of Health (SDOH)	• Developing and implementing interventions designed to identify and address Members' SDOH needs and to promote health equity, both in ways that integrate into other programs • Partnering with local organizations who are trusted messengers within the communities they serve to address SDOH and health equity

4.2.2.1 MEMBER SERVICES AND BENEFITS

4.2.2.1.A Delivery of Covered Services

1. Children

a. The Division has a special interest in ensuring timely and robust developmental screening and early intervention for children. The Offeror should keep that in mind in answering the following

Since our parent company was founded, we have provided services for children and have substantial experience serving children enrolled in Medicaid and CHIP programs across the nation. This experience brings a deep understanding of the crucial role EPSDT and Well-Child visits have in setting the foundation for a lifetime of health. ***While the benefits and needs differ slightly, our objectives for Mississippi MSCAN and CHIP children are the same: to ensure every child or youth has timely access to preventive care and necessary treatment to improve health outcomes and Member quality of life.*** Timely access for our MSCAN and CHIP children will be enabled through clear policies, procedures, and processes; highly trained and dedicated staff; a robust and supported Provider network that includes community-based organizations (CBOs); and ongoing Member and family/caregiver engagement. Our approaches to ensure screening and intervention for MSCAN and CHIP children are the same except where State requirements necessitate differentiation. We respond to 4.2.2.1.A.a.ii only with how our approach for CHIP may differ from what is described in 4.2.2.1.A.1.a.i.

i. MississippiCAN Services: Describe the Offeror's proposed approach to ensure children receive timely services, periodic health screenings and appropriate and up-to-date immunizations using the ACIP Recommended Immunization Schedule and AAP Bright Futures for all MississippiCAN Members including periodic examinations for vision, dental, and hearing and all medically necessary services. Include the following:

1. An overview of related policies, procedures, and processes

To ensure access and engagement in regular and preventive care for MSCAN Members, staff and systems will be aligned with contractual and regulatory requirements. We will develop, promote, monitor, and regularly update policies, procedures, and processes (P&Ps) to guide and evaluate performance across the delivery system and ensure contract compliance. P&Ps will stipulate methods for the provision of the full range of EPSDT services, consistent and aligned 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, the Bright Futures/AAP periodicity schedule for screenings, and the ACIP for required immunizations. Our P&Ps will address health equity, social determinants of health (SDOH), and behavioral health (BH) supports to help improve access and outcomes. We will educate all staff, Members, caregivers, and Providers on these P&Ps to collaboratively support timely screenings, immunizations, vaccinations, and referrals. We will create internal playbooks that provide detailed workflows and specific roles and responsibilities to ensure consistency, compliance, and unduplicated efforts for plan staff that meet the expectations of our Members, Providers, and DOM. Examples of related policies are summarized in the table below.

Table 4.2.2.A.1.a.i Example Policies and Procedures

Policy Name	Purpose	Description
EPSDT Services	Assures the availability and accessibility of required health care resources and help Medicaid recipients and their parents or guardians effectively use EPSDT resources.	Identifies all EPSDT required screening services and defines our monitoring practices, reports, improvement, and audit strategies. Includes requirements for Child Health Coordinators to refer Members with SDOH or BH needs to Care Management.
Quality Improvement	Outlines our plan's periodic notification system to ensure that Members receive the full range of EPSDT services, including screenings, immunization, and follow-up care.	Defines Member outreach, follow-up, and reporting protocols including Member incentives.
Health Education and Literacy	Plan to strengthen Members' understanding of their health and health care that includes but is not limited to ensuring all materials meet the 3rd grade reading level requirement.	Identifies specific health literacy initiatives and strategies to expand health education, increase Member understanding, and promote health equity.

2. An overview of how the Offeror will encourage Members to obtain services

Effective Member engagement is essential to improving health outcomes and utilization of preventive services. We will provide age-appropriate, targeted education about EPSDT services, work with key stakeholders to expand access, and leverage our proven programs to encourage Members to obtain preventive services for children. We will employ a "no wrong door" approach to facilitating access to services. Using our advanced Reporting and Analytics Platform and integration with Immunization Registries, we can proactively ensure Members are receiving early childhood care according to nationally recognized standards. We will encourage Members to obtain preventive services at every touchpoint: call center interactions, during Health Risk

Screenings and Comprehensive Health Assessments, and through events in communities all over the State.

Staffing

Our efforts to ensure children receive timely services, periodic health screenings, and appropriate and up-to-date immunizations will be led by dedicated Child Health Coordinators (CHCs) who will work directly with Members and their families to address gaps in care. The CHC will outreach in the week after birth to provide education to mothers on newborn care, post-partum follow-up, and Well-Child visit recommendations based on the periodicity schedule. If the CHC identifies a need, they will refer the Member to Care Management. The Care Manager will address the mother's needs to care for the newborn including nutrition assistance and transportation for appointments. Care Managers will monitor Care Plans to track progress and provide ongoing Member and Provider outreach and reminders to ensure compliance. Customer Service Representatives and other Member-facing staff will be highly trained on EPSDT policies and supporting Members on identifying and closing care gaps and coordinating access to needed follow-up care and treatment.

Education

Education is key to our success at increasing screening rates and catching issues early. We will educate Members and caregivers on the value of preventive care, EPSDT benefits, and how to access services. Methods we will use to educate Members about services will include:

- New Member Orientation / New Member Welcome Visit – in-home visit during the first 90 days to provide education about services and help select a PCP/PCMH
- New Member Welcome Packet - includes adhesive stickers outlining the periodicity schedule
- Member Handbook - describes EPSDT/well-child services and how to access them
- Educational mailings – information on immunizations and child development
- Postings on the public website
- Social media posts
- Member Portal – includes information on all available benefits
- Community events

Below we discuss additional ways we will encourage Members to obtain preventive services for children, including through our proven programs and partnerships with Providers and CBOs.

Proven Programs

We will employ targeted programs that have proven successful in helping Members obtain preventive services across our affiliates working with similar populations.

Maternal and Child Health Program. Our Maternal and Child Health Program is one of our most successful initiatives and includes targeted EPSDT-related education during pregnancy and from birth through the time the child turns one. The Program is designed to establish a strong foundation for moms and babies through person-centered coordinated care, CM, and SDOH supports. This program provides a comprehensive integrated approach to maternal and child health, providing a range of perinatal interventions and supports targeted to each Member's specific needs and level of risk. Through the first year of life, we offer guidance to parents through all the medical milestones needed to keep their babies healthy and thriving, while addressing SDOH and other barriers to healthy development.

Improving Maternal and Child Outcomes

Maternal Health Outcomes for similar populations enrolled in our Maternal Health Program include:

- 7.9% less likely to have a baby born at a low birth weight, under 2500g
- 20% less likely to have a baby born at a very low birth weight, under 1500g
- 31.2% less likely to have a baby born at an extremely low birth weight, under 1000g
- 3.3 times more likely to be compliant with prenatal care

First Year of Life Program. Our First Year of Life Program is designed to guide Members with newborns through 16 months through all the medical milestones needed to keep babies healthy and thriving. The program will provide a Care Manager specializing in pediatrics as the main point of contact to provide education and outreach at months 1, 2, 4, 6, 9, 12, and 15. The Care Manager will call when it is time for an EPSDT/well-child visit or immunizations, answer questions about benefits, and provide detailed information on what to expect at each stage. At our affiliate plans serving similar populations, the First Year of Life Program has demonstrated

an increase in well-child visits for those enrolled. For example, ***children 9-12 months of age enrolled in the program received 72% of well-child visits compared to 44% of children not enrolled in the program***.

Children's Program. Our children's program will be open to all children in the State, not just our Members. Participants will receive a welcome letter, an ID card, and an Activity Book. Quarterly, we will mail a book on topics such as asthma, diabetes, bullying, eating healthy and exercising, etc., and a birthday card on their birthday. Parents receive information on EPSDT services, Well-Baby and Well-Child services, immunizations, nutrition, physical activity, asthma, diabetes, bullying, and lead screenings. Through this program, we will host birthday parties, Christmas parties, and Family Fun Days with activities for children, along with educational information for parents/guardians around well-baby and well-child services, immunizations, nutrition, physical activity, asthma, diabetes, bullying, lead screening, and other seasonal topics.

Adopt-a-School. We will adopt schools in high-risk zip codes where many of our Members live. Through this program, we will reach out directly to children through newsletters, health education, and other innovative events to help educate children on various health topics, including bullying, healthy eating, hygiene, flu prevention, self-esteem, social isolation, and dental care. An affiliate serving a similar population reaches over 100 students each month through this program.

Member Incentive Programs. Our incentive program offers financial rewards to Members who actively engage in healthy activities. Our incentives motivate Members to obtain recommended preventive care and medically necessary follow-up services and empower them to live healthier lives by increasing their self-management skills. All Members are automatically enrolled and earn rewards by completing healthy activities like annual doctor visits (see table below). After the first activity is completed, a Visa® Prepaid Card is sent to the Member with their reward amount pre-loaded; subsequent rewards are added to the card automatically.

$1 Million in Incentives

For a similar population, our health plan distributed close to $1 million in Member incentive payments as rewards for compliance with well-child visits

Service	Reward	Eligible Visits	Maximum Limit
EPSDT Screens, Infant 0-12 mos.	$10 per screening	3-5 Day, 1 month, 2 months, 4 months, 6 months, 9 months	$50
EPSDT Screens, Child 1-3 yrs.	$10 per screening	12 months, 15 months, 18 months, 24 months, 36 months	$50
EPSDT Screens, Child 3-10 yrs.	$20 annually	Annual	N/A

Partnerships

We will prioritize partnerships according to needs and opportunities identified within our data, especially through our SDOH Predictive Analytics Tool and Health Equity Improvement Model. Our affiliates have found that trusted community partners are the most effective ways to reach individuals impacted by racial, ethnic, and geographic disparities. We will work with our network Providers, schools, and CBOs to ensure every child has an equal opportunity to obtain services.

Network Providers. Primary to ensuring Members obtain preventive services is a robust network of Providers and experienced in caring for and addressing the needs of children. ***Our network will include Providers trained in Trauma-Informed Care and Adverse Childhood Experiences, experienced in EPSDT, and board-certified in pediatric specialties and sub-specialties***. We will support our Providers with tools, resources, and educational materials on MSCAN benefits and EPSDT requirements through New Provider Orientations, webinars, and regional seminars, and in our Provider Manual and Newsletters. ***Our field-based Quality Practice Advisors*** will work with our PCPs, Pediatricians, and OB/GYN Providers to promote engagement in recommended care and support pregnant women in fostering a strong start for their newborns. To drive engagement, we invest in technology ***and*** staff solutions to support Providers in engaging Members in preventive care.

Technology to Alert Providers to Care Gaps. Through our online Provider Portal, we can automatically alert PCPs of EPSDT schedules, care gaps, and required screenings for every Member on their panel, including developmental, vision, hearing, and dental screenings that are due. The tools provide an individual Member Calendar, updated daily, with a view of all upcoming needs, and a planner to support timely visits. Providers can view and check on Member specific EPSDT care gaps and close those gaps during any scheduled visit. Providers can also view gap in care reports and our Provider Scorecard where Providers can compare

themselves to their peers or industry benchmarks. ***Our Clinical Data and Interoperability Gateway (CDIG) will offer enhanced data sharing capabilities through bi-directional data exchange with Providers' EHRs*** through multiple strategic partners. The CDIG enhances our ability to address care gaps at the point of care, conduct efficient quality monitoring, and gather additional health information, including Member's social support needs. Similar information is also available to authorized community partners through our Community Portal.

Provider Incentives. Provider incentives align with our Member incentives, discussed below, to encourage quality of care, including proper delivery of EPSDT and well-child services and efficiency in service delivery. Through our value-based purchasing (VBP) programs, we build collaborative relationships with our Providers and work toward shared goals. Providers in VBP are rewarded for performance against HEDIS quality measures that are focused on prevention, access to care, and appropriate treatment, including EPSDT, well-child visits, and chronic condition management.

Provider Incentives and VBP

Within specific markets, we have experienced improved health outcomes at reduced costs through VBPs, including the following improvements in a similar Medicaid affiliate:

- Combo 10 results by ***6.27%***
- Lead screening results by ***10.02%***
- Well care visits results by ***30.03%***
- Well-Child visits in the first 15 months improved results by ***24.16%***
- Well-Child visits for age 15-30 months results by ***14.86%***

Missed childhood immunizations result in lifelong health impacts for far too many children, especially children of low-income and underserved families. Health inequity, whether due to race, ethnicity, gender, socioeconomic status, or other factors, contributes to poor health outcomes. To reduce barriers to obtaining preventive services and increase health equity, we will establish a value-based program to increase immunization rates and EPSDT visits among eligible MSCAN Members. We will additionally collaborate to increase COVID-19 vaccination rates among eligible Members and their families.

School-Based Services. Our extensive experience working with child and youth populations has demonstrated the value and impact of school-based partnerships in meeting children and families where they are. We will work closely with school nurses, provide educational materials, coordinate care, promote access to school-based telehealth services, and secure sharing of health information to promote engagement in care. To minimize the burden on school nurses and administrative staff, we will coordinate with other CCOs to provide an accessible day for screenings and immunizations for all families. Our school-based services will follow all Medicaid/State Provider site guidelines, and we will ensure that mobile units operate under an authorized Medicaid Provider number.

School and Community Partnership Success

In one year for a single community in a similar state, we conducted nearly 800 EPSDT screenings at 39 screening events held at schools and community centers.

CBO Partners. As an extension of our traditional Provider network, we will collaborate with CBOs to serve as trusted messengers. With partners such as ***Choices for Children***, we will employ highly effective initiatives to improve EPSDT screening rates. We will work with ***All About Kids, Inc. to launch "Back to School EPSDT"*** fairs where children will receive free lunch, school supplies, and health screenings. In partnership with the ***Community Action Agencies, Mississippi Early Head Start, and Head Start***, we will develop referral relationships for children with identified gaps in care or unmet social needs. We will meet with organizations, such as Mississippi Shine and Embrace Grace, to identify collaborative opportunities and extend our reach by offering screening events at locations such as schools and libraries. We will train CBO partners on the ACIP Recommended Immunization Schedule and AAP Bright Futures and institute a process for closed-loop referrals.

We will partner with ***Boys and Girls Clubs*** in Mississippi for after-school programs, summer programs, parent night meetings, EPSDT screenings, and health fairs. At the after-school and summer programs, we will provide children's books to help educate Members and the community on eating healthy, exercise, bullying, and chronic conditions such as asthma and diabetes. We will conduct healthy recipe demonstrations and exercise sessions during the summer programs. We will coordinate EPSDT screenings at Boys and Girls Clubs in partnership with ***Choices for Children's Mobile Unit*** and ***Plan A Mobile Unit***.

3. How the Offeror anticipates the approach will improve health outcomes

Our multifaceted, proactive approach to encourage EPSDT screens and engagement in primary and follow-up care has resulted in consistent improvements in Members similar to MSCAN. By actively engaging our Members in preventive and early interventions services, we expect to see higher PCP engagement; increased participation in BH, vision, and dental visits; improved control of chronic conditions; lower ED and hospital use; improved medication compliance; and a better trajectory of healthy child development into adulthood. In the most recent fiscal year, we achieved the following EPSDT participation rates for young children in an affiliate health plan: 100% of 0-1, 91% of ages 1-2, and 73% of ages 3-5 received timely screenings.

4. The Offeror's process for reminders, follow-ups, and outreach to Members

Written and Online Notifications

In addition to the Member Education materials outlined above, Birthday Cards will be sent to all children to remind their parents/guardians to schedule EPSDT service(s). Our CHC will send letters to non-compliant Members that we cannot reach by phone. Our secure Portals display care gap reminders when the systems are accessed by Members or Providers. All notifications will be approved by DOM and made available in multiple formats and languages, including the development of videos and podcasts that will be available on social media, our website, and shared via texting. All Member materials will be written at the 3rd grade reading level as measured by the Flesch-Kincaid Readability Test Tool. Materials will be readily available in prevalent non-English languages spoken by 5% or more of our Members in compliance with DOM's Limited English Proficiency Policy. In addition, we will translate the materials to any language a Member requests or provide in an alternative format such as Braille, large print, audio, accessible electronic formats, and other formats. Our Customer Service Representatives are trained to read Member materials over the phone upon request.

Coordinating Care for Families

Our CM team will make scheduling appointments and accessing care as easy as possible for families, particularly given the challenges families have experienced in accessing prevention and screening visits during COVID-19. We will make every attempt to reassure our Members as we educate them on the importance of timely visits and address family concerns. Daily, our CHCs will target Members under age 21 for personalized notifications and outreach at appropriate intervals. For example, we will automatically contact Members due for screenings/services and during their birth month for wellness and dental check-ups. We will send push notifications via our Digital Care Management platform (with permission) and use social media for reminders, especially around key dates such as back-to-school. Members can also view their health alerts in the Member Portal. Our staff will support Members/caregivers who need appointment coordination and personalized education and address barriers such as transportation. Other successful strategies include helping families bring all their children at once for screening visits and doing screenings during other types of visits. As a common practice, our CM staff use best-practice techniques such as Motivational Interviewing to educate, encourage, and empower Members to actively manage their care and take responsibility for compliance. CM and other Member-facing staff are trained in Trauma-Informed Care and Cultural, Disability, and Poverty Sensitivity to support effective outreach. EPSDT services are included in Member Care Plans and our CM staff will call non-compliant Members to provide added support, including accompanying them to appointments. Our CHWs also complete home visits for medium and high-risk Members who are non-compliant or difficult to reach.

Real-Time Online Appointment Scheduling. Through our real-time Member appointment scheduling platform, we will assist Providers in managing appointments and reducing no-show rates. The platform allows Customer Service Representatives to schedule appointments with participating Providers directly with Members and issue text or email reminders as the appointment nears. We can securely attach documentation to the Member appointment for specific care gaps (e.g., EPSDT) to ensure a thorough Member office visit. Our CM staff will also make weekday after-hour and Saturday calls for Members who are difficult to reach during the week.

Outreach to Members with Special Health Care Needs. Children with special health care needs often underutilize preventive services. We will offer each of these children/families a Care Manager who can help facilitate access to EPSDT and preventive services, follow-up care, and needed treatment. The Care Manager supports the development of a Care Plan, which includes preventive services and a Self-Management Plan. Care Managers are available to accompany Members to Provider visits. Care Managers provide follow-up with all

infant Members who received neonatal intensive care for up to a year after discharge, including assisting the parent(s) to access needed services for their newborn.

Outreach to Foster Care Children. Our dedicated Foster Care Team will conduct outreach and follow-up with the Mississippi Department of Child Protection Services (MDCPS), caseworkers, and Resource Parents (as appropriate) to ensure that they are notified of members under their supervision that are due to receive EPSDT services. To support EPSDT services, our Foster Care Team will be available to provide onsite education at MDCPS offices, covering topics like EPSDT screenings, immunizations, and other preventive services. We also propose hosting quarterly meetings with our State Clients and MDCPS offices to facilitate access for Foster Care children to services like EPSDT. More information about how we will outreach to foster children can be found below in our response to Section 4.2.2.1.A.5 of the RFQ.

Telephone and Acute Care Protocols

During routine telephone contacts, Member Services and CM staff can see and provide EPSDT and well-child due date reminders and arrange for appointments and transportation. Our ongoing outreach campaigns will include expanded hours, including nights and weekends, to improve outreach response. When Members are calling in for acute care visits, we will review their charts for missed services and schedule a preventive service in place of the acute visit to ensure the Member receives a comprehensive service. When infants are seen for acute care, we will work with Providers to consider a wellness appointment at the time of the visit to keep the child up to date on vaccines and age-appropriate screenings, ensuring Providers can receive additional reimbursement when the visit meets required components and is appropriately coded.

Transportation Assistance

MSCAN Members will be reminded of their transportation benefits and how staff can help them access this benefit in the Member Handbook and on the Member Portal. With every EPSDT reminder contact, our staff will help with arranging transportation for the appointment. Assistance is offered at least three days before each due date of a child's periodic examination. Transportation brochures will be available at community events, Member workshops, waiting rooms at doctor offices, and distributed through our school and community partnerships. Children will not be transported without an age-appropriate car seat. We will work with our transportation partner to ensure families/caregivers are aware of this requirement. We will partner with community-based agencies and MSDH to provide safety-certified car seats and certified installation as necessary to support families. ***We will even have car seat installation certified staff members available as necessary to support families.***

5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance

We will train and educate Providers that they are not permitted, under any circumstances, to bill for family planning or pregnancy-related assistance. This requirement will be reflected in all contract language and audited at least annually. Members will be notified as part of their Member rights and alerted that they should not receive a bill and how to contact us if they do. This information will be included in our Member Handbook and website and accessible in multiple formats for Providers and Members. We will regularly review and monitor Member complaints and Grievances and do periodic Member outreach to verify Provider compliance with this requirement. If a Member receives a bill, we will immediately conduct a follow-up review and investigation with the appropriate Provider(s).

6. Any innovative methods that Offeror will use to augment its approach

Complementing our Provider and Member engagement strategies, we will implement evidenced-base, proven programs to support families in accessing the best possible care for their children.

Mobile Clinics. We will support mobile clinics, such as Choices for Children's Mobile Unit and Plan A Mobile Unit to expand their coverage areas. We will also ensure mobile clinics serving children are equipped with the appropriate vaccine storage solutions required to conduct Mobile Vaccine Clinics.

School-Based EHR Solution. Supporting bi-directional communication and coordination with our schools, We will partner with an innovative school-based EHR solution to enable school nurses to document visits and report care delivered in schools. ***This solution will provide us with actionable insights on our pediatric Members through near real-time monitoring of medical, behavioral, and social needs that arise where children spend most of their time***. For example, we will receive a report flagging at-risk Members with three or more school nurse visits in the week prior. Our Care Management team will triage Members identified to be at risk for ED visits for outreach and engagement to prevent ED visits and promote appropriate management of clinical needs. This solution will incorporate an additional layer of outreach by encouraging parents/guardians of Members to complete visits, including child and adolescent well-care visits and immunizations**.** Parents/guardians of members can receive communication directly from the platform to encourage them to complete a visit and we will support scheduling.

Increasing Health Literacy

As outlined in response to 4.2.2.1.E., we will distribute and promote Provider use of a toolkit on how to "Help Your Patients Understand Their Health and Health Care," which aligns with Culturally and Linguistically Appropriate Services (CLAS) standards and trains on how to use plain language to improve patient adherence and the impact of culture on how Members interact with the healthcare system. We will also promote Ask Me 3®, designed to improve health literacy and promote the Member-Provider relationship, and offer and encourage Provider trainings with CEUs on effective Member-Provider communication.

ii. CHIP Services: Describe the Offeror's proposed approach to ensure CHIP Members receive timely services, immunizations, well-child visits, and any other services described in the CHIP State Health Plan. Include the following:

While MSCAN Members have lower income thresholds, CHIP Members are just as likely to experience barriers to care and require similar social supports. CHIP Members may, for example, have two working parents creating issues around childcare and transportation during regular work hours. As stated in response to 4.2.2.1.A.1, our approach to ensuring CHIP Members receive timely preventive services mimics what is described above.

1. An overview of related policies, procedures, and processes

To account for the differences in benefits, we will have specific CHIP policies that describe the coverages and recommendations for appropriate care and screenings as indicated in the Mississippi CHIP State Health Plan. We will educate all staff, Members, caregivers, and Providers about recognizing which Members are enrolled in CHIP versus MSCAN. We will develop a CHIP-specific Member Handbook and Provider Directory.

Consistent with Appendix A, Draft Contract, if a Member no longer qualifies for CHIP under the eligibility requirements, we will notify DOM so they may assess whether the Member is eligible for MSCAN. We will also inform DOM of CHIP Members who become pregnant within seven calendar days of identification through a report, in a format and manner to be specified by DOM, to determine the eligibility of the Member under the appropriate eligibility category. As detailed below in our response to Section 4.2.2.1A.8.a of the RFQ, we will educate CHIP Members about copayment requirements and limits, including by displaying copayment services and amounts on the CHIP Member ID card, CHIP website, and related Member Portals, in the CHIP Member Handbook, and as part of our community education and outreach events. Our Customer Service Representatives for both Members and Providers will receive training regarding CHIP Member copayments, exemptions, and Out-of-Pocket limits.

2. An overview of how the Offeror will encourage Members to obtain services

Applying the same staffing, education, proven programs, and partnerships described in 4.2.2.1.A.1.a.i above, we account for variations in CHIP benefits and Member needs as follows.

Staffing

Our CHCs will be trained in the benefits and periodicity schedules recommended for CHIP Members, and outreach will be tailored for these Members and families/caregivers. Members in CHIP are more likely to change eligibility and move between products, including eligibility for Medicaid. Our staff will access historical utilization data to explain any differences in coverage and track services that may have been missed while the Member was dis-enrolled. Our Quality Practice Advisors will work directly with Providers to help them understand benefits and appropriate coding, particularly for practices that serve both MSCAN and CHIP.

Education

Member education and engagement will be tailored to accurately describe available benefits through CHIP. For example, we will offer Member incentives for participants in our CHIP program, similar to EPSDT incentives, including rewards for regular well-child visits and timely immunizations. Our Member tools and materials will be configured to recognize differences in benefits and be clearly marked for the membership being served.

Improving Child Vaccination Rates

Our affiliate partner, working with a similar population, dedicated two employees to work on site at a high-volume Federally Qualified Health Center (FQHC) serving 40,000 Members. Together they developed a sophisticated medical quality program, resulting in multiple years improvement in HEDIS health plan ratings, including increasing the Childhood Immunization Combination 10 metrics to the 90% percentile for two consecutive years.

Proven Programs

All programs discussed in response to 4.2.2.1.A.1.a.i.2 apply to CHIP Members.

Partnerships

Our Provider network will include Providers with experience serving the CHIP population. As part of onboarding and ongoing training, we will educate all Providers on CHIP benefits, cost-sharing, and the importance of timely access to care. All contracted Providers will have access to the same tools described above tailored to the population being served. Our Provider incentives will be applied to both Medicaid and CHIP populations. We will seek CBO partnerships to address CHIP-specific needs such as childcare.

3. How the Offeror anticipates the approach will improve health outcomes

Our approach is designed to ensure access to timely services and improve outcomes and experience for CHIP Members. This includes demonstrated improvement in HEDIS rates, CAHPS scores, and utilization rates. For example, for CHIP-only populations, we have been able to significantly improve Childhood Immunization Rates, as demonstrated by an affiliate with a ***25% improvement in Combination 10*** childhood immunization rates over four years.

4. The Offeror's process for reminders, follow-ups, and outreach to Members

All processes discussed in response to 4.2.2.1.A.1.a.i.4 apply to CHIP Members. ***We will offer non-emergency transportation as a value-added service for our CHIP Members*** and assist with scheduling transportation during reminder outreaches.

5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance

Our plan to communicate cost-sharing disallowance to CHIP Members is the same as discussed in response to 4.2.2.1.A.1.a.i.5 above.

6. Any innovative methods that Offeror will use to augment its approach

Our innovations for MSCAN children will equally apply to CHIP. Additionally, we will cover non-emergency transportation as a value-added service for all CHIP Members. We will incentivize PCPs/PCMHs to offer expanded hours to best serve CHIP Members whose parents/guardians may be employed during traditional business hours.

4.2.2.1.A Delivery of Covered Services

1. Children

b. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes for children?

Our health equity goals and proposed solutions to address racial, ethnic, and geographic disparities in the delivery of services and outcomes for Members who are ***children*** are outlined in this section. Our health equity program is fully described in response to Section 4.2.2.1.A.8.d of the RFQ.

We will address disparate health outcomes – especially related to obesity and diabetes – for children residing in food deserts. According to the University of Mississippi Medical Center (UMMC), rural counties in the Delta contain an average of just one supermarket for every 190 square miles[1]. We will work with the UMMC Center for Bioethics and Medical Humanities to continuously monitor and develop innovative solutions to address food deserts. We will create a partnership with Extra Table and ensure that food pantries in food deserts stay stocked with healthy foods. ***We will partner with FarmboxRx to offer home-delivered nutritious food and education***. Deliveries can be tailored to meet the Member's disease state, such as for children with diabetes. We will

[1] "Food Deserts: The What, Where, Who and Why of a Mississippi Crisis." Food Desert - University of Mississippi Medical Center, University of Mississippi Medical Center, https://umc.edu/Research/Centers-and-Institutes/Centers/Center-for-Bioethics-and-Medical-Humanities/files/food-desert.pdf.

provide educational materials for parents on eating healthy and exercising for distribution by PCPs/PCMHs in targeted areas, including the Delta. Resources will include avoiding ingredients such as high fructose corn syrup and tasty and nutritious recipes using WIC foods and SNAP items.

Our analyses using available data indicate a significant disparity in child immunization rates for Black children in zip codes 39476, 39462, 39322, 39653, 39654, 39455, and 39470, and for EPSDT/well-child visits for Black and Hispanic children in 38855, 39767, 38847, and 39477. The highest disparities were among Black children in 38944, 38846, 39337, 38627, and 38964. We will work with community partners to develop culturally responsive materials, Provider training curriculum, and effective communications to engage families in care while building trust through trusted messengers such as religious leaders and schools.

4.2.2.1.A Delivery of Covered Services

2. Behavioral Health

a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for Pediatric and Adolescent behavioral health/substance use disorder, including compliance with the SUPPORT Act.

Direct Experience in Service Delivery and Payment for Pediatric and Adolescent BH/SUD Services

With decades of experience providing Medicaid and CHIP services, we have extensive expertise in managing behavioral health/substance use disorder (BH/SUD) services for pediatric and adolescent Members. Serving the BH/SUD needs of more than 970,901 children nationwide, our national network of BH Providers includes over 15,527 Providers serving children and adolescents. Recognizing the value of an integrated approach, we manage our BH/SUD network and claims processing internally and have systems configured for administering multiple payment arrangements, including value-based payments (VBP). ***According to the most recent available data, 80.9% of our Medicaid Members across the country are aligned with a VBP arrangement.*** We support Members and Providers through a fully integrated, strengths-based, family- and person-centered Care Management (CM) Model and promote age-appropriate evidence-based care. For pediatric and adolescent BH, this includes practices such as Trauma-Focused Cognitive Behavioral (TF-CBT), Parent-Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP), and High-Fidelity Wraparound.

Understanding and Addressing the BH and SUD Needs of Children and Youth. The most common diagnosis among children we serve in similar Medicaid populations is attention deficit hyperactivity disorder (ADHD). Other common BH conditions among our children and youth include Serious Emotional Disturbance (SED), anxiety disorders, depression, learning disabilities, and developmental delays. Common among foster children is post-traumatic stress disorder (PTSD). Our experience includes CM programs designed around these conditions and staff and Providers trained in serving these needs. For example, we train Member-facing staff and Providers in topics such as Trauma-Informed Care (TIC), adverse childhood experiences (ACEs), mental health first aid, and crisis intervention and de-escalation. ***Across our markets in 2021, we completed more than 3,500 BH trainings with over 42,000 attendees.*** Examples of successful child/youth programs and practices we have developed based on experience and will replicate in Mississippi include:

Program	Description	Population
ADHD CM Program	Provides integrated CM and works with Members and families to close care gaps. The team provides education on ADHD, the management of symptoms, and the importance of follow-up care, tracking appointment and medication compliance, and assisting with scheduling and removing barriers as needed.	Ages 6-12 with ADHD
ADHD Preschool Program	Promotes BH interventions as a best practice before starting medication therapy for children under five. The purpose of the program is to encourage behavioral interventions to manage the symptoms of ADHD before starting medication, consistent with evidence-based practice guidelines. Interventions may include psychological testing, individual therapy, and parent/guardian skills training.	Up to age 5 with an ADHD diagnosis
Autism Team	Provides a dedicated Autism Team to ensure Members with Autism have all the therapies they need, collaborating with family, educational, and Provider perspectives. The team builds strong relationships with Autism Providers, meeting frequently and directly calling any time parents have concerns about testing for their child, and works with schools to secure educational plans for a child's specific needs.	Up to age 19 with an Autism diagnosis
Early Intervention	When a potential developmental concern is identified, we refer Members to the early intervention system for appropriate assessments and therapies; in Mississippi, we will refer to First Steps. Our CM team follows these Members and helps find the resources necessary to meet developmental milestones and make information and education available in convenient settings.	Ages 0-5 with potential developmental delays
Behavioral Health Medication Monitoring (BHMM)	BHMM is a best practice that was developed by an affiliate out of concern that children in foster care are medicated in larger percentages than other child and adolescent populations. The goal is to ensure that pharmacological treatment benefits the Member and that all parts of the treatment team work together to accomplish this outcome. When psychotropic medications are used in the treatment of children, their use should represent acceptable practice, promote safety, and enhance the stability and functioning of the child.	Up to age 5 on psychotropic medication

Program	Description	Population
	From program inception, our affiliate achieved a 32% reduction in psychotropic use, a 32% decrease in Members using 5+ medications, and a 34% reduction in class polypharmacy.	
High Fidelity Wrap Around (HFW)	HFW is an evidence-based model of care that uses a highly structured, team-based, family-centered process. We have experience offering this community-based approach for children, teenagers, and young adults who are involved with multiple systems and contracting with a network of Providers dedicated to supporting youth at high risk for out-of-home placement. ***In Mississippi, we will work with the Mississippi Wraparound Institute and certified HFW Providers such as Youth Villages. A similar Medicaid affiliate saw a 37% decrease in ED use after implementing HFW.***	5-19 with SED diagnosis

Compliance with the SUPPORT Act. Our plan will leverage the decades of experience of our parent company and affiliates and well-established infrastructure to successfully adhere to Sections 4.1.4 and 4.2.4 of Appendix A, Draft Contract, and all related CFRs and references, including but not limited to the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act). This includes compliance with Drug Utilization Review (DUR) requirements, the implementation of an antipsychotic medication monitoring program for children, and fraud, waste, and abuse identification requirements related to the use of controlled substances in Medicaid.

b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for adult behavioral health/substance use disorder, including compliance with the SUPPORT Act.

Direct Experience in Service Delivery and Payment for Adults with BH and SUD Needs

As an organization, we have significant experience managing BH/SUD services and Provider Networks for adult Medicaid populations, successfully delivering and paying for BH/SUD services across the nation. Built out of direct experience integrating PH and BH services, we have a well-established, integrated CM Model and approach designed to meet the whole person needs of Medicaid Members, as described in Section 4.2.2.1.A.2.c below. The BH Medical Director will help design tailored programs that address BH/SUD and integrated care needs. We recognize the impact of stigma on accessing BH/SUD care and deploy health literacy campaigns such as Stamp Out Stigma to help Members access the care they need in the most appropriate setting. We will leverage our VBP experience to promote integration between BH and primary care settings using escalating incentive payments according to the level of integration, based on SAMSHA/HRSA Standard Framework for Six Levels of Integration. We have implemented VBP programs focused on adults, including bundled payments and case rates for Medication-Assisted Treatment (MAT) and our Neonatal Abstinence Syndrome (NAS) Model to address opioid use in pregnancy.

Improvements in BH Outcomes

- From 2015 to 2020, Behavioral Health Follow Up After Hospitalization for Mental Illness increased 18% (7-day) and 33% (30-day)
- From 2017 to 2019, the rate of ED and inpatient visits decreased by 4% and 17.2%, respectively,
- The rate of PCP and outpatient visits increased by 11.1% and 8.4%, respectively.
- The average length of stay for inpatient visits decreased from 5.8 to 4.8 days

Understanding and Addressing the BH/SUD Needs of Adults. Looking at an adult Medicaid population in a similar market, the most common BH conditions for adults include psychotic disorders, mood disorders, opioid dependence, and anxiety disorders. Understanding the prevalence of BH and SUD conditions spanning adult Medicaid populations, we will develop collaborative relationships with facilities and Providers at every level of the care continuum to support a recovery-oriented system of care for individuals with a range of BH/SUD needs. Examples of programs, tools, and partnerships we have implemented in other markets and will replicate in Mississippi include:

Program	Description	Target Pop
Peer Support	Recognizing the value, we have implemented peer support programs where peer support specialists meet Members in their homes to provide education, help develop goals, and identify steps towards building a healthy life. Through shared understanding, respect, and empowerment, these specialists help Members stay engaged in the recovery process and reduce the likelihood of relapse. In 2020, in markets where Members received peer support, our affiliate health plans exceeded the 95th percentile for HEDIS Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment and Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence rates.	Members with SUD
Disease Management (DM)	Our DM programs use outreach, education, and support services to promote treatment adherence, health literacy, education, and condition self-management and to improve outcomes and functional status for Members with depression. DM is integrated into our CM program to ensure Members have timely access to needed resources across the continuum and disciplines.	Members with Depression

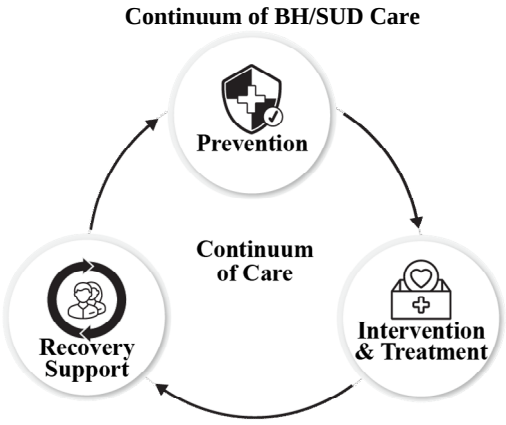
Program	Description	Target Pop
Opioid Cessation Program	Our Opioid Cessation Program coordinates timely, cost-effective, integrated services to minimize inappropriate and excessive use of opioids and prevent occurrence or exacerbation of an Opioid Use Disorder (OUD). The Program aims to improve the lives of Members at risk for or diagnosed with an OUD across the prevention-to-recovery continuum through 1) machine learning predictive analytics to help us determine which interventions and program outreach will be most impactful; 2) Motivational Interviewing to assess readiness to change and engage Members in the right services using American Society of Addiction Medicine (ASAM) criteria; and 3) Provider education, including Pain Management and Opioid continuing education and the ASAM Treatment of Opioid Use Disorders training to Network Providers free of charge. ***Across plans, the program has resulted in an 8% decrease in monthly inpatient costs, a 14.2% decrease in adult Members receiving opioids, and a 6.3% decrease in adult Members receiving benzos from 2019 to 2020.***	Members at risk for or with OUD
SUD Risk Model	We use evidence-based criteria and claims data to stratify individuals into one of six SUD segments based on utilization, clinical severity, and cost, promoting timely outreach and intervention. For example, Care Managers refer Members engaging in "doctor shopping" and other drug-seeking behavior to pharmacy lock-in programs. For Members in need of treatment, Care Managers educate them on the array of opioid treatment options and assist in scheduling appointments.	Members with SUD needs
Social Isolation Predictive Model	We use a clinically validated predictive model to identify Members at risk of loneliness and social isolation using Member-level data such as Member demographics, diagnoses, and claims history. The model triggers a direct outreach to screen the Members and engage them in the appropriate program to fit their goals and needs.	All
Schizophrenia Inpatient Model	Our model to support Members with schizophrenia utilizes schizophrenia-related claims data to identify Members with increased risk of inpatient hospitalization, such as failure to fill medication prescriptions.	Members with SMI
Antipsychotic Medication Adherence Review	Our Pharmacy and CM teams coordinate using a report of Members who have a diagnosis of SMI, have been prescribed an antipsychotic medication, and are between 1 to 5 days past their expected fill date. They target outreach when needed to support engagement and adherence.	Members with SMI on medication

Compliance with SUPPORT Act. As described above, we will leverage our extensive experience to successfully comply with Sections 4.1.4 and 4.2.4 of the Draft Contract (Appendix A) and all related C.F.R.s and references, including but not limited to MHPAEA and the SUPPORT Act. An example of how we comply is our Opioid Cessation Program. As described in the table above, our program aims to improve the lives of Members at risk for or diagnosed with an OUD, across the prevention-to-recovery continuum.

c. Describe the Offeror's approach to delivery and payment for behavioral health/substance use disorder services.

Approach to Delivery for BH and SUD Services

Our approach to delivering comprehensive, innovative BH and SUD services in Mississippi will build on the experience described and the needs of the local population. According to Mental Health America, Mississippi is ranked 44 out of the 50 States and Washington D.C. for providing access to mental health services. To help fill this gap, we will pursue strategic partnerships that elevate and support the existing system of care and leverage technology to extend the reach of Providers. This includes building programs around a circular continuum of care, as depicted here, that meets Members where they are from prevention to recovery. The following characteristics are foundational to our BH approach:



Proactive. We are dedicated to improving timely access to health care services using an array of robust predictive analytics, technology supports, and Provider training and tools to ensure that every Member with a current or potential BH need is identified early and supported to engage in care. We use every touch point as an opportunity to connect with Members in meaningful ways, build relationships, understand needs, and link them to local treatment services and support. We train, equip, and monitor Providers in the use of screening tools, such as SBIRT and PHQ-9.

Person-Centered. We provide high-touch, individual outreach and customized support based on each Member's level of need and readiness for change. We engage Members and their chosen supports in care planning around their health and wellness goals and employ a strengths-based model in helping to identify appropriate resources and interventions. Each Member is approached through a whole-person lens, with hope for their recovery as they define it, meeting them where they are, and actively engaging them in age-appropriate evidence-based prevention and treatment planning. Members with BH/SUD needs are supported by an

Integrated Care Team (ICT), which includes a multi-disciplinary staff of licensed PH and BH Care Managers, Medical Directors, pharmacists, Social Service Specialists, and Program Coordinators. Our collaborative approach focuses on the Member; engaging all stakeholders involved with their care, including the ICT, PCP/PCMH, BH Provider(s), and other specialists and social supports to address goals. Our approach supports SAMHSA's Twelve Guiding Principles of Recovery model and treatment in the least restrictive setting.

Technology-Enabled. Our telehealth and technology solutions come together to support timely access, seamless planning, and coordinated linkages between BH, PH, and community-based services for every person. Telehealth supports have been a key feature of our pandemic response across the country—improving care access statewide and expanding services in rural areas. In Mississippi, we will offer virtual visits across the State and partner with entities, such as the Center for Advancement of Youth (CAY), which combines telehealth technology, multidisciplinary health expertise, and the support of statewide agencies to serve young patients and their families.

Integrated. To integrate PH and BH services, we will build strong relationships with our community mental health centers (CMHCs) and PCMH partners, hospitals, and CBOs. Providers value our portals, trainings, case conferences, and telehealth and technology support for cross-system, cross-discipline communication, and collaboration. We also offer resources to promote integration. For example, in Mississippi, we will refer PCPs to the University of Mississippi Medical Center Child Access to Mental Health and Psychiatry (CHAMP) program for phone consults to support their patients with BH needs.

Health Literacy and Health Equity Focused. We routinely monitor data to identify and address disparities and promote health equity through targeted quality initiatives, CM activities, and Member and Provider outreach and education. Our health equity tools help us identify health disparities, mitigate barriers to health, and link at-risk Members to health education, DM, and CM resources. This includes addressing barriers such as stigma and educating the system on suicide prevention, TIC, and how to access BH/SUD care.

Evidence-Based. We will use data and predictive analytics to support early identification and drive innovative program design, deploying evidence-based interventions and training that meet the needs of MSCAN and CHIP Members. For example, according to the National Survey of Children's Health, 18.2% of children 0-17 in Mississippi experienced two or more ACEs, compared to 14.7% of children across the U.S. To help care for these individuals, ***we will provide Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) training to Mississippi BH clinicians at no cost***. Evidence-based approaches, such as TIC, Person-Centered Thinking, strengths-based CM, stages of change, and recovery principles are further incorporated into all programs and interventions.

Approach to Payment for BH and SUD Services

Our BH P4P Program will promote Mississippi BH Provider engagement of moderate to high-risk Members in appropriate care settings. Working in collaboration with CMHCs, we will financially incentivize participating BH Providers to engage Members, administer baseline and follow-up assessments, initiate treatment, and deliver timely follow-up care that results in demonstrated improvements in select BH HEDIS measures and Member outcomes. The program is backed by our analytics partner, which aggregates heath and assessment data from multiple sources to support program reporting and reduce Provider administrative burden. To support Providers in success under VBP, we will use predictive modeling and analytic tools to develop and share reports that provide data such as non-medical risks, claims, care gaps, ADT alerts for ED visits, and inpatient admissions. In sharing these reports, our dedicated Provider Relations staff offer BH Providers data transparency and identify opportunities to improve workflows and optimize Provider success.

Additionally, we will deliver innovative BH services and care coordination in a downside risk value-based arrangement with Mindoula. Each intervention will increase access to care, improve health outcomes for Members, and improve cost outcomes to the State through team-based, 24/7 care extension, psychosocial education, and skills training, addressing social determinants of health, and optimizing and enhancing our BH provider network. Our Members will benefit from Mindoula programs such as Interpersonal Violence Reduction, Suicide Prevention, OUD & SUD Exposed Pregnancy, and Substance Exposed Living.

Continuum of Support

Coupled with our programs described in Sections 4.2.2.1.A.2.a and b above and innovations in 4.2.2.1.A.2.d below, standard BH programs we will promote across the continuum include:

Program	BH Continuum	Description
Suicide Prevention Program	Prevention	Our suicide prevention program uses predictive modeling and evidence-based practices to identify suicide risk, determine the best course of intervention, and monitor the Member's treatment progress to improve outcomes. The program is based on the Zero Suicide framework and incorporates industry-standard assessments and tools such as the Columbia Suicide Severity Rating Scale, PHQ-9, Safety Planning, and Caring Contacts and includes pragmatic guidance for Network Providers through training and toolkits to ensure the entire system of care is working to identify and prevent suicide. ***A similar Medicaid affiliate saw an 8% decrease in suicide attempts*** among the foster care population after just one year of implementing Zero Suicide.
CM ADHD Outreach Intervention	Intervention	CM will receive an ADHD pharmacy claims list each week. We will utilize this intervention as a tool for outreach to Members with ADHD that are filling medications to educate on ensuring they are compliant with their medications as well as ensuring they attend the follow-up appt.
Virtual Visits	Intervention/ Treatment	We continue to invest in telehealth and virtual care solutions that not only provide Members with access to telehealth virtual visits but also enhance Member engagement to improve quality of care, increase health literacy, and promote health equity. Through telehealth vendors with Providers licensed in Mississippi, Members will have access to psychiatry and psychology services when and where they need them.
Project ECHO	Intervention/ Treatment	We will work with schools to promote and refer to the Teaching Educators About Child Behavioral Health (TEACH) Program, a joint effort between the Mississippi Department of Education and Center for Advancement of Youth (CAY) at Children's Hospital at the University of Mississippi Medical Center (UMMC) to improve the BH of Mississippi's students by increasing the capacity and confidence of educators to identify and manage common behavioral problems in the classroom setting and providing therapy services to students in need within the school setting.
Enhanced Transportation Services	Intervention/ Treatment	We will waive the 72-hour window for scheduling non-emergency transportation to allow for same-day appointments for individuals accessing BH services.
MYPAC	Intervention/ Treatment	We will coordinate and make referrals to targeted intensive CM services to keep youth in the community versus a facility.
Caregiver Support Program	Recovery Support	We will provide support and resources for parents and foster parents/guardians to support their care for children and youth with SED. The program provides caregivers with knowledge, tools, and resources to increase their capacity to meet their child's unique needs.
Online BH/SUD Resource	Prevention/ Recovery Support	Our online and mobile self-care resources will provide educational supports to improve mental health and wellbeing by enabling Members to learn more about their BH diagnoses, track their symptoms, and receive motivational ideas and tools to work toward solutions. e-Learning programs support depression, anxiety, overuse of drugs or alcohol, and complex BH conditions in a safe, confidential environment. We encourage caregivers to use it for their own support or to better understand their loved one's BH diagnosis. Based on Medicaid affiliate experience, they found an average of 39% of users demonstrating clinical improvement over six months.
BH Crisis Line	All	We will offer a BH Crisis Line that is fully staffed by BH personnel to handle BH crisis-related calls.

d. Describe any innovative methods that Offeror will use to augment this approach.

Our plan continually identifies and implements innovative programs and technologies to improve outcomes. Following are examples of innovative programs with a BH focus showing promise and success in our plans that will be implemented in Mississippi.

Program	Description	Target Population
Mindoula	We will partner with Mindoula to offer targeted interventions including psychosocial education and skills training, care coordination and navigation support, addressing social determinants of health, and optimizing and enhancing our BH Provider Networks. Mindoula's population health interventions have proven to reduce the total cost of care by an average of 30% to 50%, primarily by reducing hospital admissions and readmissions and avoidable emergency department utilization. Our Members will benefit from Mindoula programs such as Interpersonal Violence Reduction, Suicide Prevention, OUD & SUD Exposed Pregnancy, Substance Exposed Living, and Complex Population Health Management.	Members with co-occurring PH/BH conditions
On-Demand Crisis Stabilization	We will ***deploy cellular-enabled tablets*** to allow medical practitioners, hospitals, EDs, first responders, and schools without telehealth capabilities to ***reach a BH clinician immediately on-demand***, delivering ***real-time BH crisis stabilization*** and therapy services.	Members in BH crisis
BH Chatbot	We will conduct a pilot of a BH Chatbot developed by clinicians and researchers. The BH Chatbot will be able to respond to Members with depression, anxiety, or other mental health needs by triaging the right level of care, conducting standardized assessments, providing with them self-help content, or even connecting them on-demand to 5,000 standby counselors across the country or scheduling appointments later for support.	Members with mild to moderate BH diagnoses
Schizophrenia Chronic Condition	Launched in 2021 by an affiliate Medicaid plan, this clinically integrated, comprehensive program reduces the level of PH and BH utilization and costs among Members with Schizophrenia. Through a wrap-around Member-centric approach, we will address whole-person needs, medication adherence, and	Members with Schizophrenia

Program	Description	Target Population
Management Program	unmet social needs. The program is designed to enhance Members' understanding and ability to self-manage their chronic disease and improve the practice pattern of Network Providers.	
American Academy of Pediatrics Partnership	There was a 22.3% increase in ER visits for adolescents who attempted suicide ages 12 to 17 in the summer of 2020 compared to 2019 according to findings in the CDC's Morbidity and Mortality Weekly Report. ***We will pilot a program based on the American Academy of Pediatrics to expand the delivery of BH services by PCPs in medical homes,*** serving as a source of primary and secondary prevention for youth experiencing depression, anxiety, ADHD, and other common BH concerns. In addition to reducing the escalation of symptoms and preventing crisis care, our goal is to improve access to care. As part of this program, primary care network Providers will be incentivized to participate in BH trainings.	Adolescents with Mild to Moderate BH Conditions

e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes regarding behavioral health services?

This section outlines our health equity goals and proposed solutions to address racial, ethnic, and geographic disparities in the delivery of services and outcomes for Members receiving BH services. Our health equity program is fully described in response to Section 4.2.2.1.A.8.d of the RFQ.

We will reduce BH complications through education for Black adults in zip codes with the highest BH disparities (38930, 39204, 39206, 39209, 39213). We will partner with a CBO to implement an initiative led by the National Association for Behavioral Health and Wellness in targeted zip codes to address BH disparities. We will incorporate an online tool that helps Members track and manage behavioral health challenges by accessing information through books, videos, and activities in English and Spanish. Through Mindoula, we can deploy targeted population health interventions to these areas that include psychosocial skills training and addressing SDOH.

We will increase access to BH services in rural areas with the highest concentrations of Members without vehicle access, including Bolivar, Clairborne, Green, Holmes, Humphries, Issaquena, Leflore, Noxubee, Sharkey, Tunica, Washington, and Wilkinson counties. We will partner with local Providers and CBOs for referrals and ensure Members have access to a free smartphone.

4.2.2.1.A Delivery of Covered Services

3. Perinatal and Neonatal

a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for perinatal and neonatal services.

Direct Experience in Service Delivery for Perinatal and Neonatal Services

As a long-standing organization focused on Medicaid, CHIP, and other vulnerable populations, we have rich experience in administering and managing perinatal and neonatal services. ***In 2021, we managed more than 183,000 deliveries across our Medicaid affiliates.*** For populations like MSCAN and CHIP, perinatal and neonatal services often involve high-risk pregnancies and complicating factors such as BH issues and SDOH, as well as racial disparities. Our community-based, culturally responsive programs have proven outcomes to identify and address these realities and ensure all Members have access to covered services. We proactively coordinate with State agencies to identify, refer, and coordinate care in our markets. For example, in Mississippi, we will work with Mississippi State Department of Health's (MSDH) Perinatal High-Risk Management/ Infant Services System (PHRM/ISS) case managers to share information, such as assessment results, and determine roles and responsibilities for coordinating care for high-risk pregnancies. We collaborate with community supports, such as WIC, on joint education, local events, and referrals.

Maternal and Child Health Outcomes

As a result of our Maternal and Child Health Program participants are:

- 7.9% less likely to have a baby born at a low birth weight, under 2500g
- 20% less likely to have a baby born at a very low birth weight, under 1500g
- 31.2% less likely to have a baby born at an extremely low birth weight, under 1000g
- 3.3 times more likely to be compliant with prenatal care

Direct Experience in Payment for Perinatal and Neonatal Services

With a significant focus on Medicaid, we have well-established systems and infrastructure, including highly trained staff, written policies and procedures, and information technology systems, to comply with all requirements for perinatal and neonatal services described in Appendix A, Draft Contract, including the payment of perinatal and neonatal services. Our payment methodologies supporting perinatal and neonatal services in plans across the

Payment Strategy Impacts

As a result of our VBP program in a similar market to Mississippi, timeliness of Prenatal Care has increased by 21% and Timeliness of Postpartum care has increased by 42%

country include case rates, bundled payments, group prenatal and postpartum visits, and VBP. Our payment programs are designed to improve birth outcomes and promote timely prenatal and postpartum care. For example, in one of our markets, we have developed a Pregnancy Medical Home where OB/GYNs are paid to manage their patient's care throughout pregnancy and remain as the PCP after delivery.

b. Describe the Offeror's approach to delivery and payment for perinatal and neonatal services.

Approach to Delivery and Payment of Perinatal and Neonatal Services

Anchored by our successful ***Maternal and Child Health Program***, we will establish a strong foundation for moms and babies through person-centered care, coordination across systems and disciplines, innovative programs, and the provision of high-touch Care Management (CM) and social supports. We will appoint a Perinatal Medical Director to oversee our programs and outcomes.

Maternal and Child Health Program. All pregnant Members are enrolled in our Maternal and Child Health Program. Our program is a whole health approach to maternal and child health care with a range of prenatal, postpartum, infant, and early childhood initiatives and interventions that address community and Member needs. The level and intensity of support provided are determined by Member circumstances, from education on expectations and milestones via phone and text to in-person complex case management and enrollment in SUD programs for pregnant women. The core components of our program help us quickly identify pregnant Members and create a comprehensive, integrated, and seamless experience for them and their newborns.

Maternal and Child Health Program Core Components

- Early identification of pregnancy
- Risk screening and stratification
- Tailored outreach and education
- Community Baby Showers and Events
- Member incentives
- Complex CM for high risk
- Specialized management of BH and SUD
- NICU management and follow up
- Home visit programs
- On-demand virtual access to lactation support and doulas
- First year of life program to guide Members through medical milestones
- Provider education and incentives
- Community partnerships

Identification and Assessment. We have established systems and processes for the timely identification of Members who become pregnant. This includes using enrollment data, the Health Risk Screening (HRS), the SDOH Mini Screen, Notification of Pregnancy (NOP), and claims analysis. For example, Members who report being pregnant during their HRS are assisted with NOP completion in the same call. This simple operational enhancement helps connect the Member to timely services and initiates enrollment into our Maternal and Child Health Program. Members and Providers are encouraged to complete the NOP through financial incentives. We analyze claims, UM, and pharmacy data for pregnancy indicators, such as pregnancy tests, related ED visits, and prenatal vitamin fill data. We conduct Prenatal Call Campaigns for identified Members to confirm pregnancy, provide appropriate preconception, conception, and inter-conception education, and enroll in appropriate programming. To ensure pregnant members are receiving the level of care needed, we use machine learning to risk stratify the entire pregnant population, predict needs, and prioritize further outreach and engagement.

Additionally, we will use cutting-edge technology to enhance pregnancy identification and risk stratification to help us detect at-risk pregnancies sooner, prevent preterm births, and reduce racial disparities. This maternity analytics platform uses AI-based algorithms to scrub data for more than 3,000 early pregnancy identifiers to detect pregnancies earlier and uncover more data about moms and babies at risk. ***This technology has proven to identify 98% of moms before delivery and 70% in the first trimester***. Identifying these moms earlier allows for critical first-trimester prenatal visits, builds more solid doctor-patient relationships, and improves the chances they will receive quality care throughout their pregnancy. ***The use of this technology has shown a 19% reduction in unnecessary C-sections, 10% reduction in preterm birth, and 9% reduction in NICU use.***

Perinatal and Neonatal Programming. Once a Member is identified, they will be enrolled in our Maternal and Child Health Program and connected to the level of services and supports indicated, including coordination with community or State agency supports, such as PHRM/ISS. Our integrated programs leverage evidence-based practices and specialized staff with expertise in perinatal and neonatal conditions to address complex needs. For example, our ***Substance Use in Pregnancy Program*** uses Motivational Interviewing, harm reduction, the Edinburgh Depression Screening Scale, and other intervention strategies to address risks. We will partner with

the Mississippi State Department of Maternal Health SUD programs to connect Members to appropriate counseling, medication, intensive outpatient, or inpatient addiction treatment.

Our NICU program provides electric breast pumps with overnight delivery, NICU kits, in-person education, and Synagis® for NICU graduates. Additionally, we will leverage our national Neonate Center of Excellence (COE) for additional clinical guidance from a team of experts. Through utilization management decision-making support, analytics and benchmarking, sharing of best practices, and specialized training, the COE will support us in delivering high-quality, intensive neonatal services. The goals of the Neonate COE are to optimize NICU utilization, reduce NICU cost of care, increase neonate engagement in Care, improve quality of life for NICU graduates, and reduce service utilization of NICU graduates up to 60 days post-discharge.

We will offer a ***Smoking Cessation Pregnancy Program*** that employs a unique approach based on clinical guidelines published by the American Congress of Obstetricians and Gynecologists (ACOG) and U.S. Public Health Service and research current programs and best practices. Community partnerships are integrated into our programming to address SDOH and reduce disparities.

Approach to Payment. In addition to offering Provider incentives for completing our NOP form to promote early identification and risk assessment, we will engage Providers in value-based payment arrangements to improve health outcomes for Members and cost outcomes for the State. We will partner with a company to offer virtual group prenatal care through a risk-based contract that ties payments to positive results. All of our programs through Mindoula, including for Substance Exposed Pregnancy, will be offered with Mindoula accepting downside risk. We will continuously seek partners with whom our approach to payment for perinatal and neonatal services is based on solid outcomes.

c. Describe any innovative methods that Offeror will use to augment its approach.

Through our Maternal and Child Health Program and continuous quality approach, we are constantly improving services and outcomes for pregnant Members and newborns. This includes identifying and implementing innovative programs and partnerships with demonstrated success. Augmenting our Maternal and Child Health Program, we will implement new program innovations to ensure equitable outcomes for moms and babies of all races and ethnicities statewide. This enhanced approach includes five main components:

1. Enhanced pregnancy identification and risk stratification analytics to help us detect at-risk pregnancies sooner, prevent preterm births, and reduce racial disparities. The maternity analytics platform uses AI-based algorithms to scrub data for more than 3,000 early pregnancy identifiers to detect pregnancies earlier and uncover more data about moms and babies at risk. The platform reports identifying 98% of moms before delivery and 70% in the first trimester, and use of this platform has shown a 19% reduction in unnecessary C-sections, 10% reduction in preterm birth, and 9% reduction in NICU use.
2. 24/7 access to virtual lactation consultants and doulas statewide for all pregnant moms, and virtual group prenatal care based on Centering Pregnancy principles to drive positive outcomes for higher risk pregnancies.
3. Comprehensive care for substance-exposed pregnancies through Mindoula. Mindoula will offer a virtual peer support care community that helps expectant mothers with SUD alleviate the fear of stigma when accessing care. Each Member will be assigned a Clinical Team that includes a Psychotherapist, Certified Peer Recovery Specialist, Resource Advocate, and Nurse Educator. The program also offers resources to safely stabilize medications and SDOH before birth.
4. A culturally competent digital health platform connecting Black expectant and new mothers with critical resources to drive positive pregnancy outcomes. This platform will support the perinatal period for women to improve and overcome disparities in access to care and pregnancy outcomes for Black women.
5. Education, reminders, and intensive Care Management to reduce pre-term births using a partner's proven tech-enabled model. This program includes not only technological support for pregnant mothers but also deploys Community Health Workers across the State to provide additional support to Members when needed.

Further supporting our programs are proposed partnerships to better understand and address the specific needs of Mississippi residents through collaborative innovation. We will partner with Safe Sleep Mississippi and

Mississippi SIDS & Infant Safety Alliance to promote safe sleep education and resources, such as access to a Cribette, Halo Sleepsack, and Safe Sleep educational material. An affiliate Medicaid plan saw a 50.7% lower infant mortality over a two-year pilot of a similar partnership. We will partner with Converge and our Provider network to provide education and training and ensure all people can access high-quality family planning care when they need it, how they need it, and where they live.

d. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes regarding perinatal and neonatal services?

This section outlines our health equity goals and proposed solutions to address racial, ethnic, and geographic disparities in the delivery of services and outcomes for ***perinatal and neonatal members***. Our health equity program is described fully in response to Section 4.2.2.1.A.8.d of the RFQ. Mississippi ranks near the top of all States in infant mortality rates with 8.6 deaths per 1,000 births exceeding the national average of 5.7[2]. Rates are almost twice as high for Black women – 11.1 compared to 6.6 for White women[3]. We will employ our ***Maternal Health Equity Toolkit*** in developing interventions to address these disparities. Our national experts developed this Toolkit using a meta-analysis of current research and experience with best practices across our affiliate Medicaid health plans.

We will offer a ***culturally competent digital health platform to connect Black expectant and new mothers with critical resources*** to drive positive pregnancy outcomes and reduce racial disparities in pregnancy outcomes. This platform is designed to address the specific clinical, social, and cultural needs that Black expectant mothers face throughout their pregnancy and postpartum journeys. Through this, we hope to achieve improved population-level outcomes for Black Members, including reductions in preterm births and non-medically necessary C-sections and improvements in breastfeeding rates and early and consistent care engagement and adherence in the prenatal and postpartum periods.

4.2.2.1.A Delivery of Covered Services

4. Chronic Conditions

a. Describe how the Offeror will implement innovative programs to improve the health and well-being of Members diagnosed with diabetes and pre-diabetes.

Innovative Programs for Members Diagnosed with Diabetes and Pre-Diabetes

In 2016, Mississippi had the highest diabetes prevalence in the country (MSDH). In 2021, diabetes was identified as one of the top three chronic health conditions across our markets. Recognizing the need, we offer a continuum of programs and resources to appeal to a diverse set of Member and community needs and preferences, from health education on self-management to complex disease management (DM). ***We will hire a pediatrician with additional training in obesity medicine to oversee the continuous development of innovations to address diabetes, pre-diabetes, and obesity.*** We understand that Mississippi is one of the few states that cover Diabetes Self-Management Education and Support Programs (DSMES) as a Medicaid covered benefit. ***We will contract with all DSME Program Providers, including pharmacies, and educate on innovations available to support their patients with diabetes.***

Monitoring and Connecting Members to Diabetes Care. As an enhancement to our traditional detection methods, our ***diabetes predictive model*** identifies uncontrolled diabetes status for Members without a hemoglobin lab test for outreach and assistance by CM staff. The model allows us to identify unchecked diabetes and stable Members who might be at risk of becoming poorly controlled. We also monitor lab, pharmacy, and vision data to ensure that Members with diabetes receive appropriate preventive care. Through this systematic and CM monitoring, we can quickly identify, outreach, and connect Members to appropriate care and innovative programs available across the State.

Proven Programs. Our CM, Member Services, and Provider Services staff are educated on available programming to facilitate timely referrals and ensure this information is appropriately shared with Members and Providers through daily outreach, training and education, Member and Provider materials, our public website,

[2]America's Health Rankings analysis of CDC WONDER, Linked Birth/Infant Death Files, United Health Foundation, AmericasHealthRankings.org, Accessed 2022.

[3] National Center for Health Statistics, period linked birth/infant death data. Retrieved February 20, 2022, from www.marchofdimes.org/peristats.

and our secure web portals. The innovations we will implement for Members diagnosed with Diabetes and Pre-Diabetes across Mississippi include:

Program	Description
Diabetes Population Health Management Program	We will partner with Vigilant to offer a capitated, performance-based model. Vigilant developed this model in the rural Mississippi Delta among high-risk, socially, and economically disadvantaged populations with diabetes. The clinical model is patient-centered and behaviorally focused, leveraging a multi-disciplinary team that is integrative with the local health care community and reinforces primary care relationships, using data to drive interventions and outcomes. Demonstrated outcomes reported by Vigilant include: • 96% of Members engage in the Diabetes Population Health Management Program • 91% of patients achieve meaningful change with their diabetes within 3 to 6 months and 96% achieve meaningful change with their diabetes within 12 months • Hospitalization rate decreased by 50% among program users, but only 4% compared to non-users • Emergency Department rate decreased by 23% among program users, increasing 20% among non-users
Remote Patient Monitoring	We will offer a real-time remote monitoring program to identify and enroll Members with diabetes who would benefit. Members will be provided real-time glucose readings and automatic refills to deliver the right service at the right time. Program goals include improving glycemic control, reducing preventable health care utilization, promoting Member adherence to treatment guidelines, and improving self-management skills. Medicaid Members in a similar market experienced a 6% average decrease in glucose levels and a 15% reduction in ER visits compared to those not enrolled in the program.
Diabetes Disease Management Program	As part of our programs, we will offer Diabetes Disease Management program curriculum to Members living with diabetes and prediabetes. Participants will attend educational sessions (either in-person or virtual) once a week for six-weeks to better understand the disease, prevent complications, improve eating habits and relationships with health care Providers, and share the knowledge they learn with their family and community. Our affiliates have found that 100% of participants were compliant with receiving A1C testing and receiving medical attention for nephropathy.
Retinal Exams	We will partner with RetinaVue which offers easy to install, handheld retina cameras designed to help make retinal exams simple and affordable for Primary Care Providers. Through a grant which covers the cost of the technology and monthly fee, we will provide RetinaVue technology in key Provider offices to enable Primary Care Providers to perform retinal scans on our Members (and all patients) with diabetes.
Value-Added Benefits	We will partner with Diabetes Coalition of Mississippi, local CBOs, and Providers to offer and/or connect Members to nutrition and cooking classes with a dietician. This will include wrap-around support services such as medically tailored meal delivery in areas with the highest risk Members, education campaigns including Diabetic Books on cooking and super foods, and Food Bank Resources with fresh fruit and vegetables that can be tailored to dietary needs.

b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for services for Members with chronic health conditions generally.

Experience in Service Delivery and Payment for Members with Chronic Health Conditions

We have extensive experience in service delivery for Members with chronic health conditions. We track and monitor chronic disease prevalence across our populations and drill down to identify and address associated racial, ethnic, gender, and geographic disparities. We also use the Public Health Department and other community data to inform our chronic care programs, Provider Network composition, Member and Provider education, CM, DM, utilization management (UM), and quality priorities.

Networks Responsive to Clinical Needs. From our experience, top chronic diagnoses in Medicaid often include multiple BH conditions in addition to Anemia, Hypertension, Obesity, Asthma, and Diabetes. Our culturally responsive Provider Networks are built with the experience and expertise required to serve these Members, including a choice of chronic disease specialties, such as allergy and immunology, cardiology, endocrinology, hemotology, and BH. This also includes PCPs/PCMHs with direct experience screening, monitoring and coordinating treatment, and educating patients to help manage their conditions. ***To expand the capacity of these Providers, we will offer eConsult solutions that facilitate secure Provider to Provider consults. eConsults have been shown to resolve Member issues and reduce the need for additional specialist referrals by 80%.***

Chronic Condition Education and Programs. Our clinical programs are similarly built on the needs of a Medicaid population, leveraging decades of Medicaid and CHIP experience. We have implemented CM and DM programs for ADHD, asthma, anxiety, autism, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), depression, diabetes, heart failure, hypertension, pain management, sickle cell, tobacco cessation, and weight management. For example, our asthma program encompasses health coaches and tools, such as kid-friendly asthma collateral and spacers with instructional material for children and their parents. Our pharmacist-driven Medication Therapy Management (MTM) program has proven outcomes for chronic conditions, including a savings of $66.53 PMPM in reduced ER visits and inpatient stays and increased PCP services and medication adherence for diabetes, hypertension, asthma controller, and cholesterol

medications. Members can access self-care resources, such as an online health library where they can learn more about their condition and how to identify and manage symptions; an online BH tool to help manage BH and SUD conditions; and our Member Portal where they can see their care gaps and get information on our Member rewards to promote healthy choices. We support Providers in improving chronic care and outcomes through eConsults, a web-based training academy, and sharing actionable data at the point of care.

Technology Solutions. We have robust technology solutions to help Members and Providers manage chronic conditions. This includes remote patient monitoring, care gap alerts, our Provider Analytics and Patient Analytics Dashboard, and Digital CM, described further in Sections 4.2.2.1.A.4.c and d below.

Payment Programs. Our payment system is configured to recognize specialties, subspecialties, diagnoses, and evaluation and management codes to support timely and accurate claims payment and back-end reporting to facilitate appropriate monitoring of chronic care. For example, for Members with diabetes, we look for claims related to recommended lab and vision services. Providers serving Members with chronic conditions are rewarded for improving HEDIS and quality outcomes and delivering appropriate care, including regular screenings and management of chronic conditions. For example, one of our Medicaid affiliates implemented a direct Provider incentive program that rewards FQHC, RHC, and IHS clinics for improvement in HEDIS and enrolled 35 clinics which, based on their 2020 performance, saw an average of 56% improvement in HEDIS scores.

c. Describe the Offeror's approach to delivery and payment for chronic health conditions services generally.

Approach to Delivery for Chronic Conditions

Our approach to delivery for chronic conditions is part of our population health framework and includes early identification and engagement, a robust Provider Network, CM/DM interventions, identifying and addressing SDOH and health disparities, and education and engagement.

- **Early identification and engagement** is achieved through screening and assessments, predictive analytics, systematic reporting, and proactive and flexible outreach. We will outreach to every Member with a new chronic care diagnosis to ensure they are connected to a PCP/PCMH, provide education on their condition, explain how to access our Member Portal to see when they are due for recommended services, help schedule appointments and transportation, direct to our online health library for ongoing learning, provide information on Digital Care Management, and enroll in Medication Therapy Management, CM, or DM as appropriate.
- **A robust Provider Network** involves a PCP/PCHM network equipped to manage Member conditions with access to a comprehensive specialty network to refer to, as appropriate. For Members in rural areas or with other barriers, this will include access to telehealth services and on demand virtual visits with a feedback loop back to the PCP/PCMH.
- **CM/DM interventions** include the development of a care plan, health coaching, self-management skills training, caregiver support, remote patient monitoring, MTM, appointment follow-up and reminders, and connection to covered services and community resources. For example, our Weight Management Programs include linkages to area resources such as YMCAs, Boys and Girls Clubs, and Weight Watchers, with additional value-added benefits to cover related costs.
- **Education and engagement** include information and tools for Members, Providers, staff, and community stakeholders. To support health literacy, we will promote ***Ask Me 3®,*** an educational program that encourages patients and families to ask their providers three specific questions to understand their health better. We will collaborate with Providers to improve care and provide training on tools such as our Patient Analytics Dashboard that enables practice managers or individual Providers to access their patient disease registries to view evidence-based care gaps and quality improvement opportunities.

3% Reduction in ED Visits for Rural Members

Our Virtual PCP program demonstrated a 3% decrease in ED visits for non-emergent issues in a pilot area similar to rural Mississippi.

Approach to Payment for Chronic Conditions

Our approach to payment includes our VBP model, which will incentivize PCMHs to integrate BH care into their practice for individuals with complex needs. For individuals with Sickle Cell Disease, we propose to build

a VBP strategy for PCPs to better care for children and adult Members diagnosed with Sickle Cell Disease, which disproportionately affects Mississippians of African American descent. As appropriate, VBP programs will incorporate relevant chronic condition HEDIS measures, evaluating care for respiratory and cardiovascular conditions, diabetes, BH, and medication management.

d. Describe any innovative methods that Offeror will use to augment its approach.

Innovative Methods to Augment Approach to Serving Members with Chronic Conditions

In addition to the innovative methods described in the previous sections, such as ***remote patient monitoring*** for chronic heart failure, other innovative and successful programs to augment the delivery, management of, and access to chronic care services are described below.

Program	Description
Mindoulas's Sickle Cell Disease Management Program (SCDMP)	Under the SCDMP, Mindoula deploys teams of tech-enabled care extenders to deliver 24/7 care coordination, psychosocial support, and skills training/mentoring to Members with Sickle Cell Disease (SCD). Members are supported in learning how to manage SCD and affect behavior change to reduce pain crises and infection while addressing social, environmental and behavioral barriers that adversely impact medication adherence and whole health. Key elements of the program include: • 24/7 virtual and in-person care extension • Psychosocial education and skills training/mentoring • Active engagement - Mindoula Messenger, secure texting, check-ins, and calling • Support during SCD pain crisis and management of chronic condition to avoid crises • Education regarding disease process and behavior change strategies • Symptom monitoring • Treatment coordination with Providers • SDOH coordination with community resources • Medication adherence assistance • Reduction in ED utilization, admissions/readmissions
Digital Care Management (Digital CM)	Our Digital CM web- and mobile-enabled solution extends CM resources to drive deeper Member engagement and encourage self-management. Digital CM enables Care Managers to deploy customized, condition-specific programs and directly communicate through HIPAA-secure messaging. Using Digital CM's advanced analytics, Care Managers can make evidence-informed decisions to improve program adoption and care plan adherence and identify and address health disparities. Available programs include stress management, weight loss and physical activity, smoking cessation, diabetes prevention, diabetes care, CAD, CHF, hyperlipidemia, SUD, and BH.
Virtual PCP Program	We recognize that delaying care can lead to more severe or complex illnesses. To reduce SDOH barriers and increase access and engagement, we have identified 15 counties in northwestern Mississippi to pilot an innovative virtual VBP program designed to increase access and advance health equity. Through this model, Members can choose to be reassigned to a virtual PCP or continue to receive care from their local PCP. Our CM team and boots-on-ground Care Advisors will co-manage the Member's care by providing care coordination, Member education on available benefits, community resources, and CM/DM programs. Care Advisors engage Members where they are and go door to door to support them. For example, we will use claims data to monitor low PCP engagement, especially for Members with chronic conditions, and provide outreach recommendations to the virtual PCP to increase Member engagement and efficacy.
Homeless Medical Respite Model	Members discharged with post-acute medical needs while experiencing housing instability are at an increased risk of hospital readmission. In response to Mississippi's challenges around homelessness, we will adopt a Homeless Medical Respite Model to provide temporary respite beds to eligible Members who are homeless, being discharged from an acute inpatient stay, and need post-acute medical care, such as home health and nutritional services to manage a chronic condition and stay in the community.

e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes regarding members with chronic conditions?

This section outlines our health equity goals and proposed solutions to address racial, ethnic, and geographic disparities in the delivery of services and outcomes for Members with ***chronic conditions***. Our health equity program is fully described in response to Section 4.2.2.1.A.8.d of the RFQ.

We recognize that access to care is a challenge for ***Mississippians living in rural northeast Mississippi*** due to an inadequate supply of physicians, compounded with an older average age of PCPs. Delaying primary care may lead to more severe or complex illnesses, especially for those with chronic conditions. To reduce SDOH barriers and increase member engagement and access to primary care for members living in 15 counties in northwestern Mississippi, we will implement a targeted Virtual PCP program. Virtual PCP is an innovative value-based program designed to increase access, improve quality, decrease costs, and advance health equity. The program will supplement efforts by the Member's local PCP to increase engagement, not replace the PCP. Over a 9-month pilot period, a Medicaid affiliate service a similar population achieved the following outcomes for participating in Virtual PCP:

- **Reduction in ED Utilization**. A 3% decrease in non-emergent ED visits for the pilot Member cohort was attributed to Virtual PCP's assistance helping Members navigate non-emergent situations.
- **Care Gap Closures.** Virtual PCP pilot Members improved in the following HEDIS measures:

- Chlamydia Screening (13.6 percentage point increase)
- Lead Screening in Women (10.5 percentage point increase)
- Postpartum Visits (23 percentage point increase)
- Child and Adolescent Well Care Visits (2.1 percentage point increase)

- **High Member Satisfaction.** At the end of every virtual visit, Members have an opportunity to provide feedback on their experience. On a scale of 1-5, 97% rated their experience with Virtual PCP as a 4 or 5.
- **High Provider Engagement.** Provider engagement (defined as the Provider's success in engaging Members with a virtual office visit) increased from 18.9% to 35.5% during the pilot period.

We will further support Members in rural areas with chronic conditions in partnership with ***the Community Pharmacy Enhanced Services Network (CPESN)***. CPESN operates 60 independent, community-based pharmacies throughout Mississippi that collaborate to optimize appropriate medication use and promote positive patient health outcomes. CPESN will reach out to Members who have gaps in diabetes management and asthma tests, conduct the test, and notify us and the Member's PCP with the test results. They will also conduct an SDOH needs screening to identify any social barriers to accessing services required to treat chronic conditions or environmental situations that could exacerbate the condition.

In Mississippi, ***more Black (8.4%) than White (5.1%) children are diagnosed with asthma***[4]. We will identify and outreach to PCPs in areas with a high prevalence of asthma and who serve a large number of Black children. Targeted outreach will be designed to help them attain PCMH recognition and participate in VBP programs tailored to improve outcomes in this population. We will actively recruit PCPs who represent the diversity of our membership and partner with schools and Boys and Girls Clubs in zip codes identified with higher prevalence of asthma to provide education and help connect Members to PCPs. We will provide asthma management supplies (e.g., asthma spacer, peak flow meter, hypoallergenic pillow/mattress covers) to PCPs that are assigned to high volumes of our Members with asthma, so that they can provide the supplies to Members at the point of care.

4.2.2.1.A Delivery of Covered Services

5. Foster Children

a. Describe the Offeror's experience or capacity to manage the care of foster children, and/or your ability to develop a continuum of care responsive to their needs.

We recognize that children, youth, and young adults impacted by the child welfare system experience complicated physical health, behavioral health, and psychosocial issues often rooted in trauma. Our Foster Care model is designed to ensure equity, safety, stability, and compassionate family-centered care for all children involved in the child welfare system, including those receiving prevention or adoption services. We bring years of history and national experience in designing and implementing foster care-specific continuums of care across the nation through our parent company and affiliates. ***As of December 2021, we serve 240,00 children impacted by the child welfare system***. The four building blocks of our Foster Care model are Partnerships, Specialized Network, Training, and Care Management.

Partnerships

We create partnerships that meaningfully contribute to permanency, a sense of well-being, and a maximum level of health and wellness for every child. For example, we build direct relationships with Child Protective Services (CPS) caseworkers and train frontline staff to access specialized Care Management for children in their care. We will take this same approach in Mississippi alongside DOM and the Mississippi Department of CPS (MDCPS). A partnership between MDCPS and our health plan will facilitate information sharing, arrange screenings, and verify Member information.

Specialized Network

We build a network of Providers who have experience serving youth impacted by the child welfare system, such as Providers who ***deliver Evidence-Based Practices (EBPs) specific to the foster care population***. In Mississippi, this will include contracting with Youth Villages to bring their Intercept program to the State for the first time. Intercept is an intensive in-home EBP used to safely prevent children from entering out-of-home

[4] "Asthma Kids Fact Sheet - Mississippi." Mississippi Childhood Asthma Factsheet: 2017, Mississippi State Department of Health, 2018, https://msdh.ms.gov/msdhsite/_static/resources/2470.pdf.

care or to reunify them with family as quickly as possible if a period of out-of-home care is necessary. The Intercept model has proven to increase permanency outcomes for children by 24%[5].

Training

We increase the capacity for youth to receive trauma-informed care and services in the community by bringing our ***expert BH Clinical Trainers*** to train our staff and child welfare stakeholders, including resource/kinship parents, Providers, caseworkers, advocates, judges, law enforcement, and educators. We offer a catalog of nearly 100 courses specific to foster care, including Trauma-Informed Care and topics such as perinatal substance use, non-suicidal self-injury, and working with children, youth, and young adults with Intellectual and Developmental Disabilities who are impacted by the child welfare system.

Care Management

Our ***Foster Care Dedicated Care Managers*** include subject matter experts who focus on the whole child, across all systems, to promote early intervention and increase access to needed services and community-based supports. Our Foster Care CM Program improves the quality of life for children, their families, and caregivers in tangible ways by offering a single point of access, coordinated services, improved transitions of care, and increased access to health information and services. We will provide a dedicated Foster Care Help Line for efficient access by caseworkers, Resource Parents, and team members. Along with daily staff touchpoints, we will arrange quarterly meetings to share data, membership, claims, inpatient data, private duty nursing (PDN) information, educational opportunities, and EPSDT gaps. These meetings will be the foundation of our Member-focused collaboration for the foster children of Mississippi. This team will outreach to and respond to incoming requests from MDCPS caseworkers (and Resource Parents as permitted by the caseworker) to provide individualized support in removing any barriers to getting needed medical, behavioral health, pharmacy, dental, or specialty care. This team will ensure preventive care is taking place, offer coaching and support for any new or ongoing health conditions (such as depression, asthma, diabetes, depression, sickle cell, ADHD, obesity), identify additional community resource support, and support youth in transitioning from levels of care such as returning home after a hospital stay.

Care Kits

Foster Care Members will receive duffle bags and back packs that contain culturally and age-appropriate personal care items, school supplies that are customized to each Member's needs and age.

b. Describe how you would work collaboratively with the State of Mississippi through the MS Department of Child Protection Services to determine medical necessity and provide documentation of medical services for foster children in a manner that considers the unique medical and mental health needs of the population.

Determining Medical Necessity. We will use a tailored approach to developing medical necessity criteria based on national standards of care, Mississippi-specific population needs, and local best practices to develop a customized baseline for each review. We will conduct medical necessity reviews in close collaboration with each child's MDCPS caseworker to ensure the review considers the child's unique needs. Understanding that sometimes the caseworker does not have all the necessary information when a child enters foster care, we will collaborate with the caseworker and our Foster Care dedicated Care Managers to facilitate the processes for accessing appropriate care in real-time. Our Utilization Management staff will promote consistent care and begin planning for the transition when a child enters either an inpatient facility including a Psychiatric Residential Treatment Facility (PRTF) or into intensive care such as Mississippi Youth Programs Around the Clock (MYPAC). Our priority is getting timely access to care and medications that are part of a licensed medical professional's treatment plan for the child. Children and youth impacted by foster care have higher utilization of services and require meticulous care coordination, so reviewers consider many variables beyond clinical factors to assess social and other non-clinical needs such as the child's trauma history or the caregiver's ability to support the medically recommended treatment to determine appropriateness and necessity.

Focus on Collaboration

We use a PRTF Discharge Planning Checklist to ensure timely and safe discharges for children impacted by foster care.

Documentation of Medical Services. We will meet quarterly with MDCPS and DOM to provide documentation of medical services for the foster youth we serve. Information will cover active and closed cases, psychotropic medications, claims, admission discharge transfer (ADT) data, readmission data, vaccines, and

[5] Mills, Connie. "Youth Villages Intercept Program Model Receives Well-Supported Designation from Family First Clearinghouse." Youth Villages, 25 Jan. 2022, https://youthvillages.org/youth-villages-intercept-program-model-receives-well-supported-designation-from-family-first-clearinghouse/.

PDN. We will also respond to any requests from MDCPS following contracted timelines to assist with locating inpatient care, care coordination, or treatment planning for the foster youth. To enable Members, caregivers, Providers, and MDCPS staff to access Member information directly, we will provide role-based access to our secure Portal. ***Our web-based Portal is designed to support real-time sharing of Member-level clinical and Care Management information with Members, caregivers, Providers, MDCPS staff, and other authorized participants actively involved in Member care.*** Our Portal suite makes role-based information available in a format attuned to each user in the child's integrated care team. For example, the Member Portal offers access to their care plan, clinical service and medication history, pharmacy service level information, and health alerts and care gaps. With the appropriate, timely data from DOM and MDCPS, we will extend this access on role-based authorization for a Member's caregiver, Resource Parent, legal guardian, adopted parent, or birth parent. The Portal suite enables authorized MDCPS caseworkers to share and access key Member and Provider demographic and clinical information. Users can view a child's risks and care gaps, up-to-date health record data (e.g., immunizations, pharmaceutical information, allergies, labs, etc.), case plans, and even upload key documentation and assessments.

c. Describe your capacity to provide MDCPS access to all data and documentation (withstanding proprietary technology) to support the State in its efforts to accurately identify and subsequently serve the medical needs of foster children and youth.

We bring a demonstrated record of collaborating with State partners to develop platforms and mechanisms to share data. A critical success factor in the effective management and delivery of care for Members, especially for children, youth, and young adults impacted by the child welfare system who tend to move care settings and caregivers, is the appropriate and timely sharing of relevant information between and among health care Providers and other support entities such as MDCPS. Finding opportunities to share actionable information at the right time, with the right people, within the proper workflows leads to improved outcomes. We will partner with MDCPS to provide shared access to Member health information through our secure Portal suite. The information contained within the Member's health record in the Portal helps Providers, MDCPS caseworkers, and Care Managers improve care coordination, eliminate waste, and reduce errors by providing a Member's medical history and health interactions as the Member progresses through the clinical process. Resource Parents/Caregivers, MDCPS caseworkers, participating Providers, and Care Managers have access to detailed health records for Members. We allow users to view key Member contacts, allergies, medications, claims history, and more determined by their access role. Users can view a child's risks and care gaps, up-to-date health record data (e.g., immunizations, pharmaceutical information, allergies, labs, etc.), case plans, and upload key documentation and assessments.

d. Describe any innovative methods that Offeror will use to augment its approach.

FCCOE Incentive Model. Our Foster Care Centers of Excellence (FCCOEs) are PCPs/PCMHs with experience and training in serving Foster Care youth who are accountable for service delivery and motivated to improve the efficiency and quality of care for children entering foster care and those receiving ongoing care.

Partnering with MDCPS, we will identify skilled and willing providers to serve the foster and adoption population. Dedicated Providers, when available, have a better understanding of the needs of foster youth, and their enhanced skill set benefits the youth in care. We will use performance data and a package of financial and non-financial incentives to motivate identified Providers, including direct sharing of savings resulting from improved efficiencies and quality of care. We will fund a gain-sharing pool for each FCCOE based on its cost-effectiveness goals. FCCOEs will have the potential to share gains for hospital services and/or physician services based on the two components of the incentive program: quality outcomes and cost-effectiveness. Those with the best total performance outcomes will receive preferential PCP Member assignment through our default assignment process. We will assist the FCCOE to enable information flow and facilitate face-to-face coordination with Members, Medical Consenters, Care Managers, and physical and BH Providers. We will offer dedicated support from Provider Relations and Utilization Management staff; specialized education/training programs; data exchange support, such as for claims, authorizations, and remittance advice; patient roster and disease registry support; and Provider performance data.

Foster Care Transitions. Beginning at age sixteen, we will collaborate with the youth, MDCPS, Providers, and community resources to educate and develop life skills for the Member to carry into adulthood through our

Foster Care Transition program. Our Foster Care Transition Playbook will assist our dedicated Foster Care Staff in identifying life domains that are of particular importance to young adult Members and connect the Members to resources, health education, and health care. Collaborating with MDCPS, we will support the Member with transitional meetings, provide resources, and assist in the scheduling of health care appointments. Once a Member is enrolled, our dedicated Foster Care Staff will monitor and assist the Member until they transition out of Foster Care to Fee For Service under protected care. At this time, we will help the Member transition to their new coverage, utilizing the skills provided during the program. We may include a no-cost cell phone for quick and effective communication, along with financial incentives for healthy behaviors through our rewards program. Our program will align with MDCPS goals for the Member by supporting educational efforts for managing their health, maintaining health care coverage, accessing transportation, locating housing, employment skills, and resources. It is crucial for young people exiting foster care at 19 to be connected to ongoing Medicaid coverage to age 26, and have a housing, education, and financial plan in place. We will help to support those connections and identify a community of supports (caring adults, community services, natural supports) to enable them to successfully engage in their community.

Education. Combining our child welfare expertise will allow us to disseminate training to caregivers more broadly, further supporting and empowering them in providing the best possible care to our children and youth. In partnership with the National Foster Parent Association (NFPA), we will bring free online training to caregivers throughout Mississippi via an online training institute. We will collaborate with MDCPS to create new trainings to give caregivers quick and easy access to education that addresses targeted issues they commonly encounter. Offering multiple sessions in varying formats each year, we will increase access to training across Mississippi. ***We will work with MDCPS to ensure all our free training is approved for educational hours to support Mississippi's Resource Parent licensing requirements***. Training will be continual and in various formats to help the community that supports our foster youth.

We will build off our initial Foster Care training to increase skill sets. Our initial Foster Case training teaches how caseworkers and Resource Parents work with our Plan to schedule appointments, find specialists, and get support to achieve better outcomes for their children. As an example, knowing that children and youth in foster care and adoption have high Adverse Childhood Experiences (ACEs) scores, we provide Trauma-Informed Care (TIC) training for Resource Parents and caregivers. This training provides them with the understanding and skills to a trauma-informed mindset to understand and respond better to their child's behaviors, developmental, and attachment needs.

Mental Health and Psychiatry Consultation Program. We will refer PCPs to the University of Mississippi Medical Center Child Access to Mental Health and Psychiatry (CHAMP) consultation program to expand the capacity of PCPs serving foster children and expand access to mental health services. We will enroll our Providers as collaborative team members who will work with this consultation program to support a more integrated model of care.

Suicide Prevention. Through a combination of expert clinical direction and innovative machine learning, our suicide prevention program provides Care Managers with enhanced information to better identify Members for assessment, early intervention, and support. That could include identifying people with social risks, such as loneliness, or physical risks, such as severe pain or opioid misuse. We will then tailor evidence-based interventions for the individual Member. Nationally, more than 80% of individuals who die by suicide see a behavioral health clinician or PCP within a year before their death, and almost half have seen their Primary Care Provider in the prior 30 days[6]. That's why one of our central strategies of this initiative will be engaging our Care Management staff with nurses, therapists, and caseworkers. Ensuring they have the tools they need to enhance care for at-risk patients increases the likelihood of saving a Member's life.

Caregiver Partnership. This program will provide caregivers of foster children diagnosed with a serious emotional disturbance (SED) with knowledge, tools, and resources to increase their capacity to meet their child's unique needs. As part of the Caregiver Partnership program, caregivers will receive a journal to help them stay organized. Caregivers can use the journal at doctor visits to keep track of important information and

[6] Ahmedani, Brian K., et al. "Health Care Contacts in the Year before Suicide Death." Journal of General Internal Medicine, vol. 29, no. 6, 2014, pp. 870–877., https://doi.org/10.1007/s11606-014-2767-3.

daily routines such as medical history, medication list, allergies, and contact information for PCPs and other Providers.

Other Innovations. Understanding that foster children leaving care have a higher rate of experiencing homelessness, we will partner with ***Mississippi Programs of HOPE*** to address supportive housing for youth aging out of foster care. Members will receive housing vouchers, skills training, educational opportunities, and support as part of the program. We will ***develop a handbook for court-involved youth***, parents/guardians, court judges, and officials to educate decision-making teams. We will also provide ***support for obtaining a GED for foster youth***, which is shown to increase employment opportunities with higher-paying jobs, leading to healthier Members.

Local Partnerships

We will partner with Foundation for the Mid-South, whose goals align with MDCPS and our health plan of improving individual and community health outcome in chronic disease, mental health and access to care.

e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding services for Foster Children?

This section outlines our health equity goals and proposed solutions to address racial, ethnic, and geographic disparities in the delivery of services and outcomes for Members in foster care. Our health equity program is fully described in response to Section 4.2.2.1.A.8.d.

Black families experience poverty at a higher rate and are more likely to have children removed from the home due to implicit bias. 85% of the children that enter foster care in Mississippi is due to neglect[7], and 25% of Black children were not in excellent or very good health when compared with 7% of White children[8]. We will address poverty as a catalyst to neglect to address disparities amongst foster youth. Food insecurities and lack of access to healthy foods can lead to malnutrition and health issues such as diabetes and obesity. We will partner with Diabetes Coalition of Mississippi, local CBOs, and Providers to connect Members to nutrition and cooking classes with a dietician. This will include wraparound support services such as medically tailored meal delivery in areas with high-risk Members, education campaigns including Diabetic Books on cooking and super foods, and Food Bank Resources with fresh fruit and vegetables that can be tailored to dietary needs.

4.2.2.1.A Delivery of Covered Services

6. Dental Services

a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for dental services as a medical service

As an organization devoted to transforming the health of our community, we will not only provide widespread access to quality dental care but increase both Provider and Member engagement in a system that improves the overall dental health of Mississippi's Medicaid and CHIP populations. We will build relationships with Mississippi Providers, associations, and other stakeholders toward these efforts. We will ensure timely Member access to high-quality dental care, including preventive care, through a statewide dental network maintained by a subcontracted dental benefits manager (DBM). Our DBM has approximately seven years of Medicaid and CHIP experience and currently manages dental benefits and reimbursement for approximately 4 million Medicaid and CHIP enrollees in 14 States. The DBM will be delegated in Mississippi to oversee claims processing and payment, quality improvement, utilization management, and network development and management. Through our Vendor Oversight Program, we will retain full responsibility and accountability for the DBM's performance. We will contractually obligate the DBM to satisfy all relevant standards and requirements outlined in Appendix A, Draft Contract. We will meet or exceed the requirements for access to dental Providers as described in Section 6.2 of Appendix A, Draft Contract. We understand and agree to submit our DBM subcontract to DOM for its advance written approval.

Our Comprehensive Oral Health Strategy

In consultation with our DBM that employs dental clinicians with extensive Medicaid experience, we have developed a comprehensive oral health strategy that will meet Member dental health needs and is consistent with dental standards of care. We will identify and outreach to MSCAN and CHIP Members under age 21 who are overdue for an annual preventive dental care visit and encourage our network to outreach to these Members

[7]State Fact Sheet: Mississippi. Casey Family Programs, Apr. 2021, https://caseyfamilypro-wpengine.netdna-ssl.com/media/mississippi-fact-sheet-2021.pdf.

[8] "Children in Foster Care by Race and Hispanic Origin: Kids Count Data Center." KIDS COUNT Data Center: A Project of the Annie E. Casey Foundation, Annie E. Casey Foundation, June 2021, https://datacenter.kidscount.org/data/tables/6246-children-in-foster-care-by-race-and-hispanic-origin?loc=26&loct=2#detailed/2/26/false/1729,37,871,870,573,869,36,868,867,133/2638,2601,2600,2598,2603,2597,2602,1353/12992,12993.

as well. ***We will cover dental preventive care during pregnancy and postpartum as a value-added benefit due to the known significant impacts of oral health on maternal and child health.***

We will ensure that Members have transportation, including CHIP Members, to an appointment with a participating Provider that meets the State's time and distance requirements. Our strategy includes ongoing analyses of gaps in dental care and initiatives to close those gaps including Member incentives for completing preventive care visits; targeted Member outreach; ***reimbursement to Providers for practice dental visits***; educational campaigns for children; and value-added services and programs that support improved outcomes. Our notifications and follow-up for children discussed in response to Section 4.2.2.1.A of the RFQ are inclusive of reminders for preventive oral care.

Maintaining a Quality Dental Provider Network

We will identify Providers who have the right qualifications, are motivated to serve Medicaid and CHIP beneficiaries, and have the right administrative tools to succeed. To maximize our network, we will: (1) contract with any willing Provider that meets our credentialing criteria; (2) contract directly with all FQHCs in Mississippi that provide dental services; (3) contract with mobile dental Providers to offer services in rural areas; (4) identify general dentists providing specialty services to expand specialty service coverage, and track those specialty services in our information systems for future referrals; (5) accommodate local patterns of care and consider such patterns in our Provider recruitment strategy, particularly for specialty care; and (6) identify and attempt to contract with new specialists who move into the State.

Monitoring the Dental Provider Network

We will meet weekly with our DBM to review network compliance, identify issues (e.g., access and quality), and close network gaps as needed. This will include a review of county-level GeoAccess mapping, Provider-to-Member ratios, and panel status reports to confirm the availability of Providers considering distance/travel time from Members' residences. We will proactively identify areas where we meet minimum compliance thresholds and target these areas to recruit additional Providers to ensure that we maintain access standards even if there is a loss of any existing Providers in the area. If a necessary specialty dental service is accessible to a Member only through an out-of-network Provider, we will make arrangements through a Single Case Agreement (SCA) to allow the Member to access services on an out-of-network basis and recruit the Provider to join our network.

b. Describe any innovative methods that Offeror will use to augment its approach.

Innovations to Improve Quality, Engage Members, and Ensure Access

To meet the challenge of improving dental health for the Medicaid and CHIP population, we will implement the following innovative programs and initiatives designed to improve quality outcomes, engage Members in preventive dental care, and extend access to care.

Dental Hygiene Kits. Recognizing that most Mississippi counties are considered Dental Health Professional Shortage Areas (HPSA), we propose to add an enhanced benefit related to dental health promotion. We will offer one dental hygiene kit per year to MSCAN Members under age 21, CHIP Members seen in the ED for dental-related concerns, or based upon Provider request/referral. Dental Kits will include age-appropriate dental education materials, a toothbrush, toothpaste, and dental floss. We will make the kits available to selected Providers (e.g., FQHCs offering dental services) for distribution to their MSCAN and CHIP patients.

"Practice" Dental Visits. We will work collaboratively with our dental Providers and community partners to create specialized programs for high-risk Members, including Members with developmental disabilities and other special needs. Routinely, Members with a developmental delay receive preventive dental care in an outpatient hospital setting under general anesthesia. To avoid the additional risks associated with general anesthesia that result from this practice, we will offer to reimburse dentists for "practice visits" for Members to help lessen anxiety and make these visits less stressful. This approach has proven successful among our affiliated Medicaid plans in other states, allowing Members to become familiar with the Provider's office, equipment, and processes before the actual date of service and enabling the Provider to identify barriers to ensure clear communication before the appointment takes place.

Incentives for Dental Exams. Our Member Incentive Program will promote personal health care responsibility and ownership by offering a $25 incentive for Members under age 21 receiving preventive dental care. In 2021, we administered more than 400,000 incentives across our affiliate health plans for dental exams totaling over

$9,000,000 for our Members to spend in their local communities on necessities including utilities, childcare, and rent.

Preventive Dental Care in Primary Care Settings. To promote greater access, our Provider Relations Specialist will educate PCPs about the benefits of fluoride varnish for children as the least expensive and most effective way to reduce tooth decay, as well as provide education on reimbursement for these services in the primary care setting. We will train physicians and other health care Providers, such as Physician Assistants, Nurse Practitioners, and School and Public Health Nurses to apply fluoride varnish in their clinics and practices.

Mobile Dental Van. To provide additional services, including dental screenings and introduce children to good oral health behaviors in a comfortable setting, we will deploy our mobile dental van to provide same-day oral health screenings by dentists and hygienists. The mobile dental van focuses on education and provides high-quality oral health screenings and information for underserved adults and children. As noted above, we will include mobile dental Providers in our network, expanding access in rural areas.

Medically Necessary Dentures. We will provide dentures for adult Members when functionally and medically necessary to sustain a healthy weight because the Member has fewer than eight posterior upper and lower teeth in occlusion and cannot chew properly. We will establish relationships with dental Providers that provide care to low-income and disabled populations and refer Members who request dentures but do not meet our medical necessity criteria.

c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding dental services?

We describe our comprehensive health equity program in response to Section 4.2.2.1.A.8.d of the RFQ. Specific health equity goals, identified through analysis of publicly available data, to address racial, ethnic, and geographic disparities in the delivery of and outcomes regarding ***dental*** services are discussed in this section. We will measure our success by evaluating Dental HEDIS measures, filtered by race/ethnicity and zip code.

According to a 2018 report, Mississippi ranks second to last in the nation in the ratio of available dentists to patients[9]. This access issue becomes even more profound when focusing on dentists who accept Medicaid, and yet again when looking toward the rural areas. Most dental Providers are concentrated in and around Jackson. To increase access for Members residing in rural Dental Health Professional Shortage Areas, we will deploy our ***mobile dental van and mobile dental Providers*** to provide same-day oral health screenings by dentists and hygienists. As noted above, we include mobile dental Providers in our network. We will partner with rural schools to conduct events with our dental van, where we will also provide education about how to maintain good oral health.

Our initiative to ***educate and encourage PCPs to apply fluoride varnish*** while our Members are there for well-visits will support improved oral health for children in rural areas who are at increased risk for tooth decay because they do not receive fluoridated drinking water, which only 60% of Mississippians receive[10]. Additionally, we will spearhead an innovative and proven initiative[11] allowing parental caregivers to apply fluoride varnish to their child's teeth with virtual instruction from a licensed dental Provider. We hope to collaborate with the other CCOs, DBMs, and DOM to ensure this is done safely, effectively, and efficiently.

We will **partner with the Mississippi Dept of Health Dental Department to address the rate of untreated dental cavities in young Black children**, who have half the sealants and twice the dental caries as White children in Mississippi[12]. With age comes even greater dental issues that can further jeopardize overall health. Through our CHWs, Head Start and Early Head Start, and faith-based organizations such as Abundant Living

[9] Bowman, Alana. "School Works to Fill Mississippi's Dental Gap." University of Mississippi Medical Center, University of Mississippi Medical Center, 18 Oct. 2018, https://www.umc.edu/news/News_Articles/2018/10/School%20works%20to%20fill%20the%20dental%20gap%20in%20Mississippi.html.

[10] America's Health Rankings analysis of CDC, Water Fluoridation Reporting System, United Health Foundation, AmericasHealthRankings.org, Accessed 2022.

[11] Roth, Ella, and Carrie Hanlon. Nevada Pilots Innovative Program to Increase Access to Preventive Oral Care for Children, National Academy for State Health Policy, 2021.

[12] Dental Statistics, MHS Mobile Dental, http://www.mhsmobiledental.com/oral-health-statistics.html.

Community Organization, we will deploy a health education campaign using trusted messengers to encourage Members to seek preventive dental care. We will work with safety-net dental Providers such as Federally Qualified Health Centers, Department of Health Consultants, Rural Health Clinics, and Reduced Fee Clinics (UMMC School of Dentistry) to expand access points in targeted areas indicated by our data analyses where Black children are being disparately impacted.

4.2.2.1.A Delivery of Covered Services

7. Vision Services

a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for vision services.

We understand that standard eye exams are essential for maintaining wellness and serve as one of the most effective ways to defend against vision loss and detect signs of certain long-term health conditions. Eye exams can uncover health information, including symptoms of severe conditions like diabetes, high blood pressure, high cholesterol, thyroid diseases, and certain cancers. Eye doctors are often the first to discover signs of abnormal health conditions, meaning less hospitalization and lower spending on medications. Therefore, we will encourage MSCAN and CHIP Members to take care of their eyes to help decrease diagnostic claim costs, improve Member health, and enhance the quality of life by conducting automated outbound call campaigns targeting Members who are overdue for an annual eye exam. During these calls, a Member may immediately choose to be connected to a Customer Service Representative who can assist the Member with finding a Provider and scheduling an appointment. We will conduct targeted outreach to Members who may have unique vision care risk factors and needs, including those with diabetes and glaucoma.

We will ensure timely Member access to high-quality vision care through a statewide vision network maintained by a subcontracted vision benefit manager (VBM). The VBM has approximately 11 years of Medicaid and CHIP experience and currently manages vision benefits and reimbursement for approximately 12 million Medicaid and CHIP enrollees nationwide. The VBM will be delegated in Mississippi to oversee Provider data management, credentialing, claims adjudication, benefit configuration, utilization management, and Grievances and Appeals. Through our Vendor Oversight Program, we will retain full responsibility and accountability for our VBM's performance. We will contractually obligate our VBM to satisfy all relevant standards and requirements outlined in Appendix A, Draft Contract. We understand and agree to submit our VBM subcontract to DOM for its advance written approval.

Our VBM is an any-willing Provider payer, supports full-scope of-licensure patterns, and has a long-standing relationship with the Mississippi Optometric Association that will enhance and support network stability and communications with Providers. Our VBM collects and advances vision HEDIS measures, encourages eye care Providers to act as effective primary care stewards into the overall health care system, develops software solutions to increase the efficiency of eye care administration, eliminates waste and fraud via data mining, and employs evidence-based medicine claim edits and peer-to-peer interventions.

b. Describe any innovative methods that Offeror will use to augment its approach.

To meet the challenge of improving vision care and the overall health of the MSCAN and CHIP populations, we will implement the following innovative programs and initiatives designed to improve quality outcomes and engage Members in preventive vision care.

Incentivizing and Educating Providers. To improve care for our Members with diabetes, we will provide a $10 incentive payment to vision Providers for each annual diabetic retinal eye exam performed. We will educate Providers regarding the importance of annual exams and the availability of the incentive payment through annual Provider postcards and quarterly newsletters.

Mobile Vision Van. We will deploy our VBM's Vision Van to provide vision screenings for children and adults and promote the importance of eye care in the community. The Vision Van, staffed by doctors and technicians, is equipped with screening tools to test vision outside the van; equipment to perform basic vision exams; informational handouts about eye health and the importance of eye exams; and sunglasses and readers. We will deploy the Vision Van to the areas of greatest need in the State and also plan to deploy the van in partnership with schools, FQHCs, and other community-based organizations for joint vision education and outreach events.

Providing Polycarbonate Lenses as the Standard of Care. As a value-added benefit, we will offer one eye

exam per year and ***one pair of eyeglasses every calendar year for all Members over age 21***. Thinner and lighter than plastic, polycarbonate (impact-resistant) lenses are shatter-proof and provide 100% UV protection, making them the optimal choice for children and active adults. They are also ideal for strong prescriptions since they do not add thickness when correcting vision, minimizing any distortion. We will cover polycarbonate lenses as the standard of care for MSCAN and CHIP Members.

Diabetic Retinal Exam Access. Partnering with a retinal camera vendor that offers easy to install, handheld retina cameras designed to help make retinal exams simple and affordable for PCPs. By providing a grant that covers the cost of the technology and monthly fee, we will offer this technology in key Provider offices to enable PCPs/PCMHs to perform retinal scans on their patients with diabetes.

c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding visions services?

We describe our comprehensive health equity program in response to Section 4.2.2.1.A.8.d. Specific health equity goals, identified through analysis of publicly available data, to address racial, ethnic, and geographic disparities in the delivery of and outcomes regarding ***vision*** services are discussed in this section. We will measure our success by evaluating vision screening rates measures, filtered by race/ethnicity and zip code.

According to the CDC, Leake, Neshoba, and Scott counties have a disproportionately higher prevalence of vision impairment than the surrounding counties[13]. We will ***deploy our mobile vision van to conduct targeted events in partnership with schools, FQHCs, and RHCs*** in these counties to increase vision screening rates and referrals for ongoing ophthalmological care. We will collaborate with local Providers to identify strategies that modify practice patterns to ***build internal capacity for patient management in eye disease and vision impairment*** prevention.

Glaucoma disproportionately affects Black and Hispanic individuals, and they are also more likely to develop vision loss and experience blindness from glaucoma than White individuals[14]. We will create ***focused interventions for our Black and Hispanic Members who have an increased risk*** of diabetes or unaddressed cataracts. Our approach will include integrating vision health interventions into existing programs and the adoption of best practices at all levels. To further encourage screening and assessment for glaucoma, we will provide a $10 incentive payment to vision Providers for each annual diabetic retinal eye exam performed.

4.2.2.1.A Delivery of Covered Services

8. Additional Items

a. State whether the Offeror will required any cost-sharing or copayments from MississippiCAN and/or CHIP Members.

i. If yes, please describe what these cost-sharing/copayment requirements will be.

We will not impose cost-sharing or copayment requirements on our MSCAN Members. Subject to the exclusions and limits described below, we will impose copayment requirements for CHIP Members in families with incomes above 150 percent of the Federal poverty level (FPL) as described below in **Table 4.2.2.1.A.8.a.**

We will adhere to Section 4.2.10 of Appendix A, Draft Contract, all applicable State and Federal laws, the State Plan, and the requirements set forth in 42 CFR 457.515 – 457.560 concerning cost-sharing for CHIP Members. We will not impose copayment requirements on preventive services, out-of-network emergency services (beyond the amounts listed in **Table 4.2.2.1.A.8.a)**, American Indians or Alaskan Natives, or, for a Member who has an emergency medical condition, screening or treatment costs needed to diagnose the specific condition or to stabilize the Member.

Table 4.2.2.1.A.8.a. CHIP Copayments by FPL

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

Tracking the Out-of-Pocket Maximum

To ensure total copayments each year do not exceed the applicable Out-of-Pocket Maximum amount, we will track CHIP Member copayments. We will use a CHIP Members' monthly family income and family size, as reflected on the 834 file, to calculate a monthly income for the Member specifically. This calculation will

[13]"Vision Health Initiative (VHI)." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 10 Aug. 2021, https://www.cdc.gov/visionhealth/data/state-profiles/mississippi.htm.

[14]Elam, Angela R., et al. "Large Disparities in Receipt of Glaucoma Care between Enrollees in Medicaid and Those with Commercial Health Insurance." Ophthalmology, vol. 124, no. 10, 2017, pp. 1442–1448., https://doi.org/10.1016/j.ophtha.2017.05.003.

ensure that if two Members of the same household are each CHIP Members subject to copayments, we can separately account for their copayment expenditures relative to income. We will configure our claims system to reduce claim payment by the copayment amount when a claim is for a service subject to copayment and for a CHIP Member subject to copayments. Twice a week, we will compare the calculated Member monthly income data to aggregated copayment information on claims paid in the calendar year to identify if a CHIP Member's copayment expenses have reached the Out-of-Pocket Maximum. We will report individuals approaching the Out-of-Pocket Maximum to the State's fiscal agent on the Supplemental File to trigger an 834 record that suspends cost-sharing for that CHIP Member for the remainder of the year. Once we receive an 834 file changing a Member's Cost Sharing Indicator from N (Member has not reached the Out-of-Pocket Maximum) to Y (Member has met the Out-of-Pocket Maximum), we will send a letter to the CHIP Member informing them that their copayments have been suspended for the year and reminding them that their copayments may restart in the following year. The letter will also instruct the Member to present the letter when seeking future health services or request that their Provider contact us for confirmation. Additionally, we will make a copy of the letter available digitally for the Member for easy and reliable access. If a CHIP Member self-reports any cost-sharing, we will contact the Provider to request claims submission and honor the Member's receipt if the Provider does not submit a claim. Copayment reported for a service that is not a CHIP-covered benefit will not apply to the Out-of-Pocket Maximum calculation.

Educating Members about CHIP Copayments

In addition to displaying copayment services and amounts on our CHIP Member ID Card, we will educate Members regarding copayment requirements by including a cost-sharing and copayment page on our public CHIP Member website and including copayment information in our CHIP Member Handbook. We will answer copayment questions through the Member Call Center, secure Member Portal, and public website, and distribute cost-sharing flyers at in-person education and community outreach events

Member and Provider Services staff will receive training to make sure they can field calls about copayments and use our Customer Relations Management (CRM) system to look up whether the CHIP Member is subject to copayments, is exempt, or has reached the Out-of-Pocket Maximum limit. We will distribute an FAQ document to call center staff to use as a desk reference to support such calls.

b. Describe practices and policies the Offeror would plan to use to ensure that rural MississippiCAN Members would have adequate access to Non-Emergency Transportation (NET) and any innovations that the Offeror may bring to MississippiCAN in this area (Note: NET is not a covered service under CHIP).

Ensuring All Members Can Get to the Care They Need

We will provide Non-Emergency Transportation (NET) for our Members***, including CHIP Members*** as a value added benefit, to access medically necessary services in full compliance with Exhibit E of Appendix A, Draft Contract and all other applicable State and Federal requirements. We will provide NET services through a subcontracted NET Broker currently serves millions of Medicaid enrollees across the nation. Through our Vendor Oversight Program, we will retain full responsibility and accountability for our NET Broker's performance. We will contractually obligate our NET Broker to satisfy all relevant standards and requirements outlined in Appendix A, Draft Contract. We will meet or exceed the timeliness standards for Member wait times described in Exhibit E of Appendix A, Draft Contract. We understand and agree to submit our NET Broker subcontract to DOM for its advance written approval.

We will ensure the Member has transportation to their next appointment at every point of contact. We will help Members arrange transportation as part of Member Services, Care Management, and when we conduct quality call campaigns. For example, when we help a Member schedule an EPSDT service, we will offer to schedule transportation, if needed, and our NET Broker will also send a reminder. For behavioral health, obstetrician, and urgent care visits, ***we will waive the three-day requirement and offer same-day transportation, improving access to urgent care services***. We will use our Member Handbook, public website, and New Member Welcome Calls to remind all Members to contact our Member Services Call Center for assistance in finding, selecting, and scheduling appointments with Providers and arranging transportation.

NET Diversification to Meet the Needs of Rural Members

We understand that over half of all Mississippians live in a rural community and that the percentage of MSCAN Members residing in a rural area is even higher. Many rural Members require frequent trips to medical

appointments due to high rates of obesity and chronic conditions like diabetes but must often travel longer distances than Members who reside in more urban areas. To ensure that our rural MSCAN Members have adequate NET access, we will offer a broad range of NET service options. In addition to available commercial carriers offering transportation by, for example, car, taxi, or wheelchair or stretcher van, we will promote mileage reimbursement for Members that have access to a private vehicle, recruit a significant number of volunteer drivers, and initiate an independent contractor program.

Mileage Reimbursement. We will promote mileage reimbursement for Members with access to a private vehicle themselves or through a family member or friend. This NET service mode offers Members greater flexibility and freedom to make other stops before or after a medical visit and promotes independence. We will provide reimbursement on an easy-to-use reloadable debit card.

Volunteer Drivers. In our experience, utilizing volunteer drivers is particularly advantageous for long-distance trips (that often originate in rural areas) that would otherwise result in a commercial driver being unavailable for other trips for an entire day. Using volunteer drivers can offer Members more driver consistency leading to better service and better Member satisfaction. We find that Members often ask for volunteer drivers by name. Our NET Broker will configure its scheduling system to capture driver preferences and accommodate these requests whenever possible. We will partner with and support community-based organizations that offer transportation services in their communities, sometimes using volunteers. These services will complement our NET services by addressing social determinants of health, for example, trips to the grocery store or employment. Based on our prior experience with similar organizations, we have found that medical-related trips remain the most requested, followed by employment and nutrition-related trips. Whenever possible, we will help volunteer drivers for community-based organizations become credentialed, ensuring that the driver requirements and vehicle standards in Mississippi Administrative Code, Title 23, Part 201 are met, so that they can also provide volunteer NET services to our Members.

Independent Contractor Program. Our NET Broker will supplement its commercial transportation Provider network by contracting with independent contractors who are willing and able to meet MSCAN's NET credentialing requirements and vehicle standards. These drivers will commit to either a full or part-time schedule, and participate in training on how to provide NET services to MSCAN Members. Independent contractor drivers will make their schedules and be reimbursed using a commercial fee schedule.

Innovations to Improve Quality Outcomes and the Member Experience

Member to Care Program. Subcontracted NET drivers often have unique insight into changes in a Member's health and circumstances as they are a regular link between Members and their medical appointments and frequently have conversations with Members throughout the trip. Many Members use the same driver on a daily or weekly basis, building consistency, continuity of care, and reliability as Members grow to know and trust their regular driver. This relationship allows drivers to quickly identify potential issues and serve as an early alert system for the Member's Care Manager, which could prevent further health issues and reduce the overall cost of care. Whether they notice an atypical no-show, signs of elder or child abuse, an indication of poor home conditions or food insecurity, or a marked degradation in health, NET drivers are cognizant of concerns and can report issues to the Care Manager in real-time. Drivers can also communicate reminders for screenings, tests, and vaccines. Through our NET Broker, we will train drivers on how to observe and recognize Members with potential issues, as well as proper communication for screenings, tests, and vaccines. Drivers can use the NET Broker's IT platform to document evaluation and communication notes, which the NET Broker will forward to the Care Manager for follow-up with the Member.

NET to Address Social Determinants of Health. Approximately 43.2% of Members live in census tracts where the rate of individuals without vehicle access in the household is above the U.S. average of 8.6%, with Issaquena and Sharkey's counties ranking the lowest. Data gathered in 2021 from a community survey conducted in Holmes County showed 41% of participants reported transportation challenges for groceries and 31% to pick up prescriptions. ***As a value-added benefit, we will offer our Members transportation to address SDOH needs, such as trips to the grocery store or food pantry.***

Member NET Mobile Application. Through our NET Broker, we will offer a Mobile Application that Members can use to manage their NET trips without making another phone call. In addition to using the

Application to request a new trip, Members can use the Application to cancel rides that are no longer needed; request gas mileage reimbursement trips; review details about upcoming rides (for example, the ride status, NET mode, and the transportation Provider's name and contact information); and view and update their contact information.

c. Describe any additional proposed innovations for delivery of Member services or benefits that the Offeror would bring to MississippiCAN and/or CHIP that are not otherwise covered in this section.

Partnering to Expand Access to Services

As an organization that will be located in Mississippi and staffed and operated by hundreds of Mississippians across the State, we are dedicated to improving and investing in the future of health care in Mississippi. We will invest $1 million to enable William Carey University (WCU) to develop the WCU College of Medicine (COM) Institute of Primary Care in Hattiesburg. We selected to partner with WCU COM because of their community-based training model and commitment to educate and train osteopathic physicians, nurses, and other primary care providers who are dedicated to serving the medically underserved and diverse populations of Mississippi. The Institute will recruit and train students primarily from Mississippi and the Gulf South region and offer continuing education and residency resources to address the physician shortage in the region. This world-class facility will allow for advanced training in high-quality value-based care geared toward the specific needs of Mississippians including diabetes, hypertension, and cardiovascular disease. The development of the Institute will result in better quality and more quantity of physicians to improve outcomes and quality of life for all Mississippians and decrease cost outcomes for the State.

Pharmacy-Related Services

We plan to offer the pharmacy-related services described below to improve Member health outcomes and reduce medical spending by closing medication-related care gaps, improving adherence, and preventing patient harm. We will, with DOM's approval, develop value-based programs cognitive-based therapies, such as Medication Therapy Management. We will work with the State's Pharmacy Benefit Administrator (PBA), as needed, to implement these programs and will cooperate fully with the PBA.

Medication Therapy Management. We will operate an MTM program in partnership with retail pharmacies across the State to address HEDIS care gaps and improve medication adherence. Our MTM program will use pharmacy claims data provided by the PBA to generate Member-specific alerts to retail pharmacists related to medication adherence for diabetes, hypertension, cholesterol (statins), antidepressants, and HIV. This includes gaps in care related to statin therapy for patients with diabetes and will promote the use of maintenance inhalers for Members with Asthma and COPD. A retail pharmacist who receives an alert will outreach to the Member either face-to-face or telephonically to address the care gap or adherence concern.

Community Pharmacy Enhanced Services Network (CPESN) Partnership. To complement our MTM program, we will partner with the CPESN, a network of roughly 60 independent pharmacies throughout Mississippi, to address Member-specific care gaps and adherence for chronic conditions including diabetes adherence and gaps in care for diabetic patients that need statin therapy, asthma/COPD adherence and gaps in care for Members requiring a maintenance inhaler for better disease control; anxiety and depression adherence and education; ADHD adherence, education, and Provider follow-up visits; and statin use in patients with cardiovascular disease. We will also partner with CPESN to provide HbA1c point of care testing in CPESN-member pharmacies, offering Members with diabetes another convenient option to a physician visit. CPSEN will share the HbA1c testing results with the Member, the Member's PCP, and the health plan.

Polypharmacy Program. For Members with eight or more chronic conditions, we will use pharmacy claims data to identify potential drug-related problems monthly, including, for example, dangerous drug combinations and therapeutic duplications. We will resolve these issues by reaching out to Providers by letter or fax with recommendations to simplify care and by partnering with retail pharmacies to conduct follow-up phone calls to Providers.

Data Analytics to Detect Rx Diversion. We are exploring a partnership with a data analytics vendor to reduce fraud losses and beneficiary risk and mitigate Medicaid program financial risk. This vendor's solution has been successfully deployed in other States and employs next-generation analytics which detect and predict diversion of high-cost drugs and support opioid overdoses prevention and harm reduction. The solution:

- Uses advanced machine learning algorithms to identify aberrant behaviors and diversion risk associations
- Applies deep neural network and gradient boosting machine modeling to identify future risk through retrospective analysis of past overdose events
- Includes and aggregates multiple data sources including geospatial data and State and local law enforcement intelligence to increase sensitivity and predict risk
- Identifies and profiles prescribers, Members, medications, and dispensers associated with prescription drug diversion activity
- Identifies and profiles Members at risk of drug overdose to allow for early targeted intervention
- Increases referrals to Medicaid Fraud Control Units.

d. Describe any additional practices the Offeror will use to address racial, ethnic, and geographic disparities in delivery of services.

Sharing the vision and commitment of the Mississippi Department of Health's Health Equity Initiative to achieve health equity across Mississippi, we will address health equity in all our Population Health Management programs. ***We will improve health equity in Mississippi by creating accountability and oversight, developing a culturally responsive and staff and Provider network, and implementing a Health Equity Improvement Model***. Embedded in the Delivery of Covered Services sections above, we describe specific initiatives and demonstrate how we can use data to identify and address disparities. This work is all part of our overarching Health Equity strategy described herein.

Health Equity in Mississippi means every person has equal access to culturally and linguistically appropriate care regardless of geographic location, race, ethnicity, dialect, sexual orientation, gender identity, or socioeconomic status. We will work with Jackson State University in collaboration with DOM and the other CCOs to develop a Health Equity Guide to align health equity efforts across the State. As a further demonstration of our commitment to health equity, we will pursue **NCQA Health Equity Accreditation**. Health Equity Accreditation includes the continuous quality improvement necessary to advance health equity and symbolizes the importance for all organizations to work toward a more equitable health care system. These efforts will inform our Health Equity Plan and align with Population Health Management and quality goals.

Accountability and Oversight

We will build a team of committed professionals to drive our health equity efforts. Our local ***Director of Health Equity*** will oversee the strategic design, implementation, and evaluation of initiatives that address social and community health, including reducing disparities and fostering cultural humility. The Director will lead our local Health Equity Governance Committee that will meet quarterly and report to the Quality Management Committee (QMC).

The Director will manage ***three Community Engagement Specialists (CES') dedicated to facilitating regional (central, north, and south) strategic community partnerships*** to drive collaborative, community informed equity initiatives. Each CES will lead a ***Community Impact Council*** (CIC) in their region. CICs will align our PHM, health equity, and quality priorities, focusing on populations defined by Healthy People 2030. They will continuously assess, expand, and design innovative community-based programs, create solutions to emerging issues, and provide feedback on current services.

Policies and Procedures (P&Ps). Our non-discrimination policy is infused into all contracts and activities to ensure equal access regardless of race, ethnicity, cultural background, English proficiency, ability or disability, gender, sexual orientation, or gender identity. To ensure full implementation of our health equity goals, we will review every P&P to evaluate its impact on health equity. The below P&Ps are examples that have been implemented with our affiliate health plans.

P&P	Description
CLAS	Assures compliance with all CLAS standards through a lens of continual process improvement
Provider Network Management	Process for collecting Provider level demographics (e.g. RELD, SOGI) and guidelines for Provider network participation to meet diverse needs, including Member and Provider data overlays and directory flags to help connect Members to Providers that meet cultural needs
Interpreter Services	Provides for the provision of written, verbal, and in-person language services and prompt use of interpreter services and supports Members with language or hearing needs

Culturally Responsive Staff and Providers

Staff Development. We will be deliberate in developing health equity education and leadership programs available to all staff and creating the foundation and lens from which we operate. Our comprehensive training program will help staff gain a deeper understanding of our Members and how to interact with them in a culturally responsive manner. All staff will be required to participate in the training and use lessons learned to inform discussions and address health equity in all programming. Training will be offered in person, via teleconferences, and online webinars and include topics such as:

- Racial Equity: Authentic Allyship, Cultivating Equity and Inclusion Playlist, Courageous Conversations
- Unconscious Bias Training: An Introduction to Unconscious Bias, Unconscious Bias Fundamentals, and Gender Identity and Transition Guide
- Cultural Competence, Motivational Interviewing, Trauma-Informed Care, and Person-Centered Thinking
- LGBTQ+ Allyship: From Awareness to Action, Out and Proud: Approaching LGBTQ+ Issues in the Workplace

We will create a local ***Diversity, Equity, and Inclusion (DEI) program*** that supports an equitable workplace. Our ***Employee Inclusion Groups (EIGs)*** will support attracting, developing, and retaining the best talent at all levels. EIGs are designed to be voluntary, employee-led groups that offer professional and leadership development, contribute to community engagement initiatives, and support business innovation. Each group has a unique focus, including persons with disabilities and their caregivers; veterans and their families; persons who identify as lesbian, gay, bisexual, and transgender; women; and persons of color. EIGs have proven to be successful ways to promote awareness, provide education, and support employee engagement and retention across our health plans.

Provider Education. Our Provider training requirements include health equity, poverty and disability sensitivity, and cultural competency training to create an understanding of cultural humility with specific attention to the role of implicit and explicit bias in interpersonal interactions. This training is a requirement of our Participating Provider Agreements. Initial education and training for Providers will be conducted no later than 30 days before implementation of Appendix A, Draft Contract. We will complete initial education and training to newly contracted Providers at least 30 calendar days before their start date. Our Community Health Workers (CHWs) will partner with and educate Providers on how to use plain language communication and simplify health information, so it is clear and easy for Members to act upon.

We recognize some Providers have historically served impoverished and marginalized communities and have been economically impacted by low reimbursement rates, lack of access to value-based payments (VBP), and high-intensity caseloads. To support them, we will develop programs to strengthen Providers from different racial and ethnic minority groups, rural areas, and those serving more than 60% Medicaid patients in our most disenfranchised communities. Support will include quality practice enrichment training and tools, innovative contracting strategies, technical assistance to support readiness to move into VBP models, and access to actionable data.

Network Cultural Competence. We will build and maintain a Provider network that is representative of our membership. We understand the socioeconomic nuances that impact Member's ability to access health care. We will ensure accessibility, not just availability. We will use continuous network monitoring, formal recurring cross-departmental assessments, and soliciting external input to expand network analyses beyond traditional geographic mapping. This will ensures our network includes a broad representation of Providers that have historically served Medicaid enrollees, are familiar with the unique characteristics, disability needs, and cultural considerations of each covered population, and have the expertise to consistently deliver quality care through a

health equity lens. To increase the percentage of Mississippi Providers that meet minimum Federal and State disability access standards, our Provider Relations Specialists will conduct Accessibility Site Reviews. After the review, PCP/PCMHs can apply for a grant to carry out their improvement plan which could include wheelchair ramps and equipment such as accessible exam tables.

Health Equity Improvement Model

Our four-step, data-driven Health Equity Improvement Model, captured in Figure 5.2 below, brings cultural sensitivity and awareness to the delivery of care to Members, their families, and our communities. This model is inclusive of DOM's vision to achieve racial and social equity and our SDOH Strategy that focuses on eliminating disparities caused by social barriers to care. We use this model to identify, assess, and address disparities using integrated quantitative and qualitative data from multiple sources, including our Health Equity Dashboard. Starting at enrollment, we will capture RELD (race, ethnicity, language, and disability) and SOGI (sexual orientation and gender identity) data in our Reporting and Analytics Platform. We will conduct cross-sectional analyses and stratify quality performance measures, utilization metrics, disease prevalence, and geographic data to identify disparities and inform interventions that improve the health and well-being of Members and promote equity across the State. We will overlay these analyses with additional data and demographics to identify where variables such as poverty, geography, disability, and other SDOH factors contribute to health disparities. We engage Members, trusted messengers, and community and Provider partners to identify barriers and design, implement, and evaluate initiatives at the Member, Provider, and community levels.

[redacted]

[redacted]

Identify Best Practices. Should an inequity be identified, we will partner with our CICs, Providers, and community stakeholders to identify best practices and tailor solutions for the local community. This improvement model aligns with our SDOH Strategy (as captured in 4.2.3.3*),* which is important due to the direct impact of SDOH on health disparities. SDOH, such as poverty, unemployment, and lack of educational achievement affect access to care and a community's ability to engage in healthy behaviors. As such, we will overlay our analyses with additional data and demographics to determine how these variables contribute to the identified disparities. We will also use the model to predict adverse health outcome risks based on where Members live by generating heat maps that identify social predictors correlated with poor health outcomes. After identifying these geographic "hotspots," we will use them to drive holistic population health goals and reduce disparities. Through our CICs, we will hold community action meetings with Members, local Providers, and CBOs to better identify barriers and collaboratively develop action plans to improve health outcomes based on the data and dashboards described.

Design Initiatives. All the activities described above will inform our annual Health Equity Plan to track multi-year goals for holistic approaches in identified priority areas. We will continuously use data to inform our understanding of the impact of our work and to support rapid-cycle change processes that enhance our ability to promote health equity. Our Health Equity Plan will incorporate the Office of Minority Health's National CLAS standards and outline activities, efforts, and recommendations to improve health equity in the communities we serve. We will also incorporate information from publicly available reports including the Annual Mississippi Health Disparities and Inequities Report Mississippi State Health Assessment, 2021-2026 Mississippi State Department of Health State Health Assessment, the 2021 Mississippi Primary Care Needs Assessment, overall health rankings from the Robert Wood Health Foundation, the 2021 Adult Hospitals Community Health Needs Assessment conducted by the University of Mississippi Medical Center, 2019-2020 Children's of Mississippi Community Health Needs Assessment, America's Health Rankings® Health Disparity Report, and hospital and county community health needs assessments. The Health Equity Plan will be updated annually and include the following activities:

- Reducing health disparities for racial and ethnic minority populations
- Cultural responsiveness, including providing accessible and quality care for all Members
- Quality improvement related to culturally and linguistically appropriate services
- Collecting RELD and SOGI data, including aligning with the proposed equity-related NCQA data requirements, such as race/ethnicity stratifications
- Providing language assistance and maximizing care for those with limited English proficiency

Our Health Equity Plan will be responsive to Mississippi needs and State priorities, shared across our staff and delivery system to solicit feedback and promote alignment, and used to inform our annual ***Quality Management Program and Work Plan*** and population health management goals.

Implement and Evaluate. We evaluate the effectiveness of health equity initiatives primarily through our Health Equity Dashboard by measuring racial, geographic, gender, disability, or other disparities pre-and post-intervention. We will also review Consumer Assessment of Health care Providers and Systems (CAHPS), assessments, Grievances and Appeals data trends, Performance Improvement Projects, surveys, and qualitative data. Qualitative data will include the experiences of our Members, Providers, and other community stakeholders through feedback loops such as CICs and Advisory Committees. We will stratify quality performance, utilization metrics, and disease prevalence by demographic and disparity data to ensure health equity is addressed in all our population health programs, partnerships, and quality initiatives.

4.2.2.1.B Member Services Call Center

1. Describe the Offeror's Member services call center operations, including:

We will maintain and staff a toll-free, dedicated Member Services Call Center in Mississippi to serve our Members or any caller. Our Customer Service Representatives (CSRs) are supported by call center tools and technology investments to ensure prompt service and accurate information. We will maintain a 24-Hour Behavioral Health/Substance Use Disorder (BH/SUD) line for access to clinical personnel acting within the scope of their licensure to practice a BH/SUD-related profession, and a 24-Hour Nurse Advice (NAL) line to access clinical personnel who act within the scope of their licensure to advise and triage Members. Our call center will be reachable via one toll-free number separate and distinct from the Provider Services Call Center and will operate Monday through Friday from 7:00 a.m. to 8:00 p.m. (Central Time Zone), including the State holidays stipulated in Appendix A, Draft Contract. After hours, weekends, and on State-declared holidays, our Interactive Voice Response (IVR) system will inform Members, in English and Spanish, of the hours of operation, direct them to dial "911" if there is an emergency, help with languages other than English, and offer to connect them with the 24-Hour BH/SUD line or the 24-Hour NAL.

Driving First Call Resolution

By investing in call center technology and staff training, an affiliate health plan's call center posted a 90% first call resolution rate in 2021.

A Gateway to Benefits and Services

Our objective for our Mississippi call center is to be a gateway for Members to access benefits, services, and information they need to live healthier lives and self-advocate for their health, such as:

- Connecting Members with PCPs
- Scheduling PCP Appointments
- Explaining Member Rights
- Referrals for Emergency Member Issues
- Care Management Referrals, including Self-Referrals
- Assisting With Grievances and Appeals
- Assisting With Fraud, Waste, and Abuse Referrals
- Scheduling Rides for Medical Visits

To achieve this objective, we will hire high-performing and compassionate CSRs who understand and respect the diverse cultures of Mississippians. We will provide a rigorous training program and equip our CSRs with tools and technology to drive operational performance, such as getting the right answers the first time Members call, and delivering a memorable customer service experience so Members will want to call back for additional assistance. ***An affiliate health plan that has taken this approach, which we will employ in Mississippi, posted a 90% first call resolution rate in 2021***. Our Mississippi call center operations will feature the following tools and technology:

- **Telephony Solution.** Our Telephony Solution, along with our Call Manager Software, provides automatic call distribution (ACD) across our Member call queues. Refer to section 4.2.2.1.B.2 below for further information on ACD. Our Call Manager Software tracks and reports information processed through the ACD, enabling seamless and efficient call answering, monitoring, and reporting capabilities. Further, we will integrate omni-channel cloud call center technology within our Telephony Solution to provide an even more seamless experience for our Members. For instance, this technology will offer greater flexibility through enhanced IVR self-service, the option for text messaging and direct chat, an automatic call-back option, and skills-based routing to our CSRs. Powered by machine learning, this advanced routing functionality will ensure that Members will be served by CSRs who are experienced and ready to resolve their issue or concern.
- **Virtual Assistant.** We will enhance communications to meet Members where they are by implementing Virtual Assistant technology, which will provide human-like and natural communication and chat capabilities. Through the Virtual Assistant, we will offer real-time assistance in both English and Spanish for Members navigating our health plan website. For example, the Virtual Assistant will help Members access services, sign up for their secure Member Portal account, and other self-service functions.
- **Online Appointment Scheduling.** Through our online appointment scheduling software, our CSRs and

other Member-facing staff will be able to schedule Provider appointments from their desktops, laptops, or mobile devices while engaged with Members, as well as issue text or e-mail appointment reminders. Staff will be able to securely attach documentation to the appointment for specific care gaps (e.g., EPSDT/Well-Child visits and preventive services), enabling providers to deliver services for all Member needs during the office visit and gain incentive payments for closing care gaps.

- **Customer Relationship Management (CRM)**. CSRs will document all calls in CRM for tracking, workflow, and data management. Through its integration with our Management Information System (MIS), CRM offers our CSRs a 360-degree view of our relationship with Members. CRM links to Real Time Repositories (RTRs) which collect, store, and help to view data from other source systems in near real-time. This connection ensures our CSRs have ready access to Members' most up to date eligibility and demographic information, Care Manager's name, claims information, preferred language, incentive balance information, care gaps and wellness alerts, and special needs or accommodations.
- **Knowledge Management Tool**. This tool is integrated with CRM to provide real-time access to information for CSRs to quickly search for and deliver timely, accurate responses to Members' needs. CSRs can save and store information in "favorites" folders to retrieve relevant content during a live call without requiring multiple logons to other systems.
- **Computer Telephone Integration (CTI)**. CTI technology is integrated with our telephony system to automatically match inbound calling numbers with Members' records, such as call history, demographics, and care gaps. This information will appear on the CSRs' desktop screens enabling them to personalize the customer service experience and achieve first call resolution.

a. Confirming that the location of the proposed operations will be within the State of Mississippi (provide a yes or no answer; do not include address);

Yes.

b. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call) and measures to ensure standards are met (the Division retains the right to approve all call center standards);

Specific Standards for Rates of Response

We will set our call center's performance targets based on the standards listed in Section 5.1.6 in Appendix A, Draft Contract. To ensure we meet or exceed these standards, we will draw from the experience of our affiliate health plans' successful performance under similar standards. **Table 4.2.2.1.B.1.b** demonstrates an affiliate's performance against the requirements in Section 5.1.6 as well as an additional NCQA performance measure. By employing a similar training curriculum for our CSRs as our affiliates and the call center tools and technology to support them, we are confident we will meet or exceed these requirements. In addition, since we will not impose call duration limits on any caller contacting our Mississippi call center, we will not use average length of call as a performance standard. Our response to 4.2.2.1.B.2 details our ACD's capabilities and capacities to answer all calls within one ring.

Table 4.2.2.1.B.1.b Affiliate's Call Center Performance

Performance	Standard
Average Speed of Answer was 18 seconds – exceeding SLA requirement	Average Speed of Answer of no more than 120 seconds **(Section 5.1.6.1, Appendix A, Draft Contract)**
Only 3.25% of calls were abandoned – exceeding SLA requirement	Abandonment rate of no more than 4% **(Section 5.1.6.3, Appendix A, Draft Contract)**
90.84% of calls answered in fewer than 30 seconds – exceeding SLA requirement	85% of calls answered in fewer than 30 seconds (**NCQA**)

Measures To Ensure Standards Are Met

To maintain our service level standards, we will use our Call Center Workforce Management Software to support a responsive, scalable staffing model. Based on years of call data analyses from affiliate health plans with similar populations, the software factors in call-type complexity, historical call duration, call patterns including seasonal variation, market maturity, and eligibility categories specific to the State to determine appropriate staffing, analyzing down to 30-minute increments when needed. This approach will result in effective staffing levels by notifying us of rapidly changing situations in volume/call duration, which enables us to dispatch Team Leads and other staff to back up CSRs if needed.

To ensure call quality and accuracy, our full-time Quality Specialists will audit CSR interactions using our Customer Service Evaluation audit tool integrated with our telephony system. The call monitoring software records CSR phone calls and the CSR's simultaneous use of desktop resources. Quality Specialists will monitor no fewer than 3% of calls for compliance with customer care guidelines, and they will provide immediate follow-up and coaching, as necessary. Monthly, CSR Supervisors will review audit results with each CSR. This industry best practice, as cited by the Call Center Optimization Forum, compares individual performance to goals in areas such as documentation, courtesy, and call quality. ***Our proposed approach to Quality Assurance for our call center mirrors an affiliate health plan, whose monthly CSR call audit average is routinely above 96%.***

We will use our call monitoring software and CSR performance report cards to maintain all call recordings for at least six months, make them available to DOM within five business days of a request, and create and submit quarterly audit reports for DOM per the requirements in Appendix A, Draft Contract. After each call, CSRs will determine Members' satisfaction with the call and document the responses in the CRM, including routing the Member to the Grievance Department if requested.

c. Accommodations for non-English speaking, hearing impaired, and visually impaired callers, including what languages will be available;

Equipping a call center with highly trained CSRs and resources will ensure that callers speaking languages other than English and callers with disabilities have equitable access to information and services in their own language, through requested accommodations, or their preferred modes of communication. Our IVR system, for example, will recognize pauses during a call and will automatically route the call to a CSR without the need for verbal responses or keypad entries, a call center best practice feature. Members may immediately reach a trained CSR by saying "agent." In addition, CSRs will note Member language needs in CRM, enabling future CSRs to promptly and appropriately assist Members in the future.

Non-English-Speaking Callers

Our IVR system will greet callers in English and Spanish and offers self-service options, such as verifying eligibility, in Spanish. For non-English speaking callers, our call center and 24-Hour NAL will offer, at no cost to Members, real-time phone and video interpreters through our language services partner with expertise in medical interpreting in over 200 languages and meets CMS, HIPAA, and ACA regulatory requirements. Upon request, CSRs will arrange for interpretation services for in-person medical appointments.

Callers who are Deaf or Hard of Hearing

We will prominently display the Mississippi Relay phone numbers on the Member ID Card, Member Handbook, our public website, and other Member materials. We will prepare our CSRs to properly handle relay calls, such as addressing the caller and not the interpreter, pausing periodically for a response before continuing to speak, and other call etiquette protocols. We will provide auxiliary aids upon request and at no cost, including but not limited to Teletypewriter, Telecommunications Device for the Deaf, Video Phones, or American Sign Language interpretation methods for the hearing impaired. Trained professionals will 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.

Callers who are Blind or Have Low Vision

CSRs will be available to read and explain Member materials by phone. In addition, our Community Health Workers (CHWs) will provide in-person assistance as needed or requested. We will offer printed materials in other formats upon request, such as Braille, large print (18-point font or larger), audio, accessible electronic formats, and other formats. We will make wellness, disease prevention, and essential administrative information available by podcast or audio playback on our health plan website, which adheres to Federal Section 508 standards and Web Accessibility Initiative guidelines for people with disabilities.

d. The process to ensure that Member calls pertaining to immediate medical needs are properly handled;

If our Members contact the call center with immediate medical needs, we will have processes and trained staff to assist them in the moment as well as identify additional supports for their longer-term needs.

IVR Call Handling Processes

Our IVR system will greet Members and direct them to dial "911" in an emergency. The IVR will then offer to connect Members with the 24-Hour NAL. During business hours, the IVR will provide Members with the

option of speaking live with a CSR.

Nurse Advice Line (NAL). For Members who connect with the NAL, trained, on-call nurses will assess and triage Members' immediate needs using nationally recognized and annually reviewed algorithms to determine the best level of care based on presenting symptoms. If a Member's condition appears emergent, NAL nurses warm transfer the Member to 911. Alternately, when the medical condition does not warrant emergency care per the protocols, the nurse will advise the member to seek urgent care, immediately contact the PCP, or schedule an appointment with the PCP the next business day.

CSR Call Handling Processes

We will provide the training, tools, and resources, such as DOM approved call center scripts, to help CSRs make appropriate decisions when assisting Members with immediate medical needs, for example:

- **Medical emergency**. CSRs will dial "911" with the Member on the line if they believe the Member's immediate medical needs constitute a medical emergency based on the prudent layperson standard. They will assist with explaining the emergency and engage a Care Management (CM) nurse.
- **Immediate medical needs**. If CSRs determine that Members' medical needs require immediate medical attention, they will warm transfer to a CM nurse, who will assess and triage Members' medical needs as described above in 24-Hour NAL.
- **Non-immediate medical needs**. If CSRs determine that Members' immediate medical needs do not require immediate medical attention, they will assist Members with finding Providers, explaining covered benefits, scheduling appointments, and other services aligned with the Members' needs. CSRs will warm transfer to a CM nurse if at any point during the call the Member indicates a medical need.

e. Training program for call center employees including cultural competency and Care Management;

A locally hired, locally based call center trainer will design a training program to prepare CSRs to respectfully serve Mississippians of all backgrounds and abilities in a culturally responsive manner. Our training program begins with an initial onboarding period followed by quarterly trainings. The program emphasizes operational proficiency, such as first call resolution, while providing CSRs with the training and tools to deliver concierge-quality customer service, as we describe below.

Overview of the Training Program

Our training program will begin with two weeks of interactive training using classroom instruction, role-playing, hands-on demonstrations, and interactive online modules focused on key knowledge and skills areas, such as:

- Knowledge of the MSCAN and CHIP programs, such as the transportation benefit for MSCAN Members and required copays for CHIP Members
- Skills-based training for appropriate decision-making in warm transferring Members to a Care Manager or the 24/7 BH/SUD or NAL lines
- Learning to engage Members in a culturally competent manner, and, through our Unconscious Bias training, remaining aware of implicit bias and its impact on health equity

Before advancing to servicing Member calls, CSRs must pass a written competency exam. CSRs will initially listen in on Member calls, progressing to Supervisor assisted calls, and, by building their knowledge base and skills, will begin to service calls unassisted. During the first 90 days after the initial training period, trainers will monitor for competency, accuracy, consistency, and appropriate use of all documentation and desktop tools. CSRs must maintain a 90% score in call quality performance. If their scores dip below this standard, Quality Specialists and trainers will provide refreshers and remedial training as needed to help CSRs reach and maintain the standard.

Overview of the Training Topics

The training program will be organized into broad topics consisting of knowledge acquisition and skills training. Below are samples, though not all, of the CSR training program topics:

- **Fundamentals**. Such as customer service tools, including active listening and use of the language services line; conflict resolution; review of internal departments and warm transfers, including interfacing with Care Management staff; arranging interpretation and communication support services;

ethics and confidentiality of Member information, including HIPAA; claims and prior authorizations; web tools and mobile apps; emergency management protocols; and other topics

- **Program information**. Including differences between MSCAN and CHIP benefits and services; appropriate service utilization; review of benefits, including self-direction; Member materials and education; functions of Care Management and other clinical programs and how Members can self-refer; Member Rights and Responsibilities; reporting Fraud, Waste, and Abuse; and other topics.
- **Job Functions**. Warm transfer protocols and escalating urgent or emergent medical or BH crisis calls; functions of the NAL and BH/SUD lines; helping Members select PCPs; how to explain the prior authorization process; impacts of health literacy on health inequities and CSRs' role in helping Members understand how to access care and practice self-care; using DOM approved interactive scripts during Member calls; and how to document a caller's satisfaction at call conclusion.
- **Cultural Competency**. Upon hire and annually, we will require all CSRs to complete training based on the Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). We will require disability sensitivity training, including the use of People-First Language, Americans with Disabilities Act, misconceptions about persons with physical and behavioral disabilities and those receiving government-sponsored health care, and how to accommodate specific communication needs. In addition, we will provide Unconscious Bias and health equity training. Annually, we will host trainings provided by Mississippi disability advocacy groups to provide staff with locally-focused disability sensitivity training.
- **Care Management (CM) Training**. Our call center training will include an in-depth review of all CM programs and functions including how Members can access and self-refer for CM services, such as our Maternal and Child Health or Diabetes Management Programs, and how Providers can refer Members for those services using CM referrals forms located on the Provider Portal.
- **SDOH Mini-Screen Training**. We will train CSRs to conduct SDOH Mini-Screens to identify Members with barriers and to search our Community Resource Support Database to provide access to community support services. For more complex SDOH, CSRs will refer Members to our CM staff to remove these barriers.

Continuous CSR Training

We will provide ongoing program training using our Call Center Learning Software. The software will deliver high-frequency, high-impact training reinforcement directly to our CSRs. The software enables us to effectively provide training to our CSRs monthly, quarterly, or ad hoc basis and deliver "Late Breaking News" topics regarding Medicaid changes and requirements, State Health Plan Amendments, Administrative Filings, COVID-19 pandemic updates, and other topics. Ad hoc topics can be delivered in a ticker-tape format running at the bottom of our CSRs' screens, which they can click to learn more and ensure their understanding. In addition, the software facilitates maintaining logs of staff completing the trainings, topics covered, and the results of any post-course assessments for submission to DOM quarterly as required by Appendix A, Draft Contract.

f. How the Offeror will address service interruption through fail-over to an alternative site, redundant connectivity, and/or other options to mitigate downtime;

We will employ Continuity of Operations and Disaster Recovery (DR) planning best practices to anticipate and respond to service interruptions caused by disasters and emergency conditions on time. Our hardware, software, and processes are engineered to ensure high availability of all our applications, especially those supporting our call center operations. With our centralized, enterprise-wide business continuity (BC) management organization, we will maintain and oversee fully tested continuity of operations and DR plans outlining our approach to responding to call center service interruptions. Our Compliance Officer will be responsible for providing our plan to DOM for approval 60 days before the Operations Start Date.

Continuity of Operations in Action

Due to our robust continuity and DR Plans, our affiliate health plans maintained normal operating service levels before and during the COVID-19 pandemic, at no point dropping any calls even as our CSRs transitioned to work from home status.

Mitigating Downtime

To mitigate service interruptions, call center downtime, and avoid data loss, we will operate two geographically

separate enterprise data centers where all our call center data will be housed. A fully redundant wide area network will connect these data centers. We will expand to three data centers for enhanced continuity and service resiliency for our operations in Mississippi. As data is created in our production environments, it will be immediately replicated in the associated recovery data center. In an event requiring a failover from the primary to the alternate site, such as a power failure or outage, we will leverage this backup replicated data and infrastructure located in the alternate site to ensure our telephony systems can operate for a minimum of eight hours at full capacity with no interruption of data collection. Our Compliance Officer will be responsible for notifying DOM immediately when our phone systems are on an alternative power source or are inoperative. This architecture provides our critical voice networking operations the necessary resilience and service stability to quickly resume essential functions within established recovery time objectives.

Call Center Fail-Over Capability

In the event of service disruption or disaster, all business functions that rely on our telecommunications system have top priority – specifically our call centers. Like our affiliate health plans nationwide, our Mississippi call center will be engineered with several layers of redundancy, allowing for immediate, automated rerouting of inbound calls to our out-of-state Regional Service Center or other affiliates. This will ensure our Mississippi Members do not experience a disruption in service or access to care. Our Regional Service Center staff will have access to the Mississippi knowledge base, including DOM's approved scripts, ***guaranteeing equally high-quality service levels and consistently accurate information to callers as our Mississippi-based CSRs***. Should we have a system outage and cannot access information during Member calls, we will document call information manually, enter the information into the system when it becomes available, and follow up with each Member to ensure call resolution to their satisfaction.

g. For behavioral health/substance use disorder, how the Offeror will provide crisis intervention and other telephone access twenty-four (24) hours per day, seven (7) days per week;

Through our toll-free BH/SUD line we will provide crisis intervention 24 hours a day, 7 days a week, and 365 days a year to connect Members to the most appropriate level of care based on the presenting situation. BH clinical personnel will assess, triage, and address Members' immediate needs for safe and timely disposition of BH/SUD emergencies and identify longer-term supports. Calls to the BH/SUD line will always receive a live answer due to the number of redundancies in place, including overflow staff and additional BH clinical personnel during periods of high call volume.

Since CSRs may be the initial touchpoint for Members in crisis who reach the call center, we will train CSRs on BH crisis procedures and provide tools and resources to strengthen their skills in recognizing crisis calls and handling decisions. For example, CSRs will identify BH crises, such as Members using specific words and phrases suggesting potential harm to self or others and their tone of voice and other indicators of severe emotional distress. CSRs will warm transfer callers to our internal BH Crisis Team and stay with the Member until the clinician joins the call. The BH clinician will assess, triage, and address the Members' immediate needs, such as calling emergency services to dispatch an ambulance to the Member's location, directing the Member to the ED, or other BH supports consistent with Members' needs.

4.2.2.1.B Member Services Call Center

2. Describe the Offeror's proposed automatic call distribution (ACD) system and its capabilities and capacities.

Automatic Call Distribution (ACD) System

Our Telephony Solution will provide Automatic Call Distribution (ACD) across our Member call queues. Integrated with our Telephony Solution, our Call Manager Software will track and report information processed through the ACD, enabling seamless and efficient call answering, monitoring, and reporting capabilities. Our telecommunications network is engineered with several layers of redundancy, allowing for immediate, automated rerouting of inbound calls in an enterprise ACD to our Regional Service Center or other affiliates if the local Mississippi Call Center is receiving extremely high call volume or needs to close for an emergency. Staff at these locations will be trained and able to take on our responsibilities instantly to handle call center operations – allowing Members to have continuously available call services. Further, we will integrate technology within our Telephony Solution to allow for skills-based routing to our Customer Service Representatives

Post-Call Survey Results

An affiliate health plan's 2021 Member Services post-call survey results indicated:

- 99.2% of callers felt they were treated with courtesy and respect
- 95.6% of callers said our affiliate was able to resolve their need during the call

(CSRs). Powered by machine learning, this advanced routing functionality will ensure that Members will interact with CSRs who are ready to resolve the Member's particular issue or concern.

Our ACD system will allow us to respond promptly to Member calls, within one ring and with an average hold time before speaking to a live representative, never exceeding two minutes. After normal business hours, our call routing system will prompt the Member to leave a voice mail message or connect with the Nurse Advice Line or Behavioral Health/Substance Use Disorder (BH/SUD) crisis line representative. If the Member chooses to speak to a representative, our ACD will connect them. Should Members choose to leave a message, our automated answering system has adequate capacity to receive all messages, with CSRs returning these calls no later than the following business day. We will also provide Members with automatic callback functionality. The system will provide instructions on what to do in case of emergency, and information about how to report fraud, waste, and abuse.

Interactive Voice Response (IVR)

Our Customer Relationship Management (CRM) System will be integrated with our Telephony Solution for Interactive Voice Response (IVR) support, allowing self-service options and live-person assistance for Members. Upon receiving a call, our IVR will greet callers and offer push-button and voice-activated prompts in English and Spanish or ask the Member if they require assistance in a language other than English. Members may use these prompts to be routed to other areas such as Care management or engage in self-service features such as selecting their Primary Care Provider (PCP) assignment or replacing an ID card. After being asked about the need for language assistance, the IVR will ask if the Member is experiencing an urgent behavioral health crisis and offer to route them directly to our BH/SUD crisis line if needed. Callers will be advised that we use Call Monitoring Software to monitor and record calls for quality assurance purposes. This software will enable us to record and aggregate all audio calls to produce reports as required in the MSCAN and CHIP Reporting Manuals and as requested by DOM. In addition to call recording, our system will have the capability for phonetics-based speech analytics, which will detect keywords and phrases, as well as silence. Our Telephony Solution will produce historical reports so management staff can analyze trends that allow us to maintain service levels.

The IVR will enable Members to self-identify by entering their Medicaid ID and DOB, or the last four digits of their social security number. Through self-authentication of two HIPAA validation points within the IVR, our CSRs will use this information made available via Computer Telephone Integration (CTI) technology and CRM. CTI will automatically share the two pieces of HIPAA information with the agent and check it against what is stored in CRM to verify the caller's identity. The IVR automatic caller authentication means callers will not have to perform additional HIPAA validation steps once they speak to a CSR, allowing agents to begin the service discussion and meet the caller's needs faster.

4.2.2.1.C Member Handbook

1. Describe how the Offeror’s Member Handbook will inform Members about the process for accessing physical and behavioral health/substance use disorder services.

Our ***separate Member Handbooks, one for MSCAN Members and one for CHIP Members***, will conform with all requirements outlined in Section 5.4 of Appendix A, Draft Contract, including being written at the third-grade reading level and available in other languages upon request. The handbooks will promote the importance of accessing the right care at the right time and encourage Members and their parents/guardians to take charge of their overall health care. The handbooks will include reference charts of all Covered Services for each population with categories including but not limited to physical health (PH), behavioral health/substance use disorder (BH/SUD) services, vision, dental, hearing, family planning, transportation (MSCAN only), and lists any limitations, exclusions or prior authorizations required. The handbooks will outline the steps for Primary Care Provider (PCP) selection and obtaining personal assistance, if necessary, from our CSRs to complete the steps. We will explain the PCP and Patient Centered Medical Home’s (PCMH) role, responsibilities, and list appropriate appointment scheduling standards. The handbooks will highlight EPSDT/Well-Child periodicity tables and encourage families to obtain these important services for their children.

Emergency Services

Our Member Handbook will explain how to access emergency care and will provide examples to help Members distinguish between non-emergent situations, such as colds, diaper rash, and needing medication, and emergent

situations such as heart attack symptoms and trouble breathing. We inform Members that seeking emergency care does not require prior authorization and explain the function of post-stabilization services and emergency transportation. Our handbook will include information about contacting the 24-Hour NAL and how to find the phone number on their ID cards.

PCP/PCMH Services

The handbooks will inform Members about the importance of PCP visits, establishing a medical home, and how to access benefits and services through the PCP, such as preventive services to detect emerging health issues. To promote early PCP visits and establish relationships, the handbooks include a special call-out encouraging Members to make appointments with PCPs within 90 days of enrolling with our health plan.

Other sections will reinforce to Members the important role of their PCP in all ongoing care, such as when prior authorizations or urgent care services are needed as well as a PCP's responsibilities, including:

- Timely access to medically necessary services
- Following up with other Providers serving Members to avoid care gaps and ensure integrated care
- Updating Members' medical records, including care received from specialists
- Being available to Members 24/7
- Educating Members about advanced directives and how PCPs can file advanced directives in Members' medical records

Behavioral Health (BH) as an Integrated Covered Service

The handbooks will include a stand-alone section on BH with information about obtaining services, not needing a PCP referral, and how we will help manage their care by integrating BH services with support groups, integrated Care management, and other Provider specialties to ensure an integrated, holistic approach to Member care. We will provide examples of feelings of emotional distress that may require care, such as:

- Can't cope with daily life
- Feels very sad, stressed, or worried
- Is not sleeping or eating well
- Wants to hurt themselves or others or has thoughts about hurting themselves
- Is troubled by strange thoughts (such as hearing voices)
- Is having problems at home or school

These examples will assist Members with recognizing symptoms requiring intervention and who to call for appointments. We will provide a BH checklist of symptoms to parents/guardians to help them know when to seek BH services for children without delay. We will inform Members to contact their PCPs who will help them determine the level of services needed to address the symptoms, and, as BH will be integrated into Members' total care, treat Members within the context of their overall health. We will remind Members that BH services do not require a referral and that they can access BH crisis services 24/7 by calling our toll-free number.

SUD Services

The benefits grids in the handbooks will inform MSCAN and CHIP Members that SUD services such as inpatient and outpatient care are covered benefits. We will include preventive guidelines as well as information about annual screenings for alcohol and substance use, and the following information:

- Covered SUD services such as detoxification treatment, multi-systemic family support, and crisis intervention
- Education and community resource information about Member rights and responsibilities when seeking treatment for substance use and mental health, emphasizing Members' rights to be treated with respect, dignity, and cultural sensitivity
- Education about the importance of obtaining preventive services for conditions that may arise from substance use, such as dental and vision services
- Education about supportive services such as Alcoholics Anonymous, Al-Anon (support for family/friends of alcoholics), and Narcotics Anonymous offered in the community
- Education about obtaining substance use treatment in other settings such as urgent care and accessing care within hospital settings.

COVID-19 Education

Leveraging the experience our affiliate health plans accrued over the past two years with educating Members about COVID-19, we will include a section in the handbooks that will include the following topics:

Overcoming vaccine hesitancy and the importance of COVID-19 vaccinations and boosters

- Information about COVID-19 testing sites
- Obtaining face masks and other PPEs
- Contacting the PCP regarding positive results
- How to access care during a public health emergency, such as via telehealth
- Where to obtain support during a public health emergency for SDOH impacts, such as housing and food

2. Describe how the Offeror's Member Handbook will inform Members about the Offeror's Care Management System.

Our separate Member Handbooks, one for MSCAN Members and one for CHIP Members, will conform with all requirements set forth in Section 5.4 of Appendix A, Draft Contract. Each handbook will feature a prominently placed, stand-alone Care Management (CM) section providing information about the functions of CM and how to access CM services. This section will explain what CM is and that CM may be helpful for Members with special needs or with disabilities. Members will learn that Care Managers can support them with their health by providing services such as arranging for home health, ordering medical supplies, and coordinating appointments with Providers. Members will see a listing of CM programs that they may access, such as:

- Maternal Health Program
- Asthma
- Diabetes
- HIV/AIDS
- Sickle Cell
- Foster Care
- Weight Management
- Cancer
- Behavioral Health
- Substance Use Disorders
- Autism
- Organ Transplant

This handbook section will further inform Members that our Care Managers will coordinate care with Social Services Specialists if Members are experiencing barriers to care due to SDOH needs. Finally, this section will inform Members to contact Member Services at our toll-free number and ask to speak with a Care Manager if they want to learn more about CM services or wish to self-refer.

4.2.2.1.D Website and Mobile Application

1. Describe how the Offeror will ensure that Members are well-informed about the existence and functions of its Member Web Portal and Mobile Application.

Our goal is to ensure Members are well-equipped with the information, tools, and resources they need, in the manner they prefer, to appropriately access services and promote wellness. Members can receive incentives for engaging in activities on the Member Portal and Mobile Application, such as completing a Health Risk Screening (HRS).

Easy-to-Use Member Portal

In 2021, 9 out of 10 Members in an affiliate market found our Member Portal easy to use.

Informing Members About the Web Portal and Mobile Application

We have numerous points of education where Members can learn about the Member Portal and Mobile Application and their corresponding capabilities including:

- **New Member Welcome**. Within 30 days of being assigned to our health plan we will welcome Members with a New Member Welcome Call and E-mail (where available) during which we will educate Members about resources and functions available on the public website, Member Portal, and Mobile Application. We will also conduct an in-person visit for all new Members within the first 90 days.
- **New Member Welcome Packet**. In addition to the Welcome Call, we will send all new Members a New Member Welcome Packet. Our packet will include technology FAQ Flyers with easy-to-follow tutorials about how to access, and the functions of our technologies, including the Member Portal and Mobile Application. We will also provide Quick Response (QR) codes to lead members directly to a variety of technology resources (both written and audio) on our website.
- **Customer Service Interactions.** Our Customer Services Representatives will be trained to speak to Members about the public website and Member Portal during every call and walk Members through any questions they may have, such as how to earn member incentives and access their rewards or how to download the Mobile Application and create a Portal account.
- **Video Library**. To ensure information is accessible for Members of all literacy levels, we will populate a

video library with various webinars regarding frequently asked questions, including how to create a Portal account and how to download the Mobile Application.

- **In person events.** We prioritize meeting Members where they are in the community and one-on-one settings. Our staff will take advantage of these in person interactions to educate Members about technology, such as the Member Portal. We will utilize our Member Advisory Committee meetings to bring Members together to identify any barriers to learning about our technology offerings.
- **On-Demand Support**. We are enhancing communications to meet Members where they are by implementing a Virtual Assistant on the public website with intelligent and natural communication capabilities. Through the Virtual Assistant, we will offer real-time help for Members navigating the public website. The Virtual Assistant can help Members sign up for their secure Member Portal account, find and change their PCP, and other self-service functions.

2. Describe any functions beyond those required in Appendix A, Draft Contract, that the Offeror will make available to Members through its website and Mobile Application (if any).

Complementary to our high-touch approach, we will offer Members a variety of resources through the public website, secure web portals, and Mobile Application. Based on our experience in affiliate markets, we know that we can meet or exceed requirements stated in Appendix A, Draft Contract Section 5.8.3 and 5.8.3.1. We design our mobile-optimized public website, secure web portals, and Mobile Application for seamless integration of accessible content with navigation attuned to and authorized for specific user types: Members and caregivers, Providers, and DOM. Our secure web portals and Mobile Application are integrated with the enterprise data warehouse so that information is updated at least every 24 hours and is coming from and going to one source. Our website and portals adhere to Federal Section 508 standards and Web Accessibility Initiative guidelines for people with disabilities. We will prioritize the creation of channels to receive Member insights about our web and mobile offerings in support of continuous improvement and innovation. Our website and portals will be monitored and tested monthly to ensure a quality Member experience.

Public Website Functionality

- **Video Library**. As stated in response to 4.2.2.1.D.1 of the RFQ, we will provide information in accessible formats for those of all literacy levels by offering a video library where Members can learn about FAQs such as how to complete the HRS on the Member Portal and when it is appropriate the visit the ED versus a PCP.
- **Virtual Assistant**. We will implement a virtual assistant to support Members on-demand with real-time assistance navigating the public website as detailed above in 4.2.2.1.D.1.

Member Mobile Application Functionality

Our Member Mobile Application will be available through Google Play and the Apple App Store. We will provide additional capabilities on our Member Portal that include:

- **Digital Identification (ID) Card**. Members will be able to download their ID card to their mobile wallet for use in addition to having a self-service print option.
- **Geographic Provider and Facility Searches**. Within our online Provider Directory, geographic searches will enable Members to locate Providers, including facilities such as urgent care centers and hospitals nearest to them.
- **Member Incentives**. Members can view their current incentives and identify opportunities to earn additional incentive dollars, such as completing the HRS.
- **Pregnancy Program**. We will link to our award-winning Maternal and Child Health Program where Members can access pregnancy resources, including podcasts and a countdown to delivery tracker.

Member Portal Functionality

For those who do not use Mobile Applications, our Member Portal is mobile-optimized and can be accessed on a smartphone through web browsers such as Chrome and Safari. All features of the Member Mobile Application are available on the Member Portal. Additional features of the Member Portal include:

- **G&A Submission**. In addition to finding details about the Grievance and Appeals process, Members will be able to submit Grievances and Appeals through the Portal.
- **Contact Information.** Members will be able to quickly identify their PCP's contact information, the BH/SUD Crisis Line, as well as with the 24-Hour Nurse Advice Line for immediate assistance.

4.2.2.1.E Member Education and Communication

1. Describe what methods the Offeror will use to inform Members of the functions of the Member services call center and encourage use.

Table 4.2.2.1.E.1 provides the numerous methods we will use to inform Members about the call center and encourage use:

Table 4.2.2.1.E.1: Methods To Inform Members About The Call Center And Encourage Use

Methods	Examples
Member Materials	• ***New Member materials*** mailed within 14 days of enrollment will include our toll-free Member Services call center number prominently appearing on the Member ID card, the Welcome Letter, and the Member Handbook. We will inform Members to call the toll-free number to request a new Member ID, make an appointment with a PCP, find an urgent care center, speak to a registered nurse or Care Manager about health-related or SDOH needs, and other functions CSRs can assist with. • ***Mailed appointment reminders*** will inform Members to contact the call center to schedule Provider visits • ***Educational mailings*** about our Maternity Program, for example, will request that pregnant Members contact our call center to arrange for covered benefits and services
Telephonic Outreach	• ***New Member Welcome calls*** will be placed within 30 days of enrollment and will inform Members to call the toll-free number for assistance with PCP selection, completing the Health Risk Screening, language needs, and other functions • ***Annual screenings appointment reminders*** will be conducted 30 to 45 days before screenings are due will inform Members to contact the call center for assistance with appointment scheduling • ***Inbound calls*** from Members will enable us to inform about the call center's scope of functions. In our affiliate health plans, Members develop rapport with specific CSRs and will request them by name for assistance when they contact the call center. • ***We will furnish smartphones*** to Members in Care Management who do not qualify for SafeLink with unlimited talk/text to provide Members with access to the call center or direct dial to their Care Manager. We will program the phone with one-touch dialing into our SDOH Help Line for assistance with SDOH barriers to care.
In-Person	• ***Home visits*** by CHWs will support Members with disabilities or chronic conditions via 3-way calling with the call center to educate Members on how to request support and learn to self-advocate • ***New Member Welcome Visits*** during the first 90 days of enrollment will provide another opportunity to help Members locate important health plan numbers, like the call center • ***Member Education workshop*** materials will prominently display the toll-free call center number informing Members about the scope of functions they can access, such as scheduling a ride for an office visit (MSCAN Members) • ***Community Events, such as Back to School events and health fairs*** will include resource tables with educational materials informing Members to contact the call center for information about immunization schedules, including COVID-19 vaccine information, and other assistance
Digital	• ***The public website, Member Portal, Mobile Application, and Facebook page*** will display our toll-free number. CSRs will assist Members with navigating the various digital platforms including showing Members how to reset a password. • ***New Member Welcome texts*** will be sent to our Members for a digital onboarding experience to our CCO. The texts will include hyperlinks to a New Member Welcome landing page which will include the toll-free call center number for Members who wish to transition to live assistance from a CSR.

2. Describe what methods the Offeror will use to inform Member of the functions of Care Management (including the ability to self-refer) and encourage use.

The goal of our person-centered, CM program is to help Members achieve the highest possible levels of wellness and quality of life. We accomplish this through a broad array of CM functions and services. To bring these functions within reach of Members who need or can benefit from CM, we will employ numerous methods to inform Members about the functions of CM presented in **Table 4.2.2.1.E.2** below.

Table 4.2.2.1.E.2: Methods to Inform Members About Care Management and Encourage Use

Methods	Examples
Member Materials	• ***The Member Handbook,*** provided to all new Members upon enrollment and available on our Member Portal, informs Members about the availability of CM services and functions and how to self-refer by contacting a Care Manager at our toll-free call center number. The handbook, and all Member materials, will be at the 3rd grade reading level and available in any requested language and format. • ***Educational mailings*** will be sent to medium to high-risk Members to inform them about the functions of Care Management, including CM programs aligned with their needs, such as the Maternal Health Program or BH/SUD programs, and how to contact a Care Manager to learn more and enroll. • ***Quarterly Member Newsletters*** will provide information about health promotion and disease prevention including how to contact a Care Manager to enroll in CM, if appropriate.

Telephonic Outreach	• ***New Member Welcome calls*** within 30 days of enrollment encourage Members to complete the HRS, inform the Member of how to access services and benefits, including CM services, and how to contact the CM Team if they have concerns about their health • ***Inbound calls*** from Members self-referring for support for their health conditions will be connected to the CM Team for an assessment, education about the functions of CM, and possible enrollment in the program. Members will be able to bypass the call center and contact Care Managers directly. • ***Expanded phone access program*** with unlimited talk/text provide Members in CM who do not qualify for Safelink to give prompt access to their Care Managers, Providers, and our SDOH Help Line for assistance with SDOH barriers to care.
In-Person	• **New Member Welcome Visits** during the first 90 days of enrollment will provide an opportunity to teach Members about CM programs offered by the health plan • ***Home visits*** by regionally-based culturally adept Care Managers to Members with high HRS/CHA scores, recent hospital admissions, ER visits, and/or other indications of a change in condition to determine if they need CM services; if the Member is in CM, we will determine if a re-assessment is necessary or if their care plan needs updating. • ***Member Education workshops*** will include topics about specific conditions (identified by DOM) and provide information about the functions of CM to support Members with these conditions and how to self-refer by contacting a Care Manager at our toll-free number
Digital	• ***The public website, Member Portal, and Mobile Application*** inform Members how to obtain information about Care Management.
Providers	• ***Providers will educate Members*** about the functions of CM and will use CM referral forms located on our Provider Portal to easily refer Members
Community Partners	• We will collaborate with trusted messengers to assist us with informing Members about CM services.

3. Describe how the Offeror will develop and maintain a comprehensive, evidence-based health education program for Members, including:
a. An overview of the program, including accountabilities and proposed activities;

We will comply with the requirements in Section 5.2 of Appendix A, Draft Contract, and will maintain annual health education and prevention work plans for MSCAN and CHIP Members. We will submit these work plans, with quarterly updates, to DOM for approval to be reviewed and approved within 30 calendar days. All staff will be responsible for providing health education to Members at every touchpoint. Our Vice President of Population Health and Clinical Operations (VP PHCO) will ultimately be responsible for the development and implementation of our comprehensive, evidence-based health education program. The Chief Medical Director (CMD) will maintain clinical oversight for all related Member education activities, and the Quality Management (QM) team will monitor outcomes. In partnership with the VP PHCO, our Director of Health Equity will oversee the development and implementation of health literacy activities.

Our Health Education and Health Literacy Plan

To drive measurable, sustainable progress in improving Members' health, we will develop a Health Education and Literacy Plan aimed at strengthening Members' understanding of their health and health care. Evidence shows low health literacy may be a primary barrier to accessing care and a primary driver of health disparities. Beyond ensuring all materials are at a 3rd grade reading level, we will create ***health literacy initiatives to make health education more accessible***. Our plan includes:

- Engaging a Mississippi firm to conduct a health literacy review of Member education materials using evidence-based health literacy principles and recommend how to align our materials and health education messages with the target populations.
- Engaging CBOs to provide health literacy training for Member-facing staff customized to local communities.
- Designating a Health Literacy Advocate to champion health literacy within our CCO by conducting trainings, advising on material development, and leading activities during Health Literacy Month in October.
- Leveraging our Employee Inclusion Groups (EIGs) which are formed around common affinities or personal identities, such as African American, Asian, Hispanic, LGBTQ+, Persons with Disabilities, and other groups. They will support our health literacy focus by providing insights gained from shared experiences to effectively engage our Members.
- Soliciting input about health literacy initiatives from our Member Advisory Committee and Community Impact Councils. Members from one of our affiliate health plan's Advisory Committees formulated a set of guiding principles to help us be more effective in engaging and educating Members, presented **in Table 4.2.2.1.E.3.a.1** below.

Table 4.2.2.1.E.3.a.1 Member Education and Health Literacy

Objectives	Guiding Principles
Develop culturally accessible materials	Language and images will reflect Mississippi Members' communities and cultures
Ensure an appropriate perspective	Perspective will be person-to-person as if we were having a conversation with an MSCAN/CHIP Member
Include feasible calls to action	What we will ask Members to do will be realistic and attainable
Ensure a respectful tone	While meeting reading level requirements, we will avoid sounding condescending
Include Member point-of-view	Include Care Managers as they have deep insights into communicating effectively with Members and can help convey our Members' point-of-view
Ensure the Member's voice is heard	Members will participate in the Health Literacy Committee to advise us on our approach and strategies

Overview of Proposed Member Health Education Activities

To help build communities of Mississippians that understand, value, and prioritize their health, ***we will help Members understand how to navigate the health care system so they can access benefits and services to prevent the onset of illness as well as to learn to practice self-care***. We will use an innovative Multi-Cultural Toolkit to engage Black and Hispanic Members whose understanding of accessing care, such as ED visits for low acuity needs, may be influenced by faith and community-related health beliefs. Our culturally aware approach will honor Members' beliefs while educating them on more appropriate settings for care, such as urgent care centers or PCP office visits. We will organize health education topics across three broad categories:

- **Navigating Managed Care**, which promotes health literacy at the systems level to help Members learn to access benefits and services and self-advocate for their health and the health of their families. Topics will include, but not be limited to the role of PCPs and how to select PCPs, self-referring to CM, the prior authorization process, Grievances and Appeals, Member rights and responsibilities, requesting interpreters, and translated materials, and how to access SDOH support.
- **Preventive Care**, will educate Members about the importance of regular PCP visits to maintain their health, the health of their families, and prevent the onset of disease. Topics will include, but not be limited to annual EPSDT/Well-Child visits; immunization schedules, including flu shots and COVID-19 vaccinations/boosters; and early identification of pregnancy and prenatal care through our Maternal and Child Health program.
- **Self-Care**, will empower Members to self-manage conditions such as asthma, diabetes, and other disease states so they can make good choices about their long-term health. Condition-specific topics will include but not be limited to asthma and diabetes. Broader Self-Care topics will include self-referring to CM, using tools such as a Medication Planner to track medications and report reactions to Providers, and using a Personal Health Record booklet to record needed post-discharge services.

Ask Me 3 Technique

We will offer an innovative, evidence-based approach to strengthen Members' understanding of how to engage their Providers. The **Ask Me 3® technique** will prompt Members to ask three specific questions during Provider visits:

1) "What is my main problem"?,
2) "What do I need to do"?
3) "Why is it important to me"?

This innovation will help increase Members' understanding of their health and enable Providers to become active participants in increasing Members' health literacy.

Because health education information resonates with individual Members differently, we will deliver health education through a well-rounded outreach campaign consisting of mailings, phone calls, home visits, and an innovative digital engagement initiative described below. These activities, provided in **Table 4.2.2.1.E.3.a.2**, will begin upon enrollment and continue throughout Members' enrollment span with our CCO.

Table 4.2.2.1.E.3.a.2 Proposed Member Education Activities

Proposed Activities	Timeframe/Cadence
New Member Welcome Packet	Within 14 days of enrollment
New Member Welcome Calls	Within 30 days of enrollment
PCP Appointment Scheduling	Within 90 days of enrollment
Member Newsletters	Quarterly
Annual Prevention Appointment Reminders	30-45 days before appointments
Written/Telephonic Educational Interventions: Triggered by changes in condition, ED overuse, medication/treatment plan non-adherence, etc.	Episodic
Home Visits: Conduct health assessments, assist with DME, change in condition, upon Member request, etc.	Ongoing

Community Events: Health fairs, Back-to-School events, etc.	Ongoing and seasonal
Baby Showers	Ongoing
Social Media	On Demand

Digital Engagement. We will capitalize on Members' increasing tendency to access digital information to inform their everyday decisions. For example, with DOM approval, we will send welcome texts to our Members' mobile devices with hyperlinks to a New Member Welcome page featuring a YouTube video with community leaders encouraging Members to make their first PCP visit. Our welcome page will also include a video library containing educational webinars about the role of PCPs and PCP selection, as well as educating Members about the numerous self-service functions via the secure Member Portal. Driving Members to digital information enables them to acquire health care knowledge via a multi-media experience, which, for many Members, is their preferred method, especially among younger Members and families.

Community-based Activities. Our health education program will include community-based activities to engage Members where they live, work, and worship. Our community-based approach, detailed in Section 4.3.6 of our response, will align with the requirements outlined in Section 8.10.8 Appendix A, Draft Contract, to develop the campaigns with stakeholder input. We will collaborate with community-anchored partners whom Members trust for information to will help bridge Members to care. Examples include, but are not limited to, the following programmatic activities:

Healthy Lifestyles Program. Our community-based Healthy Lifestyles Program will provide education and outreach activities that promote healthy lifestyles, such as the importance of exercise and disease prevention, and will include healthy cooking demonstrations. The Program will consist of the components contained in **Table 4.2.2.1E.3.a.3** below.

Table 4.2.2.1.E.3.a.3: Healthy Lifestyles Program Components

Component	Description
Healthy Schools	We will use our children's books to educate children about bullying, asthma, diabetes, healthy eating, and smoking.
Healthy Adolescents	Our health education books for adolescents will include a book series focusing on issues such as driving, pregnancy, drugs, health, bullying, asthma, sexually transmitted diseases, and healthy choices.
Healthy Homes	This initiative will assist Members living in low-income or public housing to identify and address health hazards in the home, particularly lead. We will partner with public housing departments in cities across the State to conduct these activities.
Healthy Congregations	This program will bring health education to faith-based organizations such as churches and will offer attendees preventive screening services such as blood pressure checks, body mass index measures, glucose, or cholesterol testing.

Increasing Health Literacy Through Workforce Development. 49% of adults without a high school degree had the lowest level of health literacy compared to 15% who had a high school diploma and 3% with a bachelor's degree. We will offer a workforce development program in partnership with Mississippi community colleges and the Mississippi Department of Employment Security WIN Job Centers that includes education supports for Members to obtain their General Education Degrees.

Member Education Workshops. We are committed to collaborating with DOM to organize a minimum of 10 health education workshops targeting MSCAN Members and 10 targeting CHIP Members. We will submit our workshop plans by January 1 of each year. Our Senior Director of Marketing and Communications will be the accountable owner of these workshops and serve as our liaison with DOM to plan, execute, and evaluate their success. We will use a multi-media approach to deliver health education on the topics that are important to DOM and our Members. We will conduct demonstrations showing Members how to navigate our public website and secure Member Portal to access benefits and services. To continually align the workshops with Members' needs, we will administer a survey asking Members to evaluate the workshops and to propose topics of interest.

Partnering With Providers. We will distribute and promote Provider use of our toolkit "Help Your Patients Understand Their Health and Health Care" which aligns with Culturally and Linguistically Appropriate Services (CLAS) standards and trains on how to use plain language to improve patient adherence and the impact of culture on how Members interact with the health care system. We will offer CEUs for trainings related to effective Member-Provider communication. We will leverage the Member-Provider relationship to better understand Member needs and literacy levels and will deliver key programs and messages.

b. The Offeror's rationale for selecting areas of focus;

Our comprehensive Member education program will focus on health literacy and disease states that are prevalent in Mississippi. We will focus on these areas to align with DOM's priorities, to drive positive health outcomes, and to bring to bear our affiliates' experience with making progress on these issues.

Health Literacy. Our affiliate health plans who have made health literacy a pillar of their Member education program have reported improved health outcomes and corresponding reductions in health disparities. Member survey results from affiliate health plans corroborate that Members will engage in their care if they understand health information materials. Members at an affiliate health plan which achieved a 99% Member satisfaction rate for its Care Management programs stated that they understood the information provided to them and that their Care Managers communicated effectively with them. The same affiliate reported the following reductions in health disparities, correlating the link between health literacy and health disparity, for example:

- **HbA1c Testing**: A 70% reduction in disparity from 2019-2020, nearly eliminating the disparity for this measure between Black Members (84.7% adherence) and White Members (84.8% adherence).
- **Asthma Control**: Complete elimination of the disparity for this measure between 2019 and 2020, with 71% of Black Members and 69% of White Members adherent to this measure.
- **Postpartum care**: 50% reduction in disparity.

Infant Mortality. Mississippi ranks near the top of all States in infant mortality rates with 8.6 deaths per 1,000 births exceeding the national average of 5.7[15]. An affiliate health plan's focus on early engagement of pregnant Members drove an improvement of 5.37 percentage points in Timeliness of Prenatal Care to 96.35%, which exceeded the 75th National Percentile.

Asthma. The asthma rates in Mississippi are 9.9%, exceeding the national average of 7.8%[16]. An affiliate health plan's focus on educating Members about asthma self-management reported an improvement of 7.92 percentage points in the HEDIS measure, Medication Management for People with Asthma (MMA), which exceeded the 75th National Percentile.

Diabetes. Mississippi has the third highest rate of diabetes in the country at 13.6%[17] with Tippah County having the highest rate of all counties in the nation[18]. An affiliate health plan's comprehensive Member education approach to diabetes resulted in a 55% improvement in Comprehensive Diabetes Care – Poor HbA1c Control.

c. How the Offeror will ensure that materials are at a third (3rd) grade reading level;

We will publish Member education and communication materials at a 3rd grade reading level as validated by the Flesch-Kincaid Readability Test. In addition, we will translate the directory to any language a Member requests, or provide in an alternative format such as Braille, large print, audio, accessible electronic formats, and other formats. Our Senior Director of Marketing and Communications will certify and document compliance with the required reading level when submitting materials for DOM approval. For Members with low literacy, our CSRs will read materials over the phone in plain language, substituting medical terminology with words and expressions Members can comprehend.

d. The language alternatives available to non-English speakers/readers; and,

In addition to producing materials in English, we will publish and have readily available Member materials in prevalent non-English languages meeting the 5% threshold in compliance with DOM's Limited English Proficiency Plan and State and Federal law. In addition, we will provide interpreters trained in over 200 languages, including American Sign Language (ASL), through our ISO-certified, language interpretation services partner to support all aspects of Members' care, including collecting medical history and providing health education. We will be deliberate in seeking to hire bilingual staff to support Members speaking non-English languages. All Member materials, including our website, will inform Members how to request

[15]America's Health Rankings analysis of CDC WONDER, Linked Birth/Infant Death Files, United Health Foundation, AmericasHealthRankings.org, Accessed 2022.

[16] "Most Recent Asthma State Data." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 30 Mar. 2021, https://www.cdc.gov/asthma/most_recent_data_states.htm.

[17] "Diabetes Prevention and Control." Diabetes - Mississippi State Department of Health, Mississippi State Department of Health, 28 Mar. 2018, https://msdh.ms.gov/msdhsite/_static/43,0,296.html#:~:text=In%202016%2C%20Mississippi%20ranked%20first,deaths%20in%20Mississippi%20in%202016.

[18]Jaglois, Jessica. "Investigators: Mississippi County Has Highest Rate of Diabetes in the US." Https://Www.actionnews5.Com, Action News 5, 22 Apr. 2021, https://www.actionnews5.com/2021/04/22/investigators-mississippi-county-has-highest-rate-diabetes-us/.

translations for materials and interpreters for live conversations.

e. How Members who are visually and/or hearing impaired will be accommodated.

Community Health Workers (CHWs) will provide in-person assistance for Members who are visually and/or hearing impaired to ensure equitable delivery of Member education and communication, including through the use of American Sign Language translators.

Visual Impairments. Customer Service Representatives will always be available to read and explain Member materials by phone. We will offer printed materials in other formats upon request, such as Braille, large print (18-point font or larger), audio, and accessible electronic formats. We will make information such as wellness, disease prevention, and important administrative information available by podcast or audio playback on our public website, which adheres to Federal Section 508 standards and Web Accessibility Initiative guidelines for people with disabilities.

Hearing Impairments. We will prominently display the Mississippi Relay phone numbers on the Member ID Card, Member Handbook, our public website, and other Member materials. We will prepare our CSRs to properly handle relay calls, such as addressing the caller and not the interpreter, pausing periodically for a response before continuing to speak, and other call etiquette protocols. We will provide auxiliary aids upon request and at no cost, including but not limited to Teletypewriter, Telecommunications Device for the Deaf, Video Phones, or American Sign Language interpretation methods for the hearing impaired. Trained professionals will 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.

4. Describe how the Offeror will employ creative solutions to encourage participation in Member outreach and education activities.

Creative Solutions to Encourage Participation

We will employ creative solutions to meet Members where they are and get them engaged in outreach and education activities. Our solutions will be informed by data, including our Members preferred modes of communication, engagement statistics with our public website, Member Portal, and Member Application and from our in-person activities. We will include solutions that keep pace with and capitalize on Members' preferences to navigate digital content for information. As we have experienced in other States, offering digital content may increase Members' engagement with their health, especially younger Members and families. Our creative solutions include the following innovations:

- We will offer a culturally competent digital health platform to connect Black expectant and new mothers with critical resources to drive positive pregnancy outcomes and reduce racial disparities in pregnancy outcomes. This platform is designed to address the specific clinical, social, and cultural needs that Black expectant mothers face throughout their pregnancy and postpartum journeys.
- We will participate in community events, including health fairs, Back-to-School events, and other community health awareness events. We will bring a mascot and health-related activities for children. Our resource tables will include health education about asthma, diabetes, sickle cell anemia, EPSDT/Well-Child screenings, and other materials that will help our Members navigate benefits and services including information about Care Management, the Member Incentive Program, and others
- Care Managers and CHWs will assist Members with opting into our text messaging program if that is a preferred mode of communication. We will send welcome texts to our Members' mobile devices with hyperlinks to a New Member Welcome page featuring YouTube videos spotlighting community leaders welcoming new Members to our CCO and encouraging them to schedule their first PCP visit. We will also notify them about community events by text message.
- We will offer a video library with a variety of educational webinars informing Members how to complete the Health Risk Screening on the Member Portal, appropriate use of EDs, including links to urgent care centers, and other topics.
- We will provide a Virtual Assistant with technology to engage Members using natural communication capabilities. The Virtual Assistant will offer real-time assistance for Members such as how to sign up for their secure Member web portal account, how to find and change their PCP, and other self-service functions.
- Our Facebook page will provide relevant, timely, information, such as where to obtain face masks,

COVID-19 testing and vaccination sites, and information about about Back-to-School events for school immunizations and backpack giveaways.

- Our children's program will offer younger Members the opportunity to enroll in a health-focused club and receive a packet in the mail containing a membership card and an activity book. During the year, they will receive birthday cards, books, newsletters, and coloring books with activities focused on health and wellness.
- Our Member Incentive Program will offer financial rewards to Members actively engaged in healthy behaviors, such as completing EPSDT/Well-Child visits. This program is designed to promote Member responsibility, investment in their health, and appropriate use of health care services.

5. Describe the Offeror's proposed process for maintaining both online and print Provider Directories that include names, locations, telephone numbers, and non-English languages spoken by contracted Providers located near the Member and identifies PCPs/PCMHs and specialists that are and are not accepting new patients, as well as how the Offeror will update and notify Members of changes to the Provider directory in the required timeframe.

Our printed and online Provider Directory will comply with the requirements provided Appendix A, Draft Contract. We will produce separate MSCAN and CHIP Provider Directories to present information clearly and simply to our Members. We will comply with all Federal requirements governing the directories and communication standards, including but not limited to 42 C.F.R. § 438.10(h), 42 C.F.R. § 431.70. and 45 C.F.R. Part 92 and other applicable Federal statutes. Our Directory will contain accurate, up-to-date, and easily accessible information spanning PCPs, hospitals, specialists, Providers of ancillary services, BH/SUD facilities, and any other facilities or locations where a Member may receive services.

Ensuring Provider Directories Are Accessible

We will publish the Provider Directory at a 3rd grade reading level as validated by the Flesch-Kincaid Readability Test. The Directory will be readily available in prevalent non-English languages spoken by 5% or more of our Members in compliance with DOM's Limited English Proficiency Policy. In addition, we will translate the directory to any language a Member requests, or provide in an alternative format such as Braille, large print, audio, accessible electronic formats, and other formats. Our Customer Service Representatives are trained to read the information in the Directory, or any other materials, over the phone upon request. We will deliver hard copies to Members upon request and make them available at State Medicaid Regional Offices, WIC offices, and other locations as directed by DOM. We will provide copies of the Provider Directory at our Mississippi-based offices.

Maintaining Accurate, Complete, Provider Directories

Provider Data Management and Integrity. Provider network data will be maintained in our Provider Lifecycle System, a workflow-enabled relational repository used by our Provider Network teams for Provider prospecting, contracting, enrollment, data management, and continuous engagement. Our Provider Network team will enter and update Provider data in the system, ensuring that all data comes from one governing source for complete data integrity. We store and index Provider identifiers including Tax ID, National Provider ID (NPI), Provider's language information, locations, office hours, web URL, ADA accessibility, and other demographic information. ***We also track Provider certifications such as Trauma-Informed Care and Trauma-Focused Cognitive Behavioral Therapy.*** Address verification and standardization software will also be applied to all Provider records.

Our Provider Lifecycle System will supply data via our Real-Time Repository (RTR) technology to downstream systems needing that information, including our online Provider Directory. When updates are made to data in our Provider Lifecycle System, the change transaction automatically triggers an update for our online Provider Directory, typically within minutes via a microservice RTR. RTRs are high-performance databases designed for conveying updated information to both external and internal-facing applications.

Maintaining Data Integrity Through Provider Updates and Data Audits. We will use multiple touchpoints to inform Providers of their contractual obligation of immediately notifying us when their information changes, such as Provider orientations, email/surface mail, Provider Newsletters, Provider Relations Specialists, office visits, and other methods. Then, we inform them how to update their information and offer them numerous channels to do so, such as the Provider Services Call Center, secure messaging via the Provider Portal, by fax, and by surface mail.

We will ensure Provider data accuracy by performing ongoing data audits. We will adopt best practices from our affiliate health plans by utilizing an industry-leading Provider data validation service to ensure our Provider data is of the highest quality and accuracy. This service will conduct ongoing Provider outreach to verify information with automated transmission of updated Provider data weekly into our systems. They offer a secure, self-service web portal for Providers to update, verify, and attest to their information and quarterly database matching to identify needed updates to our Provider data. A dedicated team of data audit specialists focus on validating the Provider data to ensure integrity. Weekly, the data specialists will generate reports to validate Provider information. The data audits will validate Provider information such as, but not limited to, office hours, hospital privileges, languages spoken, accessibility for persons with disabilities, and whether the Provider is accepting new patients. Data audit specialists will conduct outreach using all available means of communication, even visiting Providers in person.

How Members Access the Provider Directory

Hard Copy Directory. We will publish a hard copy directory for MSCAN Members and a second for CHIP Members. We will publish compliant directories as referenced above and republish updated versions at least annually. We will inform Members how to obtain a hard copy via our New Member Welcome Packet as well as our public website, Member Portal, the online Provider Directory, including how to obtain a translated copy or in an alternative format. Members can obtain a hard copy through the following ways:

- Contacting the call center and requesting a mailed copy, or requesting that only relevant subsections be mailed, such as Providers in a particular county
- Contacting the call center and requesting a CSR read from the Provider Directory
- From State Medicaid Regional Offices, WIC offices, and other locations as directed by DOM
- At our Mississippi office

When a new version of the Provider Directory is available, we will notify and distribute it to the State Medicaid Regional offices and WIC Departments. We will proactively reach out to these offices and facilities monthly to audit the quantities of Directories on-hand and replenish their inventory as needed.

Online Provider Directory. Our web-based, publicly-accessible online Provider Directory will conform to all requirements in Appendix A, Draft Contract, Section 508 of the Disability Act of 1973 as amended in 1998, and all State and Federal laws and regulations including but not limited to 42 C.F.R. § 431.70. We will inform Members about the online Provider Directory in our New Member Welcome Packet, the hard copy of our Provider Directory, and on our public website, Member Portal, and Member Mobile Application. Members, Providers, and the public will be able to access our online Provider Directory from the homepage of our public website without needing a login or password. The directory loads in a separate window enabling the user to obtain information side-by-side (e.g., searching the directory and reviewing Covered Services).

Customized Provider Searches. In addition to the population type, Provider type, and location search filters required by Appendix A, Draft Contract, the ***online Provider Directory will include 18 filters that enable Members to conduct highly customized Provider searches*** by specialty or service, such as DME, home health, dentists, pharmacies, Rural Health Clinics and other Providers by zip code, town, county, or by exact location.

Filters to personalize the search will include gender and language. ***The Directory will contain separate listings for MSCAN and CHIP Providers to prevent users from accidentally moving into a Directory for any other product.*** It will integrate Providers for all services, including vision, BH, and dental, so Members and their parents/guardians never need to consult a separate directory or website. The Directory will display each Provider's practice limitations, board certifications, and hospital affiliations, disability access, and languages spoken. We will also display current photographs of Providers as available.

Continuous Online Provider Directory Enhancements. We continuously work to make our online Provider Directory even more user-friendly by soliciting direct Member feedback on its ease of use and functionality during forums such as Member focus groups, Member Advisory Committee meetings, and survey results compiled from our affiliate health plans to inform enhancements. Our online Provider Directory features a streamlined search process with a multitude of search parameters (discussed in more detail below); a print from screen capability enabling Members to print search results; easy-to-navigate drop-down menus; and formatted search results in business card-like layouts for simplified viewing. The tool will capture the Member's location

to display Providers closest to the Member (including facilities, BH or other specialty Providers, and pharmacies) within a radius on an interactive map. Members can obtain directions to a Provider's location by clicking on the "get directions" link on the map. We will use Google Maps Mapping Service Directions for driving, walking, and public transportation, where available.

Updating Provider Information

As discussed previously, our Provider Network staff will enter new/updated Provider information in our Provider Lifecycle System in one business day for distribution to downstream systems needing that information (including our Online Provider Directory) within minutes via our RTR architecture. We will engage Providers to inform us of any changes to their information and offer multiple methods to submit this information to us. In addition, our data audit team continuously conducts audits to ensure the accuracy of the information and to process any changes.

Notifying Members of Changes

We understand that occasionally Providers will leave the network. To ensure Members are promptly assigned a new Provider, we will notify Members the later of 30 calendar days before the effective date of a Provider termination *or* 15 calendar days after receipt or issuance of the termination notice. We will update our online Provider Directory after a completed termination, update the hard copy Directory before the next scheduled printing, and assist Members with selecting new Providers. Our DOM-approved notice will include information about selecting a new Provider, how a Member can continue using services during a transition period, and provide the last day Members in an ongoing course of treatment can continue seeing the terminated Provider.

6. Describe the Offeror's proposed policies, procedures, and processes regarding the Member's rights specified in Section 5.10, Member Rights and Responsibilities of Appendix A, Draft Contract.

We provide Members with a Member Handbook and website informed by 508 guidelines that conforms to DOM's communication standards and describes Members' Rights and Responsibilities. We will comply with all State and Federal requirements regarding Member Rights and Responsibilities, including, but not limited to the rights listed below. Our policies and procedures will include the following topics:

- We will provide and ensure Members receive information about our CCO that they have a right to receive.
- We will ensure compliance with information requirements in 42 C.F.R. § 438.10, and comply with all requirements in Section 5.10, Appendix A. We will provide enrollment notices, and informational and instructional materials for Members and potential Members in languages, manners, and formats that they can understand; and ensure interpretation services are available.
- We will require staff and Providers to provide culturally competent and respectful care, and we train and monitor them to ensure compliance.
- We support patient-centered care and involve patients and their caregivers and families, as appropriate, in developing the plan of care, respecting the Member's right to refuse treatment or choose alternative treatment.
- Providers may use restraint or seclusion only if a substantial risk or occurrence of serious self-destructive behavior and/or physical assault. Facility Providers must comply with Federal and State laws regarding use of the least restrictive setting and treatment interventions and report use within five days, recording compliance efforts. BH quality management staff monitor aggregate and report data to complete administrative and clinical reviews, taking action as appropriate. The Quality Management Committee assesses aggregate reports for trends and recommends appropriate action.
- Members can access and amend their Protected Health Information in their Designated Record Set (DRS) by writing to our Compliance Officer if the PHI is subject to access rights. Members must document justification for the requested amendment. Grounds for denial: We did not create the PHI, PHI is accurate and complete, PHI is not part of the DRS; or PHI is excerpted from access rights. We will provide notice of denial and written denial as required, explaining the basis for denial and the process for the Member to disagree and file a complaint with us and the U.S. Department of Health and Human Services.
- We inform Members, Providers, and staff about Member Rights and Responsibilities, including the right to exercise such rights freely. We monitor complaints and audit Care Management files, taking appropriate action upon possible evidence of adverse treatment.

- We will ensure compliance with State and Federal services provision requirements, including network and Provider access standards (42 C.F.R. § 438.206), and demonstrated capacity for expected enrollment (§ 438.207), as described in Sec 5.6.37. 9) We will furnish coordinated health care services in a medical home model, providing additional services for Members with Special Health Care Needs (§ 438.208), as described in Sections. 5.6.18-20, 26 and 33; and we will ensure that services are sufficient to achieve targeted health outcomes and authorized and provided in a fair, consistent, and unbiased manner (§ 438.10).

7. Describe the Offeror's proposed policies, procedures, and processes to ensure Marketing requirements are met in accordance with 42 C.F.R. § 438.104. Include a description of Marketing materials the Offeror proposes to send to Members. Provide samples of Marketing materials the Offeror has used for other Medicaid programs (e.g., materials included in the Member Information Packet and other educational materials sent to members after enrollment) as available.

We will have policies, procedures, and processes in place to ensure compliance with 42 C.F.R. § 438.104, all applicable State laws, and the requirements of Appendix A, Draft Contract. We will adhere to marketing guidelines during our community outreach and education activities and enrollment education and assistance. Our approach begins with clear lines of reporting and accountability within our teams. The Senior Director of Marketing and Communications (Sr. Director of Marketing) will report to the Chief Operating Officer and will be responsible for implementing our community outreach and education work plan and for overseeing our field-based Community Relations Representatives. The Compliance Officer will provide broad oversight to ensure compliance with all requirements, including prohibited activities. The Grievance Coordinator will be responsible for maintaining a marketing Grievance resolution process.

To ensure compliance with marketing requirements and restrictions, we will develop and implement policies, procedures, and processes governing Marketing activities and provide oversight and controls, such as:

- Not engaging in marketing activities to influence potential Members to enroll with our health plan or to disenroll from another health plan
- Not directly contacting potential Members
- Developing a training program for staff, Providers, and Subcontractors about allowable and prohibited activities and monitoring compliance
- Adhering to DOM's Marketing materials development and approvals process
- Monitoring and addressing complaints promptly

Training and Monitoring to Prevent Prohibited Activities

We will implement training and monitoring to align our community education and outreach activities with State and Federal marketing restrictions. Our written policies and procedures will stipulate prohibited Marketing activities, and our training will address all prohibited activities contained in Appendix A, Draft Contract. We will adhere to DOM's requirements for submitting our marketing policies and procedures, work plan, schedules, and the Marketing Complaint Tracking Log.

All Employee Training. We will provide training to all employees on State and Federal marketing restrictions as part of our new hire orientation process and annual refresher training. We will require attestations from employees that they have reviewed and understand the Marketing policies and procedures. The Sr. Director of Marketing will collaborate with the appropriate department leads to ensure department staff (such as Customer Service, Provider Relations, and Care Management) receive additional guidance on how marketing restrictions impact their interaction with Members and the larger community.

Community Relations Representatives (CRRs). Our Sr. Director of Marketing will train and provide direct oversight to our CRRs. New CRRs will complete a 30-day orientation training consisting of a detailed review of marketing policies and procedures to identify prohibited activities and to apply their learning to practice scenarios that will illustrate prohibited and allowable activities. In addition, new CRRs will shadow experienced outreach staff. The Sr. Director of Marketing will oversee CRR activities during community events to ensure they adhere to marketing rules. We will require staff to conduct community outreach in a non-discriminatory fashion, regardless of individuals' health status and future need for health care services. We will prohibit the use of language that could be construed to confuse or defraud Members or misrepresent any entity.

Providers and other Entities. Our Vice President, Network Development and Contracting, will be responsible for ensuring our network Providers and Subcontractors understand their responsibilities to comply with

marketing rules. In addition, our policies and procedures will clearly articulate the State and Federal prohibitions on promotional items, including the use of items that can influence Members' selection of a particular Provider, practitioner, or supplier for which payment may be made, in whole or in part, by MSCAN or CHIP programs. We will contractually obligate our Providers and Subcontractors to comply with the restrictions clearly outlined in all contracts. We will provide ongoing education via Provider Newsletters and weekly e-mail blasts. All these materials will be available on our website.

Monitoring and Resolving Complaints. Our Compliance Officer will oversee the development and implementation of procedures to log and resolve marketing Complaints, including procedures to address the resolution of Complaints about our health plan, our employees, contracted Providers, or Subcontractors. We will forward to DOM for further investigation and resolution of marketing complaints that cannot be satisfactorily resolved. Our Compliance Officer will be responsible for submitting all required documentation and will report to DOM within the required timeframes, including the quarterly Complaint Tracking Log.

Compliance in Developing Materials

We will submit all educational and marketing materials within required timeframes and ensure they are accurate and approved by DOM before using them. We will only distribute pre-approved materials and will seek approval even for slight modifications of our materials. We will not distribute benefits charts that DOM intends to distribute. All our materials, as well as our website, will be certified at or below a 3rd grade reading level, and we will provide language translation and interpretation services upon Member request. We will submit website screenshots to DOM for review and approval prior to making the website available and whenever we update it. Our website will meet all 508 compliance regulations and includes a translation tool. All Member facing materials and website will include the 1557 Notice of Nondiscrimination and Language Taglines.

Description Of Marketing Materials for Allowable Activities

We will distribute materials that fall into two broad categories: general brand awareness and health education. General brand awareness materials will include materials such as the Member booklets. Health education materials will include, for example, our Online Health Library, Employment Basics for People with IDD, Resources for Transition-age youth with disabilities, and children's books. Our DOM-approved Member Handbook will inform Members of their right to choose a different health plan, the open enrollment calendar, and DOM's role in assisting them through the enrollment process.

Community Engagement and Events

Our CRRs will attend community events in all of Mississippi's regions, and our staff will volunteer within their communities. Our participation and sponsorship of community events will focus on providing information about our health plan and providing education on key health issues. Our policies and procedures will stipulate allowable community activities. We will encourage participation in community events that promote health awareness, including events held throughout Mississippi by community organizations, Providers, and DOM. We will implement events and activities for children enrolled in our health plan as well as the broader community, such as providing activity books about health education and sending birthday cards. We will create, and submit for approval, 30-second video spots to serve as an entertaining way to instill healthy behaviors in children. Our CRRs will partner with schools, school nurses and organizations such as Boys and Girls Clubs and like organizations. At these events, we will provide DOM approved materials including our award-winning series of books for distribution to children and families; coloring books; well-child and well-baby education materials, and other materials. We will work closely with school nurses and community organizations to focus on the importance of supporting families with their children's prevention and wellness goals. CRRs will provide educational material to send home with the children as well as participate in parents' nights with a resource table.

Distribution of Non-Cash Promotional Items

We will adopt a low-cost, high-impact approach to disseminating non-cash promotional items. We emphasize quality promotional offerings by offering creative and useful items that encourage healthy living. For example, we will distribute children's coloring books that emphasize the importance of visiting the doctor and the dentist. We will offer small gifts of nominal value including items that are health related. These items will be branded with our logo. Examples of such items may include dental kits, jump ropes, pedometers, water bottles,

educational coloring books, and hand sanitizers. Distribution of such items will only occur after written approval has been received from DOM.

Brand Awareness through the Use of Media

During open enrollment periods, we will market throughout Mississippi using diverse media tools to increase general awareness about our CCO. Marketing efforts may include television, radio, gas pump, Mobile Application advertisements, and the use of social media, such as Facebook. We have found mobile messaging to be effective outreach for young adults and television to be effective for reaching homebound individuals.

Samples of Attached Member Marketing Materials

Please see **Attachments 4.2.2.1.E.7.a Member Marketing Sample 1** and **4.2.2.1.E.7.b Member Marketing Sample 2** for Sample Member marketing materials.

8. Describe the Offeror's proposed approach to inform Members about covered health services including: behavioral health/substance use disorder, perinatal, neonatal, Care Management, autism, and other developmental disabilities, well baby and well child, EPSDT screening, chronic health conditions, and pharmacy services.

Our approach to informing Members about covered health services will consist of multiple engagement methods combined with committed, Member-facing teams and leveraging relationships with our Providers. Our methods include:

- New Member Materials
- Appointment Reminders
- Educational Mailings
- Welcome Calls
- CHW and Care Manager Outreach
- Home Visits & Community Events
- Expanded Cell Phone Program
- Member Workshops
- Digital Engagement

Local, Dedicated Staff

Our local Customer Services Representatives (CSRs), Care Mangers, Pharmacists, CHWs, Community Relations Representatives (CRRs), and other Member-facing staff will engage with MSCAN and CHIP Members every day to inform them about and facilitate access to covered health services to prevent the onset of illness as well as to learn to manage chronic conditions. For our Mississippi Members needing a little extra help understanding the array of covered services we will offer and how to access these services, our CHWs will serve as a trusted, reliable source of information. CHWs at an affiliate health plan, for example, fielded ***1,558 inbound Member calls, completed 25,493 outbound Member calls, and attempted 2,209 home visits.*** Our Mississippi CHWs will offer Members this degree of commitment to informing them about covered health services that align with their needs.

Leveraging Relationships With Pros

We will educate our network Providers about the covered services referenced above and provide them with the tools and incentives to deliver and/or coordinate these services. For example, our secure Provider Portal will provide access to online Member Health Records, including care gaps and other clinical information, including reports to track Members who are overdue for recommended PCP visits or other services. In addition, we will develop a robust network of PCPs participating in value-based purchasing agreements, which will incentivize PCPs to engage Members and close care gaps.

Change Notices

We will meet all contractual requirements related to notifying Members of changes to covered services, benefits, and related processes, notifying them at least 30 calendar days before implementing the changes. We will provide notification of changes through general and targeted mailings, automated calls, on-hold messaging, website posting, social media campaigns, e-mail blasts, and staff contacts. All materials will be available in alternative languages and formats upon request.

Targeted Strategies to Inform Members About Covered Services

Behavioral Health (BH)/Substance Use Disorder (SUD). We will train our Care Management and CHW staff to identify Members showing signs of BH/SUD related issues and to follow up and inform each Member about BH/SUD covered benefits as well as connecting them to an appropriate BH specialist as needed. We will design and provide discharge toolkits with information about BH covered benefits and how to access benefits to support Members with follow-up appointments. In addition, we will implement a SUD Risk Model which

blends the concepts of population health and financial risk stratification with the most current evidence for treatment of different types of SUD. This model will enable our staff to identify Members in a stage of change that might be most receptive to engagement. We will provide 24/7 access to clinical BH personnel, including those who specialize in SUD, to help Members experiencing emotional distress and guide them towards accessing BH/SUD benefits and services.

Perinatal/Neonatal. Care Managers will outreach to expectant Members appearing on a daily report. The Care Managers will inform Members of programs and services available through our plan, such as our Maternal and Child Health Program, as well as programs and services available through the Perinatal High-Risk Management/Infant Services System. We will offer web-based resources about family planning on our public website and for teenagers, information about pregnancy, women's health, and family planning in our Teens on Course - Teens and pregnancy booklet. Finally, we will offer education on covered maternity benefits through Community Baby Showers and community meetings for pregnant Members.

Autism and Other Developmental Disabilities. We will build an experienced team to forge relationships and collaborate with parents of children with Autism, Autism Providers, and schools. We will inform parents of children with Autism about our covered services and how to access all needed therapies. To ensure alignment between children's specific needs and educational plans, we will communicate frequently and coordinate with local schools. For children with other developmental disabilities, we will partner with Early Intervention Programs (EIP) like Mississippi First Steps. If we identify a potential developmental concern, we will refer Members to the EIP to access assessments and therapies as early as possible. We will support our Members and their families in finding the resources necessary to meet developmental milestones and make information and education available in convenient settings.

Well-Baby, Well-Child, EPSDT Screenings. Our Child Health Coordinators will provide, manage, and oversee outreach activities and data tracking for well-baby, well-child, and EPSDT services. Coordinators will mail reminders about annual screenings and launch telephonic campaigns, calling Members/parents one evening per week and one Saturday per month. Other outreach methods will include providing Members/parents with books and other written materials, including information about the Member Incentive Program, which we also distribute to schools, Providers, and at community events. Coordinators will collaborate with our Quality department and engage FQHCs along with large Provider groups and provide a roster of Members with care gaps for Provider outreach, leading to office visits. In addition, ***we will partner with the American Cancer Society on a national program to improve HPV vaccination rates***.

Chronic Health Conditions. Another investment we will make in Mississippi is an innovation to drive better outcomes for Members with chronic conditions using Digital Care Management (Digital CM). Digital CM is a web- and mobile-enabled solution that will extend CM resources to drive deeper Member engagement and encourage self-management. Digital CM enables Care Managers to deploy customized, condition-specific programs, such as for diabetes or pre-diabetes, and directly communicate with Members through HIPAA-secure messaging. Using Digital CM's advanced analytics, Care Managers can make evidence-informed decisions to increase program adoption and care plan adherence, as well as identify and address health disparities. Digital CM will offer the following clinical programs for chronic conditions: Diabetes, Coronary Artery Disease, Chronic Heart Failure, Hyperlipidemia, and Behavioral Health & Wellness Program.

Pharmacy. Our Handbook and Public Website will inform Members about pharmacy benefits, including the Preferred Drug List (PDL) and limitations covering preferred and nonpreferred drugs. Our trained CSRs, CMs, and CHWs will inform Members about the pharmacy benefit and will also warm transfer to a pharmacy team for education about specific drugs or prescription protocols. In Mississippi, we will implement effective, targeted education strategies for specific medications, such as ADHD medication. Our CM team will mine pharmacy claims for Members with ADHD prescriptions and launch a telephonic campaign to Members' parents to educate about the support available through covered, follow-up benefits. In addition, we will implement our Behavioral Health Medication Management (BHMM) program which, through claims data, identifies children under four years old who have taken psychotropic medication for 60 or more days, or children over four years old when there is evidence of concomitant class polypharmacy or four or more psychotropic prescriptions. These criteria trigger a Psychotropic Medication Utilization Review (PMUR), which

will result in CM intervention and education.

9. Describe the timely process by which media release, public announcement or public disclosure of any change affecting benefits and services will be organized, sent, and reviewed for approval by the Division.

Process of Communicating Benefits and Services Changes. We will meet all requirements outlined in Appendix A, Draft Contract related to informing Members of changes to covered services, benefits, and related processes, notifying them at least 30 calendar days before the implementation of the changes. We will notify Members of change through general and targeted mailings, automated calls, on-hold messaging, website postings, social media campaigns, email, and through staff contact with Members. As with all Member communication, before releasing any public announcement of changes affecting benefits and services, we will work with DOM to obtain approval of any Member materials. We will submit all Member communication materials to DOM at least 60 calendar days before planned distribution.

Public Disclosure to Providers. We will submit all Provider communications materials to DOM for review and approval 60 calendar days before planned distribution, including Subcontractor disclosures, email blasts, and other everyday business templates as directed by DOM. We will communicate updates to Providers in a timely fashion as well as ensure appropriate, approved updates are available in multiple formats. In the case of breaking updates, we will provide information in our DOM-approved weekly email blasts and Provider Newsletters.

Process for Significant Changes. In the case of significant changes, we will establish a timeline and work plan to ensure a transparent process and smooth transition for DOM, our Members, and our Providers and Subcontractors. For example, we will work to secure DOM approved materials including, but not limited to:

- Member communications, such as letters, announcing changes, and informing Members of what to expect and how they are impacted
- Provider communications, such as email blasts, announcing changes, and informing Providers of what to expect and how they (and their Members) are impacted

All materials needing DOM approval will follow contractual requirements for review, ensuring appropriate and accurate information is made available to Members and Providers in a timely manner.

Media Release, Public Announcement, or Public Disclosure. Any announcement of changes to benefits and services that warrants a press release, media release, or public disclosure will occur after DOM has provided all approvals for contractual, Member, and Provider requirements. Such announcements will be shared with DOM as directed prior to public release.

4.2.2.1.F Member Satisfaction

1. Describe the Offeror's proposed approach to assess Member satisfaction including tools the Offeror plans to use, frequency of assessment, and responsible parties.

We will comply with all requirements in Sections 16.2.8 of Appendix A, Draft Contract, and Section B.3.6 of Exhibit F governing satisfaction surveys. Our Quality Management Department will lead our efforts to continually measure Member satisfaction and will be responsible for conducting formal surveys and delivering results to DOM. Our formal surveys will align with National Committee for Quality Assurance (NCQA) guidelines. We will not limit our approach to formal surveys; we will take a cross-departmental approach to capture Member feedback indicating if we are meeting our Members' expectations in helping them access quality care.

CAHPS® Member Satisfaction Survey

Annually, we will conduct a formal and comprehensive CAHPS Member Satisfaction Survey following NCQA guidelines using an NCQA certified vendor. Our Quality Department will analyze the survey results and engage a cross-functional team to review the results, develop recommendations for improvement, and implement the recommendations. In addition to the standard CAHPS Survey, we are interested in assessing and improving Members' experience specifically with BH/SUD services. Annually, ***we will conduct a CAHPS Experience of Care and Health Outcomes to measure Members' satisfaction with BH/SUD care***. We will submit CAHPS results and our proposed action plan to DOM no later than 90 days after receiving audited survey results.

Care Management (CM) Surveys

Our Care Managers will provide Members with an anonymous satisfaction survey to assess their experience with our CM program and their assigned CMs. The CM team will analyze survey results monthly and remediate any issues. In addition, the team will provide an annual report to the Utilization Management Committee (UMC) and Quality Management Committee (QMC) to address the findings and develop recommendations for improvement.

99% CM Satisfaction Rate

An affiliate's CM program serving a similar population scored a 99% Member satisfaction rate from 2019-2020.

Disenrollment Surveys

We will use a DOM-approved disenrollment survey to help us understand why Members choose to change CCOs or exit managed care and return to the FFS program if they have that option. Within five business days of a disenrollment, our Eligibility Specialists will conduct a phone survey and use a DOM-approved script to engage Members. Weekly, we will analyze disenrollment data to identify any issues with our CCO or with the managed care program. Quarterly and annually, the Operations Department will analyze the survey results to identify areas for improvement, discuss the results in QIC, and submit quarterly reports and work plans to DOM. Please see our response to Section 4.2.2.11.A of the RFQ for a comprehensive description of how we will manage the disenrollment survey process.

Additional Approaches to Assess Member Satisfaction

Ad-hoc Surveys. Periodically and with DOM approval, we will conduct ad hoc surveys to gather Member feedback about specific programs or services, such as the functionality and ease-of-use of our public website and secure Member Portal as well as the quality of our Member materials.

Grievances and Appeals. Our cross-departmental Quality Management Committee (QMC) will review Grievance and Appeal data monthly to identify trends and areas of concern, such as meeting timeliness standards requirements or the volume of denials. The QMC, together with the Quality team, will identify and recommend improvements.

Post-Call Surveys. Our Member Services department will provide Members with satisfaction surveys to rate their experience with CSRs and determine if we resolved their calls to their satisfaction. In 2021, over 94% of callers from an affiliate health plan completed the after-call survey.

Member Advisory Committee (MAC). Through our MAC we will hear firsthand what our Members (including parents, caregivers, or guardians) think, and learn how we can enhance our programs. We will use these meetings as an opportunity to solicit additional feedback on our programs.

4.2.2.1.G Member Appeals

1. Describe the Offeror's proposed Member Grievance and Appeal process specifically addressing:

Our proposed Member Grievance and Appeal process will include organizational oversight, technology, and Member education to empower Members and their authorized representatives to report any dissatisfaction, including with quality of care or services, rudeness of a Provider or health plan staff member, or failure to respect the Member's rights. This includes requesting an Appeal of an Adverse Benefit Determination that the Member believes they are entitled to receive. Our process is detailed in **Table 4.2.2.1.G.1 Process for Grievance and Appeal**.

Our ***Mississippi-based, Grievance Coordinators and Clinical Appeals Coordinators*** will report to a Supervisor of Grievances and Appeals within our Quality team. The Vice President of Quality will receive oversight from the Chief Medical Director. Our physician-led Board of Directors will have final responsibility and authority for the Quality Assessment and Performance Improvement (QAPI) Program, which includes the Grievance and Appeal process. We will track, trend and report on Grievances and Appeals, including Independent External Reviews, in our Grievance and Appeal System. We will also document clinical Appeal information in our Clinical Documentation System.

We will educate Members about the Grievance and Appeal process, their rights to an Independent External Review/State Fair Hearing, and how to obtain assistance with filing through multiple methods, including the Member Handbook, Newsletters, the public website, and the Member Portal. Members will be able to call our toll-free telephone number and our CSRs will inform them of their options to voice concerns and show them how to initiate the Grievance process.

Table 4.2.2.1.G.1 Process for Grievance and Appeal

Grievance	
Submission Timeframe	Any time after the event causing dissatisfaction, oral or written
Confirm Receipt	Within five calendar days of receipt, in writing
Resolution	Within 30 calendar days of the date we receive the Grievance or as expeditiously as the Member's health condition requires
Our Process	The Grievance Coordinator will initiate an investigation, which may include obtaining additional information from the Member and gathering applicable documentation and assistance from other departments or Subcontractors. We will ensure that the resolution of Grievances involves staff (or health care professional with appropriate clinical expertise for medically related Grievances) who have not been involved in any prior level of review or decision-making. The Grievance Coordinator will send a written Grievance resolution, which will include all required information (such as the disposition and the justification), as expeditiously as the Member's health condition requires and within 30 calendar days of receipt. **Extensions**. We may extend the resolution timeframe up to 14 calendar days if the Member requests, or if we determine it is in the Member's best interest. If the Member does not request the extension, we notify the Member in writing of the reason for the delay within two business days of the extension decision.
Appeal	
Submission Timeframe	Within 60 calendar days of the date of Adverse Benefit Determination, oral or written
Confirm Receipt	Within 10 calendar days of receipt
Resolution	Within 30 calendar days of the date we receive the Appeal or as expeditiously as the Member's health condition requires. No longer than 72 hours after receiving a request for an Expedited Resolution of an Appeal.
Our Process	We will treat any Member's oral or written dissatisfaction or disagreement with an Adverse Benefit Determination as a request to Appeal. This will include any Determination to deny or limit services; deny payment (in whole or in part); reduce, suspend, or terminate previously authorized services; or fail to timely provide services or timely resolve Complaints, Grievances, or Appeals. Our Utilization Management staff will issue the Notice of Adverse Determination (NOAD), and our Clinical Appeal Coordinator (CAC) will issue the Notice of Standard and Expedited Appeal Resolution containing all required contractual and regulatory elements. The NOAD will also include the requirement to submit an oral or written Appeal request within 60 calendar days of receipt of the NOAD; the related Appeal procedures; Member rights (including for an Independent External Review/State Fair Hearing after exhausting our process); and the requirements for requesting an Expedited Resolution. **Extensions**. We may extend the resolution timeframe up to 14 calendar days if the Member requests, or if we determine it is in the Member's best interest. If the Member does not request the extension, we notify the Member in writing of the reason for the delay within two business days of the extension decision. **Continuation of Benefits.** We will inform Members via the NOAD of their rights to make a written request for Continuation of Benefits rights within 10 calendar days of notice of Adverse Benefit Determination, pending the determination of a State Fair Hearing. CHIP Members are not entitled to a continuation of benefits pending appeal as set forth by 42 C.F.R. § 457.1260.
Appeal Filed on a Member's Behalf by a Provider	When a Provider files an appeal on behalf of a Member, we will adhere to the same timelines and processes for Members who file Appeals directly.
State Fair Hearing/Independent External Review	
Submission Timeframe	Within 120 days from the date of Our Notice of Resolution
The Process	Once the Member has exhausted all our appeal processes, MSCAN Members and CHIP Members may request a State Fair Hearing or Independent External Review, respectively. We will comply with all State Fair Hearing/Independent External Review requirements and timelines, including but not limited to our participation in the hearing and provision of the Appeal summary to DOM and the Complainants within the required timeframe.

a. Compliance with State requirements as described on the Division's Website and, Section 5.11, Member Grievance and Appeal Process of Appendix A, Draft Contract;

Our process for Member Grievance and Appeal will comply with all State requirements as described on DOM's website and Section 5.11 of Appendix A, Draft Contract.

b. Process for expedited review;

A Member, or Provider acting on behalf of a Member, may request, orally or in writing, an Expedited Appeal if the standard resolution timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. We may also make this determination without a Member or Provider request and initiate an Expedited Appeal. We will follow all steps listed in the Standard Appeal Process above for review of both the request and the Expedited Appeal including informing Members of the limited time available to present evidence and allegations in fact or law as well as documenting in writing all verbal requests

for Expedited Resolution and maintaining the documentation in the Member's case file. The Clinical Appeal Coordinator will send written notice of resolution with all required elements as expeditiously as the Member's health condition requires or within 72 hours of receipt of the request (and makes reasonable efforts to provide and document oral notice). If we deny a request to expedite an Appeal, we will transfer the Appeal to the standard resolution timeframe. Only a physician can deny a request to expedite an Appeal because it is based on medical necessity. We will make reasonable effort to give prompt oral transfer notice and provide written notice to the Member within two calendar days that we will provide the resolution within 30 calendar days of the original request. Per NCQA standards, we will also offer an expedited process for clinically urgent Grievances. We follow the same steps and timeframe as those for an Expedited Appeal.

c. Involvement of Members and their families in the Grievance and Appeal process;

As described in the overview above, we will inform Members on their filing rights, the Grievance and Appeal System, processes, and procedures of the Independent External Review for CHIP Members and the State Fair Hearings for MSCAN Members. We will also inform them how to obtain filing assistance, express our commitment to resolving their concerns, assure them that we will not retaliate against them (or their Providers) for using the Grievance System, and that the expression of dissatisfaction will not affect their health care services.

We will inform Members of the types of parties who have the right to file a Grievance or Appeal on behalf of the Member, such as: (1) the legal guardian of a Member who is a minor or incapacitated adult; (2) an Authorized Representative designated in writing to us; and (3) a Provider acting on behalf of the Member with the Member or parent/guardian's written consent. We will ensure that communication with designated Member representatives is HIPAA compliant. We will give Members and their parents/guardians reasonable opportunity to submit comments and information in person or writing (and confirm their understanding of any time limits), as well as reasonable opportunity to examine the case file, including medical records (subject to HIPAA requirements) and other materials considered during the Appeal process. The Grievance Coordinator, Clinical Appeals Coordinator, Care Manager, or other designated staff person assisting with an investigation may contact the Member and their parent/guardian to obtain needed additional information.

d. How Grievances are tracked and trended and how the Offeror uses data to make program improvements;

How Grievances Are Tracked And Trended

We will use our Grievance and Appeal System to collect, analyze, integrate, and report Grievance and Appeal System data as well as our Clinical Documentation System to analyze Appeals data. We will record all required elements (such as receipt date, category/subcategory, and resolution date). We will provide reporting and maintain Grievance System and related supplemental documentation in accordance with State record retention requirements.

Our Grievance and Appeal System is closely linked with our QM, CM and Utilization Management (UM) Programs. Our cross-departmental Quality Management Committee (QMC) will review Grievance System data quarterly to identify trends and areas of concern, including whether timeliness standards are met; identify patterns related to specific issues, Providers, or internal departments; and target any corrective actions, such as policy, process, or other organizational improvements. We will incorporate aggregate Member satisfaction data (which includes Complaint, Grievance and Appeal information) into the annual QM Program Evaluation. Annually, the QM staff will review Grievance procedures to determine if any Grievance and Appeal System policies and procedures require modification (subject to written DOM approval). Our staff and committees will immediately escalate potential quality of care issues to QM staff and potential fraud and abuse to Compliance staff for investigation (and, ultimately, escalate for Credentialing Committee review as appropriate).

Using Data to Improve Programs

We will use Grievance and Appeal System data to identify and implement plan-wide, departmental, or Provider/Subcontractor corrective actions to address network gaps, appointment availability, and wait times; Provider compliance issues; issues with written materials; additional Provider or staff training needed; fraud, waste, and abuse; and business process improvements. For example, if Grievance data shows an appointment availability trend indicating a potential network gap, the QM team will report the information to the Contracting and Network Development team to address the potential network gap. The information will also be reported to

Provider Relations staff to determine if any retraining is required for individual Providers.

When we determine a specific Provider has met a Grievance or Appeal threshold relating to the Provider's office (e.g., three Grievances in three months), PR and QM staff (as applicable) will conduct an additional Provider office visit within 45 calendar days and forward the results to the Credentialing Committee. We will monitor each department's reviews and corrective actions to identify needed improvements to our processes.

e. How Grievances are addressed prior to the filing of a Member appeal; and

Upon receipt of a Member's Grievance, the Member Services team or a Care Manager will attempt to resolve the Member's issue using the first call resolution standard. If the issue is not fully resolved, we will request the Member's permission to route the issue to the Grievance department for a more thorough investigation. The Grievance team will provide a resolution within 30 calendar days.

f. Process to review decisions overturned in external reviews and State Fair Hearings and the Offeror's approach to address any needed changes based on this review.

Our policies and procedures for participating in and responding to Independent External Reviews (IER) for CHIP Members and State Fair Hearings for MSCAN Members will comply with all contractual requirements outlined in Section 5.11of Appendix A and Exhibit D.

- We agree to abide by all IER and State Fair Hearing decisions and understand that DOM's IER and State Fair Hearing decisions are final.
- Should an IER or State Fair Hearing result in the reversal of an Adverse Benefit Determination made by us, we will bear all costs associated with the hearing. These costs may include but are not limited to medical appropriateness reviews by the Independent Physician Reviewers, review fees, attorney's fees, and court reporter's fees.
- Upon receipt of an IER or State Fair Hearing decision that overturns our decision, the Clinical Appeals Coordinator will forward the decision to the appropriate internal staff for the approval of services, which shall be provided as expeditiously as the Member's health condition requires, but no later than 72 hours from the date we receive notice reversing the determination.
- Our Compliance Officer will meet with the CMD and other appropriate staff (such as the Vice President of Quality) as soon as is practicable, but within seven business days of the decision, to review the IER or State Fair Hearing decision which overturned our decision.
- Our team will assess each aspect of our decision and process, such as timing, incorrect application of clinical decision criteria, or whether any steps were not properly followed. Then we will report the IER or State Fair Hearing decision and any recommendations for improvement based on a review of the decision to the QMC for review and further action, if necessary.
- Recommendations may include staff retraining or re-education, review of criteria used in decision making, or potential changes to policies and procedures (to be submitted to DOM for written approval).

ATTACHMENT 4.2.2.1.E.7.a MEMBER MARKETING MATERIAL SAMPLE 1 AND ATTACHMENT 4.2.2.1.E.7.b MEMBER MARKETING MATERIAL SAMPLE 2

Two (2) marketing samples not to exceed five (5) pages each.

SAMPLE 1

Know Where to Go for Care

Get the Right Care at the Right Place

Make sure you know where to get medical care when you need it. If you get sick or hurt, you have several options to get the care you need.

PRIMARY CARE PROVIDER (PCP)

Your PCP is your main doctor. Call the office to schedule a visit if you don't need immediate medical care.

See your PCP if you need:

- Help with colds, flus and fevers
- Care for ongoing health issues like asthma or diabetes
- An annual wellness exam
- Vaccinations
- General advice about your overall health

24/7 NURSE ADVICE LINE

Our 24/7 Nurse Advice Line is a free health information phone line. Medical professionals are available to answer questions about your health. They can also help decide if you should see your PCP and assist with setting up your appointment.

Call our 24/7 Nurse Advice Line if you need:

- Help knowing if you should see your PCP
- Help caring for a sick child
- Answers to questions about your health

URGENT CARE CENTER

Urgent care centers help diagnose and treat illnesses or injuries that aren't life threatening but can't wait until the next day. If your PCP's office is closed, an urgent care center can give you fast, hands-on care. Urgent care centers can also offer shorter wait times than an emergency room (ER).

Go to an in-network urgent care center for:

- Sprains
- Ear infections
- High fevers
- Flu symptoms with vomiting

Start Earning xxxxxxxxxxxx Reward Dollars

It's easy to earn xxxxxxxxxxxxx **reward dollars.**

After you complete a healthy activity, we will add the reward dollars you have earned directly to your Xxxxxxxxxxxxx Prepaid Card.

We will mail your XXXXXX Card to you after you complete your first healthy activity. You can keep earning Xxxxxxxxxx rewards by completing more healthy activities. Your rewards will be added to your card once we are notified.

EARN REWARDS WITH THESE HEALTHY ACTIVITIES: *You can earn* xxxxxxxxxxxx *rewards for:*

Completing your Health Information Form	**$25**
Annual PCP Well Care Visit	**$25**
Annual comprehensive diabetes care	**$30**
Annual child wellness exam	**$20**

And many more!

USE YOUR xxxxxxxxxxxxx REWARDS TO HELP PAY FOR:

- Utilities
- Transportation
- Telecommunications – Cell Phone Bill
- Childcare services
- Education
- Rent

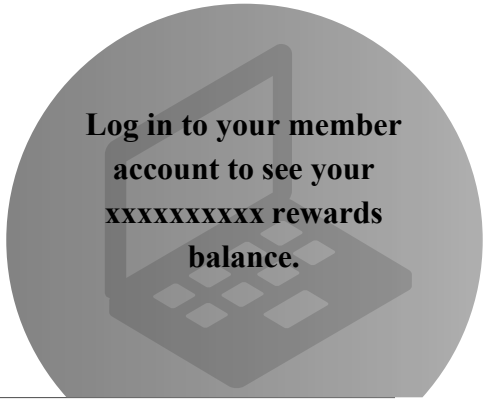
OR, YOU CAN USE THEM TO:

- Shop for everyday items*

**This card may not be used to buy alcohol, tobacco, or firearms products.*

This card is issued by xxxxxxxxxxxxx cannot be used everywhere xxxxx debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.

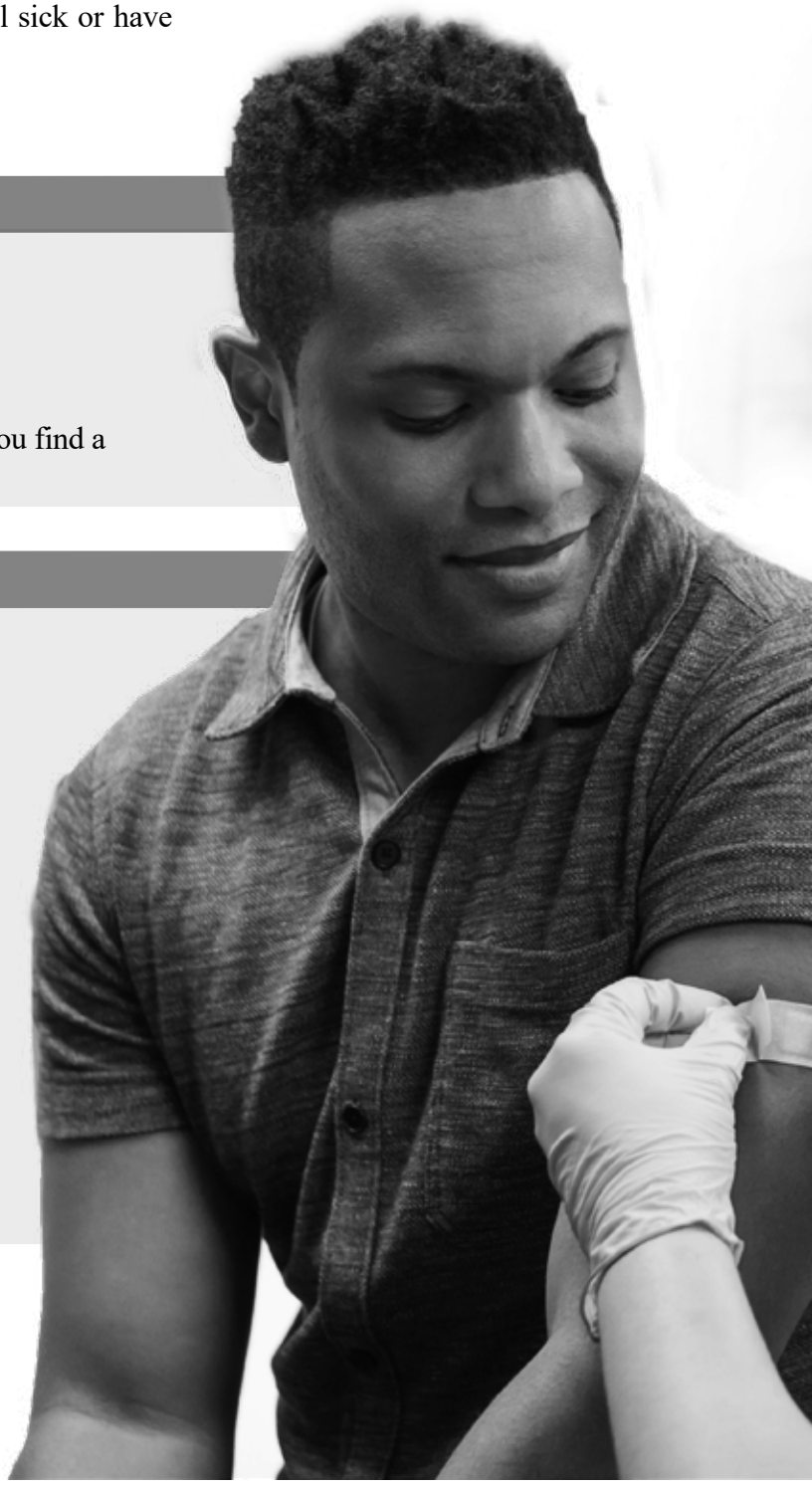


Your Primary Care Provider (PCP)

Your primary care provider (PCP) is your main personal doctor.

After you choose your PCP, it's important for you to meet your PCP so you can get to know each other. Building a strong relationship with your PCP helps you feel comfortable talking about your health.

Your PCP will keep your records and be aware of any changes to your health. Always contact your PCP when you feel sick or have any health questions, so you can receive the best care.



FIND A PCP

Visit* XxxxxxxXxxxxxXxx*.com to choose or change your PCP.

-or-

***Call us at* 1-XXX-XXX-XXXX.** We can help you find a PCP.

YOUR ANNUAL WELLNESS EXAM

After you choose your PCP, call to set up your appointment.

A yearly checkup with your PCP is the best way for you to stay informed about your health. Talk with your doctor about any changes you've noticed or concerns you may have. Your PCP may recommend tests or other preventive care services to help monitor your health. Take this opportunity to ask any questions you may have.

If you need help scheduling this visit, call us at 1-XXX-XXX-XXXX.

Earn XxxxxxxXxxxxxXxx *rewards by completing your annual checkup and screenings with your PCP. See page 9 for details about this rewards program.*

STAY INFORMED ABOUT YOUR CHILD'S HEALTH

Babies and young children need to see their doctor regularly, too. It is important for your child to have an annual health check even when they are not sick. The chart below shows when babies, young children and teens should see a PCP.

HEALTH CHECK SCHEDULE

Birth

- ○ 3 to 5 days
- ○ 1 month
- ○ 2 months
- ○ 3 months
- ○ 4 months
- ○ 6 months
- ○ 9 months

Early Childhood

- ○ 12 months
- ○ 15 months
- ○ 18 months
- ○ 24 months
- ○ 30 months
- ○ 3 years
- ○ 4 years

Middle Childhood & Adolescence

- ○ Every year until your child is age 21

Your child's health check includes an examination and vaccines to help prevent diseases. Talk with your child's doctor about any health issues or concerns.

Earn $10 in *Xxxxxxxxxxxxxxxxxx* rewards for each infant well care visit for babies up to 15 months old!
($60 Maximum)

Notification of Pregnancy

Take Care of Yourself and Your Baby

Our Xxxxxxxxxxxxx program provides customized support and care for pregnant women and new moms. This program helps you focus on your health during your pregnancy and your baby's first year.

Xxxxxxxxxxxxxxxxxxxxx OFFERS THESE BENEFITS AT NO COST TO YOU:

- Information about pregnancy and newborn care
- Community help with housing, food, clothing and cribs
- Breastfeeding support and resources
- Medical staff to work with you and your doctor if you experience any issues during your pregnancy
- Text and email health tips for you and your newborn

GET STARTED

If you are pregnant, complete our Notification of Pregnancy Form online or on the next page. We will follow up to talk with you about the details of our Xxxxxxxxxx program.

Once we receive your form, you will start earning rewards for doctor visits. See page 9 for details about the rewards program.

How do I start?

Make an appointment with your child's primary care physician (PCP). Contact Health Plan to get help with:

- Finding a provider or dentist
- Setting up an appointment
- Arranging transportation to the appointment
- Answering your questions about screenings or immunizations
- Talking with a case manager to help you find and get other services

What happens after seeing your PCP?

After the screening, the provider will help you understand the results. If you do not understand something, feel free to ask questions. Here's what could happen if the doctor finds a problem:

- For special problems, the provider will treat the problem or refer your child to a specialist for help.
- For vision problems, your child could see an eye doctor and get eyeglasses.
- For hearing problems, your child could see a specialist and get hearing aids.

Are vaccines safe?

Yes. Vaccines are very safe, and are important for a child's health. If you have questions about vaccines, please contact Health Plan or your healthcare provider.

XXX-XXX-XXXX
Relay XXX

XxxxxxxxXxxxxxX
xx.com

0-6 YEARS

E — **EARLY:** To treat problems soon

P — **PERIODIC:** To set up regular appointments

S — **SCREENING:** To check for a medical problem

D — **DIAGNOSIS:** To find a medical problem

T — **TREATMENT:** To care for a problem

Why are EPSDT screenings important?

Seeing your primary care physician (PCP) regularly and caring for problems early could:

- Help your PCP get to know your child
- Help your child stay healthy as he or she grows
- Find health problems before they get worse
- Stop health problems that make it hard for your child to learn
- Help your child have a healthy smile

When and how often do I need to schedule a screening?

Getting a screening at the right time is the best way to make sure your child continues to be healthy.

Babies need check-ups at:

Birth | 3-5 days | 1 month | 2 months | 4 months | 6 months | 9 months | 12 months

Toddlers need check-ups at:

15 months | 18 months | 24 months | 30 months

Young Children need check-ups at:

3 years | 4 years | 5 years | 6 years

Older Children, Teenagers and Young Adults under 21 years of age need a check-up every year.

Recommended Immunizations for Children from Birth Through 6 Years Old

Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years
HepB	**HepB**			**HepB**						
		RV	**RV**	**RV**						
		DTaP	**DTaP**	**DTaP**		**DTaP**				**DTaP**
		Hib	**Hib**	**Hib**	**Hib**					
		PCV	**PCV**	**PCV**	**PCV**					
		IPV	**IPV**	**IPV**						**IPV**
				Influenza (Every Year)						
					MMR					**MMR**
					Varicella					**Varicella**
					HepA					

Shaded boxes indicate the vaccine can be given during shown age range.

FOOTNOTES:

* Two doses of Flu vaccine can be given 4 weeks apart for ages 6 months-8 years who are receiving the vaccine for the first time.

* Two doses of HEP A vaccine can be given at 12 months and 23 months for lasting immunity.
* A two dose or three dose Hib vaccine can be given depending on the vaccine used in the primary series.
  A two dose or three dose Rotavirus vaccine can be given depending on the vaccine used in the primary series.
*

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.

[END OF RESPONSE]

Source: www.cdc.gov

4.2.2.2 PROVIDER NETWORK AND SERVICES

4.2.2.2.A Provider Network

1. Explain the Offeror's plan to develop a comprehensive Provider Network to ensure it meets the Division's access and availability requirements for all covered benefits. Specifically include:

We will build our comprehensive Provider network on the premise that network adequacy is more than having the right number of Providers; it means partnering with Providers that can best meet the whole health needs of Members and eliminate barriers to access. As a local organization that will be staffed and operated by hundreds of Mississippians across the State, we are dedicated to improving and investing in the future of health care in Mississippi. As an organization that will be located in Mississippi and staffed and operated by hundreds of Mississippians across the State, we are dedicated to improving and investing in the future of health care in Mississippi. ***We will invest $1 million to enable William Carey University (WCU) to develop the WCU College of Medicine (COM) Institute of Primary Care in Hattiesburg.*** We selected to partner with WCU COM because of their community-based training model and commitment to educate and train osteopathic physicians, nurses, and other primary care providers who are dedicated to serving the medically underserved and diverse populations of Mississippi. The Institute will recruit and train students primarily from Mississippi and the Gulf South region and offer continuing education and residency resources to address the physician shortage in the region. This world-class facility will allow for advanced training in high-quality value-based care geared toward the specific needs of Mississippians, including diabetes, hypertension, and cardiovascular disease. The development of the Institute will result in better quality and more quantity of physicians to improve outcomes and quality of life for all Mississippians and decrease cost outcomes for the State.

Our plan to build a network that is not only adequate but accessible for all Members includes the following components to ensure consistent, timely, and culturally competent access to primary and specialty care for all Members:

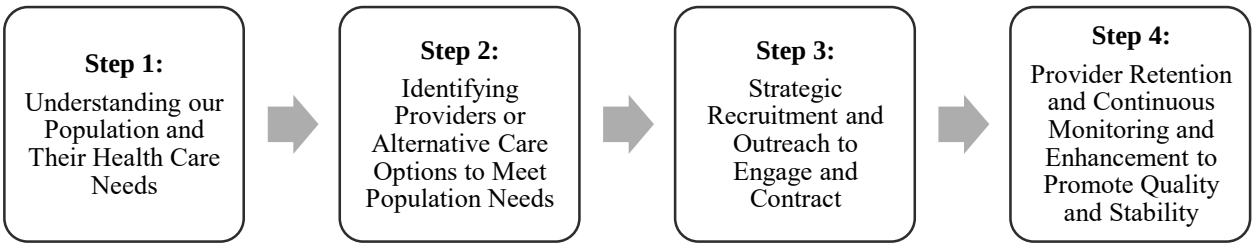
- ***Focusing on health equity and population health*** needs through strategic contracting and infrastructure investments, informed by data-driven population health and social determinants of health (SDOH) assessments and analyses. We will use continuous network monitoring, formal recurring cross-departmental assessments, and solicit external input to expand network analyses beyond traditional geographic mapping. This will ensure our network includes a broad representation of Providers that have historically served Medicaid Members, are familiar with the unique characteristics, disability needs, and cultural considerations of each covered population, and have the expertise to consistently deliver quality care through a health equity lens.
- ***Creating Medicaid-tailored access*** leveraging an in-depth understanding of Mississippi's Provider landscape, Member demographics, and the specific cultural, health, and unmet social needs of each eligible population. Our network will honor existing referral patterns, including through contracts with Providers in the border States of Alabama, Arkansas, Louisiana, and Tennessee. Our network will include all of Mississippi's critical access hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) – Providers that are critical to serving residents of rural counties. We will further support our network with telehealth Providers and through our out-of-area/out-of-network policies to exceed DOM's Provider network access and availability requirements as outlined in Section 6.2 of Appendix A, Draft Contract.
- ***Maintaining a high-value network*** by focusing on recruiting and retaining Providers that provide the most efficient, culturally competent, and highest quality care to our Members – aligning with DOM's goals of improving health outcomes for Members and cost outcomes for the State. For example, through our value-based purchasing (VBP) models, we will incentivize Providers to improve access to primary and specialty care and advance individual and population health outcomes. We also continually work to enhance and evolve our network through innovative infrastructure and capacity-building initiatives that expand access.
- ***Prioritizing Provider satisfaction and retention*** by listening to our Providers and engaging them as partners. We will include Providers on our physician-led Board of Directors and Committees to inform our strategic direction and day-to-day operations. These partnerships will offer us the ability to collaborate with

our network to proactively and promptly resolve access barriers or network adequacy issues.

Approach to Building Our Network

Our network development efforts will be led by a dedicated, full-time Vice President of Network Development located in Mississippi, which exceeds the Appendix A, Draft Contract requirement of a Manager-level position. The VP of Network Development and network team will build a network that exceeds DOM's adequacy requirements through focusing on the needs of each region to address whole-person and specialized care needs, empowering Member choice, and supporting Members to receive the right care, at the right time, in the right setting. By following the four-step process outlined in **Figure 4.2.2.A.1.A** and further described in the narrative below, we will establish, monitor, maintain, and enhance our Provider network for MSCAN and CHIP Members.

Figure 4.2.2.A.1.A Network Development Approach



Step 1: Understanding Our Population and Their Health Care Needs

Starting with the MSCAN and CHIP populations, programs, and requirements outlined in Appendix A, Draft Contract, we will gather input from multiple sources described below to identify Member needs. Members, Providers, community partners, and DOM are the experts on the needs, opportunities, and barriers in Mississippi and will collaboratively inform our network development strategy through the following activities:

- **In-depth population assessments of cultural, health and social determinants of health (SDOH) needs** To build a network that meets the needs of our Members, we must first know our Members. We will incorporate findings from work that has already been completed across Mississippi, such as the 2019 Community Themes and Strengths Assessment, local Community Needs Assessments, and the Mississippi Primary Care Needs Assessment. We will supplement this data with our cutting-edge health care analytic capabilities to provide a comprehensive view of population needs, including food insecurity, housing instability, education, and transportation.
- **Community input** from advocates that work directly with the MSCAN and CHIP populations, such as: Diaper Bank of the Delta; Columbus Housing Authority; Mississippi SHINE Project; Healthy Families Mothers and Babies; Hunger Coalition of Northeast Mississippi; Delta Health Alliance; Madison Countians Allied Against Poverty (MadCAAP); United Way of the Capitol Area; and Midtown Partners. We will also participate in Public Hearings to listen to Member feedback about their health care needs and access issues they may experience.
- **Provider input** from Provider associations includes the Mississippi State Medical Association (MSMA), Community Health Center Association of Mississippi (CHCAMS), and the Mississippi Rural Health Association.
- **Assess existing patterns of care and referrals,** measuring our network penetration against fee-for-service (FFS) and other CCO networks to ensure continuity of care. Data from network trends will help maintain a robust network, and we will pull in data from sources such as single case agreement (SCA) utilization and Grievance and Appeals trends. We will use identified trends as sources for network recruitment.
- **Industry-leading prospecting, network analytics, and geo-mapping capabilities** to analyze accessibility, out-of-network utilization, and target network improvement opportunities, focusing on Member choice, cultural needs, and timely access.

Step 2: Identifying Providers or Alternative Care Options to Meet Population Needs
Powered by information gathered in Step 1, we will identify and target Providers that can meet Member needs, fill gaps, improve timely and convenient access, expand Member choice, and fulfill our Cultural Competency Plan. This will include identifying non-contracted Providers who accept MSCAN and CHIP today, non-MSCAN Providers who we can assist in enrolling in Medicaid, contracted Providers with closed panels who may be willing to take on more patients, out-of-state and catchment area Providers, and new Providers coming into Mississippi or completing medical school. When there are no Providers available, we will look at alternative care options, telehealth, innovative partnerships with Providers in other geographic areas, and the use of advanced Emergency Medical Technician programs through the Mississippi Paramedic Training Program. To address the SDOH needs of our Members and complement Provider clinical services, we will leverage non-traditional entities, including faith-based organizations, to engage Members about health care topics.

Step 3: Strategic Recruitment and Outreach to Engage and Contract
Our local Network Development team will be responsible for strategic Provider outreach, recruitment, and contracting. We will implement innovative recruitment strategies in Mississippi that have successfully built trust and attracted Providers into our affiliated health plans' networks in similar States, such as:

- Offering an open specialty network and eliminating prior authorizations for certain in-network specialty services; is especially attractive for specialists who do not typically accept Medicaid
- Designing VBP options that increase Provider revenue while improving quality, managing costs, and increasing Member satisfaction
- Being an active participant in the Provider community; in our affiliate health plans across the nation, we have a close working relationship with State hospital associations and primary care associations, and our health plan executives routinely belong to advisory councils consisting of government, Provider, and community-based leaders focused on collaboration

Step 4: Provider Retention and Continuous Monitoring to Promote Quality and Stability
The last step in our network development process will be focused on Provider retention. Much of what attracts Providers to our affiliated health plans across the country is what makes them stay, evidenced by a ***99% retention rate at our affiliated health plans*** with populations and programs similar to those in Mississippi. We will retain, support, and reward Providers in delivering high-quality, accessible care through our high-touch Provider engagement model, comprehensive training and technical assistance offerings, and Provider incentive programs, including VBP options. When our continuous monitoring efforts identify any potential network gaps, we have enhancement strategies to ensure continued, consistent, and timely access for our Members to receive all covered benefits in accordance with the network standards in Section 6.2 of Appendix A, Draft Contract.

a. The Offeror's recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, contract processing and execution, and carrying out recruitment efforts;

Our Mississippi-based Network Development team will use a high-touch, high-tech strategy for strategic Provider outreach, recruitment, and contracting combining local knowledge and personal engagement with advanced network analytic tools. We will build on the successful strategies that our affiliated health plans have deployed to build an MSCAN and CHIP network that ensures all Members will have access to timely and culturally competent primary, specialty, and emergency care to meet their physical health, behavioral health, substance use disorder, dental, and vision needs.

Identifying Network Gaps
Our network analytics and monitoring tools will enable us to proactively identify areas where Provider shortages could emerge, impacting Member choice. To identify network gaps, our cross-functional staff will continuously compile and analyze data using tools and data sources including, but not limited to:

- County-level geographic mapping, including time and distance from Members' residences
- Provider-to-Member ratios
- Panel status reports
- Appointment access and availability and timeliness audits

- Member and Provider satisfaction surveys
- Health Professional Shortage Area data from the Health Resources and Services Administration
- Population Health, Community Needs Assessments, SDOH, Health Equity, and Mississippi Primary Care Needs Assessment data

Please see **Table 4.2.2.2.A.1.A** in our response to Section 4.2.2.2.A.1.d of the RFQ below for additional methods we will use to monitor our Provider network and identify gaps. Although we do not expect any network gaps that would prevent us from meeting DOM's network adequacy requirements, we recognize that some regions of Mississippi and certain Provider types will require special attention as part of our recruitment strategy. For example, our Network Development team will target Provider shortage areas in the Delta to recruit additional Providers, when available, to ensure we maintain access standards. To address shortages of specialists in Mississippi – particularly endocrinologists, rheumatologists, neurosurgeons, and pediatric reconstructive plastic surgeons (related to burns, birth defects, cleft palate, etc.) – we will enter into strategic contracting agreements with national health systems, such as Community Health Systems to bring these specialists in from other States.

Developing Recruitment Work Plans

Our Network Development leadership will ensure accountability for network management through a comprehensive Recruitment Work Plan, which will be developed at least annually and measured on an ongoing basis to ensure we stay on track with recruitment and contracting efforts. Our Recruitment Work Plan will describe steps, deadlines, and responsible staff for recruiting high-quality Providers that allow us to offer choice to Members so that they can receive the right care, at the right time, at the right place. Our steps to develop Recruitment Work Plans will include the following:

- Analyzing and demonstrating network adequacy for all Provider types, including Providers who serve pediatric Members and Indian Health Care Providers, using reports and other data
- Developing lists of targeted Providers and recruiting for participation in the network
- Reducing contracting barriers through creative quality and cost-based VBP strategies
- Considering Members' prevalent languages spoken, cultural diversity, health literacy, health disparities, and disabilities, and developing work plan steps to recruit Providers to meet these needs
- Developing and building strategic alliances with critical access hospitals, facilities, FQHCs, RHCs, large PCP and specialty groups, and Community Based Organizations (CBOs) to enhance network diversity, increase Provider quality, and reduce medical costs
- Collaborating with the Population Health and Clinical Operations team to develop initiatives to support network growth based on performance, quality, and cost
- Collaborating with our IT Department and other CCOs to identify solutions to resolve Provider administrative issues that are barriers to recruitment

Contract Processing and Execution

Once our Network Development team identifies Providers to recruit into our network, our Network Contracting team will meet with the Providers, often face-to-face, to share information about our health plan, discuss the responsibilities of a Network Provider, and answer any questions. As part of the contracting process, we will review the contract, the steps and timeframes of contract processing, and the credentialing process that Providers will follow with the Credentialing Verification Organization (CVO). We design our contracting process with the Provider in mind, using a methodical and efficient process for creating compliant Provider agreement templates, outreaching to Providers, tracking contract and credentialing documents, and following up to address concerns and secure executed documents.

We recognize that the contracting process sets the foundation of our ongoing collaborative relationships with Providers. Our Network Contracting team will maintain Provider relationships established during the initial contract meetings until contract execution and will help Providers with any initial questions they have regarding claims submission. This high-touch approach will support a seamless entry into our network.

Carrying Out Recruitment Efforts

We will use our Recruitment Work Plan as the guide to recruit and develop an MSCAN and CHIP tailored network, employing face-to-face recruitment strategies and leveraging these personal engagements to identify the challenges Providers and their communities face. We will recruit and contract with large PCP, specialty group, facility-owned, and shared Provider practices. We will also recruit targeted pediatric specialty groups, such as Gulf Coast Children's Clinic and Desoto Children's Clinic.

We will implement innovative recruitment strategies in Mississippi that have successfully built trust and attracted Providers into our affiliated health plans' networks in similar states, such as:

- Collaborating with statewide associations and statewide/national partners to identify high performing PCPs, specialists, and behavioral health Providers, as well as ancillary services
- Offering an open specialty network and eliminating prior authorizations for in-network specialty services; this is especially attractive for specialists who do not typically accept Medicaid
- Designing VBP options that increase Provider revenue while improving quality, managing costs, and increasing Member satisfaction
- Incentivizing Providers and negotiating flexible contracting arrangements to proactively outreach to and recruit Providers, particularly in rural areas or those contracted in other programs
- Focusing recruitment efforts on existing MSCAN and CHIP Providers, particularly in rural areas, by monitoring Provider referral patterns and SCAs for contracting opportunities and calling on those Providers to join our network
- Outreaching to out-of-state Providers, as approved by DOM, from our affiliate networks to fill gaps in rural and/or underserved areas, particularly where there are patterns of care for border communities, such as Baptist Memorial Hospital and Health Care Services in Memphis to serve Northern Mississippi Members, USA Health University Hospital in Mobile to serve Southeast Mississippi Members, and Ochsner Health in New Orleans to serve Southwest Mississippi Members
- Meeting with Indian Health Care Providers regarding the critical role they play in providing culturally appropriate care to our American Indian Members and answering questions about payment clarity and integrity as a network Provider
- Meeting with Providers in response to an electronic Contract Request Form or a Provider referral from DOM, a Provider workshop attendee, a health plan associate, a Member, or another Provider
- Calling and/or visiting targeted specialty Providers in areas where gaps exist

b. The Offeror's strategy for retaining specialists and how the Offeror will provide access to specialists if not in the network;

Specialist Retention Strategies

We will retain specialists in our MSCAN and CHIP network through proven strategies in our affiliated health plans with similar populations and programs, including:

- **Provider Engagement Model.** Our high-touch support will include assigning a local Provider Relations Specialist (PRS) as a ***dedicated point of contact for each specialty Provider group*** to collaborate with office administration, physicians, and clinical staff from the specialty practice to provide education, remove barriers, and manage the overall relationship with our health plan. We will also have dedicated PRS' specifically for behavioral health clinicians, and these PRS' will have specialized training in authorizations, claims, and billing issues unique to behavioral health clinicians. In addition, our PRS' will work hand-in-hand with our Quality Practice Advisors to support specialist Providers to improve quality by reviewing performance data and care gaps and developing strategies to better serve Members. The personalized support we offer specialists will be a key part of our retention strategy.
- **Reducing Administrative Burden.** ***We will not require prior authorizations for any office visits to specialists*** and will continuously review prior authorization data to determine opportunities to remove codes from the prior authorization requirement. We will also collaborate with other Mississippi CCOs at the direction of DOM to identify uniform approaches to utilization management for the benefit of specialists and their assigned Members.
- **Payment Approaches.** We will offer flexible contracting practices and VBP models that provide specialists

the opportunity to increase their revenue while improving Members' health outcomes and managing costs. For example, we will use Pay for Performance (P4P) and shared savings contracts with pediatric endocrinologists and pediatric pain specialists. Specialists can use some of the payments received to reinvest in their practices, expanding capacity and improving quality.

- **Data Sharing.** In addition to the Provider Portal, our Clinical Data and Interoperability Gateway will enable us to share timely Member information with specialists via bi-directional data exchange with their EHRs. For example, when Members are referred to a specialist, the specialist will be able to see the Member's health information such as lab results and medication history, directly in their EHR system, better equipping them with necessary information during the visit.
- **Training and Technical Assistance.** We will provide unique training opportunities and support to enhance our specialists' ability to treat Members. For example, we will explore options to offer specialists Project ECHO opportunities to expand their use of evidence-based practices.
- **Investment Support.** We will offer our specialists access to grants that may be used to purchase telehealth equipment, including computers, tablets, mobile devices, and assistive technologies, to support the growth of their practice capabilities while helping them better serve Members.

Member Access to Out-of-Network Specialists

We will enhance our specialist network when there is not an in-network specialist available near the Member's home by:

- Arranging for specialty care from another network Provider who is willing to travel to another geographic area
- Entering into an SCA and authorizing medically necessary services from an out-of-network specialist located near the Member
- Contracting with out-of-state specialists, including key specialty Provider types and hospitals in border States
- Leveraging telehealth technology to access specialists timely or conveniently, or to access telehealth-only Providers for services such as behavioral health therapy or a second opinion

c. If Subcontractors will be used for certain service areas (e.g., dental, behavioral health/substance use disorder), how their network development efforts will be coordinated with the overall recruitment strategy and how the Offeror will provide oversight and monitoring of network development activities;

Coordination of Overall Recruitment Strategy

Our health plan will use Subcontractors to deliver dental, vision, and non-emergency transportation services. Dental and vision services will be provided through our affiliates, who have an aligned recruitment strategy with our health plan, thereby supporting a cohesive and integrated recruitment approach. In addition, we have subcontracted with our non-emergency transportation vendor in other States and have experience closely coordinating with them on transportation network needs.

Our health plan's network leadership will coordinate overall recruitment strategies with our Subcontractors through:

- Communicating regularly with Subcontractor staff responsible for network development and adequacy through e-mail, telephone calls, and at quarterly Joint Oversight Committee (JOC) meetings
- Sharing health plan data and reviewing Subcontractor data used to identify gaps, including geographic mapping, Access and Availability Evaluations, Grievance and Appeal data, and satisfaction surveys
- Incorporating Subcontractors' network development activities into our annual Recruitment Work Plan
- Participating in compliance activities that address network adequacy and network development activities
- Coordinating network recruitment and contracting across Provider and facility types

Our close working relationship with Subcontractors will yield a unified network development strategy where all parties work toward a shared vision, and all aspects of care are considered and addressed.

Oversight and Monitoring of Subcontractor Network Development Activities

Our network leadership will communicate regularly with Subcontractor staff to oversee network development activities in line with the annual Recruitment Work Plan. Our network leadership or staff will participate in

quarterly JOC managed by the Compliance Department. The agenda will include network status, compliance with access and availability requirements, and the number and type of contracted Providers in network. Our health plan Compliance Officer will be responsible for conducting a formal audit of Subcontractors, at least annually, and ad-hoc audits if warranted. The Compliance Department will also document Subcontractors' monthly and periodic reporting and specify the targeted performance metrics. We will have policies to ensure standards are met and address non-compliance through education, Corrective Action Plans (CAP), or in the case of serious non-compliance, revocation of delegation authority.

d. Proposed method to assess and ensure the network standards outlined in Appendix A, Draft Contract, are maintained for all Provider types, including using GeoAccess to ensure network adequacy;

Method to Assess Network Standards

Our Network Development team will deploy best-in-class prospecting, network analytics, and geographic mapping capabilities to ensure that we meet or exceed DOM's requirements for access and accessibility in Section 6.2 of Appendix A, Draft Contract. We will continuously analyze accessibility and target network adequacy at the State, regional, local, and Provider-type levels. This will include drilling down to evaluate adequacy by the county classification. We will also incorporate our understanding of the rural nature of Mississippi, the MSCAN and CHIP program requirements, and the Provider landscape, considering factors such as population demographics, patterns of care, and Provider capacity (e.g., panel status, willingness to accept Medicaid and CHIP).

We will tailor our network monitoring activities to the needs of MSCAN and CHIP Providers and Members. Expanding our analysis beyond geographic mapping, we will conduct a detailed and ongoing review of cultural and linguistic needs, health disparities, and SDOH needs by leveraging predictive analytics to generate heat maps that identify leading social indicators correlated with poor health outcomes. We will comply with all documentation and reporting requirements in Section 6.2 of Appendix A, Draft Contract, including submitting quarterly Network Geographic Access Assessment Reports to DOM. **Table 4.2.2.2.A.1.A** includes the key data sources our team will analyze to assess network access and identify areas to strengthen the network.

Table 4.2.2.2.A.1.A Tools and Data Sources Used to Assess Network Standards

Tool or Data Source (and frequency)	How Data/Tool Supports Network Assessment
Network Analysis Tool (monthly)	Provides a comprehensive analysis of network strength and identifies Provider targets for recruitment by specialty and geography.
County-level geographic mapping; Provider-to Member Ratios; and Panel Status Reports (monthly)	Confirms the availability of network Providers by type, considering time and distance from Members' residences, and identifies potential gaps and/or capacity issues.
Appointment Access and Availability and Timeliness Audits (quarterly, annual)	Proactively identifies potential capacity and access issues and Provider compliance with network standards; confirms adequate access to after-hours/weekend care.
Population Health, Community Needs Assessments, SDOH, Health Equity, and Mississippi Primary Care Needs Assessment (continuous; annual report)	Culturally and Linguistically Appropriate Services (CLAS) evaluation that overlays network access with membership characteristics such as race, ethnicity, religion, and language to identify gaps in network concordance, quality of care, and access. Metrics include cultural, geographic mapping, discriminatory and cultural Grievances, and health disparities identified within patient panels.
Current and Anticipated Enrollment by Zip Code (monthly)	Considers Member demographics and health care needs, and helps anticipate potential service or network expansion needs.
SCAs, Out-Of-Network Utilization Reports, Authorized Transportation Reports (quarterly)	Identifies potential availability issues by region/Provider type (categorized by type for the population served, services authorized), Member patterns of care trends, and contracting/workforce development opportunities.
CAHPS/Satisfaction Surveys (annual); Grievances and Appeals (quarterly)	Identifies Member and Provider satisfaction issues and complaint trends related to access, accessibility, and appointment availability.
Claims and Encounter Data (monthly and ad hoc as needed)	Detects patterns of care, under-use, or inappropriate use of services, and potentially preventable event trends that may indicate a network deficiency.

Improving Access as Needed to Ensure Standards are Met

When we identify a network gap or access issue, we will quickly implement actions to immediately provide all medically necessary services required to meet Member needs, even if those services are not available from a contracted Provider. These actions include: incentivizing PCPs to open panels, expand their scope of services,

or serve more Members; asking Providers contracted through other lines of business to expand to serve MSCAN and CHIP Members; providing ADA-compliant transportation to the closest network Providers available through the non-emergency transportation (NET) benefit; facilitating an SCA with an out-of-network Provider; and contracting with Providers located in bordering counties and states to support existing patterns of care. To support telehealth adoption, we will provide education and technology support to PCPs, including FQHCs and RHCs. Additionally, PRSs will assist Providers in securing NET for Members for whom transportation is a barrier to care. Where necessary and appropriate, we will work collaboratively with other CCOs in Mississippi to build Provider capacity through grant programs to rural hospitals and scholarships for Mississippi colleges and universities.

Supporting Providers to ensure they meet ADA Accessibility Standards. To increase the percentage of Mississippi Providers that meet minimum Federal and State disability access standards, our Provider Relations Specialists will conduct Accessibility Site Reviews. After the review, PCP/PCMHs can apply for a grant to carry out their improvement plan which could include wheelchair ramps and equipment such as accessible exam tables.

e. The Offeror's process for continuous network improvement, including the approach for monitoring and evaluating PCPs'/PMHCs' compliance with availability and scheduling appointment requirements and ensuring Members have access to care if the Offeror lacks an agreement with a key Provider type in a given geographic area; and,

Process for Continuous Network Improvement

To support continuous network improvement and ensure access and availability for our Members, our Network Development team will meet monthly to identify improvement opportunities based on the network assessment activities described in response to Section 4.2.2.2.A.1.d above and from the feedback we receive from Providers in the field and through advisory committee meetings. In addition to ongoing improvement activities, we will also conduct an Access and Availability Evaluation semi-annually. This Evaluation will analyze compliance with appointment access and availability and after-hours access standards and network compliance with the time, distance, and cultural competency standards previously described. The Network Development team will report assessment results to the Utilization Management Committee and the Quality Management Committee (QMC) at the individual practitioner, Provider, physician group, or facility level, or as an aggregate by Provider type and incorporate into the Quality Evaluation. Network Development staff will compare results against standards and analyze root causes of deficiencies. The Utilization Management Committee will identify opportunities for improvement and recommend actions to correct deficiencies. Such actions could include targeted Provider contracting initiatives, modified Provider scheduling practices, expanded office hours or travel to another area to provide services, identified sources of Provider dissatisfaction, and strengthened retention strategies. Network Development staff will measure and report the effectiveness of interventions monthly to the Performance Improvement Team, quarterly to the Utilization Management Committee, and annually to the QMC.

Monitoring and Evaluating PCP/PCMH Availability and Appointment Requirements

Our Provider Relations team will monitor PCP/PCMH compliance with appointment availability and timely access standards described in Section 6.2.2 of Appendix A, Draft Contract. We will report PCP/PCMH well care, routine, and urgent appointment availability to DOM quarterly. In addition, through an online dashboard updated in real-time, we will analyze data and trends to identify appointment access issues and then proactively resolve them through collaborative action planning with Providers and reviews of recruitment opportunities. Further, as PRSs conduct visits, they will review data accuracy and appointment availability standards when completing roster reviews, check the standards set by DOM, and inquire about a Provider's ability to treat Members within those timeframes. We recognize the importance of Member feedback and satisfaction with timely treatment. We will give Members a voice in this compliance process by encouraging and educating them to report access issues around appointment availability in real-time through our Member Services Call Center or our secure Member Portal messaging. Appointment availability will be a standing agenda item for our Member Advisory Committee and Joint Oversight Committee meetings.

As part of the Access and Availability Evaluation described above, we will evaluate and report on Member experience related to PCP/PCMH appointment accessibility, Member Grievances related to PCP/PCMH access, urgent care appointment access, and PCP/PCMH after-hours access.

The measurements we will use to monitor and evaluate PCP/PCMH availability, and appointment requirements include:

- **Primary well care, routine, and urgent appointments:** Quarterly audits of PCPs/PCMH appointment access and availability, annual CAHPS Member Satisfaction Survey, and quarterly Grievance and Appeals analyses related to access to care
- **Primary care after-hours access:** Measured annually by calls to PCP offices after hours to confirm there is a mechanism for Members to have access to primary care 24/7
- **Ongoing PCP appointment accessibility:** Measured through access and availability outreach and reporting conducted by our Provider Relations team and dedicated staff that outreach to Providers to validate appointment availability

When PCPs/PCMHs are not meeting the appointment availability standards, our PRSs will offer support to help them manage their availability or improve their scheduling systems.

Ensuring Access to Care Across Geographies

We will enhance our network when there is no network Provider available near the Member's home in a given geographic area. These enhancement strategies will include:

- Arranging for the Member to see a network Provider who is willing to travel to another geographic area, or by using telehealth or the NET benefit
- Entering into a single case agreement (SCA) and authorizing medically necessary services from an out-of-network Provider located near the Member
- Contracting with Providers located in bordering counties and states

At times it is necessary and prudent to arrange for a Member's care with out-of-state Providers who may be out-of-network. This situation occurs mainly in a tertiary care setting, catchment areas, or when the Member has a specialty Provider need best treated at a Center of Excellence located outside of Mississippi. The SCA process described above would apply to both in and out-of-state services. When necessary, we will pay for a Member's travel, including ground or air medical transportation, lodging, meals, and associated medical expenses at the out-of-state or away-from-home location**.**

f. How the Offeror will ensure appointment access standards are met when Members cannot access care within the Offeror's Provider Network.

We will ensure the appointment access standards set forth in 6.2.2 of Appendix A, Draft Contract, are met even when Members cannot access care within our network. Our Care Managers will play a critical role in ensuring Members' timely access to care from out-of-network Providers. We will thoroughly train Care Managers and Member Services staff on appointment access standards. Care Managers will be responsible for helping to locate and connect Members receiving Care Management services with out-of-network Providers when necessary to access care. As part of identifying an appropriate out-of-network Provider to meet the Member's needs, Care Managers and Member Services staff will ensure the Provider is available within an acceptable timeframe, assist with scheduling the appointment, and arrange transportation. Our Care Managers will also follow-up with Members to ensure they are satisfied with the Provider, including appointment scheduling and access.

To ensure ongoing availability, we will include provisions requiring out-of-network Providers to comply with DOM's appointment access standards in SCAs. We will monitor out-of-network Provider compliance as part of the Access and Availability Evaluation to ensure Providers comply with these standards. When an out-of-network Provider is non-compliant with appointment standards, our Provider Relations team will perform additional outreach to the non-compliant group to educate them on appointment standards. We may take corrective action against Providers who continue to be out of compliance, including continued additional monitoring or restriction from providing services to our Members in the future.

g. Describe the role of the Contractor's Provider Representatives, how the Offeror will recruit and maintain these individuals, and how the Offeror will ensure that representatives stay current on Medicaid policy.

Provider Representative Responsibilities

Our Provider Relations Specialists (PRSs) will serve as provider representatives and be dedicated liaisons, problem solvers, and performance improvement support for the Providers within our MSCAN and CHIP network focused on improving the quality and cost-effectiveness of care and establishing best practices. We understand that Mississippi Providers are particularly interested in having access to data to improve their practice management and patient outcomes and that reducing hospital readmissions is an important focus for DOM. We will customize our PRSs training and arm them with the tools to work with Providers to address Mississippi's priorities. PRSs specific job duties will include:

- Serving as the dedicated point of contact with Providers to proactively provide education, remove barriers that impede Providers from effectively serving our Members, and manage the overall relationship with our health plan
- Collaborating with Providers to implement best practices to help them recognize and capitalize on areas of opportunity; for example, helping establish procedures for same-day and next-day appointments
- Conducting monthly site visits with high-volume Providers (e.g., PCPs, PCMHs), and quarterly site visits with all assigned Providers
- Engaging Providers on attaining and maintaining PCMH recognition
- Performing HEDIS, utilization, and other analyses and creating Provider performance reports including data customized to the individual practitioner level for practice administrators; working hand-in-hand with our Provider Partnership Associates to review these reports and develop solutions for performance improvement
- Creating and communicating milestone documents, dashboards, and success or improvement metrics
- Providing information and status updates for Providers regarding VBP and incentive agreements
- Conducting initial Provider orientations, with frequent touchpoints with Providers in the first 90 days after joining our network to ensure successful acclimation to our health plan and support Provider retention
- Educating Providers regarding policies and procedures related to referrals, claims submission, credentialing documentation and the CVO process, Provider Portal, EHRs, and Electronic Data Interface

Recruitment and Retention

We will hire PRSs from the regions of Mississippi they will serve, reflecting the cultural makeup of our membership. We will have specially trained PRSs focusing on PCPs/PCMHs, behavioral health Providers, and specialists. We will hire experienced health care industry professionals in Mississippi, recruiting through our connections with local Provider associations and industry groups and by posting with national job search engines. We will recruit and maintain PRSs through competitive salaries and benefits, career advancement opportunities, and paid education and training programs.

Training

Our PRS onboarding program will include fundamental, program-specific, job function, and cultural competency courses given by our local and corporate trainers. Training will include Medicaid 101, MSCAN and CHIP, Provider Billing Handbook, compliance, accessing appropriate services, covered benefits, and Provider and Member education materials. We will also provide additional customized training to PRSs dedicated to certain Provider types (e.g., specialists, BH Providers, PCPs/PCMHs). We will regularly update training to reflect changes in MSCAN and CHIP program requirements. PRSs will receive ongoing training from our Population Health, Compliance, and Quality departments when new Medicaid policies are issued by DOM or CMS or when monitoring efforts identify a need for re-education. We will provide ongoing training to PRSs based on trends we identify in Provider inquiries and needs (e.g., using reports to view Member population health categories to guide engagement activities) to ensure all PRSs are equipped to respond efficiently.

2. Describe how the Offeror will develop and maintain collaborative relationships with low, medium, and high intensity residential treatment facilities and medically monitored inpatient treatment facilities.

We will work with the statewide network of Psychiatric Residential Treatment Facilities (PRTFs), medically monitored inpatient treatment facilities (ITFs), and other BH/SUD Providers as defined by the American

Society of Addiction Medicine to maintain collaborative relationships with low, medium, and high residential treatment facilities and medically monitored inpatient treatment facilities for the benefit of our Members. Our Mississippi-based, dedicated, full-time Vice President of Network Development and Behavioral Health Medical Director will manage relationships with facility leadership. We will staff our ***regional Provider teams with Behavioral Health PRSs*** to support Providers at these facilities. Our collaboration with residential and inpatient facilities will be focused on training, improving data sharing around timely notice of admissions to maximize the effectiveness of treatment, discharge planning including timely provision of post-discharge follow-up care, and reducing readmissions. Our Participating Provider Agreements will include a requirement that all Members receiving inpatient and residential services be provided with a transition of care plan that provides for outpatient follow-up and/or continuing treatment prior to discharge from the residential or inpatient setting.

Collaboration through Training and Outreach

Provider Relations and CM teams will outreach to BH Providers on a routine basis to share information and obtain feedback on the success/failure of established processes. We will invite BH Providers to attend our Provider Workshops, covering topics such as trauma-informed care. BH PRSs will meet with each facility to gain awareness of capacity, offer training to new staff, review profile reports, and address any questions or concerns. Additionally, our Behavioral Health Clinical Trainer will hold in-person training at residential and inpatient facilities on topics including strategies to reduce readmissions and support Members in recovery.

Collaboration with Residential Treatment Facilities and ITFs on Timely Notice of Admissions

Our first step, aimed at ensuring timely notification of a Member's admission, will be to develop a Memorandum of Understanding (MOU) with all hospitals that have onsite psychiatric services, which will include processes for the hospital to notify us within 24 hours of a BH admission so our Transition of Care Program team (TCP team) may participate in discharge planning. We will share our proposed MOU with DOM for review and approval. The MOU will outline processes for the use of a ***Discharge Coordination Form*** and for the TCP team to work with the facility on discharge planning. This process will ensure the Member has a treatment plan that addresses their unique needs in the least restrictive level of care. Our second step, aimed at reducing hospital administrative burden, will be to work directly with each hospital to develop a sustainable and straightforward notification process. Our third step, aimed at assessing the effectiveness of the notification processes, will be to track notification activities by the hospital. After collecting data for six months, we will share results and survey each hospital to assess their satisfaction with the processes and their ability to maintain the notification process. Our QMC will incorporate findings into our annual Quality Management Work Plan.

Discharge Planning From Admission

Through near-real-time admission, discharge and transfer (ADT) data feeds and our collaborative relationships with ITFs, we will be made aware of Member inpatient admissions. Once we know of the inpatient admission, the TCP team will engage the hospital to begin discharge planning. While the Member is still in the hospital, we will coordinate the scheduling of follow-up treatments and outpatient care within seven days of discharge. In addition, we will begin discharge planning with the facility from the date of admission and at each live review conducted during the Member's stay. For optimal communication, we will provide the discharge summary to the outpatient BH Provider and the Member's PCP. The TCP team will contact the Member to remind them of the appointment and address any barriers. Following the first appointment after discharge, the TCP team will contact the treatment facility to confirm the Member kept the appointment. If not, we will contact the Member to reassess barriers and reschedule the appointment to occur as soon as possible and within 30 days of discharge.

Collaboration with Substance Use Disorder Treatment Facilities

Engagement in post-detoxification follow-up treatment and support services for persons diagnosed with substance use disorders (SUD) is the single best predictor of successful recovery. We will work with network SUD Providers to remind them of the importance of encouraging Members to establish a relationship with their PCP/PCMH and make an appointment for an annual physical exam if they have not already done so. We will require SUD Providers to notify us immediately should a Member miss their appointment, and our Care Managers will work with the Member to reschedule. We find that SUD Providers support this holistic approach

to recovery. We will continue to reinforce the importance of our ongoing communication as the Member goes through the recovery process.

Collaboration with Pediatric Behavioral Health Providers

Based on our experience in affiliated health plans with populations and programs similar to Mississippi, BH services for children result in the best outcomes when treatments are focused on resiliency and recovery, provided in the least restrictive setting, and focused on maintaining the family unit. We consider characteristics of the local delivery system, such as the availability of alternative levels of care to support the Member after discharge from an acute hospitalization and the treatment team's ability to provide all recommended services within the estimated length of stay. Collaboration with pediatric BH Providers will have varied clinical focus based on each Member's unique needs.

3. Describe the Offeror's process for working with Providers and the Credentialing Verification Organization (CVO) to educate and assist Providers in completing the credentialing and recredentialing process with the CVO.

We will support DOM's transition to a CVO to simplify the MSCAN and CHIP enrollment process for Providers and improve efficiencies by reducing the administrative burden. Working in collaboration with DOM, the CVO, and Providers, we will meet the requirements outlined in Section 6.5 of Appendix A, Draft Contract. We have worked successfully with State partners, Providers, and fiscal intermediaries through our affiliated health plans to implement centralized credentialing. We will leverage this affiliate experience as we interface with DOM's CVO and work with Providers on proper submission guidelines.

We will use a multi-pronged approach to educate Providers about the credentialing and recredentialing process. First, we will post a link to the CVO's credentialing and recredentialing process on our website for Providers who may not be contracted with our health plan. For Providers interested in joining our health plan, our Network Contracting team will inform Providers about the steps involved in the CVO's credentialing process and how it interfaces with our health plan contracting process. Once Providers become part of our network, we will educate them regarding recredentialing through our initial Provider orientation and through our Provider Manual. This education will include the process for adding a new Provider or new location to a Provider group already contracted with our health plan. Our PRSs will also assist network Providers as they learn the process and go through recredentialing.

We propose to assign a single point of contact from our health plan to liaise with the CVO regarding any questions about information received from the CVO and to bring forward any feedback we receive from Providers regarding the credentialing process. We will work collaboratively with the CVO to ensure we will have the ability to track/view the status of Provider applications to effectively share this information with Provider partners to support seamless collaboration.

4. Describe the Offeror's approach for timely contracting of Providers upon receipt of information from the CVO that a Provider's credentialing is complete.

When recruiting Providers into our network, our Network Contracting team will meet with Providers regarding the contracting process, review the Provider Agreement, answer questions, and negotiate terms. To support timely contracting of Providers following the completion of the credentialing process by the CVO, we will request that Providers sign the Provider Agreement prior to the credentialing process completion. Once we are notified by DOM/the CVO that the credentialing process is complete and we receive the file interface exchange containing the Provider's credentialing approval, we will notify the Provider within seven calendar days regarding approval or denial of their contract request. Upon successfully completing credentialing through the CVO, we will countersign the Provider Agreement.

After the Provider Agreement has been executed by both the Provider and our health plan, we will immediately initiate the steps to load the Provider information into our Provider Lifecycle System. The Provider Lifecycle System feeds into our claims processing system to ensure we complete the contracting process and load the Provider information into our claims processing system within 21 calendar days from the date of notification from DOM. Data in our Provider Lifecycle System flows to other downstream systems needing that information, including our Provider Directory for near real-time updates thanks to our Real Time Repository (RTR) data architecture.

5. Submit templates of the Offeror's standard Provider contracts.

We have read, understand, and will comply with all Provider Agreement requirements described in Section 6.6 of Appendix A, Draft Contract. Please refer to **Attachment 4.2.2.2.A.5.a Participating Provider Agreement, Attachment 4.2.2.2.A.5.b Participating Provider Agreement- Dental, Attachment 4.2.2.2.A.5.c Participating Provider Agreement-Vision** for our sample boilerplate Participating Provider Agreement, including Exhibits that govern our contractual relationships with Ancillary, Clinic, Group, Hospital, Primary Care, and Specialist Providers. We will ensure that all Provider Agreements meet DOM's contractual requirements. For CHIP Providers, our Participating Provider Agreement will also include a product attachment specific to the CHIP program.

6. Describe the Offeror's proposed policies and procedures for addressing the loss of a large Provider group or health system, including:

Through our Provider Relations Model, we will work closely with Providers as partners to ensure we do not lose a large Provider group or health system from our network. We will exhaust all efforts to prevent a significant loss of Providers. However, in the unlikely event that a loss occurs, our policies, procedures, and systems are set up to minimize any adverse impact for Members. We will comply with all DOM requirements articulated in Section 6.4 of Appendix A, Draft Contract for every circumstance involving a Provider termination, including submitting Provider Termination Work Plan and supporting documentation to DOM.

Our policies and procedures will include methodologies and proactive risk management strategies to ensure continued Member access should termination occur. We will comply with all DOM requirements related to the loss of a large Provider group or health system from our network, including, but not limited to, those outlined in Sections 6.4 Provider Terminations, 7.6 Provider Agreements, and applicable parts of Section 7 Care Management Services of Appendix A, Draft Contract. **Table 4.2.2.A.6** below highlights an example of a proposed policy that will include notification letter templates and work processes including system work processes and impact analysis templates.

Table 4.2.2.A.6 Example Proposed Policies and Procedures

Policy Name	Purpose	Description
Provider Termination Policy	To ensure all Provider Terminations are implemented accurately, timely, and in compliance with State and Federal laws.	Outlines the development of a termination work plan including specific steps/actions and due dates. The work plan includes Provider Impact and Analysis, Provider notification of termination, Member Impact and Analysis, Member notification of Termination, Member transition and continuity of care, System Changes, Provider Directory updates, Contractor Online Directory Updates, Communication Plan and Termination Retraction Plan (if applicable) and notification requirements to DOM.

a. System used to identify and notify Members affected by Provider loss;

Identification of Members

Upon receipt of a Provider's notification of termination, our Provider Relations Department will notify the Eligibility Specialist. The Eligibility Specialist will identify Members impacted by the termination by generating a report listing all Members assigned to each terminated Provider. For all other types of Providers, a Claims Liaison will create a claims report listing all Members who have seen the Provider within six months prior to the termination date.

Notification to Members

Within 15 calendar days of notice or issuance of termination, the Eligibility Specialist will mail all affected Members a notification of termination (at 3rd grade reading level) containing the following information, with a copy to their PCP/PCMH (unless terminated):

- Provider name and notification of termination
- The date after which the Member cannot use the terminated Provider
- How to select a new Provider and contact information for the Member Services Call Center
- Inclusion of optional Providers to choose from
- The Member's right to request continued care from the Provider
- Notice of PCP/PCMH assignment if the Member does not call or use the Member Portal to change their PCP/PCMH

- To promote access to high quality, convenient Providers, we will assign the Member to a new PCP/PCMH, in part, based on the distance to the PCP/PCMH and the PCP's/PCMH's quality score
- If the Member is enrolled in medium or high-risk Care Management, we will assign the Member to a PCMH

We will also email Members for whom we have email addresses, notifying them they have an important message that they can access through the Member Portal. The message will contain the same information as the mailed notice described above. For Members in Care Management, this will alert the Care Manager(s) to outreach to impacted Members notifying them of the situation and assisting them with selecting a new PCP/PCMH. For Members in foster care or whom otherwise have another caseworker, we will notify the applicable State agency, facility, or if appropriate, their Parents/Caretakers/Caretaker relatives of the Provider's termination and assist with any Member needs.

b. Automated systems and membership supports used to assist affected Members with Provider transitions;

We will support Members with Provider transitions using our automated technology systems, including our CRM, Member Portal, and online Provider Directory. Member Services and CM staff will use the information available in these systems to assist Members who contact the call center or who are in Care Management to choose a new PCP/PCMH or locate another Provider to promote Member choice of a high-quality Provider.

Members can use the Member Portal to change their PCP/PCMH and use the online Provider Directory to assist them in their selection. The Directory will use a Member's location to find the nearest Provider and includes helpful information such as hours of operation, non-English languages spoken, names, locations, telephone numbers, and status of Providers accepting new Members. Our Directory will also support Members seeking Providers with location accessibility, such as platform lift, elevator, and size of interior travel paths. Our systems will automatically update the online Directory after a termination is completed and updated in the Customer Relationship Management system.

Our technology systems enable us to quickly respond and support Members impacted by Provider transitions:

- The Provider Lifecycle System component of our Management Information System (MIS) automates our health plans' Provider relationships with continuous data management, such as managing termination dates/other data changes
- Customer Relationship Management (CRM) receives, validates, integrates, manages, transmits, and reports on all levels of Member demographic information and Member preferences
- Our secure, web-based Member Portal allows Members to review and select from available Providers when a Provider loss requires them to choose a new PCP/PCMH
- Our Provider Portal gives Providers access to information about the Member's care history and needs to facilitate continuity of care when the Member begins seeing a new Provider following a Provider loss
- The Member Health Record in the Provider Portal securely displays a Member's medical, behavioral, and pharmacy utilization as well as lab test results, care gaps, health alerts, SDOH, and other clinical information
- The Patient Panel Roster includes updated demographic and administrative information as well as care gaps for all Members under the Provider's care
- Our Clinical Documentation System displays the Member's Care Plan, which includes the Member's identified health problems, treatment goals and objectives, milestone dates, and progress in an online format

c. Systems and policies used to maintain continuity of care of Members experiencing Provider transition; and,

Systems to Support Continuity of Care

As described above in the response to Section 4.2.2.2.A.6 of the RFQ, our technology systems will support continuity of care for Members when they experience a Provider transition by helping the new Providers receive historical information about the Member. For example, through the Provider Portal, the new Providers can access information on their new Members' health care needs and conditions, including the care plan, medication history, laboratory tests, radiologic studies, prior authorizations, assigned health plan Care Manager, and be alerted to care gaps or upcoming appointment needs. Through the Provider Portal, we will offer the new Provider information to prevent unnecessary duplication of tests or unintentional changes to medication

regimens for which the Member is already stabilized and could negatively impact Member outcomes. In addition, Care Managers will use our Clinical Documentation System to support Member continuity of care, documenting the Provider transition, adjustments to treatment goals, and other Care Manager actions in the care plan, based on outreach to the Member regarding the transition.

Policies to Support Continuity of Care

Our Provider Agreements will require that Providers give us 180 days' notice before voluntarily leaving our network at the end of the initial term, at the end of any renewal term, or in accordance with alternative terms of the Provider Agreement. By having 180 days' notice, we will implement our four-step Network Development Strategy described above to retain or replace the Provider and maintain continuity of care for our impacted Members. Providers must supply copies of medical records for each Member to the new Provider and must facilitate the Member's transfer of care at no charge to the Member.

We will allow Members to continue an ongoing course of treatment from the terminated Provider (unless the Provider is terminated due to cause) for up to 60 calendar days from the date we notify the Member of the termination or 60 calendar days from the date of Provider termination, whichever is greater. Upon request from a Member undergoing active treatment related to a chronic or acute medical condition, we will reimburse the Provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, we will reimburse the Provider for the provision of covered services to a Member who is in the second or third trimester of pregnancy, extending through the completion of postpartum care relating to the delivery.

d. Approach to cover membership needs with existing network resources following terminations.

We will submit a Provider Termination Work Plan as required by Section 6.4 of Appendix A, Draft Contract for every Provider termination. We will identify new network Providers for impacted Members and transition those Members to new PCPs/PCMHs, including specialists acting as PCPs. Upon notification of a termination, we will use network assessment methods such as geographic mapping and the Access and Availability Evaluation to measure the impact of the Provider termination on our existing network's compliance with geographic and appointment access standards (e.g., appointment wait times remain within contract standards). Our Performance Improvement Team and QMC will identify compliance issues based on this assessment and determine solutions. Our Network Development team will incorporate the results into the Recruitment Work Plan for implementation.

Our Member Services Call Center and CM teams will support Members to identify convenient, high-quality Providers to meet their specific care needs. Our Network team will determine the two closest Providers to the Member's zip code, and an Eligibility Specialist will send the suggestions to the Member. If the Member does not select a Provider, they will be auto-assigned to the nearest, most highly qualified Provider. Where necessary, we will provide incentive payments to Providers to expand their panel capacity to accept more Members through extended hours or staffing to ensure continuity, coordination of care, and continued timely access. Our CM team will closely monitor impacted Members to address and alleviate any resulting barriers to care from the new Providers, such as concerns related to SDOH and NET.

7. Describe any Provider incentive programs the Offeror plans to implement to improve access and the quality of care.

To improve our MSCAN and CHIP Members' access to care while also improving the quality of care, we will offer financial and non-financial Provider incentive programs. Our incentive program for network Providers will include VBP arrangements, described in our response to Section 4.2.3.1 of the RFQ, promoting integrated primary care in alignment with DOM's goals.

Financial Provider Incentive Programs

We realize that all Providers participating in MSCAN and CHIP have not all advanced at the same pace in terms of readiness to participate in VBP models. By providing the right incentives to the right practices at the right time, we will leverage proven methods to successfully advance Providers across a continuum of payment and care transformation. To achieve this goal, we propose to offer VBP across the entire spectrum of the Health Care Payment Learning & Action Network (HCP-LAN) Framework.

Our Integrated Primary Care Value Based Purchasing (IPC-VBP) approach will support the expansion and use of PCMHs in Mississippi and include value based purchasing (VBP) models that offer an enhanced

reimbursement structure to Providers ready to accept downside risk, in addition to upside quality payments. [redacted]

Please refer to our response to Section 4.2.3.1 of the RFQ for the full description of our proposed VBP models. We will also implement Provider incentives for actions such as expanding panel capacity to accept more Members through extended hours or staffing and payments to PCPs/PCMHs for completing behavioral health screenings.

Non-Financial Provider Incentive Programs

We will offer non-financial Provider incentives, such as the following:

- **Preferential Member Auto-Assignment.** We will recognize Providers for their outstanding performance and consistent support of our quality improvement programs by offering them a preferential assignment of Members in the auto-assignment process. Our PCP auto-assignment algorithm will incorporate PCPs' quality scores to align Members with Providers who consistently meet high-quality standards.
- **Reduced Administrative Burden.** We will incentivize Providers with excellent quality and appropriate utilization by waiving prior authorization requirements for select services.
- **Quality Awards for Excellence in Care.** We will recognize Providers with the highest quality scores for the year with an annual Quality Award for Excellence in Care.
- **Service to the Underserved**. On an annual basis, we will recognize an outstanding PCP, nurse practitioner, and/or physician assistant in each region of the State who makes a significant contribution to local community health and addressing health disparities. We will recognize them in the press and our Provider and Member Newsletters, and they will be eligible to direct a contribution from our health plan to an approved charity of their choice.
- **Preferred Provider Partnership**. We will have a preferred Provider program to waive authorizations and remove administrative burden when Providers demonstrate high quality. For example, we will waive certain authorization requirements for preferred Providers who commit to entering into value-based contracts.

8. Explain the Offeror's proposed process to maintain the Offeror's Provider file with information about each Provider sufficient to support Provider payment including the ability to:

Provider File Process Supporting Provider Payment

We will receive all required data for the Provider File from DOM via a file transfer at regularly scheduled intervals determined by DOM. Once we receive this information, we will upload it into our Provider Lifecycle System. We will maintain Provider files with details on each Provider sufficient to support timely and accurate Provider payment and meet Federal and DOM reporting requirements. Our Provider Lifecycle System is an integrated component of our MIS, which automates the entire lifecycle of our Providers' critical operational areas.

Ensuring Sufficient Information to Pay Providers. As part of the Provider contracting process, our Provider Data Management (PDM) team will enter a Provider's demographic, specialty, location, affiliation, and related information in the Provider Lifecycle System. This information will include Provider name, group name, W-9 form showing legal entity name and tax identification number (TIN), taxonomy code, address, effective date, end date, primary specialty, Medicaid identification number, payment information, National Provider Identifier (NPI), and licensing/credentialing information, including the DEA license and CLIA certificate as indicated. The Provider's financial affiliation(s), license status, specialty/practice type, pay class (including Provider's contractual relationship with us) support our claims payment processes. We will add the Provider data to support payment and reporting for services obtained from an out-of-network Provider, not in our Provider Lifecycle System. We will also perform reconciliation with CMS's National Plan and Provider Enumeration System (NPPES) to ensure the accuracy of NPIs and use DOM's Provider data file for validation of Medicaid identification numbers.

Provider Data Integration in Our MIS. Our Provider Lifecycle System is integrated with our MIS supporting automated electronic data exchange between our system components, including our Claims Processing System, Clinical Documentation System, Encounter Data System, Enterprise Data Warehouse, and Reporting and Analytics Platform. Provider data is audited and reconciled in our Provider Lifecycle System before distribution to other systems to ensure data consistency and integrity throughout our operations.

a. Issue IRS 1099 forms

By January 31st of each year, as required by Federal law, our Finance Department will issue 1099 forms for all Providers (in and out-of-network) who received claims payment of $600 or more in the previous year. We will review and validate the accuracy of our Provider files at regular intervals throughout the year to expedite the issuance of 1099s in January. Our Mississippi-based Chief Financial Officer and Vice President of Finance will ensure accuracy and oversee the proper issuance of 1099 forms by January 31st of each year. Providers will not need to complete any forms for 1099s to be issued. If Providers have questions, they will be able to contact the PSCC or reach out to their local PRS.

b. Meet all federal and Division reporting requirements, and

We will work collaboratively to meet all DOM and Federal reporting requirements outlined in Appendix A, Draft Contract related to Provider information and Provider network statistics. We will have a project manager dedicated to reporting activities, with support from our Data and Analytics Manager. Through our experience and strong relationships with Providers, supported by our Provider Relations team, we will ensure that we maintain up-to-date Provider data in our systems to maximize the value and reliability of our payment and reporting processes. We will also require Subcontractors to verify and report network and utilization information to ensure our compliance with Federal and DOM reporting requirements.

Our Reporting and Analytics Platform includes a full suite of tools, including desktop reporting and Key Performance Indicator (KPI) dashboard capabilities to provide the reporting capabilities needed to report on all data sets required for Federal, State and MSCAN and CHIP reporting, including those related to Provider data, 1099 reporting, HEDIS, EPSDT services, and claims timeliness. For example, we will use the following reports to monitor and manage Provider information:

- **Provider Data Management Dashboard.** Our Network Management staff will review a Provider Data Management Dashboard that is updated weekly to enable continuous monitoring of the administration and management of Provider data. The dashboard is designed to measure the volume of and success in completing quality management processes relating to Provider claims and service activities.
- **Data and Reports Supporting Our Provider Relations Team.** Our Provider Relations staff will use data,

analytics, and reports to track various activities, including the trending of issues impacting claims, encounter data, and reports. We will document, maintain, and track all claims issues and communication with Providers, including any Provider issues received from the Provider Services Call Center. For example, if we identify a Provider claims issue, our Customer Services Representative (CSR) will use contextual documentation and reporting from our Reporting and Analytics Platform, sourced from our Claims Processing System to solve their issue in real-time. Updated Provider demographic information from multiple communication sources will be entered and updated in our Provider Lifecycle System by our PDM team, ensuring that all Provider data comes from one governing source, as well as ensuring correct outcomes in areas such as claims adjudication, authorizations, 1099 forms, and our Provider Directory listings.

c. Cross-reference to state and federal identification numbers to identify and report excluded Providers.

Processes for Cross-Referencing State and Federal Exclusions Lists

Per our policies, Providers who do not have a Mississippi Medicaid ID number or have a revoked/suspended Medicaid/Medicare ID number will not be eligible to participate with our health plan. In addition, the safety features built into our Provider Lifecycle System will prevent entering a Provider record unless the Mississippi Medicaid ID number is entered. This safety feature enables our Provider Lifecycle System's "Sanction Pay Class" mechanism can ensure no Provider on an Exclusion List is eligible for payment. Upon notification from DOM that a Provider has been sanctioned, we will notify the Provider (via letter) and provide verification to DOM that no claim will be paid to the sanctioned Provider. We will report Provider network statistics (including reporting of excluded Providers) to DOM on both a monthly and ad-hoc basis.

Provider Data Collection/Validation Process. We will collaborate with the CVO to confirm Providers have the valid information to be credentialed and/or recredentialed as MSCAN and/or CHIP Providers. In between credentialing and recredentialing cycles, we will query the US Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities Database and DOM's Excluded Provider Listings on a monthly basis. If Providers are found in either database, we will notify our Vice President of Population Health and Clinical Operations and Compliance Officer. The Compliance Officer will notify DOM and the Provider will be immediately suspended from the network. We would then recoup any claims paid to the Provider during the exclusion period.

Preventing Payment to Excluded Providers. Our Claims Processing System contains adjudication logic that prevents claims from advancing to payment status for Providers found to have Federal or State exclusion status. The system flags Provider records so that claims from excluded Providers will automatically deny, supporting the other controls described above. A detailed explanation is on the remittance to indicate the denial reason and will be available to Providers via phone, fax, and through our secure Provider Portal.

4.2.2.2.B Provider Services Call Center

1. Describe the Offeror's Provider services call center operations including:

Our health plan will offer Providers a dedicated Provider Services Call Center staffed by Customer Service Representatives (CSRs) who live in Mississippi, have a deep understanding of Mississippi culture, and are thoroughly trained on the State's MSCAN and CHIP programs. We will equip our CSRs with a fully integrated suite of desktop tools containing resources and information available online in real-time, specific to Provider needs. Through our Customer Relationship Management (CRM) system, CSRs will be able to quickly search, retrieve, and save relevant content and documents, such as authorization or claims information, for ease of assistance. CSRs will be able to view documentation of interactions (electronic, physical, and telephonic) from all Provider-facing staff, who will log engagement in a single relational repository for all Provider data across all core Provider functions. As a result, Providers will receive efficient and knowledgeable service aimed at first-call resolution on even the most complex issues.

Provider Services Call Center functions will include:

- Assisting Providers with questions concerning Member eligibility and enrollment status
- Assisting Providers with prior authorization and referral procedures
- Assisting Providers with claims payment procedures and handling Provider disputes and issues
- Handling Provider Grievances

- Facilitating the transfer of Member medical records among and between medical Providers, as necessary
- Educating Providers on covered medical services, excluded medical services, and benefit limitations
- Providing PCPs/PCMHs a monthly list of Members who are under their care, including identification of new Members and Members who were disenrolled, and an explanation guide
- Referring Providers to the Fraud, Waste, and Abuse Hotline
- Coordinating the administration of out-of-network services
- Assisting Providers in escalating issues to their dedicated, local Provider Relations Specialist (PRS)

We understand and will comply with the contractual requirements for Provider Services Call Center operations as outlined in Section 6.9.1 of Appendix A, Draft Contract.

a. Hours of operation;

Our Provider Services Call Center staff will answer calls Monday through Friday from 7:30 a.m. to 5:30 p.m. Central Time (CT). For Provider calls received after hours and on weekends, including on State-designated holidays, Providers may speak with a Registered Nurse from our 24-hour Nurse Advice Line for emergency prior authorization requests and other urgent clinical issues. Our secure Provider Portal and automated Interactive Voice Recognition (IVR) system offer Providers self-service options 24/7 from verifying the eligibility and PCP/PCMH assignment of Members being seen by that Provider to checking authorization and claims status.

b. Describe how the Offeror will ensure call center employees will have cultural competency;

We are committed to establishing multicultural principles and practices throughout our organization as we work towards the critical goal of developing a culturally competent service system. We will implement a Cultural Competency Plan based on the Culturally and Linguistically Appropriate Services (CLAS) Standards as developed by the United States Department of Health and Human Services (HHS), Office of Minority Health, as our official guidelines for providing culturally sensitive services. We will ensure CSRs understand the tenets of our Cultural Competency Plan and how to facilitate services to Providers in accordance with the Plan through call shadowing, ongoing call monitoring, coaching, and refresher training on specific cultural competency issues from actual Provider calls.

In addition, upon hire and quarterly, all CSRs will receive Cultural Competency training from our Mississippi-based Customer Service Trainer. Additional training offered through our learning management system will include Trauma-Informed Care and Adverse Childhood Experiences, Racial Equity and Unconscious Bias, Poverty Competency, Disability Sensitivity, People-First Language, and Person-Centered Thinking. Training will be offered in person through teleconferences and online webinars. We will develop scripts for CSRs to use when making outbound calls to Providers and responding to incoming Provider calls. We will review these scripts annually to determine any necessary revisions. We will submit our Call Center scripts to DOM for review and approval 60 days prior to use.

In addition to specific training opportunities, we are committed to hiring from the communities we serve, and CSRs will be encouraged to share and utilize their own cultural diversity to enhance our MSCAN and CHIP programs. We will offer a variety of diversity and inclusion groups that staff can join to bring greater cultural competency awareness to our entire health plan. We will monitor the effectiveness of our cultural competency activities through annual surveys, Grievances, and ad hoc feedback from individual Providers concerning the cultural awareness and sensitivity of our staff.

c. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call, abandonment rate, call monitoring requirements) and measures to ensure standards are met (the Division retains the right to approve all call center standards);

Measures and Standards

We will monitor performance using the call center measures required in Section 6.9.1.2 of Appendix A, Draft Contract, as well as additional internal measures. We will use the following measures and standards that meet or exceed DOM standards:

- Average monthly speed to answer of 30 seconds or less
- Average monthly abandonment rate of 4% or less
- Average monthly call quality score of 90% or greater

Since we do not impose call duration limits on any caller, we will not use the average length of call as a call center standard. ***In one of our affiliated health plans serving populations similar to those in Mississippi, the monthly average speed to answer after the initial IVR is 25 seconds, the monthly abandonment rate averages 2.12%, and the call quality score averages 97.65%.***

Ensuring Standards are Met

Our innovative Provider Services Call Center workforce management system will support a responsive, scalable staffing model to determine appropriate staffing to ensure we can respond to Provider call volume and meet the standards listed above. In addition, to ensure overall call quality and accuracy, our Call Center Quality Specialists will audit at least 3% of calls using a customer service evaluation system integrated with our telephony system. Our PSCC audit report cards will address courtesy, accuracy, quality measures, and cultural competency. CSR Supervisors will receive audit results daily and provide immediate coaching as necessary. Audits will identify trends, allowing us to provide staff training to address errors in call quality and processes. We will provide the findings of our audits to DOM via a quarterly report, make recordings available to DOM upon request within five business days, and maintain the recordings for at least twelve months. Please see our response to 4.2.2.2.B.2of the RFQ for more information on how we ensure standards are met.

d. Training program for call center employees including local and statewide cultural competency; and,

All newly hired Provider Services Call Center staff will receive training from and will shadow our Mississippi-based Customer Services Trainer. All Mississippi CSRs will undergo new hire training that includes:

- **Fundamentals** include active listening, use of the language line, conflict resolution, review of internal departments and warm transfers, including interfacing with Care Management staff, arranging interpretation and communication support services, claims and prior authorizations, online tools and Mobile Applications, Subcontractor roles, and responsibilities, and emergency management protocols
- **Program Information** including Medicaid 101, MSCAN and CHIP, Provider Billing Handbook, accessing appropriate services, review of benefits, Provider materials, and education, an overview of our Provider Relations Model, how to refer Providers to the Fraud, Waste, and Abuse Hotline, and how Providers can refer Members for Care Management and other clinical programs.
- **Job Functions** include assisting Providers with Member eligibility status, prior authorization and referral procedures, claims payment, out-of-network services coordination, Grievances and Appeals, and use of the Provider Portal. CSRs will be trained on when they need to escalate a Provider concern to the correct department via the CRM system.
- **Health Equity** We will work with Jackson State University in collaboration with DOM and the other CCOs to develop a Health Equity Guide to align health equity efforts across the State.
- **Competency** based on our Cultural Competency Plan, HHS' CLAS Standards, and training materials from Mississippi agencies and organizations such as the Mississippi Department of Health and the University of Southern Mississippi. Our cultural competency training program will address both statewide and regional cultural sensitivity considerations through the following topics:
  - Cultural Competency Defined
  - Health Literacy Defined
  - Limited English Proficiency
  - Becoming Culturally Competent
  - Cultural Diversity in Mississippi
  - Translation and Interpretation Services
  - Disability Sensitivity and Awareness
  - Disability Etiquette
  - Cultural Competency Compliance
  - Cultural Competency Resources

Ongoing training topics will be held on at least a quarterly basis. They will include refreshers on excellent customer service, critical thinking skills, effective communication, conflict resolution, managing emotions, empathy, self-awareness, and a global mindset. Training will include subjects identified as trends through call quality audits, escalated calls, and team lead assistance calls. Additionally, we will conduct regular training huddles to communicate "Late Breaking News;" Provider Bulletins; updates related to State Plan or CHIP State Health Plan Amendments or Administrative Code filings; system enhancements; benefit, billing, and claims-related updates; and changes to work processes or call scripts. In addition to team huddles, our Call Center

Learning Software will allow us to send role-specific updates to PSCC staff and verify understanding of those updates through knowledge checks. We will submit quarterly reports to DOM detailing the Provider Services Call Center staff training conducted, topics covered, and the number and positions of staff completing the training.

e. A description of any plans to use electronic communication to respond to Provider inquiries.

Providers will be able to access our secure web-based Provider Portal 24/7 to answer many of their inquiries on a self-service basis. They will receive in-person training on the Portal's features from their local PRS. The Portal's capabilities include: Member eligibility inquiry, authorization submission, and status, claim submission, claim status, claim payment history, and a growing number of clinical applications. These clinical applications include online care gap notifications and health alerts, Member health records, ADT notifications, Patient and Provider Analytics, care and disease management referrals, and clinical practice guidelines. If a Provider cannot resolve their inquiry through self-service, they will be able to submit a secure email to our call center staff through the Portal and receive a response within one business day. And, as always, Providers will have access to their local, dedicated PRS.

2. Describe how the Offeror will assess the quality and efficiency of the Call Center.

As described in our response to 4.2.2.2.B.1.c of the RFQ, we will use DOM call center standards to monitor the quality and efficiency of the Call Center. These standards include average monthly speed to answer, average monthly abandonment rate, and call quality score. Our response to 4.2.2.2.B.1.c also describes how we will monitor individual CSR performance through call audits and provide training and coaching to enhance the level of service to Providers. In addition, each CSR will go through a monthly performance review with their supervisor.

To maintain service level standards for quality and efficiency, we will use our innovative workforce management system to support a responsive, scalable staffing model. Based on years of call data analyses with our affiliated health plans with similar populations, our predictive modeling software will factor in call-type complexity, historical call duration, call patterns including seasonal variation, market maturity, and Mississippi-specific program features to determine appropriate staffing.

We will review call trends to identify and resolve common issues among Providers and produce a monthly Call Trend report for DOM. We will also monitor the overall effectiveness of our CSRs through annual Provider surveys, analysis of Provider Grievances, and ad hoc feedback from individual Providers. We will use the data from our monitoring efforts to make process and quality improvements not only to our Provider Services Call Center but to our overall health plan operations in coordination with our Quality Department.

4.2.2.2.C Provider Education and Communication

1. Describe how the Offeror will educate network PCPs/PCMHs about Care Management services, how to connect with Care Management, and how the Offeror will encourage PCPs/PCMHs to utilize Care Management. Include information about measurement of Care Management engagement of providers and how the Offeror will address providers who appear to be underutilizing the system.

Educating PCPs/PCMHs About Our Care Management Program and Processes

We will use a high-touch, high-tech approach to educating and connecting our MSCAN and CHIP network PCPs/PCMHs with our Care Management (CM) program. Our education will begin with the contracting process, and our Network Development team will work with Providers to develop Provider Agreements specifying the role of PCPs/PCMHs in our CM program. During Provider orientation, Mississippi-based Provider Relations Specialists (PRSs) will continue providing PCPs/PCMHs with information on our CM program, such as their responsibility for mandatory referrals for Members with chronic conditions, training on the provision of social determinants of health (SDOH) screening and billing associated Z codes, and the wide range of CM programs that are available to their Members (e.g., maternal and child health program, readmission reduction program, asthma disease management program). PRSs will provide continued education to Providers about the CM program and the needs and utilization of their assigned Members during monthly, quarterly, and as-needed visits. In addition, we will educate PCPs/PCMHs about CM topics through our accredited continuing education platform and other Provider materials, including our Provider Manual.

Connecting PCPs/PCMHs with Care Management

PCPs/PCMHs will be able to connect with our CM program, both through interactions with our Care

Management, Provider Relations, and Quality teams and through our technology offerings. PCPs/PCMHs will be able to refer Members to CM by calling our Provider Services Call Center, submitting a form through our website or secure Provider Portal, or by faxing a referral form.

PCPs/PCMHs will be essential to Integrated Care Teams, which will consist of CCO staff and external partners working collaboratively with Members and families to support personal health and wellness goals and provide input into developing a person-centered care plan. Members will determine Integrated Care Team participants, which, at minimum, will include the Member, the Member's Care Manager, PCP/PCMH, and other treating Providers. We will provide PCPs/PCMHs access to Member care plans and assessment information to support the Member's overall care and treatment.

In addition to Integrated Care Team meetings, our local Care Managers will be available to provide support to both Members and Providers by attending Provider visits, and this will offer another touchpoint between PCPs/PCMHs and our Care Managers to collaborate on care plans and treatment plans. Care Managers will alert Providers to Members overdue for preventive or follow-up services for chronic conditions by phone and via the Provider Portal. Medical leadership will conduct peer-to-peer outreach based on identified trends, such as high ED use or opioid prescribing. Our Quality Practice Advisors from our Quality team will go onsite to Provider offices to educate on closing care gaps and clinical best practices.

To complement our high-touch approach, we will also use technology to connect PCPs/PCMHs with CM information. For example, our Provider Portal will have extensive data analytics and report features to support, measure, and improve CM engagement by Providers and their assigned Members as summarized in **Table 4.2.2.2.C.1.**

Table 4.2.2.2.C.1 Provider Portal Features to Support Care Management

Provider Portal Feature	How the Feature Connects PCP/PCMHs with Care Management
Member Panel Roster including care gap alerts and reports	Providers can quickly review and filter on detail-level information and export and print a care gap report. These alerts notify a Provider about the potential need for interventions, diagnostic tests, and labs for certain conditions, or for EPSDT, Well- Baby, Well-Child, and preventive services. Care gap alerts are generated for disease management, and an ED flag is generated for any Member that has been to the ED more than three times in a 90-day period.
Patient Analytics Dashboard	Our Patient Analytics Dashboard enables practice managers or individual Providers to access their patient disease registries to view critical information, including care gaps and quality improvement opportunities, and to improve their population management functions. Patient Analytics offers Providers an integrated view of their patients' Member-level physical and behavioral health diagnoses, in addition to medication, lab, and care team data. The tool allows Providers to conduct population management, such as analyzing patients that need a flu vaccine and having the practice manager issue reminders.
Provider Analytics Dashboard	Our Provider Analytics Dashboard enables Providers to assess cost and utilization trending, quality measure performance, disease prevalence, readmissions, and health trends. Providers are offered many of these metrics on a risk and severity adjusted basis. Providers have access to custom selection, drill-down, and export capabilities to identify performance trends. By using the dashboard, Providers can identify areas to improve their performance and the health outcomes of their Members.
Care Gap Analysis Tool	Providers can access our daily care gap analysis tool directly from the Provider Portal homepage to identify and close patient gaps in care. The care gap information is re-computed and updated in near-real-time to ensure. Providers are working from the most up-to-date information to address gaps. Data is available at Member, Provider, and practice levels and features all clinical and HEDIS reasoning.

PCPs/PCMHs will also have access to our Community Resource Support Database, our searchable database of vetted and regularly updated health and wellness resources that Providers can use to help connect Members with services to address SDOH.

Encouraging PCPs/PCMHs to Engage with Care Management

We share DOM's belief that PCPs/PCMHs should be interacting as often as possible with CM for the benefit of our Members. We will educate PCPs/PCMHs on the positive impact that our CM program has on Member outcomes. In particular, for our VBP Providers, we will emphasize how their encouragement of Member participation in our CM program can result in improved metrics that will lead to financial rewards in the form of Pay for Performance or shared savings. Please see our response to Section 4.2.3.1 of the RFQ for more information about our proposed VBP model. We will financially incentivize PCPs/PCMHs by reimbursing them for participation in Integrated Care Team Meetings.

Measuring Engagement of PCPs/PCMHs in Care Management

We will measure the engagement of PCPs/PCMHs in CM by tracking PCP/PCMH referrals to our CM program, as well as PCP/PCMH participation in other CM activities, such as Integrated Care Team meetings. We will also measure PCP/PCMH Member engagement and Provider loyalty. Engagement measures the Provider's efficacy with engaging their assigned Members to be seen for a primary care visit annually. Loyalty measures the Provider's ongoing effort to maintain exclusivity as the PCP. Our experience shows that Providers that have lower engagement and loyalty scores will also be less likely to engage with our CM program.

Working with PCPs/PCMHs Underutilizing Care Management Program

When we identify Providers underutilizing our CM program, for example, a Provider with a very low proportion of patients being referred to CM or lack of engagement in Integrated Care Team activities, our PRSs will outreach to the PCP/PCMH. PRSs will receive a list of their assigned PCPs/PCMHs with low referral numbers for targeted outreach, education, and support and to understand any barriers the PCP/PCMH is experiencing in the CM process. We will discuss strategies, such as those listed above, to promote involvement in the CM program.

2. Describe how the Offeror will educate network PCPs/PCMHs regarding how and when to refer a Member for behavioral health/substance use disorder treatment, and how to collaborate with behavioral health/substance use disorder Providers and systems.

Educating PCPs/PCMHs on Behavioral Health and Substance Use Disorder Referrals

Given the high prevalence of behavioral health (BH) disorders among the MSCAN and CHIP populations, we recognize the importance of PCPs/PCMHs in helping to screen and intervene when Members have a BH condition. To equip our PCPs/PCMHs with the knowledge and resources they need to effectively play this role, we will educate PCPs/PCMHs on screening Members for BH/substance use disorders (SUD), the process for making referrals for treatment and the available referral options, best practices for referral efficiencies, and collaborating with a Member's Integrated Care Team on the care plan. Dedicated local PRSs will continue working with PCPs/PCMHs during site visits on practice transformation to promote integrated care delivery. For example, we will train PCPs/PCMHs on evidence-based BH/SUD screening tools, such as PHQ-9, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and Adverse Childhood Experiences (ACE), how to bill for them, and what to do if the screening results suggest the need for a referral. We will connect PCPs/PCMHs with resources to better meet the BH/SUD needs of their patients. These resources include:

- Our ***local BH Clinical Trainer***, who will meet with Providers regarding BH screening tools and other BH clinical topics
- Our accredited ***continuing education platform contains advanced BH clinical trainings*** and a 12-part BH series focused on training physical health Providers
- Provider toolkits that include information and resources for conditions such as ADHD, anxiety, depression, and SUD; toolkits will include overviews, fact sheets, and BH/SUD screening tools
- BH/SUD clinical practice guidelines (CPGs) that are based on reliable evidence formulated by nationally-recognized professional organizations, government institutions, statewide collaborative, and/or a consensus of health care professionals in the applicable field
- Our Online Provider Directory, which allow Providers to identify BH Providers for referrals; our Provider Services Call Center and PSRs are also available to help PCPs/PCMHs identify appropriate BH Providers

Educating PCPs/PCMHs on Collaborating with BH and SUD Providers

We will implement our successful Provider education program used by many of our Medicaid affiliates that incorporates the Substance Abuse and Mental Health Services Administration's (SAMHSA) Integrated Practice Assessment Tool (IPAT) to understand PCP/PCMH integrated care readiness. To develop competency, we will train PCPs/PCMHs on the IPAT tool and SAMHSA's Standard Framework for Levels of Integrated Health care. Our Mississippi-based, dedicated, full-time VP of Network Development and BH Medical Director will establish the foundation of our integrated whole-person care approach with our entire Provider network. We will staff our regional Provider teams with BH PRSs to help PCPs/PCMHs identify and implement methods to strengthen their collaboration with BH and SUD Providers and systems. We will share claims data with PCPs/PCMHs, so that they are armed with the information to effectively partner with BH and SUD Providers to reduce BH ED utilization and BH readmissions. To support our Members in being able to access convenient,

whole-person care, we will incentivize co-location of physical health and BH Providers at PCMHs, FQHCs, and RHCs, as well as for the co-location of Medication Assisted Treatment in primary care practices, particularly PCMHs, to help combat opioid overdose. ***We will offer incentives for completing Screening, Brief Intervention, and Referral to Treatment (SBIRT)*** and follow-up to ensure the Member completed the BH referral appointment.

We will educate PCPs/PCMHs about the options they have for consultation and collaboration with BH/SUD professionals. For example, we will provide PCPs/PCMHs with access to psychiatrists for physician-to-physician e-consults. Additionally, both the University of Mississippi Medical Center (UMMC) Child Access to Mental Health and Psychiatry (CHAMP) program and Mindoula's model for technology-enabled, evidence-based collaborative care will allow local PCPs/PCMHs to consult with mental health professionals across Mississippi and nationwide regarding diagnosis and treatment planning. ***Mindoula's population health interventions have proven to reduce total cost of care by an average of 30% to 50%, primarily by reducing hospital admissions and readmissions and avoidable emergency department utilization.***

3. Describe how the Offeror will develop the Provider Manual, including brief descriptions of major sections.

We will develop, submit for approval, maintain, and distribute separate Provider Manuals for the MSCAN and CHIP programs, in compliance with the requirements in Section 6.9.2 of Appendix A, Draft Contract, as well as Federal regulations and NCQA standards. **Table 4.2.2.2.C.3** outlines the major sections that the Provider Manuals will contain and provides brief descriptions of each section.

Table 4.2.2.2.C.3 Summary of Provider Manual Sections

Section	Description of Key Content
Introduction	Overview of the MSCAN and CHIP programs, our health plan's organization, and administrative structure. Contact information including relevant telephone number(s), email address(es), and websites.
Cultural Competency and Health Literacy	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 and that said items are available at no cost.
Care Management	Description of our health plan's CM program and protocols. Descriptions of the role of a PCP (including the PCP's importance to the Care Management team). Description of the role of a PCMH. Covered Services, including excluded services, co-payments, and benefit limitations. Value-added services. ED utilization (appropriate and non-appropriate use of the ED). Information about how Members may access specialists, including standing referrals and specialists as PCPs.
Medical Management	A definition of "medically necessary" is consistent with the language in Appendix A, Draft Contract. Prior authorization clinical and technical criteria guidelines for all services requiring prior authorization. Prior authorization requirements, including the requirement that a Member may receive a minimum of a three day emergency supply for drugs requiring prior authorization until authorization is completed. Information about EPSDT, Well-Baby, and Well-Child screening requirements and services and Providers' responsibility to follow up with Members who are not in compliance with the requirements and thus have care gaps.
Quality	Quality Department and QAPI. Medical record review. Value-based purchasing and other Provider incentive programs. Provider performance expectations, including disclosure of quality management and utilization management criteria and processes.
Member Rights and Responsibilities	Information about Member privacy and confidentiality requirements. Contact follow-up responsibilities for missed appointments. Member Grievance, Appeal, and State Fair Hearing procedures and timeframes as specified in 42 C.F.R. 438.400 through 42 C.F.R. 438.424 and described in Section 5.11 of Appendix A, Draft Contract, the Member's right to file Grievances and Appeals, the availability of assistance to the Member for filing Grievances and Appeals, and the Member's right to request a continuation of benefits.
Provider Rights and Responsibilities	Credentialing, contracting, Provider Agreements, billing and claims, and compliance program including Fraud, Waste, and Abuse. Prior authorization review and reconsideration. Information about filing Provider disputes, Grievances, Appeals, and State Fair Hearings. Information about the process for communicating with our health plan on limitations on panel size. Information about the process for contacting us regarding assignment of a Member to an alternate PCP/PCMH. Explanation of DOM's requirements that our health plan 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 MSCAN or CHIP.
Provider Services	Provider Services Call Center, Customer Service Representatives, and a description of our Provider Portal and process for accessing it. Mandatory orientation, training resources, and technical assistance. Billing instructions, including claims submission time frame requirements and manual or invoice pricing requirements.

4. Describe how the Offeror will develop Provider trainings and workshops, including brief descriptions of six (6) possible topics.

We will build upon our national Centers of Excellence existing library of evidence-based trainings through collaboration with Mississippi-based subject matter experts, DOM, other Mississippi CCOs, Provider

associations, and local advocacy groups to design Provider trainings and workshops, including the six in-person and five live webinars required in Section 6.9 of Appendix A, Draft Contract. Based on our understanding of the MSCAN and CHIP membership and the educational needs of the Providers serving them, we propose the following six topics for these Provider trainings and workshops as a representation of our comprehensive Provider education program:

PCMH Provider Panel. To support DOM's efforts to increase the number of NCQA-recognized PCMHs in Mississippi, we propose to offer a Provider workshop that will allow PCPs that are considering pursuing formal PCMH recognition to hear lessons learned and best practices from their peers. We will identify approximately three to five PCMHs from different regions of Mississippi and of varying practice sizes to sit on the panel. Each PCMH panelist will provide an overview of their practice transformation journey. We will also identify questions that a facilitator will ask of the PCMH panelists, such as:

- What tips would you give to a PCP practice that is at the beginning of its journey to PCMH recognition?
- In what ways has your organization's use of data evolved over time?
- In what ways has your organization's leadership helped set the stage for sustaining and building on quality improvements and appropriate cost reductions?
- Have there been benefits/challenges to your organization's practice transformation / PCMH recognition that you did not anticipate? If so, what?

Workshop attendees will also have the opportunity to ask their own questions of the panel to support dialogue and relationship building, and ultimately help PCPs in Mississippi have support and guidance from their peers in addition to the assistance that our health plan will provide related to PCMH practice transformation.

Process Improvement: Effective Plan, Do, Study, Act (PDSA) Cycles. This training will offer Providers insights into process improvement and how to make the PDSA process more effective to achieve improved outcomes and satisfaction for Members. We will walk through process improvement examples using Mississippi-specific improvement opportunities common among MSCAN and CHIP Providers and key Provider types (e.g., PCPs/PCMHs, BH Providers). Training participants will also have the chance to evaluate barriers that can impede the PDSA process, strategies to address those barriers, and learn additional tips from other Providers participating in the session.

Strategies for Member Engagement. This training will offer Providers tips and best practices for engaging Members, including resources that CCOs offer to support Member involvement in their own care. Recognizing the role that health literacy plays in Member engagement and patient activation, this training will also discuss resources available to support Members' health literacy and the relationship between higher Member activation and improved health outcomes. Similarly, because SDOH needs have the potential to impact Member engagement, we will also cover how Providers can use Z codes to report SDOH needs and how CCOs can use that data with Providers as another management and performance tool. During this training session, we will also examine common reasons for lack of Member engagement and non-adherence with treatment plans and strategies for working with Members who are non-adherent. This training will close with a facilitated roundtable where Providers form small groups to discuss barriers to Member engagement and non-adherence that they have faced and the strategies that have been most effective for them.

Post Traumatic Stress Disorder (PTSD) and Trauma-Informed Care. This training will educate PCPs/PCMHs and BH Providers for both adults and children on the diagnostic category of trauma and stressor-related disorders, including PTSD. Topics that will be covered include: recognizing the symptoms of PTSD, using screening tools, identifying the recommended treatment options for individuals who could have PTSD, the importance of SDOH in the Trauma-Informed Care treatment plan, and the overutilization of psychotropics for children and youth in Mississippi's child welfare system.

The Cost of Poverty Experience Training. This immersive poverty simulation training is one of the most popular offered by one of our affiliate health plans with populations and programs similar to Mississippi. Attendees describe an eye-opening experience to the challenges Members face. This nationally recognized interactive simulation will guide participants through realistic challenges and decisions confronting people in

poverty, focused on scenarios of poverty and family, Black maternal health, SDOH, the effects of addiction, mental health, and food insecurity.

Chronic Disease Care Management for Black Members. We understand Black Members have higher rates of certain chronic conditions than the general population, including Sickle Cell Disease, anemia, obesity, hypertension, diabetes, and chronic kidney disease. We will offer comprehensive Provider training around these chronic conditions disproportionately affecting Mississippi's Black population through a culturally competent lens that includes SDOH and implicit bias. We will offer Providers information on our health plan's chronic disease management programs, how to engage Members to secure their participation in them, and educate Providers on how they can participate in our VBP program to be rewarded for their role in impacting health outcomes and costs related to chronic conditions.

5. Describe how the Offeror will provide education to Providers concerning cultural competency, health equity, and implicit bias, and how the Offeror will ensure that Providers apply this training.

Educating Providers on Cultural Competency, Health Equity, and Implicit Bias

Our Provider education program will include education and support initiatives to help Providers provide culturally competent care that promotes health equity among MSCAN and CHIP Members. We will include mandatory training on cultural competency, health equity, and implicit bias in our Provider orientation given by our Mississippi-based PRSs and through Community Based Organizations. For example, ***we will partner with the March of Dimes to provide "Breaking Through Bias" implicit bias training for OB Providers***. We will intertwine SDOH and healthy equity issues into our Provider engagement activities. Our Provider Partnership Associates will also provide training on cultural humility and implicit bias when meeting with Providers regarding clinical quality measures.

We will promote and provide a link to the Department of Health and Human Services Office of Minority Health's "Think Cultural Health" Program on our website and will offer training modules such as "Cultural Humility and Unconscious Bias in Healthcare," which we developed with feedback from the Provider Community at a national level. We will also offer training modules on "Moving from Cultural Competency to Cultural Humility" and "Cultural Diversity in Mississippi." We will offer CEUs for implicit/unconscious bias and health equity training.

We will communicate, educate, and hold our MSCAN and CHIP Providers accountable to the principles articulated in our Cultural Competency Plan through our Provider Agreements, Provider Manual, and ongoing in-person and online training. Specifically, our Providers will be required to ensure that:

- The Member understands they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the Member's race/ethnicity and language and its influences on the Member's health or illness
- Provider office staff that routinely interact with Members have access to, and are encouraged to participate in, cultural competency training and development
- Provider office staff responsible for data collection make reasonable attempts to collect race and language-specific Member information. Staff will also explain race/ethnicity categories to a Member so that the Member is able to identify their race/ethnicity (and that of their child, if necessary)
- Treatment plans are developed, and clinical guidelines are followed with consideration of the Member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process
- Provider office sites have posted and printed materials in English, and if required by DOM, any other non-English language

Evaluating Providers' Incorporation of Training Into Practice Model

We will evaluate our Providers' understanding, adoption, and application of our health plan's cultural competency, health equity, and implicit bias training through Provider and Member Surveys, engagement with

our Care Management and Provider Services Call Center staff, and through Member Grievances. Our Quality and Compliance departments will incorporate cultural competency measures into our annual Quality Management Work Plan and Compliance Work Plan. Finally, because a key to improving health equity is reducing barriers to social determinants of health, we propose to employ VBP models that provide a Pay for Performance incentive to PCPs/PCMHs that evaluate a Member's risk for specified SDOH barriers (by using Z codes) and make timely referrals for service. We will monitor and analyze Z code utilization to identify opportunities to further incentivize Providers to capture this information from Members.

6. Describe the Offeror's proposed approach to assess Provider satisfaction, including tools the Offeror plans to use, frequency of assessment, and responsible parties.

We will assess our MSCAN and CHIP Provider satisfaction using various Provider surveys, frequent engagement by local PRSs with their assigned Providers, feedback from Provider associations, and information from any Provider Grievances or Appeals. We describe each of these methods below.

Annual Provider Satisfaction Survey. We will conduct a formal and comprehensive Provider Satisfaction Survey with Primary Care, OB/GYN, and specialist Providers. We will conduct separate surveys for MSCAN and CHIP and will submit the proposed survey questions and methodology to DOM for the purposes of creating a uniform survey. We anticipate proposing survey questions covering the following areas: finance, utilization, quality management, VBP, network, care management, and provider relations. Our Quality Management Committee (QMC) will oversee the development of proposed survey questions, and will submit them to DOM for approval prior to use. Our Provider Relations team will create an annual Provider Services Work Plan to address lower-performing areas the survey identifies, in combination with information gained from the other Provider satisfaction assessment areas below.

Provider Workshop Surveys. At the conclusion of all Provider workshops and webinars, including those presented in collaboration with DOM and other Mississippi CCOs, we will distribute an evaluation questionnaire to assess Provider satisfaction with the content, instructors, and value of the training to their practice management. Also, each of the modules offered through our accredited continuing education platform assess not only Provider knowledge (required to earn CEU), but also Provider satisfaction with the content and delivery format.

Ad Hoc Provider Surveys. We will conduct confidential ad hoc surveys via email to assess anticipated process changes or to assess the need for training on new policies.

Engagement by PRSs. Our PRSs will regularly meet with Providers in their offices, at hospitals, and in the community to discuss Provider performance, review detailed clinical and financial data, and provide support on topics important to Providers. We will use these opportunities to proactively seek input from Providers on how we can further collaborate with them to reduce administrative burden and help them better serve their patients, ultimately improving Provider satisfaction.

Feedback from Provider Associations. Our Provider-facing staff will attend local Provider workshops and conferences held by Mississippi associations such as the Community Health Center Association of Mississippi, Mississippi Rural Health Association, and the Mississippi chapters of the Academy of Family Physicians and American Academy of Pediatrics to continue developing relationships with MSCAN and CHIP Providers and understanding their needs. In addition, our Medical Directors will be active in their local specialty societies and will seek opportunities to meet with Provider association leadership and other CCOs to identify approaches to increase the uniformity of processes across CCOs.

Provider Grievances and Appeals. Our Provider Grievances and Appeals Team will monitor on a monthly basis Provider Grievances and Appeals to identify trends in Provider satisfaction.

7. Describe the Offeror's proposed approach to educating Providers concerning EPSDT services and Well-Baby and Well-Child Services, including but not limited to screening instruments, practices, and schedules; identification and referral of children with developmental delays; use of Care Management to facilitate care of children; and required documentation for reimbursement of EPSDT services.

Educating Providers About EPSDT and Well-Baby/Well-Child Services

Education about EPSDT and Well-Baby/Well-Child services is a critical element of our Provider education curriculum to help ensure our Members receive the appropriate services for their age whenever they are needed. We will begin educating our MSCAN Providers regarding their role to ensure Members receive EPSDT

services and our CHIP Providers regarding Well-Baby and Well-Child Services during the contracting process. We will specify the obligations of our PCPs/PCMHs in their Provider Agreements and will reinforce these concepts through Provider orientation, Provider Manuals, Provider newsletters, office visits, and ongoing trainings such as Provider workshops and webinars.

We will train and offer technical assistance to Providers on the use of our secure Provider Portal, as well as our EPSDT and Well-Baby/Well-Child Provider Toolkits. Available on our website, these toolkits contain coding guidelines and HEDIS Quick Reference Guides. Through the Provider Portal, we will automatically alert PCPs/PCMHs of their Member's EPSDT and Well-Baby and Well-Child needs, existing care gaps, and required screens, including developmental and preventive dental screens. Through our online Provider Portal, we can automatically alert PCPs of EPSDT schedules, care gaps, and required screenings for every Member on their panel, including developmental, vision, hearing, and dental screenings that are due. The tools provide an individual Member Calendar, updated daily, with a view of all upcoming needs, and a planner to support timely visits. Providers can view and check on Member specific EPSDT care gaps and close those gaps during any scheduled visit. Providers can also view gap in care reports and our Provider Scorecard where Providers can compare themselves to their peers or industry benchmarks. Our Clinical Data and Interoperability Gateway (CDIG) will offer enhanced data sharing capabilities through bi-directional data exchange with Providers' EHRs through multiple strategic partners. The CDIG enhances our ability to address care gaps at the point of care, conduct efficient quality monitoring, and gather additional health information, including Member's social support needs. Similar information is also available to authorized community partners through our Community Portal.

Our Quality Practice Advisors will make monthly visits to PCPs/PCMHs to discuss EPSDT and well-child screenings; provide education on periodicity schedules, lead testing, and immunizations; discuss common conditions in children (e.g., asthma, diabetes, obesity, depression) and programs available to support them; and identify Members due for screenings and immunizations/vaccinations. We will give PCPs/PCMHs a quarterly list of Members who are overdue for EPSDT or Well-Baby/Well-Child services.

In addition to educating and empowering our Providers to monitor that their Members receive timely EPSDT and Well-Baby/Well-Child services, we will track our Members' completion of EPSDT and Well-Baby/Well-Child services, implementing strategies to close gaps in care including Member and Provider, such as incentives for Providers to implement back-to-school initiatives to close gaps. Further, we will incorporate goals related to the provision of EPSDT and Well-Baby/Well-Child services into our VBP arrangements with PCPs/PCMHs to incentivize them to proactively engage Members around these services.

Identification and Referral of Children with Developmental Delays

Through the education methods described above, we also inform Providers on how to identify and refer children with developmental delays to specialists and the Mississippi Early Intervention Program (First Steps). We will train Providers on how to use our Online Provider Directory, which allows Providers to identify appropriate specialists based on the child's need so that the child can be quickly connected to services. Our Provider Services Call Center will also be available to help Providers identify the appropriate specialists.

Use of Care Management to Facilitate Care

The EPSDT program and Well-Baby/Well-Child services are important tools to identify Members early who may be facing complex physical or behavioral health conditions so they can receive medically necessary treatment, as well as access to our CM interventions. We will educate Providers about our CM program and how our CM services can assist Providers in facilitating appropriate care for Members. For example, our CM staff will provide support, education, and follow-up with Members for EPSDT screenings and immunizations, and refer medium and high-risk Members assigned a Care Manager for further support.

Required Documentation for Reimbursement of EPSDT Services

We will educate Providers that they must sign an EPSDT Provider Agreement with DOM in order to bill for EPSDT services. We will train Providers on the documentation requirements under this EPSDT Provider Agreement, such as documenting in the Member's medical record the specific age-appropriate screenings in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule. Our EPSDT Provider

Toolkits contain EPSDT coding guidelines to ensure that Providers are correctly coding to receive accurate reimbursement. We will also offer webinars on topics specific to EPSDT documentation and billing, such as commonly denied claims reasons and how to avoid them and live discussions of coding scenarios.

8. Describe the Offeror's proposed approach to educating Providers regarding the needs of Members with the following conditions or circumstances:

We will engage Providers in a continuum of two-way communication and education regarding the needs of Members, from education during recruitment and contract negotiations, to regular Provider performance meetings, to periodic trainings on the evolving needs of Members, to review of outcomes for VBP programs. We will use the Provider orientation, Provider Manual, Provider Newsletters, Provider Portal, in-person meetings, and email communications to educate Providers and supply data about the needs of Members, including Members experiencing perinatal, BH, SUD, and chronic disease conditions, as well as children in foster care.

Through our advisory committees, including our Provider, Member, and Community Advisory Committees, we will seek input on Provider training needs related to treating Members with perinatal, BH, SUD, and chronic conditions as well as those children impacted by the child welfare system. We will enhance our Providers' clinical expertise and improve Members' health outcomes through accredited continuing education that offers empowering, research-informed content aimed at improving the skills, strategy, and performance of the health care team, patient quality of care, and the health outcomes of the community. Our Provider education curriculum will use active learning principles for adult education.

a. Perinatal;

Through our Maternal and Child Health Program, which we describe in detail in response to Section 4.2.2.1.A.3 of the RFQ, we will provide education and support to Providers to help them address the needs of moms and babies. We will leverage our Neonate Center of Excellence to distribute best practices and provide medical consultation to Providers. In addition, our accredited continuing education program includes courses for OB/GYNs and pediatricians such as Evolving Care of the Prenatally Opioid Exposed Neonate, Treating Pregnant Women with Addiction, and Intimate Partner Violence.

We will educate Providers on the health disparities in pre-term birth and perinatal outcomes that exist in particular areas of Mississippi, such as Hinds, Rankin, and Jackson counties, and will target customized Provider education efforts to these high-need areas of the State. We will partner with the March of Dimes to provide "Breaking Through Bias" implicit bias training for OB Providers. We will intertwine SDOH and healthy equity issues into our Provider engagement activities. Our Provider Partnership Associates will also provide training on cultural humility and implicit bias when meeting with Providers regarding clinical quality measures. We will also educate Providers about programs that we will offer to our Members to support improved perinatal outcomes and Member satisfaction, such as group prenatal care, doula support, and access to lactation consultants, and how Providers can refer their patients to such programs.

b. Behavioral Health;

We will educate our network Providers about Members' right to BH services in parity with physical health services and hold them accountable to their contractual obligations as PCPs to screen and refer Members to BH specialists. Our expert BH Clinical Trainers will train Providers and other stakeholders. We will offer a catalog of nearly 100 courses specific to behavioral health, including Trauma-Informed Care and topics such as perinatal substance use, non-suicidal self-injury. Multiple training topics explore ways for physical and behavioral health providers to coordinate services, such as integrated care, cultural competency, common psychotropic medications, positive psychology, strengths-based treatment model, and motivational interviewing. In addition, we offer a workshop to explain the use of psychotropic medications in treating BH and SUD. We will also bring partnerships that will educate Providers on Members' BH needs, such as:

- **Mindoula**. We will partner with Mindoula to offer targeted interventions for high-risk populations with co-occurring behavioral health (BH) and medical conditions. Mindoula's population health interventions have proven to reduce total cost of care by an average of 30% to 50%, primarily by reducing hospital admissions and readmissions and avoidable emergency department utilization. To maintain Member engagement, Mindoula combines 24/7/365 "boots on the ground" care extension with a virtual 24/7/365 team to provide team-based, tech-enabled, personalized, synchronous around-the-clock support to our Members. Through

Mindoula, PCPs/PCMHs will be able to obtain support and education regarding the needs, diagnoses, and recommended treatment courses for Members with BH needs.

- **UMMC Center for Advancement of Youth and Division of Child Psychiatry.** We will partner with UMMC's CHAMP program to assist our PCPs/PCMHs in obtaining education and assistance on questions on mental health care. The CHAMP program will provide support to allow PCPs/PCMHs to better care for Members with BH diagnoses with guidance from UMMC psychiatrists and psychologists.
- **American Academy of Pediatrics.** We will partner with the American Academy of Pediatrics to provide education to our PCPs/PCMHs on how to conduct the PHQ-9 and how to act upon the results to encourage PCPs/PCMHs to conduct this important screening during well-child check-ups.

c. Substance Use Disorder;

We will educate our network Providers about our Members' right to SUD services and PCPs' contractual obligations to screen and refer Members for SUD treatment. We will train Providers on how to use and bill for screening tools, such as SAMHSA's SBIRT, so that Providers are equipped to identify and address SUD needs among their patients and help connect them with SUD-covered services. Our accredited continuing education program includes numerous courses on SUD and treatments, including an 11-part series titled "Substance-Related and Addictive Disorders," and "Co-Occurring: Substance Use and Mental Health Disorders."

We will offer empowering interprofessional continuing education to our providers at no cost through leading-edge and research informed educational activities, equipping them to deliver current therapies and better health outcomes. Clinicians are encouraged to tap into a professional peer network of Providers to share best practices and consult on the latest therapies at no cost – making leading-edge healthcare more accessible to all of our communities. We will offer educational activities including live courses, internet enduring material, virtual live courses, and repeated seminar series. Four activities are already accredited for over 155 continuing education hours for physicians, nurses, and pharmacists, including: (1) Pain Management and Opioids (2) Evolving Care of the Prenatally Opioid Exposed Neonate (3) Treating Pregnant Women with Addiction; and (4) Supporting Patients with Alcohol Use Disorder.

Project ECHO MAT programs across the country have led to a significant uptake in the number of PCPs prescribing MAT for Members living with opioid use disorders. We have numerous affiliates across the country supporting Project ECHO projects with PCPs to expand access to MAT. We will partner with entities such as the University of Mississippi Medical Center to develop a Project ECHO training program to educate PCPs/PCMHs on treating patients with chronic pain using non-pharmacological multi-modal treatment plans to help reduce opioid dependency and prevent opioid use disorder.

d. Chronic Conditions; and

Our accredited continuing education program covers trainings on a range of chronic diseases, including diabetes and Sickle Cell Disease (SCD). Through our Care Management program, we will provide education and support to Providers about the needs of their individual patients that can also be applied across their patients with chronic disease. For example, through our Sickle Cell Case Management Program, we will educate Providers about SCD, best practices for SCD treatment, and about the cultural stigmas often associated with SCD. Please see our response to Question 4.2.2.1.A.4 for more information about our approach to service delivery for Members with chronic health conditions.

We will regularly report chronic condition outcome data to PCPs/PCMHs by chronic disease state and population health category to give them clear, aggregated results that allow them to understand the needs of their Members and take timely steps toward improvement. Specifically, for our Members with diabetes, we plan to engage Vigilant Health Resources. Vigilant's Delta Diabetes Project has received national recognition for its clinical excellence and economic efficacy in producing sustained improvement in metabolic health of some of the State's most challenging populations. Through this diabetes management program, we will educate Providers on clinical and claims data for Members with diabetes to better support them in meeting Members' needs.

We will encourage Providers to use local Project ECHOs to practice at the top of their license, acquire new skills and competencies (including increasing culturally competent and equitable care), and treat Members with

common complex conditions instead of referring to a specialist. We will educate our PCPs/PCMHs about local Project ECHO opportunities, such as courses in Hepatitis C, HPV Vaccination, and Pediatric Dentistry.

e. Foster Children.

We will collaborate with the Mississippi Department of Child Protection Services (MDCPS) and DOM through regular task force meetings and use this collaboration to customize Provider education based on Mississippi's specific needs as well as our affiliate health plans' experiences with children and youth impacted by the child welfare system. We will educate Providers about our Care Management services tailored to children in foster care and the obligations of Providers who serve as those Members' PCPs. We will have a dedicated Care Management team that collaborates with Providers, including residential Providers, regarding care planning for our foster care Members.

Beyond FCCOEs, we will bring our expert BH Clinical Trainers to train Providers to enhance the continuum of care capacity. Our accredited continuing education program includes courses from child welfare and BH experts including: "Trauma Training for Caregivers" and "The Adverse Childhood Experience Study." In addition, we offer a catalog of nearly 100 courses specific to foster care, as well as courses that address topics such as non-suicidal self-injury and working with children, youth, and young adults with Intellectual and Developmental Disabilities who are impacted by the child welfare system. To support higher-quality care delivery for our foster care Members, we will also offer Providers training in Trauma-Focused Cognitive Behavioral Therapy, including training focused on problematic sexual behavior and traumatic grief and loss. Our local BH Clinical Trainers will also provide targeted and customized trainings to Mississippi Providers on the care needs of our foster care Members. We will equip Providers with a Trauma Informed Care Toolkit that contains evidence-based trauma screening and assessment tools.

4.2.2.2.D Collaboration with Providers

1. Describe how the Offeror will collaborate with PCPs/PCMHs regarding the care of Members with chronic illnesses, including but not limited to diabetes, asthma, and obesity.

PCP/PCMH Collaboration and Chronic Disease Care Management

PCPs/PCMHs will be essential partners in improving the health outcomes and quality of life for Members living with chronic illnesses – including diabetes, asthma, and obesity – a priority focus area in the Mississippi Comprehensive Quality Strategy. In particular, we will leverage our PCMH program, described in our response to Section 4.2.3.2 of the RFQ, to partner with PCMHs on our chronic disease management activities. Developed nationally to address the needs of patients living with chronic conditions, the PCMH model will assist us in establishing strong Member-Provider relationships, supporting continuity of care, reducing redundant services and ED utilization, providing more cost-effective care, and improving health outcomes. We will assign to all medium and high-risk Members to a PCMH, many of whom will have at least one chronic condition, in compliance with Section 6.2.5 of Appendix A, Draft Contract.

We will invest in PCPs' ability to provide their own care coordination and chronic disease management by offering a PCMH recognition value-based purchasing (VBP) model that provides an upfront Per Member Per Month for PCPs to gain or maintain PCMH recognition, as described further in our response to Question 4.2.3.1. PCPs can use this upfront payment to hire nurse Care Managers and other staff to support Members with complex health conditions, such as chronic conditions. Our PCMH program will include processes linking the care coordination provided by the PCMH with the activities of our Care Management (CM) staff so that PCMHs enhance, but do not duplicate, our health plan's CM services. For example, our Clinical Documentation System will alert our Care Managers to the Member's PCMH assignment and the PCMH's assigned Care

Manager responsible for that Member to allow for close coordination as we work together to improve care for Members.

Beyond our PCMH program, we will support all PCPs with tools to support Member engagement, health literacy and education on chronic condition self-management, connections to Community Based Organizations (CBOs) to address social determinants of health (SDOH), and treatment adherence to improve outcomes and functional status. Our Care Managers will actively engage PCPs/PCMHs and other treating Providers through regular phone calls, emails, in-person meetings, joint care conferences, and joint assessments, which also helps to support a seamless Member experience.

We will empower PCPs/PCMHs with technology solutions, including a self-service Provider Portal with robust data analytics. Provider Relations Specialists (PRSs) and Quality Practice Advisors will educate PCPs/PCMHs about our CM and Quality Programs and best practices in delivering care to Members with chronic conditions and empower PCPs/PCMHs with practice, Member, and disease-specific data (e.g., HEDIS measures, utilization data, cost of care data, daily discharge reports) to identify and manage Members' chronic conditions. In addition, ***our Clinical Data and Interoperability Gateway will enable us to share timely Member information among PCPs/PCMHs and specialists via bi-directional data exchange with Provider EHRs, better equipping them with important information during Member visits***. As our Provider partnerships are bidirectional, we will leverage the Provider-patient relationship to better understand Member needs and health literacy and deliver key programs and messages when caring for Members with chronic conditions.

Collaborating with PCPs/PCMHs to Improve Care for Members with Diabetes

We understand that diabetes disproportionately affects Black MSCAN and CHIP Members living in rural communities and that a significant percentage of MSCAN Members have diabetes and co-occurring conditions such as hypertension, kidney disease, cardiovascular disease, nerve damage, and neuropathy. We propose to implement the following strategies described in **Table 4.2.2.2.D.1.a**, working collaboratively with PCPs/PCMHs to help improve outcomes for Members with diabetes and reduce the disparities that exist among racial and ethnic groups and across regions of Mississippi.

Table 4.2.2.2.D.1.a Strategies with Providers to Improve Diabetes Outcomes

Strategy	Description
Collaborate with and Expand Diabetes Self-Management Education and Support Programs	We understand that Mississippi is one of the few states in the country that cover Diabetes Self-Management Education and Support (DSMES) Programs as a Medicaid covered benefit. We plan to employ evidence-based best practices from affiliate markets with similar populations as Mississippi to develop a multi-pronged strategy to collaborate with current DSMES Program Providers in Mississippi, support expansion of additional DSMES Providers, and provide wrap-around support services to Members with diabetes. Our strategy includes the following key elements: • Contracting with all DSMES Program Providers, including pharmacies. • Supporting existing DSMES Program Providers and the expansion of DSMES Programs through: o Subsidizing the cost of renewal for DSMES accreditation or initial accreditation o Providing funding for PCP/PCMH practice staff to become certified diabetes educators to increase practice efficiency; certified diabetes educators can complete patient training, counseling, and follow-up on behalf of Providers o Building VBP models with enhanced reimbursement for DSMES Providers that improve outcomes for diabetes related measures o Providing enhanced Provider/Patient analytics, offering Providers more insight into their patients with diabetes, including alerts for appropriate screenings and care gaps • Wrapping around the services provided by DSMES Providers: o Partnering with Vigilant Health Resources to develop a targeted Diabetes Management program in areas with the highest prevalence of diabetes, such as the Mississippi Delta. This collaborative Diabetes Management program will include a coordinated referral into the program that includes nutrition classes and cooking classes with a dietician. We will provide wrap-around support services that may include medically tailored meal delivery in areas with the highest risk Members, education campaigns including Diabetic Books on cooking and superfoods, and Food Bank Resources with fresh fruit and vegetables that can be tailored to dietary needs. o Partnering with UMMC to offer Members remote patient monitoring where Members receive a remote monitoring glucometer, real-time phone-based clinical support, and diabetes management coaching. o Offering closed-loop referral and follow-up for Member SDOH needs that could impact diabetes-related outcomes. o Partnering with a retinal camera vendor that offers easy to install, handheld retina cameras designed to help make retinal exams simple and affordable for PCPs. By providing a grant that covers the cost of the technology

Strategy	Description
	and monthly fee, we will offer this technology in key Provider offices to enable PCPs/PCMHs to perform retinal scans on their patients (including our Members) with diabetes.
Support Provider Learning Collaborative Opportunities	We will sponsor learning collaborative opportunities for our PCPs/PCMHs to come together on a regional basis to discuss challenges, resources, and best practices for how to improve the delivery of care for their patients with diabetes. We propose to hold these learning collaboratives in the areas of Mississippi with the greatest disparities in diabetes-related outcomes. Our PRSs and Quality Practice Advisors will help facilitate these collaboratives, sharing their own insights on best practices for diabetes care and health plan performance data on the greatest opportunities for performance improvement and gap closure.
Offer Diabetes Management Tool Kits	We will offer all PCPs/PCMHs a diabetes management toolkit that includes clinical practice guidelines from nationally recognized organizations or government institutions (e.g., American College of Endocrinology, American Diabetes Association, Centers for Disease Control and Prevention), as well as those published by Mississippi-specific collaborative efforts (e.g., Diabetes Coalition of Mississippi). The toolkit will provide resources for Providers to understand the existing disparities in diabetes-related outcomes and actionable strategies that Providers can take with their patients to help close those disparities.
Support Collaboration Between PCPs/PCMHs and Pharmacies	We will partner Community Pharmacy Enhanced Services Network that collaborates to optimize appropriate medication use to promote positive patient health outcomes. Our partner will provide outreach to Members who have gaps in tests for diabetes management (e.g., HbA1c testing), conduct the test, and notify us and the Member's PCP/PCMH with the test results. The will also conduct SDOH needs screening.

Across our affiliated health plans, we have achieved meaningful improvements in health outcomes for our Members with diabetes through our collaborative approach with Providers through efforts such as those described above. For example, ***over a nine-year period in a state with similar populations and programs as Mississippi, our affiliated health plan improved its performance on the HEDIS measures for Comprehensive Diabetes Care – Poor HbA1c Control by 55% and improved performance in Comprehensive Diabetes Care – HbA1C control (<8.0%) by 38%***.

Collaborating with Providers to Improve Care for Members with Asthma

We understand that asthma is one of the most common chronic conditions among children of all races in MSCAN and CHIP and that it disproportionately impacts Mississippi's Black Medicaid beneficiaries. **Table 4.2.2.2.D.1.b** below describes the strategies we will implement in Mississippi in coordination with our PCP/PCMH network to improve care for Members with asthma.

Table 4.2.2.2.D.1.b Strategies with Providers to Improve Asthma Outcomes

Strategy	Description
Support Collaboration Between PCP/PCMHs and Schools	We recognize the need for our health plan to coordinate with PCPs/PCMHs and schools around asthma management and the preventive and rescue medications that are such an important part of helping Members manage their asthma. While our asthma CM program will be available to all Members with asthma across Mississippi, we also propose to work with PCPs/PCMHs in communities with the highest prevalence of asthma among school-age children to support enhanced communication between PCPs/PCMH and schools. For example, as part of the Integrated Care Team process, our CM team will work with PCPs/PCMHs to develop and share asthma action plans with school nurses. These action plans will contain information on the child's asthma triggers; names of medications to take based on signs, symptoms, and peak flow measurements; and symptoms or peak flow measurements that indicate the need for urgent medical attention.
Provide Resources for Use at the Point of Care	We will provide asthma management supplies (e.g., asthma spacer, peak flow meter, hypoallergenic pillow/mattress covers) to PCPs/PCMHs in communities with the greatest disparities in asthma care and most impacted by SDOH, so that they can provide the supplies to Members at the point of care.
Expand Use of Asthma Certified Educators	We will promote and expand asthma certified educators in Mississippi through enhanced reimbursement and by subsidizing the costs associated with receiving certification so that PCPs/PCMHs, such as FQHCs and school-based health centers, may have a certified asthma educator on staff to promote improved outcomes among their patients, including our Members.
Offer Asthma Tool Kits	We will offer all PCPs/PCMHs asthma tool kits that contain clinical practice guidelines including those published by the National Asthma Education and Prevention Program and the U.S. Department of Health and Human Services, National Institute of Health, National Heart, Lung, and Blood Institute. The tool kits will also include materials specific to the Asthma Medication Ratio (AMR) HEDIS metric, including a description of the measure, tips for rate improvement, and Member education and talking points. In addition to the tool kits, our Pharmacy team will send letters to PCPs/PCMHs identified in the AMR population as having asthma. The letter will include a medication therapy review by a Health Plan Pharmacist and encourage the Provider to consider adding a controller agent or inhaled corticosteroid if appropriate.

Strategy	Description
Support Collaborate Between PCPs/PCMHs and Pharmacies	In addition to partnering with CPESN on diabetes care, we will also partner on asthma care. Our partner will provide outreach to Members who have gaps in tests for asthma monitoring, conduct the test, and notify us and the Member's PCP/PCMH with the test results.
Targeted interventions to Address Disparities	We will identify and outreach to PCPs in areas with a high prevalence of asthma and who serve a large number of Black children. Targeted outreach will be designed to help them attain PCMH recognition and participate in VBP programs tailored to improve outcomes in this population. We will also actively recruit additional PCPs who represent the diversity of our membership and partner with schools and Boys and Girls Clubs in zip codes identified with higher prevalence of asthma to provide education and help connect Members to PCMHs.

Using interventions such as these in a State with a similar Medicaid and CHIP population, our affiliated health plan ***improved Members' AMR rate from 66.10% in calendar year 2017 to 69.99% in calendar year 2019***.

Collaborating with PCPs/PCMHs to Improve Care for Members with Obesity

As identified by the Mississippi Comprehensive Quality Strategy, obesity is a key driver of chronic conditions among MSCAN and CHIP Members, given its correlation to risk for developing heart disease, hypertension, asthma, diabetes, and cancer. We are particularly concerned about the role obesity plays in the disparate health outcomes for Black Mississippi Members and where cultural traditions around food may contribute to this chronic condition. Our collaborative efforts with PCPs/PCMHs will rely heavily on increasing coordination with Members' social and educational communities to address SDOH and educating PCPs/PCMHs on culturally competent and respectful engagement with Members around healthy body image. Specifically, we will collaborate with Providers on the following strategies described in **Table 4.2.2.2.D.1.c** to improve care for Members with obesity.

Table 4.2.2.2.D.1.c Strategies with Providers to Improve Obesity Outcomes

Strategy	Description
Increase Access to Healthy Foods	We will work with FQHCs and other Providers that have a large number of Members with obesity on their panel to establish and stock an on-site "food pharmacy" that includes ingredients and food boxes tailored to different populations' nutritional and cultural needs. We will work with Extra Table in Mississippi to source the foods for these "food pharmacies."
Increase Access to Weight Management Programs	We will supply PCPs/PCMHs with resources to inform Members on weight management programs that are available through our health plan. For example, we will offer our pediatric Members a weight management program that provides coaching by registered dieticians and exercise physiologists, and we will offer our adult Members Value-Added Benefits such as Weight Watchers vouchers. We will educate PCPs/PCMHs on these programs and how to refer Members, and also provide them with materials they can offer to Members at the point of care so that Members can understand the various resources available to them from our health plan.
Promote Local Education Opportunities	We will promote local health programs, such as Southern Remedy, an initiative of Mississippi Public Broadcasting, as resources for PCPs/PCMHs to use when talking to their patients about good nutrition and physical activity. Southern Remedy includes simple tips that Providers can discuss with their patients, such as using smaller dinner plates for calorie control and providing a nutrient rich shopping list.
Offer Obesity Tool Kits	We will offer all PCPs/PCMHs obesity tool kits that include educational resources from the American Academy of Pediatrics and the Academy of Nutrition and Dietetics, as well as local resources designed to address cultural factors that can contribute to obesity.

2. Describe how the Offeror will collaborate with PCPs/PCMHs to reduce pre-term births and improve perinatal care.

The focus of our collaborative efforts with MSCAN and CHIP PCPs, including PCMHs and OB/GYNs acting as PCPs, will be to reduce the nearly 50% of premature births caused by hypertension and pre-eclampsia. Our High-risk Pregnancy Program will provide Care Management for medium and high-risk Members through the postpartum period to decrease pre-term delivery and improve the health of mothers and their babies. A health plan Care Manager with obstetrical nursing experience will serve as the lead Care Manager for a Member at high risk of early delivery or who experiences complications from pregnancy. This Care Manager will collaborate with the Member's PCP/PCMH through Integrated Care Team meetings and in the development of the Care Plan to address Member-specific barriers to care. Our Chief Medical Director will seek input from the Provider community on interventions to impact perinatal care through participation in local professional associations. Strategies to reduce pre-term births and improve perinatal care in collaboration with PCPs/PCMHs are discussed in Table **4.2.2.2.D.2**.

Table 4.2.2.2.D.2 Strategies to Collaborate with PCPs/PCMHs to Improve Perinatal Care

Strategy	Description
Detect Pregnancies Earlier	We will partner with a technology company that will provide cutting-edge technology to drive dramatic improvements in birth outcomes. Their enhanced pregnancy identification and risk stratification will help us detect at-risk pregnancies sooner, prevent pre-term births, and reduce racial disparities. Once we detect at-risk pregnancies, our Care Management team will coordinate with the Member's PCP/PCMH to connect them into prenatal care earlier, helping to impact the disparities associated with prenatal care among the MSCAN population. ***The use of this platform has shown a 19% reduction in unnecessary C-sections, a 10% reduction in preterm births, and a 9% reduction in NICU use.*** In addition to the data analytics to support early identification of pregnancies, we will incentivize Providers to complete the NOP form so that we can jointly work with Providers to get Members into prenatal care and address any risk factors that could contribute to poor outcomes for the mom or baby.
Education and Consultation for Neonatal Care	Working with our Neonate Center of Excellence, we will collaborate with Providers through NICU rounds and education and will offer Providers additional support and expertise around medical neonatal review and consultation. We will also collaborate with DOM, Mississippi pediatricians, FQHCs, and professional associations on the NICU Task Force. We will target customized education to Providers in the areas of the State with the highest pre-term birth rates, including Providers located in Hinds, Jackson, Madison, and Rankin counties.
Connections with State and Community Resources	We will explore collaboration opportunities between our PCPs/PCMHs and available State and community resources, such as the WIC program and other community-based organizations. For example, we will coordinate with PCPs/PCMHs to place WIC resources and materials on controlling hypertension during pregnancy in key Provider offices to support PCPs/PCMHs in their care delivery while getting information into the hands of Members sooner. We will also educate PCPs/PCMHs about DOM's Perinatal High Risk Management/Infant Services System as an option for high-risk Members who meet the program's criteria.
Support for Substance-Exposed Pregnancies	Although hypertension and pre-eclampsia are the most significant drivers of pre-term births, substance use during pregnancy also contributes to preterm birth and poor perinatal outcomes. Through our partnership with Mindoula, we will offer the Opioid Use Disorder and Substance Use Disorder Exposed Pregnancy Program, which will help pregnant women develop coping mechanisms, build resiliency, and address SDOH. We will educate PCPs/PCMHs about this program, so that they can refer Members as appropriate and receive wraparound support to the important medical care they offer to Members.
VBP Strategies	We will develop VBP strategies to incentivize PCPs, OB/GYNs, and pediatricians for improving maternal and newborn health outcomes and will include these strategies in our VBP proposal described further in our response to Question 4.2.3.1

In one of our affiliated health plans with populations and programs similar to Mississippi, our maternal health initiatives in collaboration with OB/GYN and pediatricians produced the following outcomes between 2017 and 2020:

- 52% increase in the proportion of deliveries with a NOP
- 24.6% reduction in opioid use during pregnancy
- 61.4% increase in TDAP vaccination rates during pregnancy
- 3.2% reduction in the rate of C-Sections
- 35.9% reduction in the percent of babies in the NICU after delivery
- 21.1% reduction in the rate of ED visits for pregnant Members
- 9.0% reduction in the rate of inpatient visits for pregnant Members
- Increase in the average number of prenatal visits from 8.5 to 9.6 visits

3. Describe any other conditions for which the Offeror anticipates collaboration with providers to develop improved care for Members.

Collaboration with Providers as it relates to the PCMH program is discussed in our response to Section 4.2.3.2 of the RFQ. In addition to our PCMH strategies, we will have an Advisory Board comprised of external Providers offering guidance on opportunities for our health plan and Mississippi Providers to work together to improve Member health outcomes and reduce costs for DOM. Below we summarize three conditions – behavioral health conditions, sickle cell disease, and persistent or preventable hospital readmissions – for which we anticipate collaborating with MSCAN and CHIP Providers to improve care for Members. We will work with the Advisory Board, DOM, and other CCOs to further develop and refine these approaches using Mississippi-specific data and community input.

Behavioral Health

We recognize that behavioral health is a priority focus area in DOM's Comprehensive Medicaid Quality Strategy, with schizophrenia and bipolar disorders being the top two APR-DRGs coded for Medicaid enrollees. We, therefore, understand the need in Mississippi to equip Providers with the resources to diagnose, treat and refer Members with behavioral health conditions to help them get connected with appropriate care. To that end,

we will collaborate with PCPs/PCMHs by offering supports in their diagnosis and treatment of Members with behavioral health conditions. For example, through our partnership with Mindoula, our PCPs/PCMHs will have access to Mindoula's Collaborative Care Program. Through this model, our PCPs/PCMHs will be able to receive support from Mindoula's virtual behavioral health Care Manager, virtual consulting psychiatrist, and a software registry that monitors Member progress. Mindoula virtual psychiatrists can provide treatment recommendations to support the PCP/PCMH in treating mild-to-moderate behavioral health and substance use disorder diagnoses, as well as provide ongoing psychiatric input. Mindoula's Collaborative Care Program has been shown to double the effectiveness of depression care, improve physical functioning, and significantly reduce health care costs, including inpatient medical and behavioral health costs.

In addition to our partnership with Mindoula, we will work with the University of Mississippi Medical Center's Child Access to Mental Health and Psychiatry (CHAMP) program to assist our PCPs/PCMHs in obtaining education and consultation on questions on mental health care. The CHAMP program will provide support to allow PCPs/PCMHs to better care for Members with mental illness locally, with guidance from UMMC psychiatrists and psychologists.

We will also take a collaborative approach to increasing the capacity of Mississippi Providers to treat Members with chronic pain, including our Members who have or are in recovery from a SUD. In partnership with the UMMC, we will develop a Project ECHO training program to educate PCPs on treating patients with chronic pain using non-pharmacological multi-modal treatment plans.

Sickle Cell Disease

SCD is a genetic blood disorder affecting approximately 100,000 people in the United States, mainly Black people. According to a 2019 CMS publication on SCD among Medicaid beneficiaries, Mississippi had the highest SCD prevalence rate, 2.20 per 1,000 Medicaid beneficiaries, and was the only State with an SCD prevalence rate of 2 or greater.[1] We will collaborate with Providers to deliver our comprehensive Sickle Cell Care Management Program, which includes Provider education, partnership, and support. We will educate PCPs/PCMHs and ED clinicians about SCD and our Sickle Cell Care Management Program, treatment best practices, and care standards, including tools and strategies from the National Institute for Children's Health Quality SCD Regional Collaboratives Program. Our Sickle Cell Care Management team will closely collaborate with PCPs/PCMHs and hematologists on the development of Members' care plans and will notify Providers when we identify Members who are non-adherent with their hydroxyurea medications. We will establish data and benchmarks for PCP/PCMH treatment and track measures such as pediatric and adult use of hydroxyurea and rates of pneumococcal immunization. Through these collaborative efforts, we will increase the number of Providers in Mississippi who feel comfortable and equipped with the resources to effectively treat SCD. We will also increase specialist capacity for serving Members with SCD through our VBP arrangements; for example, we will use VBP models to offer Provider groups the opportunity to earn additional revenue that can be used to recruit hard-to-find specialists, such as pediatric pain specialists, who will have a critical role in caring for children with SCD.

We will educate Providers to address cultural stigmas often associated with SCD, thereby improving the delivery of culturally appropriate care and reducing disparities. To support Providers in connecting their patients to community resources, we will educate Providers about resources such as patient and parent support groups and mentoring programs for teenagers living with SCD offered through the Mississippi Sickle Cell Foundation. Our collaboration with Providers through our Sickle Cell Care Management Program in a Medicaid affiliate resulted in an ***18% reduction in SCD-related ED utilization, a 13% reduction in SCD crisis-related ED utilization, and a 51% reduction in SCD-related inpatient utilization***.

Persistent or Preventable Readmissions

The Appendix A, Draft Contract identifies Members with persistent and/or preventable inpatient readmissions as one "condition" for enrollment into the Care Management Program, and reducing potentially preventable

[1] Wilson-Frederick SM, Hulihan M, Anderson KK. Prevalence of Sickle Cell Disease among Medicaid Beneficiaries in 2012. CMS Office of Minority Health Data Highlight, No. 16. Baltimore, MD. 2019.

readmissions is a significant focus of DOM's Comprehensive Quality Strategy. We view close collaboration with a continuum of Providers to be an essential element in reducing preventable readmissions, and we anticipate collaborating with our Providers to offer proven strategies for reducing readmissions among MSCAN and CHIP Members, such as:

- Incentivizing PCPs/PCMHs to extend primary care office hours and coordinate after-hours care to allow Members to receive care in the most appropriate setting and avoid care delays due to challenges seeking care during normal business hours. We will also collaborate with PCPs/PCMHs in discharge planning and ongoing Member communication about where and when to seek hospital-based care.
- Offering tools that allow our Providers to receive timely, actionable information from health care settings, including inpatient settings. ADT data will be made available to our PCPs/PCMHs and will allow Provider Care Management teams to engage patients at transitions in care and help avoid readmissions. We will also assist Providers by following up with Members.
- Through our Readmission Reduction Program, engaging not only with Members, but also their PCPs/PCMHs and hospital discharge planning staff and other hospital Providers to identify and address barriers that may have led to the admission. As part of this program, we will conduct Readmission Rounds with hospitals. Please see our response to 4.2.2.3.C.3.e of the RFQ for more information on our Readmission Reduction Program.
- Establishing weekly meetings with each hospital in our network to review complex cases and discuss opportunities for process improvements and better Care Management coordination with our hospital partners to prevent future readmissions. We will encourage not only hospital leadership but also hospital-affiliated inpatient and outpatient Providers to participate in these meetings to contribute to solutions for reducing readmission rates.

An analysis of the effectiveness of the Readmissions Reduction Program across affiliate health plans found that Members enrolled in the program had a statistically significant lower rate of potentially preventable readmissions (PPR) when compared to Members that were not enrolled in the program (11.61% PPR and 13.12% PPR, respectively).

4.2.2.2.E Provider Payment

1. Describe the Offeror's proposed process for ensuring that non-participating Providers who provide emergency services to Members are paid on a timely basis.

We will cover and pay for Emergency Medical Services regardless of whether a Provider has a contract with us, in accordance with Appendix A, Draft Contract. We will configure our Claims Processing System to reimburse non-participating Providers at the Mississippi Medicaid fee schedule rate for any emergency service provided in an Emergency Department (ED) or other location.

Our utilization management processes will ensure that we will not deny payment for treatment obtained under either of the following circumstances:

- 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.
- We or the Member's PCP/PMCH instructed the Member to seek emergency services.

We will not limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms, inclusive of dialysis services. We will cover emergency services regardless of whether the ED Provider or hospital notifies the Member's PCP, PCMH, or us of the Member's screening and treatment within ten calendar days of presentation for emergency services.

We will not require prior authorization for emergency services by either participating or non-participating Providers, as documented in our current Utilization Management (UM) Program Description and associated policies and procedures (collectively P&Ps). Our UM P&Ps will comply with all regulatory, contractual, and accrediting guidelines, including those related to emergency services, and we will submit our UM Program Description to DOM for approval. Our Population Health Department will maintain the UM P&Ps, which address UM processes such as prior authorization, retrospective review, Care Management, and discharge

planning. These documents are reviewed and revised at least annually or more frequently as needed.

Rapid Claims Payment

We will adjudicate all clean claims, including those from non-participating ED Providers, within the contractual timeframes required by DOM. We will ensure standards for timeliness are met or exceeded as noted in Section 9.1.1 Claims Payment Generally of Appendix A, Draft Contract. We have the capability to pay at least ninety percent (90%) of all Clean Claims 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 when an alternative payment schedule has been agreed upon. All other claims except for Providers under investigation for Fraud, Waste, and Abuse (FWA) will be paid within one hundred twenty (120) calendar days of receipt. ***We exceed these requirements in other markets. For example, for 2021, one of our affiliates paid 97.2% of clean claims within 15 days and 99.9% within 30 days.***

Multiple Claims Submission Options. To ensure expedited payment to non-participating Providers for ED services, we will provide several claims submission and payment options that are readily accessible to all Providers. For example, non-participating Providers will be able to submit HIPAA compliant electronic claims to us from over 80 claims clearinghouses. In addition, after submitting their first claim, non-participating Providers will be able to register for a secure Provider Portal account to be able to submit their EDI claims directly to us. We will scan paper claims within 24 hours of receipt into our integrated document imaging, workflow automation, and claims pre-processing system. These claims will then be transferred systematically to our Claims Processing System within 48 hours of receipt. Both paper and electronic claims undergo identical pre-processing validation and edits prior to loading into our Claims Processing System.

Resolving Claim Pends and Rejections Expeditiously. We will ensure timely payment for emergency services when a claim is not initially clean, including processes for prompt resolution of pended claims by a Claims Analyst. In the event a paper claim fails pre-adjudication edits, our system will automatically generate and send a letter to the submitting Provider, rejecting the claim and citing the specific edit(s) responsible. Our claims workflow software manages the workflow of any pended claim in real-time. If a claim pends, an electronic work item is immediately routed to a Claims Analyst for resolution and re-adjudication. Our claims workflow identifies and escalates any pended claim approaching 20 calendar days to a Claims Supervisor to ensure timely resolution.

If a claim from a non-participating Provider of emergency services is received, the claim will pend in our Provider Lifecycle system as they are not yet in our system. Our Provider Lifecyle System will then review the state file to ensure the Provider's information submitted on the claim is correct. Once the Provider Lifecyle System builds the non-participating Provider's record, the data will be sent electronically to the Provider Relations team or our Claims Liaisons to have the claims processed. If a claim is rejected from a non-participating Provider of emergency services, the Provider will receive communication from the Provider Lifecycle System as to the error that caused the rejection. This will enable the Provider to correct the issue identified and be able to submit the claim for processing.

Audits to Ensure Timely Payment

We will monitor internal claims turnaround time reports daily to ensure that claims are being adjudicated using DOM's processing and our internal standards. We will identify all claims not paid within 20 calendar days of receipt and work with internal departments as necessary to collect the information needed to ensure the claim is paid within the required timeframe.

In addition, our parent company's centralized Claims Audit Division (CAD) will perform independent and objective audits of claims payment accuracy. Audits help ensure that Provider payment processing is in accordance with appropriate rates, and in accordance with State and Federal regulations. The CAD will objectively evaluate claim entry, adjudication processes, and whether determinations on enrollment, benefit, and payment are accurate. The audits will be based on a random sample of processed claims (adjudicated, rejected, appealed) to assess claims for processing, payment, and financial accuracy. Audits will assess multiple attributes including outliers, tracing claim dollars to the specific underlying source documents, the accuracy of claim data entry, third party liability, and verification that claims coding is consistent with Provider credentials.

The CAD will provide monthly and quarterly reports to our local claims team summarizing audit results. We will also conduct weekly teleconferences with our centralized claims resources to identify and resolve issues before they become critical.

2. Discuss the Offeror's willingness to pay claims with dates of services on and after the date of credentialing irrespective of the date the credentialed Provider is loaded into the Offeror's claims processing system.

We will configure our Claims Processing System and develop associated policies and procedures to allow us to pay claims with dates of services on and after the date that a Provider is credentialed, irrespective of the date the credentialed Provider is loaded into our Claims Processing System. We are willing and able to systematically support claims processing and payment in this circumstance without delay.

3. To the extent that any subcontractor(s) will be processing and/or paying claims, include a systems diagram explaining this process, as well as an explanation of the Offeror's business relationship with any such subcontractor(s).

Our Dental, Vision and NET vendors will be processing and paying claims. System diagrams describing these processes, including how our vendors will submit encounter data to us, are provided in **Figures 4.2.2.2.E.3.a** through **4.2.2.2.E.3.d** below. Our Dental and Vision vendors are affiliate companies, and our non-emergency transportation (NET) vendor is an unrelated entity.

Figure 4.2.2.2.E.3.a Dental Vendor Claim Adjudication Process

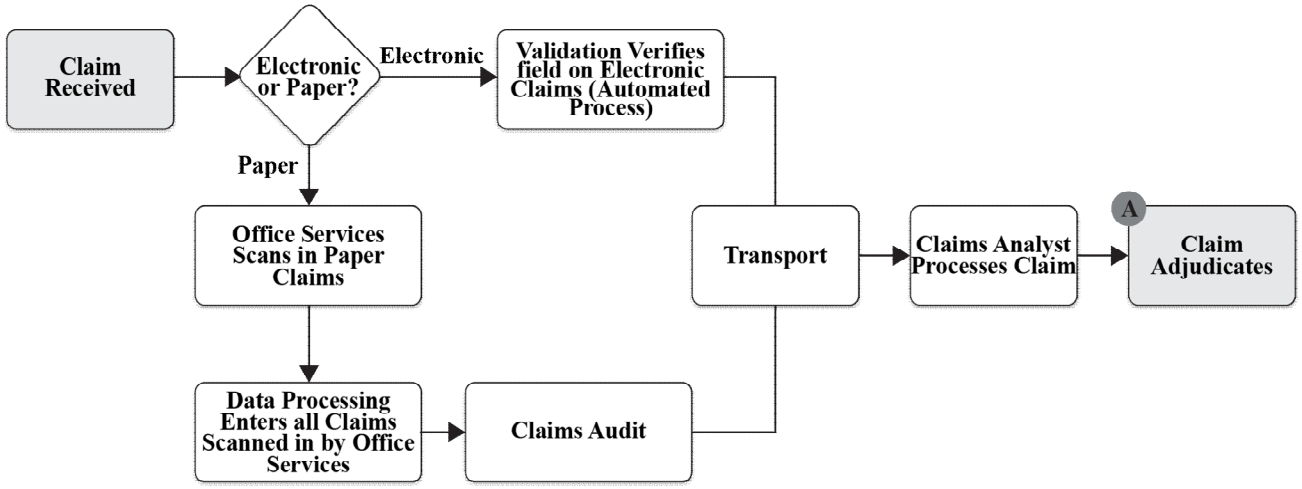


Figure 4.2.2.2.E.3.b Vision Vendor Claim Adjudication Process

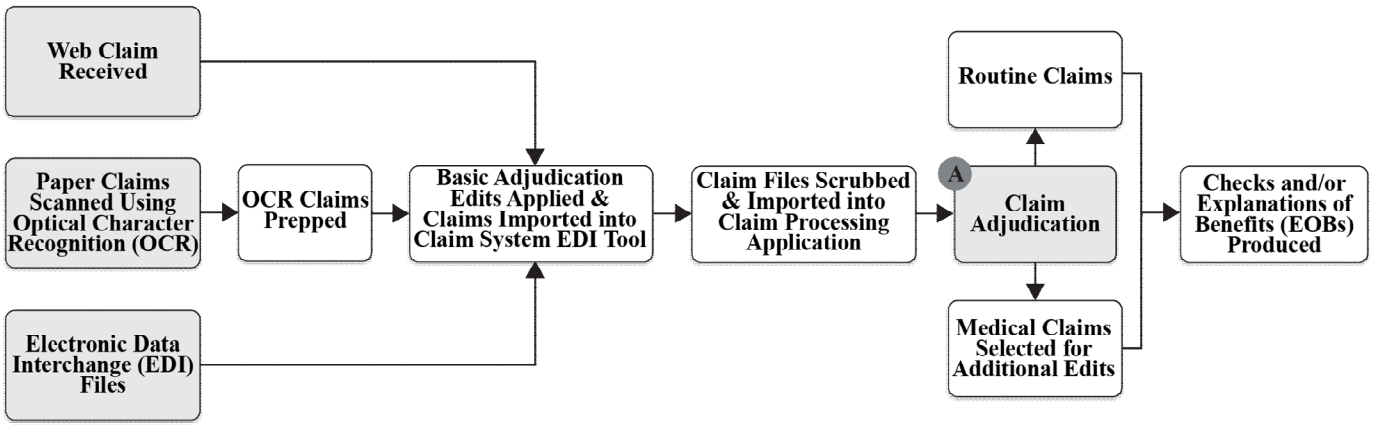


Figure 4.2.2.2.E.3.c Dental and Vision Encounter Process

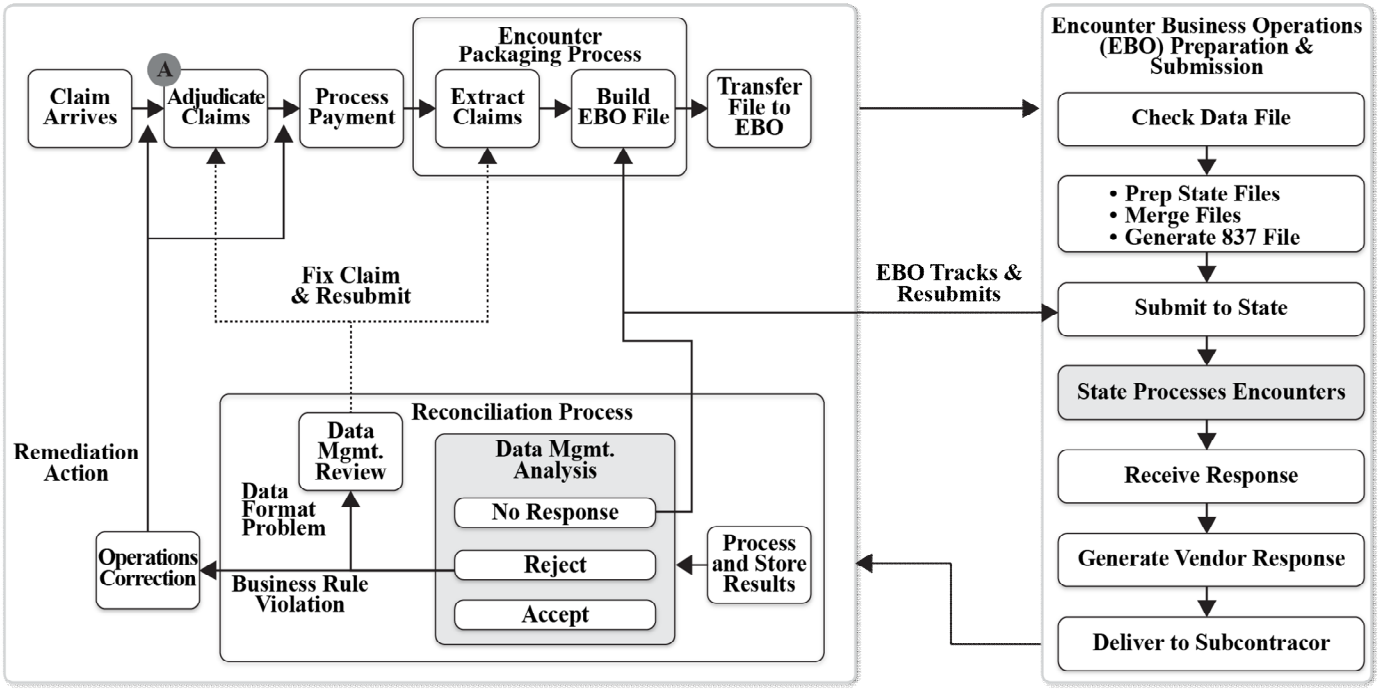
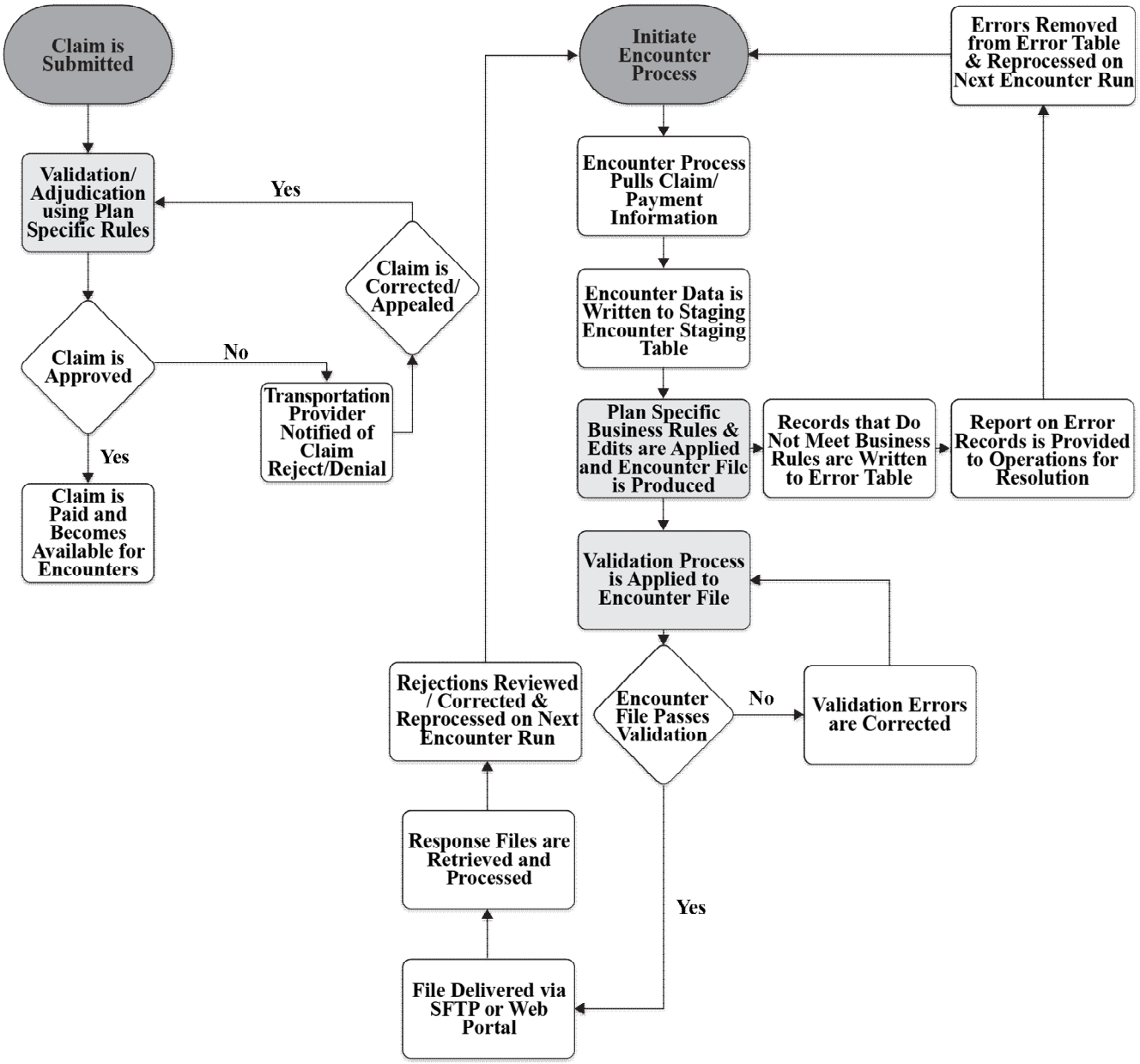


Figure 4.2.2.2.E.3.d NET Vendor Claim Adjudication and Encounter Processes



4.2.2.2.F Provider Grievances and Appeals

1. Describe the Offeror's proposed Provider Grievance and Appeal process specifically addressing:

a. Compliance with State requirements as described in Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process of Appendix A, Draft Contract;

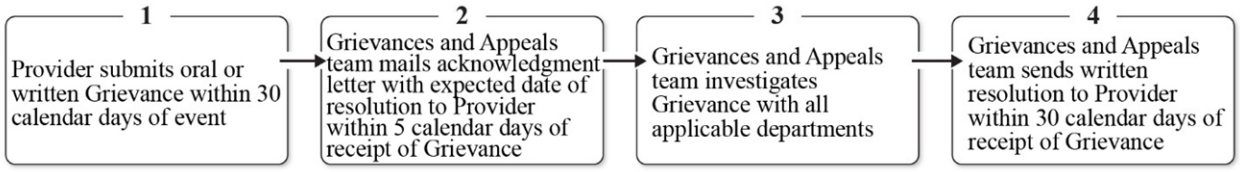
We will comply with all State requirements as described in Section 6.10 of Appendix A, Draft Contract, as well as adhere to those in the State's Quality Strategy. We will seek written approval from DOM for our Provider Grievance and Appeal policies and procedures; we will not modify them without the prior approval of DOM and will provide DOM with a copy of the modification for review and approval at least 60 days before we plan to implement the modification. We will review our Grievance and Appeal policies and procedures at least annually. We will provide information about our Grievance and Appeal process to Providers through our public website, Provider Manual, Provider Newsletters, Provider Orientation, contact with Provider Services staff, in written notices of Adverse Action, and as part of the remittance advice mailing. These materials will advise Providers of their right to file a request for a State Administrative Hearing upon notification of an Appeal decision with which the Provider disagrees.

Our dedicated Provider Grievance and Appeal staff will administer the Provider Grievance and Appeal and Claims Denial Appeal processes using our secure Grievances and Appeals System to document the receipt, notification, investigation, status, and resolution of each Grievance and Appeal and to track State Administrative Hearings and generate required reporting. For Providers of dental and vision services, our respective Subcontractors will manage the related Grievances and Appeals. We will establish requirements for these delegated responsibilities in the subcontractor contracts. Our Subcontractors will be required to submit monthly and quarterly reports on Grievances and Appeals, which will be reviewed by our Vendor Oversight team.

Provider Grievance Process

A Provider may submit an oral or written Grievance to any health plan staff regarding any issue except for an Adverse Determination, which is handled through the Provider Appeals process. Providers may also electronically file and track Grievances through our Provider Portal. **Figure 4.2.2.2.F.1.a** below provides an overview of our Provider Grievance process, which aligns with contractually required timeframes for receipt, acknowledgment, and resolution of Provider Grievances. We will extend the Grievance resolution timeframe up to 14 calendar days if the Provider requests it or if we determine the extension is in the Provider's best interest, in which case we send written notice of the reason for the extension within five calendar days of the extension decision. In situations where a Provider Grievance needs to be escalated for immediate action, our staff are trained to follow the escalation process described in our response to Section 4.2.2.2.F.1.b of the RFQ.

Figure 4.2.2.2.F.1.a Provider Grievance Process



Provider Appeal Process

Appeals may be for clinical or claim denial reasons. We describe the process for each type of appeal below.

Clinical Appeal Process. Providers may file a clinical appeal on behalf of a Member following the Member Appeal procedure. Our processes and procedures for Member Appeals are described in our response to Section 4.2.2.1.G of the RFQ.

Claims Appeal Process. In addition to the reconsideration process and our Grievance and Appeal System described above, we will offer Providers the opportunity to Appeal a claim denial if they are not satisfied with our initial adjudication. Providers may file a claim Appeal by submitting a written request accompanied by a completed Appeal form, either electronically through our Provider Portal or by mailing it to our dedicated Post Office box**.** Claims staff will facilitate investigation and resolution, forwarding claim Appeals requiring clinical documentation review to our Medical Director. We will send Providers written acknowledgment with the expected resolution date within 10 calendar days of receipt and a written resolution in the form of an Explanation of Payment within 30 calendar days of receipt. We will send written resolutions within three calendar days of receipt of a request for an Expedited Resolution of an Appeal outlining why the Appeal was upheld or that the claim is being reprocessed.

A Provider may file a Grievance as described above if dissatisfied with any matter related to a request for correction/adjustment or a claim Appeal. If our final resolution is to deny the claim Appeal and the Provider has exhausted our processes, we will provide written notice to the Provider, which will include the Provider's right and the procedure to request a State Administrative Hearing. In addition, our Provider agreements will include provisions for arbitration.

Appeal Extensions. We will extend the resolution timeframe up to 14 calendar days if the Provider requests it or if we determine the extension is in the Member's or Provider's best interest, in which case we send written notice of the reason for the extension within two business days of the extension decision.

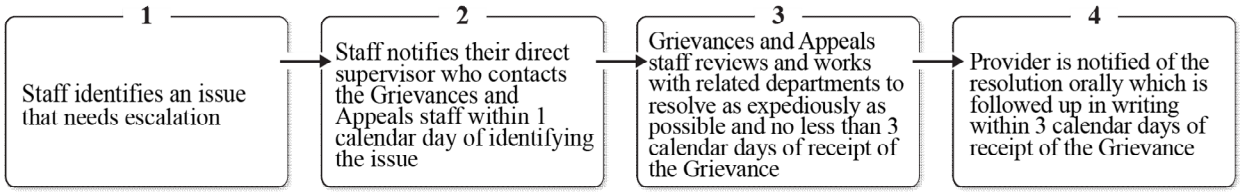
State Administrative Hearing. A Provider may request a State Administrative Hearing after exhausting our

Appeal processes within 30 calendar days of our final decision. We will comply with all State Administrative Hearing requirements and timelines including, but not limited to ensuring that all Appeal documentation, including any Grievances, is submitted to DOM within the requested timeframe and that all appropriate staff Members with knowledge of the Appeal are available to speak and provide relevant information at the Hearing. If DOM's final determination requires payment of the claim, we will pay each claim within 30 calendar days of receipt of DOM's notice. Should a State Administrative Hearing result in the reversal of a decision we made with which the Provider disagrees, we agree to bear all costs associated with the hearing.

b. Process for elevating Provider Grievances; and,

Our staff will be trained on how to identify and elevate a Provider Grievance that is related to an issue(s) that could potentially cause or has caused harm to a Member. The elevation process will be included in our Grievance and Appeal policies and procedures. Issues needing to be elevated include but are not limited to: a Member unable to get needed medication or medical equipment, potential quality of care issue, abuse of a vulnerable adult, child neglect or abuse, or issues navigating the foster care system. The elevation process is highlighted in **Figure 4.2.2.2.F.1.B** below.

Figure 4.2.2.2.F.1.b Grievance Elevation Process



The Grievance and Appeal team will use our secure Grievance and Appeal System to document the receipt, notification, investigation, status, and resolution of each elevated Grievance and Appeal. Grievances may be elevated to the Chief Medical Director or Chief Executive Officer depending on the nature of the grievance.

c. Process for identifying, tracking, and trending Grievances, using data to make program improvements, and sharing data with the Division.

When a Grievance is received, Grievance and Appeal staff will review the Grievance to ensure it meets the definition of a Grievance according to Appendix A, Draft Contract. If the event causing the Grievance is past 30 days or if it is related to an Adverse Determination, the Grievance will be referred to Provider Relations for further action. We will use our Grievance and Appeal System to record, track, and report Provider Grievance and Appeal data. Grievances and Appeals will be categorized by NCQA and DOM guidelines. We will maintain all required Grievance and Appeal System data and supplemental documentation following State record retention requirements.

Grievance and Appeal staff will review and analyze data monthly, quarterly, and annually to identify trends and areas of concern. Staff will conduct a barrier analysis and work cross-functionally with other departments to implement interventions to improve processes and Provider satisfaction. Grievance and Appeals data will be reported quarterly to the Quality Management Committee for review and further recommendations. An annual review of Grievance and Appeal data will be conducted by Quality Management Leadership and will be included in the Quality Management Program Evaluation and presented to the Quality Management Committee and the Board of Directors.

We will share Grievances and Appeals detailed and summary data with DOM per Appendix A, Draft Contract, and the CCO Reporting Manual and via any ad hoc requests. If applicable, we will report MSCAN and CHIP data separately. Any concern over Fraud, Waste, and Abuse (FWA) will be shared with our Compliance Department who will alert our internal FWA team and DOM Program Integrity team for further review and investigation as needed.

ATTACHMENT 4.2.2.2.A.5 PARTICIPATING PROVIDER AGREEMENT

Templates of the Offeror's standard Provider contracts.

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between PROVIDER ("Provider") and HEALTH PLAN ("Health Plan") (each a "Party" and collectively the "Parties"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("Effective Date").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means, as appropriate in the context, Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary.

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

1.15. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Attached hereto as Schedule C is the initial list of the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list containing the names, office telephone numbers, addresses, tax identification numbers, hospital affiliations, specialties and board status (if applicable), State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least sixty (60) days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted

Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within thirty (30) days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of

professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at

one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within ten (10) days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within thirty (30) days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than

$25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV – RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and each Contracted Provider will provide Health Plan with at least fifteen (15) days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI – DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within sixty (60) days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII – TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of three (3) year(s), after which it will automatically renew for successive terms of one (1) year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than one hundred eighty (180) days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than one hundred eighty (180) days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least one hundred eighty (180) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least one hundred eighty (180) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least ninety (90) days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the sixty (60) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Company's or Payor's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the ninety (90) day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this

Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

To Health Plan at: To Provider at:

Attn: NAME	Attn: NAME
HEALTH PLAN	ORGANIZATION
STREET	STREET
CITY, STATE, ZIP	CITY, STATE, ZIP
	EMAIL

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to Health Plan.

* * * * *

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:	**PROVIDER:**
	(Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name:	Print Name:
Title:	Title:
Signature Date:	Signature Date:
	Tax Identification Number
	State Medicaid Number:
To be completed by Health Plan only:	National Provider Identifier:
Effective Date:	Medicare Number:

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1 Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following: (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.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Hospital agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Hospital's performance data.

2 Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Practitioner's performance data.

3 Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing forty-five (45) days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use ancillary provider's performance data.

4 FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to

Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5 Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use facility's performance data.

6 Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of Health Plan. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.5.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.5.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.5.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.5.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with Health Plan's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

6.10 Person-Centered Planning, Care/Service Plan, and Services ("PCSP"). Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

6.10.1 Members shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

6.10.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its

implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the member.

6.10.3 LTSS providers shall be aware of, respect, and adhere to a member's preferences for the delivery of services and supports.

6.10.4 LTSS providers shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to members and the person(s) supporting them who have disabilities and/or are limited English proficient.

6.10.5 Health Plan agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if state requirements differ) and provide a copy to all LTSS providers responsible for implementation.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid
Attachment B: [Reserved]
Attachment C: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
CONTRACTED PROVIDERS

ENTITY/GROUP/CLINIC/FACILITY NAME	TAX ID #	NPI #

NOTE: This Schedule is intended to capture all groups, clinics and facilities participating under the Agreement (i.e., are Contracted Providers under this Agreement) as of the Effective Date.

ATTACHMENT 4.2.2.2.A.5 PARTICIPATING PROVIDER AGREEMENT - DENTAL

Templates of the Offeror's standard Provider contracts.

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "**Agreement**") is made and entered by and between ___("**Provider**") and Dental Subcontractor.

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company (as hereafter defined), and Provider desires to participate in such products as a "participating provider," all as hereinafter set forth.

WHEREAS, DENTAL SUBCONTRACTOR desires for Provider to provide such health care services to individuals in such products, and DENTAL SUBCONTRACTOR desires to have Provider participate in certain of such products as a "participating provider," all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section xx or Section xx, all of which are hereby incorporated herein by reference and may be amended from time to time as provided herein.

1.2. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.3. "Company" means (collectively or individually, as appropriate in the context) DENTAL SUBCONTRACTOR and/or its affiliates, except those specifically excluded by DENTAL SUBCONTRACTOR.

1.4. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement and may be included within a Product Attachment.

1.5. "Contracted Provider" means a physician, dentist, hospital, health care professional or any other provider of items or services that (i) is employed by or has a contractual relationship with Provider, and (ii) has been approved for participation by a Company. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider and for which Provider has been approved for participation by a Company.

1.6. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by a Payor, under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of the Company's provider networks or vendor arrangements, except those excluded by DENTAL SUBCONTRACTOR.

1.7. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.8. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be medically necessary under the applicable Coverage Agreement.

1.9. "Participating Provider" means, with respect to a particular Product, any physician, dentist, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with a Company to provide Covered Services to Covered Persons, and that is designated by the Company as a "participating provider" in such Product.

1.10. "Payor" means the entity (including a Company) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not a Company, such entity contracts, directly or indirectly, with a Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.11. "Payor Contract" means the contract with a Payor, pursuant to which a Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of the Company's provider networks or vendor arrangements, except those excluded by DENTAL SUBCONTRACTOR. The term "Payor Contract" includes a Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which the Company or Payor arranges for the provision of Covered Services to eligible individuals.

1.12. "Product" means any program or health benefit arrangement designated as a "product" by a Company (e.g., PPO Product, DENTAL SUBCONTRACTOR Product, Medicaid Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through a Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by DENTAL SUBCONTRACTOR) that provides Covered Persons in such product with incentives or access to Participating Providers in such product.

1.13. "Product Attachment" means an Attachment setting forth certain requirements, terms and conditions specific to one or more Products, including certain provisions that must be included in a provider agreement under the laws of the State, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.14. "Provider Manual" means the manuals, requirements, policies and procedures adopted by a Company to be followed by Participating Providers, including, without limitation, those relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as the same may be amended from time to time by the Company.

1.15. "Regulatory Requirements" means all applicable statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.16. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement, and the Provider Manual and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment).

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a "Participating Provider" in each Product identified in a Product Attachment designated on Schedule A of this Agreement or added to this Agreement in accordance with Section 2.2 hereof. Requirements set forth in such Product Attachments that, by their context, apply to a particular subset of providers shall apply to Provider as applicable under the circumstances of such Provider's clinical scope of practice.

2.2.1. If a Company desires to add one or more Contracted Providers to an additional Product, the Company will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving the Company written notice of its decision to opt-out within thirty (30) days of the Company's giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not constitute "Participating Providers" in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that a Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Attached hereto as Attachment B is the initial list of the Contracted Providers participating under this Agreement as of the Effective Date. Provider shall provide a Company on an annual basis or more often upon request with a list containing the names, office telephone numbers, tax identification numbers, hospital affiliations, specialties and board status (if applicable), addresses, State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the parties, and shall provide the Company with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the parties.

2.2.4. Provider shall, at all times during the term of this Agreement, require all of its providers to participate (or be eligible and willing to participate) under this Agreement as "Contracted Providers." Subject to a Company's approval, Provider may add new providers to this Agreement as "Contracted Providers." In such case, Provider shall use best efforts to notify the Company, in writing, of the prospective addition at least sixty (60) days in advance. Each such new provider may become a "Contracted Provider" once he, she or it meets the requirements contained elsewhere in this Agreement. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide

Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements. Each Contracted Provider shall direct or refer Covered Persons to Participating Providers, unless otherwise authorized by a Company or Payor.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of a Company and Payor, which generally will be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; policies and procedures requiring notification for certain Covered Services; medical management programs including those components relating to quality improvement, utilization management, disease management, and case management, and on-site reviews; grievance and appeal procedures; coordination of benefits and third party liability policies; and carve-out and third party vendor programs. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. DENTAL SUBCONTRACTOR shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, DENTAL SUBCONTRACTOR shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, DENTAL SUBCONTRACTOR will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by DENTAL SUBCONTRACTOR through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider agrees as follows: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) if applicable, a Medicare-certified provider under the federal Medicare program and (iv) a Medicaid participating provider under applicable federal and State laws; and (b) that all employees of Provider or the Contracted Provider will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by the Company that such Contracted Provider has successfully completed the Company's credentialing process.

2.6. Eligibility Determinations. Provider or the Contracted Provider shall verify whether an individual seeking Covered Services is a Covered Person. Company will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. The Company does not guarantee that persons identified as "Covered Persons" are eligible for benefits. If a Company, Payor or its delegate determines that an individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement.

2.7. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of a Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the

Contracted Provider deems appropriate regarding health care quality or medical treatment decisions or alternatives.

2.8. Carve-Out Vendors. Provider acknowledges that a Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as the Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third-party vendors designated by the Company for those Covered Services identified by the Company from time to time for a particular Product.

2.9. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with a Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this provision should be construed as limiting the ability of either party or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other Payors consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting a Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by a Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.10. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, a Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements.

2.11. Notice of Certain Events. Provider shall give written notice to DENTAL SUBCONTRACTOR of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or the Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or the Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any lawsuit or claim filed or asserted against Provider or the Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify DENTAL SUBCONTRACTOR in writing within ten (10) days, and in any such instance described in subsection (iv) above, Provider must notify DENTAL SUBCONTRACTOR in writing within thirty (30) days, from the date it first obtains knowledge of the same.

2.12. Use of Name. Provider and each Contracted Provider hereby authorize each Company to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Companies for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of a Company without the Company's prior written consent.

2.13. Compliance with Regulatory Requirements and Payor Contracts. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider

Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on a Company, the Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse the Company for such amounts.

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Submission. As provided in the Provider Manual, Contracted Providers shall submit to the Company or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to the Company or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounters in accordance with the Provider Manual.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services hereunder. The applicable Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or a Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

3.6 Robocalls. In accordance with Federal Communications Commission (FCC) regulations regarding robocalls, Provider and Contracted Provider hereby agree to accept robocalls from DENTAL SUBCONTRACTOR and its representatives involved in executing the Agreement.

ARTICLE IV – RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted clinical standards. Such records shall be maintained for a period of not less than five (5) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation, they must be retained until the review, audit, or litigation is complete.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) the applicable Company and Payors, during regular business hours and upon prior notice; (ii) government agencies, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to a Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of their facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner. Provider shall maintain and make records available for review by authorized federal and State agencies during the term of this Agreement and for a period of five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, Provider shall maintain records for a period of five (5) years or until all issues are finally resolved, whoever is later.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, Provider and each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance that are necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the aggregate unless a lesser amount is accepted by DENTAL SUBCONTRACTOR or where State law mandates otherwise. Provider and each Contracted Provider will provide DENTAL SUBCONTRACTOR with at least fifteen (15) days notice of such cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon DENTAL SUBCONTRACTOR's request, Provider and each Contracted Provider will furnish DENTAL SUBCONTRACTOR with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at DENTAL SUBCONTRACTOR's request defend) each Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by DENTAL SUBCONTRACTOR. DENTAL SUBCONTRACTOR agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by a Company or its directors, officers, agents or employees.

ARTICLE VI – DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Except as provided below or superseded by applicable Regulatory Requirements, any dispute between the parties (or involving a Contracted Provider) with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to each of the parties' satisfaction, or if there are no applicable procedures in the Provider Manual, then the parties agree that they shall engage in a period of good faith negotiations between designated representatives of the parties who have authority to settle the Dispute, which negotiations may be initiated by either party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within sixty (60) days of such request, either party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. Either party wishing to pursue the Dispute as provided in Section 6.1 shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar a party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII – TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the effective date designated by DENTAL SUBCONTRACTOR on the signature page of this Agreement ("Effective Date"), and will remain in effect for an initial term of three (3) year(s), after which it will automatically renew for terms of one (1) year each, unless this Agreement is sooner terminated as provided in this Agreement or either party gives the other party written

notice of non-renewal of this Agreement not less than ninety (90) days prior to the renewal date of this Agreement. In addition, either party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product, effective as of the renewal date of this Agreement, by giving the others written notice of such non-renewal not less than ninety (90) days prior to the renewal date of this Agreement; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either party giving the other party at least ninety (90) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either party giving the other party at least ninety (90) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either party giving at least ninety (90) days prior written notice of termination to the other party if such other party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other party (or the Contracted Provider) fails to cure the breach within the sixty (60) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2. must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, DENTAL SUBCONTRACTOR has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by DENTAL SUBCONTRACTOR, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a party giving written notice thereof to the other party if the other party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by DENTAL SUBCONTRACTOR giving written notice thereof to Provider if the Contracted Provider fails to adhere to DENTAL SUBCONTRACTOR's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall: (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the ninety (90) day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.2, 5.3, 6.2, 7.3, 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship among the parties is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated or transferred by Provider without DENTAL SUBCONTRACTOR's prior written consent. DENTAL SUBCONTRACTOR shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of DENTAL SUBCONTRACTOR, or purchaser of the assets or stock of DENTAL SUBCONTRACTOR, or the line of business or business unit primarily responsible for carrying out DENTAL SUBCONTRACTOR's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of the parties hereto will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the parties signing it for their benefit and the benefit of each Company. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than a Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the parties.

8.7.1. DENTAL SUBCONTRACTOR may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by DENTAL SUBCONTRACTOR to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. DENTAL SUBCONTRACTOR may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies DENTAL SUBCONTRACTOR in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by DENTAL SUBCONTRACTOR, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, DENTAL SUBCONTRACTOR may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between the Company and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

To DENTAL SUBCONTRACTOR at:	To Provider at: Attn: _____ _____ _____

or to such other address as such party may designate in writing.

8.12. Force Majeure. Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either party's employees, or any other similar cause beyond the reasonable control of such party.

8.13. Proprietary Information. Neither party shall disclose to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other party during the course of this Agreement, except to agents of such party as necessary for such party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to a Company's programs, policies, protocols and procedures is proprietary information and

Provider shall not disclose such information to any person or entity without DENTAL SUBCONTRACTOR's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Company.

* * * * *

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule A, effective as of the date set forth beneath their respective signatures.

DENTAL SUBCONTRACTOR:	**Provider**:
	(Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name:	Print Name:
Title:	Title:
Signature Date:	Signature Date:
To be completed by DENTAL SUBCONTRACTOR only:	Tax Identification Number:
Effective Date:	State Medicaid Number:
	National Provider Identifier:

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below and designated by a check mark as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

☐ Attachment A: Medicaid

☐ Attachment B: Medicare

☐ Attachment C: Commercial-Exchange

☐ Attachment D: CHIP

- ☐ Exhibit A-1: Dental Fee Schedule for State Medicare and Commercial Exchange
- ☐ Exhibit A-2: Medicaid Negotiated Rates

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
CONTRACTED PROVIDERS

Please check here if attaching separate roster* (must include TIN and NPI): ☐

*Upload roster file here:

If not attaching roster, please fill in the information for each Contracted Provider below:

ENTITY/GROUP/CLINIC NAME	TAX ID #	NPI #

NOTE: This Schedule is intended to capture all professionals, groups and clinics participating under the Agreement (i.e., are Contracted Providers under this Agreement) as of the Effective Date.

Attachment A: Medicaid

STATE PRODUCT ATTACHMENT

This State Product Attachment (the "Product Attachment") is incorporated into the Participating Provider Agreement (the "Agreement") entered into by and between Provider (as defined in Agreement) and Dental Subcontractor as of the Effective Date.

ARTICLE I - RECITALS

1.1 DENTAL SUBCONTRACTOR has contracted with Health Plan, (who has contracted with the State to arrange for the provision of medical services to Covered Persons under the State Program.

1.2 Provider has entered into the Agreement with DENTAL SUBCONTRACTOR. This Product Attachment is intended to supplement the Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to Covered Persons as it pertains to the State Program. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern.

1.3 Notwithstanding any provisions set forth in this Product Attachment, to the extent applicable, Provider shall comply with all duties and obligations under the Agreement, the Provider Manual and this Product Attachment. Provider agrees and understands that Covered Services shall be provided in accordance with the contracts between MEDICAID AGENCY, HEALTH PLAN and DENTAL SUBCONTRACTOR ("State Contract"), the Provider Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To the extent Provider is unclear about Provider's duties and obligations, Provider shall request clarification from DENTAL SUBCONTRACTOR.

ARTICLE II - DEFINITIONS

The definitions listed below will supersede any meanings contained in the Agreement.

2.1 ***Action*** means DENTAL SUBCONTRACTOR's decision to deny or limit authorization or payment (in or whole or in part) for dental care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or DENTAL SUBCONTRACTOR's failure to provide services in a timely manner; failure to resolve complaints, grievances, or appeals within the time frames specified in this contract

2.2 ***Agent*** means an authorized entity that acts on behalf of MEDICAID AGENCY.

2.3 ***Appeal*** means a request for review by DENTAL SUBCONTRACTOR of a DENTAL SUBCONTRACTOR action related to a Covered Person or Provider. In the case of a Covered Person , the DENTAL SUBCONTRACTOR action may include determinations on the dental health services a Covered Person 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 a Covered Person). In the case of a Provider, the DENTAL SUBCONTRACTOR action may include, but is not limited to, delay or non-payment for Covered Services.

2.4 ***Complaint*** means an expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day or receipt.

2.5 ***Cultural Competency*** or ***Culturally Competent*** means the ability to understand, communicate with, and effectively interact with people across cultures. Cultural competence comprises four components: (i) awareness of one's own cultural worldview; (ii) attitude towards cultural differences; (iii) knowledge of different cultural practices and worldviews; and (iv) cross-cultural skills.

2.6 ***Grievance*** means an expression of dissatisfaction about any matter or aspect of DENTAL SUBCONTRACTOR or its operation, other than an DENTAL SUBCONTRACTOR Action.

2.7 ***Medical Necessity*** or ***Medically Necessary*** means services, supplies, or equipment provided by a licensed health care professional that are: (i) appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury; (ii) in accordance with the standards of good medical practice consistent with the individual patient's condition(s); (iii) not primarily for the personal comfort or convenience of the Covered Person, family, or Provider; (iv) the most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person; (v) furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient; (vi) not experimental or investigational or for research or education; (vii) are provided by an appropriately licensed practitioner; and (viii) are documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

2.8 ***Medical Record*** means a single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services.

2.9 ***Member(s)*** or ***Covered Person(s)*** means Medicaid beneficiaries who have enrolled with HEALTH PLAN in the State Program. A Covered Person may also be referred to as an Enrollee or Member.

2.10 ***State Program*** means the State Medicaid coordinated care program for select Medicaid beneficiaries.

2.11 ***Non-Contracted Provider*** means a health care provider who has not been credentialed by and does not have a signed provider agreement with DENTAL SUBCONTRACTOR.

2.12 ***Panel*** means a listing and number of Covered Persons that Provider has agreed to provide services for in accordance with the State Contract

2.13 ***Provider Network*** means the Panel of health service provider with which DENTAL SUBCONTRACTOR contracts for the provision of Covered Services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.14 ***State Plan*** means the State 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 STATE CODE.

ARTICLE III - PRODUCT REQUIREMENTS

3.1 Hold Harmless. Provider agrees to not hold Covered Persons liable for: (a) any and all debts of DENTAL SUBCONTRACTOR if DENTAL SUBCONTRACTOR should become insolvent; (b) payment for Covered Services provided by DENTAL SUBCONTRACTOR if DENTAL SUBCONTRACTOR has not received payment from the State for the Covered Services, or (c) if Provider fails to receive payment from the State or DENTAL SUBCONTRACTOR; or (d) to the extent applicable, the payments to Provider for

furnishing Covered Services that are in excess of the amount that normally would be paid by the Covered Person of DENTAL SUBCONTRACTOR authorized or provided the services directly. Provider, agent, trustee, or assignee shall not maintain any action at law against a Covered Person to collect sums owed by DENTAL SUBCONTRACTOR. In addition, Provider agrees to honor and be bound by applicable State and federal laws and regulations, including relevant sections of the Balanced Budget Act of 1997, which protect Covered Persons against balance billing.

3.2 Cultural Competency. Provider must ensure that cultural differences between the Provider and Covered Persons do not present barriers to access and quality dental care. Provider must be able to demonstrate the ability to provide quality dental care across a variety of cultures.

3.3 Access to Records. Provider shall maintain current, detailed, organized medical records for each Covered Person sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed pursuant to this Agreement and/or the State Contract. Provider shall make such Medical Records accessible and available to providers providing services to Covered Persons, and to MEDICAID AGENCY for purposes of Medical Record Review. Provider 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 MEDICAID AGENCY, the State Attorney General, authorized federal or State personnel or the authorized representative of these parties including, without limitation, any employee, agent, or contractor of MEDICAID AGENCY, the Centers for Medicare and Medicaid Services ("CMS"), and MEDICAID AGENCY's fiscal agent. Access will be at the discretion of the requesting authority and will be either through on-site review of records or by submission of records to the office of the requester. Any records requested hereunder shall be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) calendar days following a request, for desk audits. Requests may be written or verbal. Provider shall maintain and make records available for review by authorized federal and State agencies during the term of this Agreement and for a period of five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, Provider shall maintain records for a period of five (5) years or until all issues are finally resolved, whichever is later.

MEDICAID AGENCY shall have unlimited rights to use, disclose, and duplicate, all information and data developed, derived, documented, or furnished by Provider hereunder in accordance with applicable State and federal laws and regulations.

Any person (including an organization, agency or other entity, but excluding a Covered Person) that fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the inspector General of the Medicaid Agencyof 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, MEDICAID AGENCY, 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, MEDICAID AGENCY may make a determination to terminate the contract.

3.4 Primary Care Access Standards. Provider shall provide Covered Services to Covered Persons in accordance with the following access standards:

3.4.1 Dental Providers:
a. Routine visits: Not to exceed forty-five (45) calendar days; and,
b. Urgent care visits: Not to exceed forty-eight (48) hours.

Provider must be accessible to Covered Persons and must maintain a reasonable schedule of operating hours.

Provider acknowledges and agrees that MEDICAID AGENCY shall have the right to periodically review the adequacy of service locations and hours of operation, and will require corrective action to improve Covered Persons' access to services.

3.5 State Authority. Provider agrees and acknowledges that MEDICAID AGENCY shall have the right to invoke any remedy available under State Contract against Provider that it may bring against DENTAL SUBCONTRACTOR, including but not limited the right to terminate this Agreement. In addition, this Agreement may be terminated immediately upon written notice by DENTAL SUBCONTRACTOR upon the entry of a valid order issued by the State Insurance Department or other lawful authority.

3.6 Compliance with Federal Law. Provider shall comply with all applicable standards, order or requirements issued under Section 306 for the Clean Air Act (42 USC 1857(h)). Section 508 of the Clean Water Act (33 USC 1368). Executive Order 11738 and Environmental Protection Agency regulations (40 CFR part 15) and 42 C.F.R. §438. Any violations must be reported to the DSHS, DHHS and EPA.

3.7 Program Exclusion. In the event Provider is excluded from participation by Medicare or Medicaid, including any other state's Medicaid or SCHIP program, DENTAL SUBCONTRACTOR shall have no obligation to reimburse Provider for services other than Emergency Care rendered on or after the effective date of Provider's exclusion. Provider shall screen its employees for excluded persons. DENTAL SUBCONTRACTOR shall immediately terminate Provider in the event Provider is excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

3.8 No Restriction on Health Status Advice. Nothing herein shall be construed as prohibiting Provider, when acting within the lawful scope of practice, from discussing Medically Necessary care with a Covered Person, or advising or advocating appropriate medical care with or on behalf of a Covered Person about (i) the Covered Person's health status, medical care or treatment options, including any alternative treatment, alternative therapies, consultation or tests that may be self-administered; (ii) any information the Covered Person needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; (iv) the Covered Person's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions; or (v) that the Covered Person may be responsible for non-Covered Services only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that the item or service rendered is a non-Covered Service and that the covered Person will be financially responsible for the item(s) and/or service(s).

3.9 Exclusion of Provider Due To Patients with Expensive Medical Conditions. DENTAL SUBCONTRACTOR shall not exclude or terminate Provider from participation in the DENTAL SUBCONTRACTOR Provider Network due to the facts that the Provider has a practice that includes a substantial number of patients with expensive medical conditions

3.10 Healthcare Opinions and Counsel. Covered Persons are entitled to the full range of their healthcare Providers' opinions and counsel about the availability of Medically Necessary services under the provisions of the State Contract.

3.11 No Termination of Contract of Employment. DENTAL SUBCONTRACTOR cannot terminate a contract or employment with Provider for filing a Complaint, Grievance, or Appeals on a Covered Person's behalf.

3.12 Compliance with the Quality Management and Utilization Management Programs. Provider shall comply with the quality management and utilization management program standards outlined in Section 9, "Quality Management", of the State Contract.

3.13 Continuation of Care Under Capitation Arrangements. If this Agreement provides for reimbursement of Provider on a capitation basis, should the Provider terminate this Agreement for any reason, Provider will provide Covered Services to Covered Persons assigned to the Provider under the Agreement up to the end of the month in which the effective date of termination falls.

3.14 Confidentiality. Provider must comply with all applicable laws and regulations pertaining to the confidentiality of Covered Person's Medical Records, including obtaining any required written Covered Person consents to disclose confidential Medical Records.

3.15 Insolvency. In the event DENTAL SUBCONTRACTOR becomes insolvent or unable to pay Provider, Provider shall not see compensation for services rendered from the State, its officers, Agents, or employees, or the covered Persons or their eligible dependents.

3.16 Claims Submission. Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to DENTAL SUBCONTRACTOR within ninety (90) calendar days from the date of denial.

3.17 Prohibition Against Intentional Segregation. Provider shall not intentionally segregate Covered Persons in any way from other persons receiving services and shall provide Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

a. Denying or not providing a Covered Person any Covered Service or availability of Participating Provider. Health care and treatment necessary to preserve life must be provided to all Covered Person who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

b. Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons, public or private patients, in any manner related to the receipt of any covered Service, except where Medically Necessary.

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

3.18 Provider Preventable Conditions. DENTAL SUBCONTRACTOR shall not pay a Provider for a "Provider Preventable condition" as defined by the federal regulations and the State Plan in accordance with 42 C.F.R §438.6(b). Provider shall provide DENTAL SUBCONTRACTOR with immediate written notice of any Never-Event, which notice shall include any such information relating to the Never-Event, as is required by DENTAL SUBCONTRACTOR to provide accurate and complete reporting to MEDICAID

AGENCY regarding such Never-Event. DENTAL SUBCONTRACTOR shall deny payment of any claims submitted for payment for a Never-Event.

3.19 Compliance with State and Federal Disclosure Requirements. Immediately upon Provider's knowledge of the same, Provider shall submit to DENTAL SUBCONTRACTOR, in connection with any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider (as defined by 42 C.F.R. §455.101: i) notice that such person has been excluded from the Medicare and Medicaid programs for any reason; and, ii) the information required under 42 C.F.R. §455.106 where such individual has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs. Such 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. 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 Provider has an ownership or control relationship. Provider shall provide information concerning each person with ownership or control, and shall submit to DENTAL SUBCONTRACTOR, immediately upon request, any and all information necessary for DENTAL SUBCONTRACTOR to make all required disclosures under 42 C.F.R. §455.104 and §455.106. DENTAL SUBCONTRACTOR shall be entitled to, and shall terminate or revoke this Agreement for cause for any reason set forth in 42 C.F.R. §§ 455.420, 1001.1001 and STATE CODE. Provider must make all disclosures required under 42 C.F.R. §1002.3.

3.20 Ongoing Course of Treatment. Unless the Provider is being terminated for cause, Provider must allow a Covered Person to continue an ongoing course of treatment from the Provider for up to sixty (60) calendar days from the date the Covered Person is notified by DENTAL SUBCONTRACTOR of the termination or pending termination of Provider, or for up to sixty (60) calendar days from the date of Provider termination, whichever is greater. A Covered Person is considered to be receiving an ongoing course of treatment from Provider under the following circumstances: i) during the previous twelve (12) months, the Covered Person was treated by Provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized; ii) an adult Covered Person 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; iii) any child (under age 21) 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 Provider; or iv) a Covered Person who is pregnant may continue to receive care from Provider through the completion of the Covered Person's postpartum care. Such transitional period may be extended by DENTAL SUBCONTRACTOR if the extension is determined, in consultation with the Covered Person and Provider, to be clinically appropriate. To be eligible for payment for Covered Services provided to a Covered Person after Provider is terminated from the network, Provider must agree to meet the same terms and conditions as Participating Providers.

3.21 Clinical Guidelines. Provider shall comply with DENTAL SUBCONTRACTOR's clinical guidelines. Provider acknowledges and agrees that DENTAL SUBCONTRACTOR will, as required under the State Contract, annually measure Provider's performance against at least two (2) such clinical guidelines, and Provider shall take corrective actions where necessary to ensure compliance with the guidelines.

3.22 Member Rights. Provider shall comply with any applicable federal and State laws that pertain to Member rights.

3.23 Encounter Data. Provider must submit to DENTAL SUBCONTRACTOR accurate and timely encounter data in compliance with DENTAL SUBCONTRACTOR's Provider Manual and/or encounter policies and procedures.

3.24 Credentialing. Provider shall at all times during the term of the Agreement be properly licensed in accordance with all applicable State law and regulations, be eligible to participate in the Medicaid program, and have in effect appropriate policies of malpractice insurance as may be required by DENTAL SUBCONTRACTOR and/or MEDICAID AGENCY. Provider must also be enrolled in the State Medicaid program using the same National Provider Identifier (NPI) numbers. Providers who are nurse practitioners acting at PCPs shall be held to the same requirements and standards as physicians acting at PCPs. In connection with these requirements, Provider shall furnish DENTAL SUBCONTRACTOR with a copy of the Provider's current license issued by the State, cover page of malpractice insurance, and such additional information as may be specified by MEDICAID AGENCY.

ARTICLE IV - STATE-MANDATED REQUIREMENTS

4.1. Termination. If Provider terminates this Agreement for any reason, Provider shall give DENTAL SUBCONTRACTOR at least sixty (60) days prior written notice of such termination.

4.2 Non-Assignment. This Agreement is intended to secure the services of and be personal to Provider, and shall not be assigned, sublet, delegated, or transferred by Provider without the prior written consent of DENTAL SUBCONTRACTOR.

Attachment A: Medicaid

SCHEDULE A
STATE MANDATED ATTACHMENT
(REGULATORY REQUIREMENTS)

This Schedule A sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Medicaid Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Health Benefit Plan (as defined below), or to such Covered Person, as applicable.

State and federal specific provisions to be included in this section with respect to this Medicaid Product.

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE - State
DENTAL PROVIDER SERVICES

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed

Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for physician Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for physician Covered Services is: (1) the rate agreed upon by the Parties as set forth in the fee schedule attached hereto as Exhibit A-2: Medicaid Negotiated Rates and incorporated herein by reference; or (2) if there is no agreed upon rate set forth in the attached Exhibit A-2: Medicaid Negotiated Rates, then the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the State's Medicaid fee schedule. If there is no established Medicaid fee rate for a Covered Service rendered to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CDT codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment B: Medicare

MEDICARE PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Attachment***") is made and entered between Dental Subcontractor ("***Dental Subcontractor***") and Provider (as defined in the Agreement).

WHEREAS, Dental Subcontractor and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company; and

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on the signature page of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as "Participating Providers" in the Product described in this Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 Medicare Product. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the following Product: Medicare Product (which is sometimes referred to in this Attachment as this "***Product***"). The term "***Medicare Product***" refers to those programs and health benefit arrangements offered by Dental Subcontractor or another Company in connection with one or more of the following Medicare product types that is administered, sponsored or regulated by the federal government (or any agency, department or Medicaid Agency thereof) on its own or jointly with a State that administers or regulates such program or plan (each a "***Medicare Product Type***"): a non-Dual Eligible Special Needs Plan Medicare Advantage plan ("***MA Plan***"); a Medicare Advantage prescription drug plan ("***MA-PD Plan***"); a Dual Eligible Special Needs Plan ("***DSNP Plan***"); a Capitated Financial Alignment Demonstration ("***MMP Plan***") plan or program (e.g., a plan or program adopted or established under the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments); or other Medicare Product Types. The Medicare Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a Medicare Product. The Medicare Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicare Product. Provider acknowledges that it will participate in each Medicare Product for which a Compensation Schedule(s) is attached to this Medicare Product Attachment.

2.2 Participation. Except as otherwise specified in this Attachment, all Contracted Providers under the Agreement will participate in the Medicare Product as "Participating Providers," and will provide to Covered Persons enrolled in the Medicare Product, upon the same terms and conditions contained in the

Agreement, as supplemented or modified by this Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Attachment and the Agreement (including the Provider Manual). Provider acknowledges that all or certain of Dental Subcontractor's duties with respect to the Medicare Product may be delegated to a Company, a Payor or their delegates. Neither Dental Subcontractor, Company nor any Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels and/or Medicare Product Types, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Medicare Product.

2.3 Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule for the Medicare Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicare Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicare Product in accordance with the applicable provisions of the Agreement or this Attachment.

4. CMS Regulatory Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicare Product under a Governmental Contract.

5. Compensation Schedule. This Section sets forth or describes the Compensation Schedule applicable to the various Medicare Product Types.

5.1 Schedule. The Compensation Schedule for the Medicare Product at any given time is the lesser of (i) the Allowable Charges for the particular Covered Service, or (ii) the appropriate amount for such Covered Service under the Company's fee schedule in effect on the date of service for the Medicare Product. Upon Provider's reasonable written request from time to time the Company will provide Provider with a representative sample of the fees then in effect under the Company's fee schedule applicable to the Medicare Product.

5.2 Other Terms and Conditions. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in the Medicare Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment B: Medicare

SCHEDULE A
CMS REGULATORY REQUIREMENTS

This Schedule sets forth required provisions that are applicable to all Medicare Product Types under this Medicare Product Attachment.

1. DEFINITIONS. The following terms shall be defined as set forth below as used in this Medicare Product Attachment. Capitalized terms not otherwise defined in this Schedule shall be defined as set forth in the Agreement or elsewhere in the Medicare Product Attachment.

1.1 ***Capitated Financial Alignment Demonstration Program*** means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 ***Clean Claim*** means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 ***CMS*** means Centers for Medicare and Medicaid Services.

1.4 ***CMS Contract*** means the contract between Dental Subcontractor or a Payor and CMS, or among Dental Subcontractor or a Payor, CMS and the State, that governs the terms of Dental Subcontractor's or Payor's participation in a Medicare Plan.

1.5 ***Covered Persons*** means those individuals who are enrolled in a Medicare Plan.

1.6 ***Covered Services*** means those services which are covered under a Medicare Plan.

1.7 ***Downstream Entity*** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between Dental Subcontractor and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.8 ***First Tier Entity*** means any party that enters into a written arrangement, acceptable to CMS, with Dental Subcontractor to provide administrative services or health care services for a Medicare eligible individual under a Medicare Plan.

1.9 ***HHS*** means the United States Department of Health and Human Services.

1.10 ***Medicare Advantage Program*** means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.11 ***Related Entity*** means any entity that is related to Dental Subcontractor by common ownership or control and (1) performs some of Dental Subcontractor's management functions under contract or delegation; (2)

furnishes services to Covered Persons under an oral or written agreement; or (3) leases real property or sells materials to Dental Subcontractor at a cost of more than $2,500 during a contract period.

1.12 ***State*** means one or more applicable state governmental agencies of the State of State.

2. COVERED SERVICES. Provider shall furnish Covered Services to Covered Persons as set forth in the Agreement and this Medicare Product Attachment.

3. SUBCONTRACTOR OBLIGATIONS. To the extent that Provider engages any other person (excluding an employee) or entity to perform services in connection with a Medicare Product, including any Downstream or Related Entity, Provider agrees that such engagement shall be set forth in a written agreement that requires such other person or entity to assume the same obligations that Provider assumes under this Medicare Product Attachment.

4. GOVERNMENT RIGHT TO INSPECT.

4.1 Provider agrees that HHS, the Comptroller General or their designees have the right to audit evaluate, collect and inspect any books, contracts, computer or other electronic systems, (including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of this Medicare Product Attachment or from the date of completion of any audit, whichever is later. *42 C.F.R. § 422.504 (i)(2)(i) and (ii)*

4.2 Provider agrees that HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 4.1 of this Medicare Product Attachment directly from Provider or any other First Tier, Downstream or Related Entity. For records subject to review under this Section 4.2, except in exceptional circumstances, CMS will provide notification to Dental Subcontractor that a direct request for information has been initiated. *42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)*

4.3 Provider further agrees that HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any books, contracts, medical records, documents, papers, patient care documentation and other records of the Provider, that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Medicare Product Attachment, or as the Secretary of HHS may deem necessary to enforce the CMS Contract. Provider shall cooperate with and shall assist and provide such information and documentation to such entities as requested. Provider shall retain, and agrees that this right to inspect, evaluate and audit shall extend for a period of ten (10) years following the termination date of this Medicare Product Attachment or completion of audit, whichever is later, unless (i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies Payor at least 30 days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by Payor, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit at any time. This provision shall survive termination of this Medicare Product Attachment. *42 C.F.R. § 422.504 (e)(2)*.

5. CONFIDENTIALITY AND ENROLLEE RECORD REQUIREMENTS. Provider shall comply with all confidentiality and enrollee record accuracy requirements, including: (1) abiding by all federal and State laws regarding the confidentiality and disclosure of medical records or other health and enrollment information; (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoena; (3) maintaining the records and information in an accurate and timely manner; and (4) ensuring timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §422.504(a)(13) and 422.118*

6. HOLD HARMLESS.

6.1. Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of Payor. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(i)*

6.2. With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. *42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance*

With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. If Provider contracts with Contracted Providers to provide Covered Services to Covered Persons, Provider will inform Contracted Providers of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose, and must prohibit any Downstream Entities from imposing, cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with Dental Subcontractor or Payor. Provider shall accept payment from Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

7. COMPLIANCE WITH CMS CONTRACT. Provider shall perform its obligations under this Medicare Product Attachment in a manner consistent with and in compliance with Dental Subcontractor's and Payor's contractual obligations under the CMS Contract. *42 C.F.R. §422.504(i)(3)(iii)*

8. PROMPT PAYMENT. Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance with Exhibit 1 to this Medicare Product Attachment. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Dental Subcontractor, Payor or (if Provider contracts with Downstream Entities) Provider, as applicable, as designated by Provider or such Downstream Entity, as applicable. *42 C.F.R. §422.520(b)(1) and (2)*

9. COMPLIANCE WITH FEDERAL AND STATE LAWS. Dental Subcontractor, Provider, Payor, and any Downstream or Related Entity shall comply with all applicable laws including Medicare laws, regulations and CMS and/or State instructions. *42 C.F.R. §422.504(i)(4)(v)*

10. DELEGATION OF DUTIES. In the event that Dental Subcontractor delegates to Provider any function or responsibility imposed pursuant to the CMS Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Medicare Product Attachment shall be subject to the prior written approval of Dental Subcontractor or Payor and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

10.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment). If such attachment is not executed, no administrative functions shall be deemed as delegated.

10.2 CMS, Dental Subcontractor and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Dental Subcontractor or Payor determine that such parties have not performed satisfactorily.

10.3 Dental Subcontractor or Payor will monitor the performance of the parties on an ongoing basis.

10.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement to this Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by Dental Subcontractor, or the credentialing process will be reviewed and approved by Dental Subcontractor and Dental Subcontractor must audit the credentialing process on an ongoing basis.

10.5 If Dental Subcontractor or Payor delegates the selection of providers, contractors, or subcontractors, Dental Subcontractor or Payor retains the right to approve, suspend, or terminate any such arrangement. *42 C.F.R. §§ 422.504(i)(4) and (5)*

11. NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS. Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42 C.F.R. §422.110(a)*

12. SERVICE AVAILABILITY. Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

13. CULTURAL COMPETENCE. Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R. §422.112(a)(8).*

14. FOLLOW-UP CARE. Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42 C.F.R. §422.112(b)(5).*

15. ADVANCE DIRECTIVES. Provider shall comply with Dental Subcontractor's and Payor's policies and procedures concerning advance directives. *42 C.F.R. §422.128(b)(1)(ii)(E).*

16. PROFESSIONALLY RECOGNIZED STANDARDS OF CARE. Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R. §422.504(a)(3)(iii).*

17. CONTINUATION OF BENEFITS. Provider shall provide Covered Services as provided in the Agreement and this Medicare Product Attachment: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Medicare Product Attachment. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)*

18. PHYSICIAN INCENTIVE ARRANGEMENTS. If Provider is a physician or physician group, neither Payor nor Dental Subcontractor shall make any specific payment, directly or indirectly, to Provider as an

inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. Provider agrees that, if Dental Subcontractor or Payor has a physician incentive plan that places Provider at substantial financial risk (as determined under 42 C.F.R § 422.208(d)) for services that Provider does not furnish itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with the requirements at 42 C.F.R. § 422.208(f). *42 C.F.R. §422.208.*

19. INFORMATION DISCLOSURES TO CMS. Provider shall cooperate with Dental Subcontractor and Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

20. NOTICE OF PROVIDER TERMINATIONS. Dental Subcontractor shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

21. RISK ADJUSTMENT DATA. Provider shall provide to Dental Subcontractor risk adjustment data as required by CMS. *42 C.F.R. §§ 422.310(d)(3), (4).* Upon Dental Subcontractor's or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. Provider certifies based on best knowledge, information and belief that the data it submits under 42 C.F.R. § 422.310 are accurate, complete and truthful. *42 C.F.R. §§ 422.310(e) and 422.504(l)(3).*

22. COMPLIANCE WITH DENTAL SUBCONTRACTOR POLICIES AND PROCEDURES. Provider shall comply with Dental Subcontractor's and Payor's policies and procedures. In addition, if Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon Dental Subcontractor's request, consult with Dental Subcontractor regarding Dental Subcontractor's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b)*. Provider shall comply with Dental Subcontractor's quality assurance and performance improvement programs. *42 C.F.R.§422.504(a)(5).*

23. WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION. In the event Dental Subcontractor suspends or terminates this Medicare Product Attachment with respect to Provider or any physicians employed or contracted with Provider, Dental Subcontractor shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by Dental Subcontractor, and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1)*

24. NOTICE OF WITHOUT CAUSE TERMINATION. Dental Subcontractor and Provider must provide a minimum of sixty (60) days written notice, or such longer period specified in this Agreement, to each other before terminating this Medicare Product Attachment without cause. *42 C.F.R. §422.202(d)(4)*.

25. COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS. Dental Subcontractor and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R. §422.504(h)(1).*

26. FEDERAL FUNDS. Provider acknowledges that payments Provider receives from Dental Subcontractor or Payor to pursuant to this Medicare Product Attachment are, in whole or part, from Federal funds. Therefore, Provider and any of its Downstream or Related Entities are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 84; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of Federal Funds. *Medicare Managed Care Manual, Ch. 11 § 120.*

27. EXCLUDED PERSONS/PROGRAM INTEGRITY. Provider warrants to Dental Subcontractor and each Payor that it is not excluded and shall not employ or contract for the provision of health care, utilization review, medical social work, or any administrative services pursuant to this Agreement with any individual or entity (hereafter, "person") whom Provider knows or reasonably should have known is excluded from participation in the Medicare and Medicaid program under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person currently is employed by or under contract with Provider. Provider shall review the Office of Inspector List of Excluded Individuals and Entities and the System for Award Management exclusion list and verify on a monthly basis or as often as required by CMS guidelines, that the persons it employs or contracts for the provision of such services pursuant to this Agreement are in good standing. Provider shall promptly disclose to Dental Subcontractor and Payor any exclusion, or other event that makes a Provider employee or Downstream or Related Entity ineligible to perform work related to Medicare or Medicaid. *42 C.F.R. § 422.752(a)(8).* Provider shall promptly notify Dental Subcontractor and Payor in writing in the event that Provider is criminally convicted or has a civil judgment entered against Provider for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services. Provider agrees to be bound by the provisions set forth at 2 C.F.R. Part 376.

28. COMPLIANCE: TRAINING, EDUCATION AND COMMUNICATION. Provider agrees it, its employees, and Downstream and Related Entities who provide services under this Medicare Product Attachment shall receive general compliance training as well as fraud, waste, and abuse ("FWA") training, and that such training shall occur within ninety (90) days of initial hiring and annually thereafter. Unless otherwise agreed to by Dental Subcontractor or Payor in writing, such training shall be the general compliance and FWA training modules located on the CMS Medicare Learning Network ("MLN") at: https://learner.mlnlms.com/Default.aspx. Dental Subcontractor and Payor shall accept the system-generated certificate of completion as evidence of compliance with the training requirement. The FWA training requirement is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment in Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS. However, compliance with the general training requirement is still required. Provider shall maintain records of Provider's and its employees' training. *42 C.F.R. § 422.503(b)(4)(vi)(C)(3).*

29. COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS. Provider shall cooperate and comply with all applicable State, federal Dental Subcontractor and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to Dental Subcontractor and Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

30. OFFSHORE SUBCONTRACTORS. In addition to the applicable requirements of Section 10 of this Medicare Product Attachment, Provider shall disclose to Dental Subcontractor in writing, 30 days prior to signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. Dental Subcontractor *Management System memos 7/23/2007, 9/20/2007, and 8/26/2008.*

31. SCOPE AND CONFLICTS. Nothing in this Medicare Product Attachment shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, including the Provider Manual, except as stated in this Medicare Product Attachment. In the event of any conflict between this Medicare Product Attachment and any provision of the Agreement, the provisions of this Medicare Product Attachment shall govern. In the event that any provision of this Medicare Product Attachment conflicts with the provisions of any statute or regulation applicable to Dental Subcontractor, the provisions of the statute or regulation shall have full force and effect unless such statute or regulation is preempted by federal law.

32. TERMINATION. This Medicare Product Attachment shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. This Medicare Product Attachment may be further terminated by Dental Subcontractor immediately upon written notice to Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or SAM as excluded or is otherwise suspended or excluded from participation in Medicare or Medicaid.

Attachment B: Medicare

EXHIBIT 1
COMPENSATION SCHEDULE
ALL MEDICARE PRODUCT TYPES
DENTAL PROVIDER SERVICES

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicare Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

For Covered Services rendered to Covered Person who are eligible for Medicare and enrolled in a Medicare Plan that may, or may not, include coverage for both Medicare and Medicaid Covered Services, Contracted Provider's maximum compensation is as follows:

1. Where Payor is the Payor for both Medicare Covered Services and Medicaid Covered Services:

    i) For Covered Services that are Medicare Covered Services and Medicaid Covered Services, Contracted Provider's maximum compensation shall be the Allowed Amount. Except as otherwise provided in this Compensation Schedule the Allowed Amount is: (1) the rate agreed upon by the Parties as set forth in the fee schedule attached hereto as Exhibit A-1: Dental Fee Schedule for State Medicare and Commercial Exchange and incorporated herein by reference; or (2) if there is no agreed upon rate set forth in the

attached Exhibit A-1: Dental Fee Schedule for State Medicare and Commercial Exchange, then Payor may establish a payment amount to apply in determining the Allowed Amount; or

ii) For Covered Services that are Medicare Covered Services and are not Medicaid Covered Services, Contracted Provider's maximum compensation shall be the Allowed Amount. Except as otherwise provided in this Compensation Schedule the Allowed Amount is: (1) the rate agreed upon by the Parties as set forth in the fee schedule attached hereto as Exhibit A-1: Dental Fee Schedule for State Medicare and Commercial Exchange and incorporated herein by reference; or (2) if there is no agreed upon rate set forth in the attached Exhibit A-1: Dental Fee Schedule for State Medicare and Commercial Exchange, then Payor may establish a payment amount to apply in determining the Allowed Amount; or

iii) For Covered Services that are Medicaid Covered Services and are not Medicare Covered Services, Contracted Provider's maximum compensation shall be the Allowed Amount. Except as otherwise provided in this Compensation Schedule the Allowed Amount is: (1) the rate agreed upon by the Parties as set forth in the fee schedule attached hereto as Exhibit A-2: Medicaid Negotiated Rates and incorporated herein by reference; or (2) if there is no agreed upon rate set forth in the attached Exhibit A-2: Medicaid Negotiated Rates, then the lesser of: (i) Allowable Charges; or (ii) Payor's maximum reimbursement schedule, which shall be one hundred percent (100%) of the amount payable by Medicaid, not including any Cost-Sharing Amounts that would have been applied by Medicaid, based on the Medicaid payment rate in effect on the date of service. If there is no established Medicaid payment rate for a Covered Service rendered to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount.

2. Where Payor is only the Payor for Medicare Covered Services, Contracted Provider's maximum compensation shall be the Allowed Amount. Except as otherwise provided in this Compensation Schedule the Allowed Amount is: (1) the rate agreed upon by the Parties as set forth in the fee schedule attached hereto as Exhibit A-1: Dental Fee Schedule for State Medicare and Commercial Exchange and incorporated herein by reference; or (2) if there is no agreed upon rate set forth in the attached Exhibit A-1: Dental Fee Schedule for State Medicare and Commercial Exchange between the parties, then Payor may establish a payment amount to apply in determining the Allowed Amount.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CDT codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency; or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the

Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment C: Commercial-Exchange

COMMERCIAL-EXCHANGE PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "Attachment") is made and entered between Dental Subcontractor and Provider (as defined in Agreement).

WHEREAS, DENTAL SUBCONTRACTOR and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "Agreement"), pursuant to which Provider and its Contracted Providers participate or other Downstream Entities participate in certain Products offered by or available from or through a Company;

WHEREAS, pursuant to the provisions of the Agreement, this Product Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as Participating Providers in the commercial and exchange Products described in this Product Attachment, and will be considered to be and will be governed under this Product Attachment as Downstream Entities as defined in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Commercial Exchange Product, the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement.

1.1 "***Commercial-Exchange Product***" refers to those programs and health benefit arrangements offered by a Company that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial-Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the Company's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, employer-sponsored or other private health insurance exchange, except those excluded by DENTAL SUBCONTRACTOR. The Commercial-Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.2 "***Delegated Entity***" means any party, including an agent or broker, that enters into an agreement with DENTAL SUBCONTRACTOR to provide administrative services or health care services to qualified individuals, qualified employers or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.3 "***Downstream Entity***" means any party, including an agent or broker, that enters into an agreement with a Delegated Entity or with another Downstream Entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and DENTAL SUBCONTRACTOR. The term "Downstream Entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.4 "***Emergency" or "Emergency Care***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.5 "***Emergency Medical Condition***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.6 "***State***" means the State of State, or such other state to the extent that a Coverage Agreement or Covered Person is subject to such other state's law.

2. Commercial-Exchange Product. This Product Attachment constitutes the "Commercial-Exchange Product Attachment" and is incorporated into the Agreement between Provider and DENTAL SUBCONTRACTOR. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Product Attachment applies with respect to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by a Commercial-Exchange Product.

3. Participation. Except as otherwise provided in this Product Attachment or the Agreement, all Contracted Providers under the Agreement will participate as Participating Providers in this Commercial-Exchange Product, and will provide to Covered Persons enrolled in or covered by a Commercial-Exchange Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers, to comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

4. Attachments. This Product Attachment includes, at Schedule A, the Regulatory Requirements with which Participating Providers are required to comply based on State laws governing the applicable Coverage Agreement or Covered Person and at Exhibit 1, the Compensation Schedule for the Commercial-Exchange Product, each of which are incorporated herein by reference.

5. Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Commercial-Exchange Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

6. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Commercial-Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

7. Federal Requirements. The following requirements apply to Delegated and Downstream Entities under this Commercial Exchange Product Attachment, which includes but is not limited to Provider and all Contracted Providers.

7.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment) attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

7.2 CMS, DENTAL SUBCONTRACTOR and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, DENTAL SUBCONTRACTOR or the Payor determine that Provider or any Downstream Entity has not performed satisfactorily.

7.3 Provider and all Downstream Entities must comply with all applicable laws and regulations relating to the standards specified under 45 CFR §156.340(a);

7.4 Provider and all Downstream Entities must permit access by the Secretary and OIG or their designees in connection with their right to evaluate through audit, inspection or other means, to the Provider's or Downstream Entities' books, contracts, computers, or any other electronic systems including medical records and documentation, relating to DENTAL SUBCONTRACTOR's obligations in accordance with federal standards under 45 CFR §156.340(a) until ten (10) years from the termination date of this Product Attachment.

8. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Commercial-Exchange Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Coered Persons.

Attachment C: Commercial-Exchange

SCHEDULE A
REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

Include specific provisions set forth in this section required by State or federal law with respect to this Ceommercial-Exchange Product.

Attachment C: Commercial-Exchange

EXHIBIT 1
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is: (1) the rate agreed upon by the Parties as set forth in the fee schedule attached hereto as Exhibit A-1: Dental Fee Schedule for State Medicare and Commercial Exchange and incorporated herein by reference; or (2) if there is no agreed upon rate set forth in the attached Exhibit A-1: Dental Fee Schedule for State Medicare and Commercial Exchange, then Payor may establish a payment amount to apply in determining the Allowed Amount.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CDT codes, DPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day

of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

4. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

5. Payment for Multiple Procedures. Where multiple outpatient surgical or scope procedures performed on a Covered Person during a single occasion of surgery, reimbursement will be as follows: i) the procedure for which the Allowed Amount under this Compensation Schedule is greatest will be reimbursed at one hundred percent (100%) of such Allowed Amount; ii) the procedures with second and third greatest Allowed Amounts under this Compensation Schedule will each be reimbursed at fifty percent (50%) of such Allowed Amounts; iii) any additional procedures will not be eligible for reimbursement.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

7. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment D: StateCHIP

PRODUCT ATTACHMENT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM
AND STATE MANDATED ATTACHMENT

This State Children's Health Insurance Program Product Attachment and State Mandated Attachment (the "Product Attachment") is incorporated into the Participating Provider Agreement (the "Agreement") entered into by and between Provider (as defined in Agreement) and Dental Subcontractor as of the Effective Date. The Product Attachment is intended to supplement the Agreement by setting forth the CHIP specific requirements with which Provider must comply in order to participate in the State Children's Health Insurance Program ("CHIP Program"), as those terms are defined below.

ARTICLE I
RECITALS

1.1 DENTAL SUBCONTRACTOR has contracted with Health Plan, who has contracted with the state of State's to arrange for the provision of medical services to Covered Persons under the State CHIP Program.

1.2 Provider has entered into the Agreement with DENTAL SUBCONTRACTOR to provide Covered Services to Covered Persons.

1.3 This Product Attachment applies to dental services rendered by Provider to individuals covered under the Health Plan's contract with MEDICAID AGENCY (" State CHIP Contract") for the State CHIP Program. This Product Attachment supplements the Agreement by setting forth certain additional or modified rights and responsibilities of the parties relating to the provision of medical services (including Covered Services) to Covered Persons enrolled in the State CHIP Program. Exhibit 1 of this Product Attachment sets forth the Compensation Schedule applicable to the State CHIP Program. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern with respect to medical services (including Covered Services) rendered to Covered Persons enrolled in the State CHIP Program.

1.4 Except to the extent modified by this Product Attachment, Provider shall comply with all provisions of the Agreement and DENTAL SUBCONTRACTOR's Provider Manual, and Provider shall comply with all provisions of this Product Attachment, in the connection with the provision of medical services to Covered Persons enrolled in the State CHIP Program. Provider agrees that Covered Services also shall be provided in accordance with the State Contract, any applicable State Medicaid or CHIP Program Provider Manuals and Handbooks, and all applicable State and federal laws and regulations. To the extent Provider is unclear about Provider's duties and obligations, Provider shall request clarification from DENTAL SUBCONTRACTOR.

ARTICLE II
DEFINITIONS

For purposes of this Product Attachment and the Agreement, the following terms shall be defined as set forth below, and the definitions listed below will supersede any different meanings contained in the Agreement. Capitalized terms used in this Product Attachment and not defined below shall have the same meaning set forth in the Agreement.

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

2.2 ***Action*** means Contractor's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or Contractor's failure to provide services in a timely manner; failure to resolve Grievances or Appeals within the time frames specified in this Contract.

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

2.4 ***Attachment(s)*** means the attachments to this Agreement, including addenda and exhibits, all of which are hereby incorporated herein by reference.

2.5 ***Auto Enrollment*** means the process by which Members who have not voluntarily selected a CHIP Contractor are assigned to a CHIP Contractor.

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

2.7 ***Benchmark Plan*** means the State and School Employee's Health Insurance Plan.

2.8 ***Care Management*** means 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.

2.9 ***Case Identification Number with respect to the Member*** means Immediate Family Members and individuals living with the Member.

2.10 ***Child*** means an individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Child is also referred to as Member.

2.11 ***CHIP*** means the Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

2.12 ***Closed Panel*** means Providers who are no longer accepting new Members for Contractor as part of CHIP that have a Closed Panel.

2.13 ***Complaint*** means an expression of dissatisfaction received orally or in writing.

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

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

2.16 ***Cost Sharings*** means in accordance with 42 C.F.R. §457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

2.17 ***Covered Services*** means Medically Necessary health care services covered under the terms of the applicable State Contract and rendered in accordance with the Provider Manual.

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

2.19 ***Custodial Nursing Home*** means residential designation after a Member has exhausted skilled services. However, the Member continues to have the need for non-skilled, personal care, including assistance with activities of daily living such as bathing, dressing, eating, toileting, ambulating and transferring in a nursing facility.

2.20 ***Deliverables*** means documents, records, and reports required to be furnished to MEDICAID AGENCY for review and/or approval pursuant to the terms of this Contract.

2.21 ***Direct Paid Claims*** means claims payments before ceded Reinsurance and excluding assumed Reinsurance except as otherwise provided in Exhibit D, Medical Loss Ratio Requirements, of the State CHIP Contract.

2.22 ***Disenrollment*** means an action taken by MEDICAID AGENCY, or its Agent, to remove a Member's name from the monthly Member Listing report following MEDICAID AGENCY's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor.

2.23 ***Medicaid Agency*** means, Office of the Governor, State.

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

2.25 ***Emergency Medical Condition***, in accordance with Section 1932(b) of the Act and 42 C.F.R. §457.10, means 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.

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

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

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

2.29 ***Health Plan Organization (Health Plan)*** means an organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP.

2.30 ***Immediate Family Member with respect to the Member*** means the biological, adoptive, or step-parent, Child, or sibling of the Member; i) the stepparent, stepchild, stepbrother, or stepsister of the Member; ii) the father–, mother–, daughter–, son–, brother–, or sister–in–law of the Member; iii) the grandparent or grandchild of the Member; and iv) the spouse of a grandparent or grandchild of the Member.

2.31 ***Marketing*** means the activities that promote visibility and awareness for CHIP and the Health Plans participating in the program. In compliance with Section 1932(d) of the Act, all activities are subject to prior review and approval by MEDICAID AGENCY and may not contain misleading information.

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

2.33 ***Medical Necessity or Medically Necessary*** means services, supplies, or equipment provided by a licensed health care professional that are: (i) appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury; (ii) in accordance with the standards of good medical practice consistent with the individual patient's condition(s); (iii) not primarily for the personal comfort or convenience of the Covered Person, family, or Provider; (iv) the most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person; (v) furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient; (vi) not experimental or investigational or for research or education; (vii) are provided by an appropriately licensed practitioner; and (viii) are documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

2.34 ***Member(s) or Covered Person(s)*** means an individual who meets all of the eligibility requirements for State CHIP, and is currently enrolled with a health plan for the provision of services under State CHIP. A member or Covered Person may also be referred to as an Enrollee.

2.35 ***Non-Contracted Provider*** means a health care provider who has not been credentialed by and does not have a signed provider agreement with DENTAL SUBCONTRACTOR.

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

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

2.38 ***Preferred Drug List (PDL)*** means a medication list recommended to MEDICAID AGENCY by the Pharmacy & Therapeutics Committee and approved by the Executive Director of MEDICAID AGENCY. 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. Adherence to guidance provided in MEDICAID AGENCY's PDL is required.

2.39 ***Primary Care Provider (PCP)*** means any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in CHIP, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

2.40 ***Prior Authorization*** means a determination to approve a provider's request, pursuant to services covered in CHIP, to provide a service or course of treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

2.41 ***Provider Manual*** means the DENTAL SUBCONTRACTOR manual of policies, procedures, and requirements to be followed by Participating Health Care Providers. The Provider Manual includes, but is not limited to, utilization management, quality management, grievances and appeals, and Payor-specific program requirements, and may be changed from time to time by DENTAL SUBCONTRACTOR.

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

2.43 ***Rural Health Clinics*** means the Rural Health Clinics (RHCs) program is intended to increase primary care services in rural communities. RHCs can be public, private, or non-profit. RHCs must be located in rural, underserved areas and must use mid-level practitioners.

2.44 ***State Child Health Plan*** means the State of State's plan submitted to HHS for the administration of CHIP as defined in Title XXI of the Social Security Act.

2.45 ***Subcontractor*** means an entity with which Contractor enters into an agreement to provide contractually required services.

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

2.47 ***Transitional Care Management*** means a type of care management program to support Members' transition of care when discharged from an institutional clinic or inpatient setting.

2.48 ***Unpaid Claim Reserves*** means 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.

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

ARTICLE III
PRODUCT REQUIREMENTS

3.1 **Hold Harmless**. Provider agrees to not hold Covered Persons liable for: (a) any and all debts of DENTAL SUBCONTRACTOR if DENTAL SUBCONTRACTOR should become insolvent; (b) payment for services provided by the DENTAL SUBCONTRACTOR if the DENTAL SUBCONTRACTOR has not received payment from the State for the services, or if Provider, under contract or other arrangement with DENTAL SUBCONTRACTOR, fails to receive payment from the State or DENTAL SUBCONTRACTOR; or (c) to the extent applicable, the payments to Provider for furnishing Covered Services that are in excess of the amount that normally would be paid by the Covered Person if DENTAL SUBCONTRACTOR authorized or provided the services directly.

3.2 **Cultural Competency**. Provider must ensure that cultural differences between the Provider and Covered Persons do not present barriers to access and quality health care. Provider must be able to demonstrate the ability to provide quality health care across a variety of cultures.

3.3 **Access to Records**. Provider shall maintain current, detailed, organized Medical Records for each Covered Person sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed pursuant to the Agreement and/or the State CHIP Contract. Provider shall make such Medical Records accessible and available to providers providing services to Covered Persons, and to MEDICAID AGENCY for purposes of Medical Record review. Provider 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 MEDICAID AGENCY, 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 MEDICAID AGENCY, the Centers for Medicare and Medicaid Services ("CMS"), and MEDICAID AGENCY's Agent. Access will be at the discretion of the requesting authority and will be either through on-site review of records or by submission of records to the office of the requester. Any records requested hereunder shall be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) calendar days following a request, for desk audits. Requests may be written or verbal. Provider shall maintain and

make records available for review by authorized federal and State agencies during the term of the Agreement and for a minimum period of five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, Provider shall maintain records for a period of five (5) years or until all issues are finally resolved, whichever is later.

MEDICAID AGENCY shall have unlimited rights to use, disclose, and duplicate, all information and data developed, derived, documented, or furnished by Provider hereunder in accordance with applicable State and Federal laws and regulations.

Any person (including an organization, agency or other entity, but excluding a Covered Person) 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, MEDICAID AGENCY, 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, MEDICAID AGENCY may make a determination to terminate the contract.

3.4 **Access Standards**. Provider shall provide Covered Services to Covered Persons in accordance with the following access standards:

3.4.1 Specialty Care:

a. Not to exceed forty-five (45) calendar days.

3.4.2 Dental Providers:

a. Routine visits: Not to exceed forty-five (45) calendar days; and
b. Urgent care visits: Not to exceed forty-eight (48) hours.

If Provider is a physician, Provider shall maintain hospital admitting privileges with a hospital that is a Participating Provider as required for the performance of his or her practice or shall have a written agreement with another Participating Provider who is a physician who has such hospital-admitting privileges.

Provider must be accessible to Covered Persons and must maintain a reasonable schedule of operating hours.

Provider acknowledges and agrees that MEDICAID AGENCY shall have the right to periodically review the adequacy of service locations and hours of operation, and will require corrective action to improve Covered Persons' access to services.

3.5 **State Authority**. Provider agrees and acknowledges that MEDICAID AGENCY shall have the right to invoke any remedy available under the State CHIP Contract against Provider that it may bring against DENTAL SUBCONTRACTOR, including but not limited to the right to terminate the Agreement. In addition, this agreement may be terminated immediately upon written notice by DENTAL SUBCONTRACTOR upon the entry of a valid order issued by the State Department of Insurance or other lawful authority.

3.6 **Compliance with Federal Law**. Provider shall comply with all applicable standards, order 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, Environmental Protection Agency regulations (40 CFR part 15) and 42 C.F.R. §438. Any violations must be reported to the DSHS, DHHS and EPA.

3.7 **Program Exclusion**. In the event Provider is excluded from participation by Medicare or Medicaid, including any other state's Medicaid or SCHIP program, DENTAL SUBCONTRACTOR shall have no obligation to reimburse Provider for services other than Emergency Care rendered on or after the effective date of Provider's exclusion. Provider shall screen its employees for excluded persons. DENTAL SUBCONTRACTOR shall immediately terminate Provider in the event Provider is excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

3.8 **Behavioral Health Services**. Provider shall schedule Covered Persons receiving inpatient psychiatric services and outpatient follow-up and/or continuing care treatment appointment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. Behavioral Health Service Providers must contact Covered Persons who have missed appointment within 24 hours to reschedule such appointments.

3.9 **No Restriction on Health Status Advice**. Nothing herein shall be construed as prohibiting Provider, when acting within the lawful scope of practice, from discussing Medically Necessary care with a Covered Person, or advising or advocating appropriate medical care with or on behalf of a Covered Person about (i) the Covered Person's health status, medical care or treatment options, including any alternative treatment, alternative therapies, consultation or tests that may be self-administered; (ii) any information the Covered Person needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; (iv) the Covered Person'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 (v) that the Covered Person may be responsible for non-Covered Services only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that the item or service rendered is a non-Covered Service and that the Covered Person will be financially responsible for the item(s) and/or service(s).

3.10 **PCP Responsibilities**. If applicable, and Provider is a PCP, Provider shall comply with the following:

3.10.1 PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record.

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

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

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

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

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

3.10.4 PCP shall provide the full range of Well-Baby, Well-Child Care, well-adolescent care and childhood and adolescent immunization services recommended by the Advisory Committee on Immunization Practices (ACIP) for all Covered Persons under the age of nineteen (19) as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. §457.495 and the provisions of State CHIP Contract, including periodic examinations for vision, dental, and hearing and all Medically Necessary services. The following minimum elements must be included in the periodic health screening assessment of children:

- *Comprehensive health and development history (including assessment of both physical and mental development);*
- *Measurements (including head circumference for infants);*
- *Comprehensive unclothed physical examination;*
- *Immunizations appropriate to age and health history;*
- *Assessment of nutritional status;*
- *Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);*
- *Vision screening;*
- *Hearing screening;*
- *Dental and oral health assessment;*
- *Developmental assessment; and*
- *Health education and anticipatory guidance.*

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

3.10.5 Specialists as PCPs. Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the

specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

3.11 **Exclusion of Provider due to Patients with Expensive Medical Conditions**. DENTAL SUBCONTRACTOR shall not exclude or terminate Provider from participation in DENTAL SUBCONTRACTOR's Provider Network due to the facts that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

3.12 **Healthcare Opinions and Counsel**. Covered Persons 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 the State CHIP Contract.

3.13 **No Termination of Contract or Employment**. DENTAL SUBCONTRACTOR cannot terminate a contract or employment with Provider for filing a Complaint, Grievance, or Appeals on a Covered Person's behalf.

3.14 **Compliance with the Quality Management and Utilization Management Programs**. Provider shall comply with the quality management and utilization management program standards outlined in Section 9, "Quality Management", of the State CHIP Contract.

3.15 **Continuation of Care Under Capitation Arrangements**. If applicable this Agreement provides for reimbursement of Provider on a capitation basis, should the Provider terminate this Agreement for any reason, Provider will provide Covered Services to Covered Persons assigned to the Provider under the Agreement up to the end of the month in which the effective date of termination falls.

3.16 **Confidentiality**. Provider must comply with all applicable laws and regulations pertaining to the confidentiality of Covered Person's Medical Records, including obtaining any required written Covered Person consents to disclose confidential Medical Records.

3.17 **Referrals**. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.18 **Insolvency**. In the event DENTAL SUBCONTRACTOR becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, its officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.19 **Claims Submission**. Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to DENTAL SUBCONTRACTOR within ninety (90) calendar days from the date of denial.

3.20 **Prohibition Against Intentional Segregation**. Provider shall not intentionally segregate Covered Persons in any way from other persons receiving services and shall provide Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

a. Denying or not providing a Covered Person any Covered Service or availability of Participating Provider. Health care and treatment necessary to preserve life must be provided to all Covered

Person who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

b. Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons, public or private patients, in any manner related to the receipt of any Covered Service, except where Medically Necessary.

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

3.21 **Provider Preventable Conditions**. If applicable, DENTAL SUBCONTRACTOR shall not pay a Provider for a "Provider Preventable Condition" as defined by the federal regulations and the State Plan in accordance with 42 C.F.R. §438.6(b). Provider shall provide DENTAL SUBCONTRACTOR with immediate written notice of any Never-Event, which notice shall include any such information relating to the Never-Event as is required by DENTAL SUBCONTRACTOR to provide accurate and complete reporting to MEDICAID AGENCY regarding such Never-Event. DENTAL SUBCONTRACTOR shall deny payment of any claims submitted for payment for a Never-Event.

3.22 **Compliance with State and Federal Disclosure Requirements**. Immediately upon Provider's knowledge of the same, Provider shall submit to DENTAL SUBCONTRACTOR, in connection with any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider (as defined by 42 C.F.R. § 455.101): i) notice that such person has been excluded from the Medicare and Medicaid programs for any reason; and ii) the information required under 42 C.F.R. § 455.106 where such individual has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. Such 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. Federal regulations contained in 42 CFR § 455.104 and 42 CFR § 455.106 also require disclosure of all entities with which Provider has an ownership or control relationship. Provider shall provide information concerning each person with ownership or control, and shall submit to DENTAL SUBCONTRACTOR, immediately upon request, any and all information necessary for DENTAL SUBCONTRACTOR to make all required disclosures under 42 C.F.R. § 455.104 and § 455.106. DENTAL SUBCONTRACTOR shall be entitled to, and shall, terminate or revoke this Agreement for cause for any reasons set forth in 42 C.F.R. §§ 455.420, 1001.1001 and STATE CODE. Provider must make all disclosures required under 42 C.F.R. § 1002.3.

3.23 **Ongoing Course of Treatment**. If applicable, unless the Provider is being terminated for cause, Provider must allow a Covered Person to continue an ongoing course of treatment from the Provider for up to sixty (60) calendar days from the date the Covered Person is notified by DENTAL SUBCONTRACTOR of the termination or pending termination of Provider, or for up to sixty (60) calendar days from the date of Provider termination, whichever is greater. A Covered Person is considered to be receiving an ongoing course of treatment from Provider under the following circumstances: i) during the previous twelve (12) months, the Covered Person was treated by Provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized; ii) an adult Covered Person 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; and iii) any child (under age19) with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from Provider. Such transitional period may be extended by DENTAL SUBCONTRACTOR if

the extension is determined, in consultation with the Covered Person and Provider, to be clinically appropriate. To be eligible for payment for Covered Services provided to a Covered Person after Provider is terminated from the network, Provider must agree to meet the same terms and conditions as Participating Providers.

3.24 **Clinical Guidelines**. Provider shall comply with DENTAL SUBCONTRACTOR's clinical guidelines. Provider acknowledges and agrees that DENTAL SUBCONTRACTOR will, as required under the State Contract, annually measure Provider's performance against at least two (2) such clinical guidelines, and Provider shall take corrective actions where necessary to ensure compliance with the guidelines.

3.25 **Member Rights**. Provider shall comply with any applicable Federal and State laws that pertain to Member rights.

3.26 **Encounter Data**. If applicable, provider must submit to DENTAL SUBCONTRACTOR accurate and timely encounter data in compliance with DENTAL SUBCONTRACTOR's Provider Manual and/or encounter policies and procedures.

3.27 **Credentialing**. Provider shall at all times during the term of the Agreement be properly licensed in accordance with all applicable State law and regulations, and have in effect appropriate policies of malpractice insurance as may be required by DENTAL SUBCONTRACTOR and/or MEDICAID AGENCY. Providers who are nurse practitioners acting at PCPs shall be held to the same requirements and standards as physicians acting at PCPs. In connection with these requirements, Provider shall furnish DENTAL SUBCONTRACTOR with a copy of the Provider's current license issued by the State, cover page of malpractice insurance, and such additional information as may be specified by MEDICAID AGENCY.

ARTICLE IV- ADDITIONAL REQUIREMENTS

4.1 **DENTAL SUBCONTRACTOR Requirements**. DENTAL SUBCONTRACTOR must adhere to the following requirements:

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

b. DENTAL SUBCONTRACTOR 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;

c. DENTAL SUBCONTRACTOR 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;

d. DENTAL SUBCONTRACTOR cannot terminate a contract or employment with a provider for filing a Grievance or Appeal on a Member's behalf;

4.2 **Provider Requirements**. Provider must adhere to the following requirements:

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

b. Provider shall cooperate with the Quality Management and Utilization Management program standards outlined in the State CHIP Contract and the Provider Manual.

c. PCPs must comply with requirements of PCP Responsibilities outlined in the State CHIP Contract and the Provider Manual.

d. Should Provider terminate its agreement with DENTAL SUBCONTRACTOR, Provider must provide services to the Members assigned to Provider under the contract up to the end of the month in which the effective date of termination falls;

e. 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;

f. Provider must make referrals for social, vocational, education or human services when a need for such service is identified;

g. In the event DENTAL SUBCONTRACTOR becomes insolvent or unable to pay the participating provider, a Provider shall not seek compensation for services rendered from the State, its officers, Agents, or employees, or the Members or their eligible dependents;

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

4.3 **Termination**. If Provider terminates the Agreement for any reason, Provider shall give DENTAL SUBCONTRACTOR at least sixty (60) days prior written notice of such termination.

4.4 **Non-Assignment**. The Agreement is intended to secure the services of and be personal to Provider, and shall not be assigned, sublet, delegated, or transferred by Provider without the prior written consent of DENTAL SUBCONTRACTOR.

4.5 **Member Financial Liability**. Providers may collect from Members co-payments for Covered Services as set forth in the Provider Manual.

4.6 **Subcontractual Services and Reporting Requirements**. Subcontractors will provide delegated services and reports as set forth in Exhibit 2 of the Product Attachment.

ARTICLE V
CMS REGULATORY REQUIREMENTS

5.1 **Person-Centered Planning, Care/Service Plan, and Services**. Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

a. Members shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

b. The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the member.

c. LTSS providers shall be aware of, respect, and adhere to a member's preferences for the delivery of services and supports.

d. LTSS providers shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to members and the person(s) supporting them who have disabilities and/or are limited English proficient.

e. DENTAL SUBCONTRACTOR agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if state requirements differ) and provide a copy to all LTSS providers responsible for implementation.

Attachment D: State CHIP

SCHEDULE A
STATE MANDATED ATTACHMENT
(REGULATORY REQUIREMENTS)

This Schedule A sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Medicaid Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Health Benefit Plan (as defined below), or to such Covered Person, as applicable.

Include specific provisions set forth by State or federal law with respect to this Medicaid Product.

Attachment D: StateCHIP

EXHIBIT A
COMPENSATION SCHEDULE
DENTAL PROVIDER SERVICES

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed

Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for physician Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for physician Covered Services is: (1) the rate agreed upon by the Parties as set forth in the fee schedule attached hereto as Exhibit A-2: Medicaid Negotiated Rates and incorporated herein by reference; or (2) if there is no agreed upon rate set forth in the attached Exhibit A-2: Medicaid Negotiated Rates, then the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the State's Medicaid fee schedule. If there is no established Medicaid fee rate for a Covered Service rendered to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CDT codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

ATTACHMENT 4.2.2.2.A.5 PARTICIPATING PROVIDER AGREEMENT - VISION

Templates of the Offeror's standard Provider contracts.

PROVIDER PARTICIPATION AGREEMENT

This Provider Participation Agreement ("Agreement") is the contract between Vision Subcontractor (referred to in this Agreement as "Vision Subcontractor, Company, We, Us, or Our"), on behalf of itself and/or its affiliates, and Provider, an individual licensed to provide (or legal entity whose members are licensed to provide) optometric, ophthalmologic, or other vision care services or supplies (referred to in this Agreement as "Provider, You or Your").

You represent to be: [ ] a sole proprietor; [ ] a duly organized professional organization or other corporate entity;
[ ] a partnership; or [ ] other entity (specify) _____. If You are a duly organized professional organization or other corporate entity, a partnership, or other entity (as specified), a listing of the individuals associated with this Agreement must be provided to Us with submission of this Agreement. You affirm that You are duly organized, validly existing and in good standing under the laws of the state where You render Covered Services. The person signing on Your behalf affirms that she or he has full power and authority to enter into this Agreement on behalf of You and each individual practitioner or other person or persons who shall be bound by such signature.

This Agreement is entered into by and between the undersigned parties.

Contact Information to be used for giving notice under the Agreement.

PROVIDER/GROUP

Legal Name of Provider/Group: _____

D/B/A name, if applicable: _____

Signature: _____

Title: _____

Printed Name: _____

Date: _____

Tax ID: _____

Office E-Mail* _____

Street: _____

City: _____

State: _____ Zip: _____

Fax Number: _____

CAQH #: _____

VISION SUBCONTRACTOR

Signature: _____

Title: _____

Printed Name: _____

Office E-mail:

Street:

City:

State: Zip:

This Agreement is effective on _____ (as designated by Us).

Execution constitutes agreement to the attached terms of this Agreement and the following Exhibits:

Exhibit A: Fee Schedule, general	Exhibit D: Medicare Advantage Required Provisions

Exhibit A-1:	Exhibit E: Medicaid Product Attachment
Exhibit B: Definitions	Exhibit F: Commercial-Exchange Product Attachment
Exhibit C: State Specific Provisions	

***This email address will be used as the primary mode of contact regarding notifications concerning the Agreement.**

THE PARTIES AGREE TO THE FOLLOWING:

I. Your Responsibilities

A. You agree to provide Covered Services to Members in accordance with this Agreement, any current or future Amendments, Attachments Exhibits, and the Vision Subcontractor Provider Manual ("Provider Manual").

B. You represent and warrant that: You are fully licensed to practice medicine, optometry, or to provide optical services; are board eligible or certified in the medical specialty of ophthalmology, if applicable; are in good professional standing to provide Covered Services to Members; You have and will maintain a current, valid Drug Enforcement Administrative registration number and unrestricted prescription privileges, if applicable; and You, if applicable, are a member in good standing with admitting privileges with a hospital that is a Participating Provider.

C. You agree that You have and will keep in effect professional liability insurance of at least $1 million per occurrence and $3 million aggregate, or such other general and professional liability insurance as required by state law or as mutually agreed to by You and Us.

D. If You are a separate legal entity, rather than an individual, You represent and warrant that You shall remain fully licensed and in good standing to do business and provide Covered Services and all of Your agents and employees meet the obligations of this Agreement, where applicable.

E. You agree to maintain where credentialing is required at all times, licensure, accreditation, and credentials sufficient to meet Our credentialing verification program requirements, which includes those items listed within any applicable state or federal credentialing applications or Our credentialing application, and to notify Us promptly of any changes to any information relating to Your professional credentials during the term of this Agreement.

F. You agree to make every reasonable effort to notify Us within three (3) days of the occurrence of any disciplinary proceedings of sufficient gravity to be reported to or initiated by the applicable state licensing board or state board of examiners of any state in which proceedings may be brought against You, or any other similar regulatory authority.

G. You agree to accept as payment in full the compensation described in Exhibit A(s) of this Agreement for Covered Services provided by You to a Member. The remainder of this paragraph is not applicable to Members enrolled in Self-Insured Plans. In no event, including but not limited to Our insolvency or breach of this Agreement, shall You bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or other persons acting on Members' behalf for Covered Services provided pursuant to this Agreement. This provision shall not, of course, prohibit You from collecting from Members (a) Copayments, Coinsurance and applicable Deductibles specified in the applicable Plan, or (b) fees for non-covered services delivered at a Member's specific request, as long as You have notified the Member in advance in writing that the Plan will not cover the requested services and the Member chooses to receive the service at their own expense. This provision shall survive the termination or expiration of this Agreement, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of the Member. This

provision supersedes any oral or written contrary agreement now existing or hereafter entered into between You and a Member or person acting on the Member's behalf. Any modification, addition or deletion to this provision shall become effective on a date no earlier than fifteen (15) days after the Department of Insurance and, if applicable, the Centers for Medicare and Medicaid Services (CMS), have given written approval for the proposed changes.

H. If applicable, You are entitled to bill and have the responsibility for collecting from Members all Copayments, Coinsurance, or Deductibles applicable to Covered Services provided to Members according to the applicable Plan.

I. You shall provide or make mutually satisfactory arrangements for call coverage or other back-up coverage for the provision of Covered Services to Members at all times in accordance with Company's standards for Provider as referenced in Company's Provider Manual.

J. You agree not to discriminate against Members on the basis of race, color, national origin, gender, age, religion, marital or health status, health insurance coverage, or other source of payment. As part of this requirement, Your office must be accessible to the disabled, or must have in place reasonable arrangements to accommodate disabled Members.

K. You agree to the procedures and guidelines set forth in the Vision Subcontractor Provider Manual ("Provider Manual"), which is incorporated into this agreement by reference. We may unilaterally modify, amend, or update the Provider Manual from time to time, or as required by state or federal law, and any such changes are incorporated into this Agreement by reference.

L. You agree to cooperate with and participate in any quality management program and procedures, utilization management, member grievance, provider credentialing and network management, and other medical management programs and procedures established by Us or a Payor.

M. You agree to use best efforts to refer Members to Plan's Participating Providers. You also agree to provide Covered Services in accordance with the availability and accessibility standards outlined in Our Provider Manual.

II. Our Responsibilities

A. We agree to pay You for Covered Services provided to Members based on the applicable Provider Fee Schedule attached to this Agreement as Exhibit(s) A or Amendments to this Agreement. We agree to pay claims within any state required claims payment timeframes, as applicable, and in accordance with Our claims payment policies and procedures as described in our on-line Provider Manual. Completed claims payable under a Self-Insured Plan may be paid from funds provided by the Payor in which the applicable Member is enrolled. In the event the Payor fails to make adequate funds available to Us for purposes of issuing payment on such claims, You shall have no recourse against Us and shall look solely to Payor for such payment owed.

B. We agree to list You as a Participating Provider in applicable Plan provider directories. You authorize Us to use Your name and address in such materials.

C. We agree to furnish You with password protected access to Our secure website, allowing access to the Provider Manual in addition to information regarding, but not limited to, Member eligibility, claims processing, and Our Policies and Procedures, as described in the Provider Manual.

D. We agree not to discriminate against You with respect to participation, reimbursement, or indemnification while acting within the scope of Your license or certification under applicable State law or regulation solely on the basis of Your license or certification.

E. We agree not to discriminate against Members on the basis of race, color, national origin, gender, age, religion, marital or health status, health insurance coverage, or other source of payment.

III. Term, Termination and Cancellation

A. Term. This Agreement begins on the Effective Date and renews automatically from year to year unless otherwise terminated as set forth below.

B. Termination For Cause. Either party may terminate this Agreement immediately for cause by providing written notice of termination to the other party, which notice shall include the specific reason for termination. Cause for termination includes, but is not limited to, the following: (1) Our failure to maintain all licenses or certifications required under this Agreement; (2) We determine reasonably and in good faith that continuation of the Agreement may adversely affect the quality of services provided or the Members' health or safety; (3) The voluntary or involuntary initiation of insolvency proceedings by Us or other similar bankruptcy proceedings by You; (4) Breach of any material provision of this Agreement by either party; (5) Your failure to maintain all licenses or certifications required to perform Your duties under this Agreement, or to comply with any applicable state or federal laws, regulations, or Our requirements; (6) Any misrepresentation, falsification, or omission of any material information in Your application submitted to Us; (7) Commission of any act or any conduct or allegation of conduct for which Your license or certification may be subject to revocation or suspension, whether or not actually revoked or suspended, or if You are otherwise disciplined by any licensing, regulatory, professional entity or any professional organization with jurisdiction over You; (8) Your failure to maintain all required liability insurance coverage; and (9) business reasons of the terminating party.

C. Without Cause. Either party may cancel this Agreement , including any individual Plan Fee Schedule, at any time without cause upon sixty (60) days prior written notice, or as required by state and federal laws. Upon receipt of the sixty (60) day written cancellation notice, You may request cancellation of this Agreement in less than sixty (60) days if We are not financially impaired or insolvent. Non-payment for goods or services rendered by You is not a valid reason for avoiding the sixty (60) day advance notice of cancellation.

D. Termination of Payor. If a Payor agreement with Us is discontinued for any reason, the termination date of the Payor agreement will automatically apply to the Exhibit A (Provider Fee Schedule) applicable to that Payor. We will make best efforts to provide timely written notification to You of any such Payor agreement termination.

E. After Termination. Upon termination of this Agreement for any reason, the rights of each party shall terminate. Any such termination, however, shall not release You or Us from obligations under this Agreement arising prior to the effective date of termination. After termination, We and Our designees shall continue to have access to the records maintained by Provider in accordance with this Agreement for a period of at least ten (10) years from the date of the last Covered Services, or as otherwise required by state or federal law. Termination shall not affect the rights, obligations, and liabilities of the parties arising out of the transactions occurring prior to effective date of termination, including payment of claims for dates of service up to termination.

IV. Dispute Resolution

A. The parties agree to make reasonable, good faith efforts to resolve all disputes informally in accordance with the Provider Grievance procedures established by Us. If You are not satisfied with any informal resolution, You may request in writing an appeal, which shall be considered by a Grievance Committee in accordance with Our Provider Grievance procedures.

B. In the event a dispute is not resolved per Section A above, it may be submitted to mandatory, binding arbitration by a single, impartial arbitrator selected by the American Arbitration Association within sixty (60) days

of the last attempted resolution or other time frame as required by state law. The arbitration shall be conducted in accordance with the commercial arbitration rules of the American Arbitration Association, and shall be held in a location mutually agreed to by the parties. Each party shall assume its own costs, but shall share the cost of the arbitrator equally. Judgment upon any award rendered by the arbitrator may be entered in any court having jurisdiction. This arbitration provision shall not apply if prohibited or not required by applicable state law.

C. Any dispute between Us and You concerning any amount owing or alleged to be owed under this Agreement shall be resolved between the Us and You. You shall not involve the Member in such dispute. You may appeal to Us for any such payment determination as outlined in Our Provider Manual.

V. Records and Confidentiality

A. The parties agree that all medical or clinical records of Members shall be treated as confidential and that both shall comply with all applicable federal and state laws and regulations regarding such records.

B. You agree to maintain for at least ten (10) years, or as may otherwise be required by state or federal law, after the date of services patient records for all services provided to Members in accordance with industry and regulatory standards. Subject to applicable law and regulations, You shall provide Us or Our designee with reasonable access during regular business hours to medical records, books, and other provider records relating to services provided to Members, and shall make all such records as required by law available to any applicable federal or state regulatory authorities in conjunction with its regulation of Our affairs, Member grievances and complaints, quality of care or other similar matters. Provider shall provide copies of any records to Us upon request at no charge.

C. Proprietary information received by You from Us shall be treated and kept as confidential and, unless otherwise required by law, shall not be disclosed to any person unless authorized in writing by Us. All reimbursement amounts and Plan information shall be strictly treated as confidential.

VI. General Provisions

A. Entire Contract. This Agreement, any Exhibits, any current and future Amendments, and the Provider Manual constitute the entire contract between You and Us. We do not require Providers to sign exclusive agreements nor have stipulations in our Agreement which requires You to participate in multiple product lines as a condition of contracting with Us.

B. Definitions. Definitions of capitalized terms used in this Agreement are contained in Exhibit B.

C. Provider-Member Communication. We allow for open Provider-Member communication regarding appropriate treatment alternatives and will not penalize You for discussing medically necessary or appropriate care for a Member, including the discussion of services that have been determined to not meet the definition of Covered Services under the benefit Plan.

D. Member Grievances. You agree to cooperate with Us or Payor, as applicable, in the implementation of Member grievance procedures and assist Us in taking any appropriate corrective actions. You agree to cooperate with Members in all grievance proceedings and to comply with all final determinations made by Us or Payor pursuant to such grievance procedure. You agree to notify Us promptly of any Member grievances known by You.

E. Assignment and Delegation of Duties. Neither party may assign, delegate, or transfer any duties, rights, or interests under this Agreement without the other party's prior written consent; provided, however, that any reference to Us shall include any successor in interest, and We may assign any or all of Our duties, rights, and

interests in whole or in part to an affiliate, and may delegate or transfer any or all of Our duties or obligations under this Agreement if We notify You in writing prior to any such delegation or transfer.

F. Liability for Defense. Neither party shall be liable for defending, nor for the expense of defending, the other party, or its agents or employees, against any claim, legal action, dispute resolution, or administrative or regulatory proceeding arising out of or related to such other party's actions or omissions or this Agreement.

G. Independent Contractor. This Agreement is not intended to create, nor shall it be construed to create, any relationship between Us and You other than that of independent persons or entities contracting for the purpose of this Agreement. Neither party nor any of their representatives shall be construed to be the agent, employer, employee, or representative of the other.

H. Applicable State Law. The validity, enforceability, and interpretation of this Agreement shall be governed by any applicable federal law and by the applicable laws of the state where You provide Covered Services to Members.

I. Amendment. We may amend this Agreement and Attachments by providing no less than thirty (30) calendar days prior written notice to You. In the event You object to any Amendment, including an Amended Exhibit A which serves to modify a current Plan or add a new Payor Plan or Plans, You must notify Us in writing within (30) days following receipt of the Amendment that You do not accept the terms of such Amendment. Notification to Us of Your rejection of any proposed amendment means that the remainder of this Agreement shall remain in force without the proposed Amendment, subject to any termination provisions as provided for herein. Notwithstanding the above, We may amend this Agreement to comply with any changes in federal or state law or regulations and will provide You with written notice of any such amendments. Except as provided in this Section, this Agreement shall not be modified or amended except as agreed to in writing by Us and You.

J. Exhibits. The Exhibits are a part of this Agreement, and shall supersede other parts of the Agreement in the event of a conflict.

K. Notices. Any notice required by this Agreement shall be in writing and shall be sent by United States mail, first class postage, facsimile (fax), or electronic mail (e-mail) to the parties according to the contact information indicated on page 1 of this Agreement.

L. Enforceability. The invalidity and unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision. The waiver by either party of a breach of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach thereof.

EXHIBIT A

PROVIDER FEE SCHEDULE

This Exhibit sets forth the payment methodology information relating to the reimbursement to be paid to Provider by Vision Subcontractor for the provision of Covered Services.

Provider compensation for Covered Services shall be the lesser of: (1) Provider's usual and customary/billed charges, or; (2), any maximum allowable reimbursement described in any Payor specific fee schedule provided to Provider. Should Provider choose not to participate as a Participating Provider for any of the individual current, or future Payor Plan or Plans, Provider is required to provide notification to Vision Subcontractor pursuant to Section VI., K. of the Agreement.

Fee schedule(s) may differ from Payor to Payor and Plan to Plan, and may be modified or amended by Us in accordance with the procedures described in this Agreement.

THIS EXHIBIT IS AN ESSENTIAL PART OF THE AGREEMENT OF THE PARTIES AND MUST BE INCLUDED WITH ANY AND ALL COPIES OF THE AGREEMENT.

EXHIBIT B

DEFINITIONS

The following definitions apply to terms used in this Agreement:

A. Copayment - the amount indicated in a Plan description, which is due and payable, by a Member directly to You for a Covered Service. Copayments typically are described as a flat dollar amount for each particular type of service or supply.

B. Coinsurance - the amount indicated in a Plan description, if any, which is due and payable by a Member directly to You for Covered Services, independent of any required Copayments or deductibles. Coinsurance amounts typically are described as a percentage of the rate negotiated between Company and Provider in effect as of the billing date for the provision of Covered Services.

C. Covered Services - vision care services or supplies for which a Member is entitled to receive benefits under a Plan directly or indirectly provided, administered, or insured in whole or in part by Us.

D. Deductible - the amount indicated in a Plan description, if any, which must be paid by a Member for Covered Services before Company would assume any liability for all or part of the cost of additional Covered Services. Deductibles typically are described as aggregate dollar amounts and typically apply to all services covered under a Plan during a specific period.

E. Member - a person (or his or her spouse or other eligible dependents) who is eligible for, and properly enrolled and covered under, a Plan directly or indirectly provided, administered, or insured in whole or in part by Us. Members can include Medicare beneficiaries enrolled in a Medicare product offered as a Plan.

F. Participating Provider - shall mean a licensed eye care professional, practitioner, or facility, or other related legal entity, that satisfies Our credentialing criteria and has entered into a written agreement with Us to

participate in any provider panel established by Us for the provision of Covered Services to Members, and to comply with the reimbursement mechanisms and quality management, utilization management, provider credentialing and network management, grievance, and other procedures established or set forth by Us.

G. Payor – a managed care organization, such as a PPO or HMO, employer, association, municipality, union, multi-group trust, or other entity which has established a Plan or Plans for the benefit of eligible persons affiliated with the Payor, in which Plan is directly or indirectly provided, administered, or insured in whole or in part by Us (Payor agreement).

H. Plan - a health care benefits plan financed by or otherwise maintained by a Payor pursuant to which Members receive specified benefits related to Covered Services.

I. Self-Insured Plan – a Plan that is established, maintained and funded by a Payor and with respect to which We provide administrative services only. We have no financial obligation or financial risk under, and are not considered a fiduciary of, a Self-Insured Plan. We and the Payor offering a Self-Insured Plan have entered into an administrative services agreement under which Payor is solely responsible for funding the payment of claims for Covered Services provided to its Members.

EXHIBIT C

STATE SPECIFIC PROVISIONS

[INSERT STATE SPECIFIC PROVISIONS HERE]

EXHIBIT D

MEDICARE ADVANTAGE ADDENDUM

This Medicare Advantage Addendum ("Addendum") to the participating provider agreement ("Agreement") between Vision Subcontractor ("Company") and Provider is made and entered into by and between Company and Provider (each a "Party" and, collectively, the "Parties") effective as of _____, 201__, and supplements and amends the terms of the Agreement with respect to the provision of Covered Services to Covered Persons (as such terms are defined herein) enrolled in a Medicare Advantage plan ("MA Plan"), a Medicare Advantage – Prescription Drug plan ("MA-PD Plan"), and/or a Capitated Financial Alignment Demonstration plan ("CFAD Plan") (each such MA Plan, MA-PD Plan and CFAD Plan to be alternatively referred to herein as a "Medicare Plan," and collectively as the "Medicare Plans").

WHEREAS, Company and Provider are bound by the Agreement, pursuant to which Provider has agreed to provide Covered Services to Covered Persons as specified therein;

WHEREAS, Company and Provider mutually and respectively desire to amend the Agreement to include the provision of Covered Services as defined in this Addendum to Covered Persons who are enrolled in a Medicare Plan;

WHEREAS, Provider is certified to participate in the State Medicaid program, and, to the extent that Provider qualifies as a Medicare Provider or Supplier, Provider has signed a participation agreement with CMS and has been approved by CMS as meeting conditions for coverage of Provider's services;

WHEREAS, Company or a Payor has been accepted by CMS, or has an application pending with CMS, to participate in the Medicare Advantage Program and/or a Capitated Financial Alignment Demonstration Program; and

WHEREAS, the Parties agree to supplement and amend the Agreement to include the requirements applicable to Participating Health Care Providers' participation under the Medicare Plans.

NOW THEREFORE, in consideration of the mutual promises of the Parties, the sufficiency of which is hereby acknowledged, the Parties agree as set forth below:

1. DEFINITIONS. The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Addendum. Capitalized terms not otherwise defined in this Addendum shall be defined as set forth in the Agreement.

1.1 Capitated Financial Alignment Demonstration Program means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 Clean Claim means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 CMS means Centers for Medicare and Medicaid Services.

1.4 CMS Contract means the contract between Company or a Payor and CMS, or among Company or a Payor, CMS and the State, that governs the terms of HMO's or the Payor's participation in a Medicare Plan.

1.5 Covered Persons means those individuals who are enrolled in a Medicare Plan.

1.6 Covered Services means those services which are covered under a Medicare Plan.

1.7 Downstream Entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between Company and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.8 First Tier Entity means any party that enters into a written arrangement, acceptable to CMS, with Company to provide administrative services or health care services for a Medicare eligible individual under a Medicare Plan.

1.9 HHS means the United States Department of Health and Human Services.

1.10 Medicare Advantage Program means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.11 Related Entity means any entity that is related to Company by common ownership or control and (1) performs some of Company's management functions under contract or delegation; (2) furnishes services to Covered Persons under an oral or written agreement; or (3) leases real property or sells materials to Company at a cost of more than $2,500 during a contract period.

1.12 State means one or more applicable state governmental agencies in the State of State.

2. COVERED SERVICES. Provider shall furnish Covered Services to Covered Persons as set forth in the Agreement and this Addendum.

3. SUBCONTRACTOR OBLIGATIONS. To the extent that Provider engages any other person (excluding an employee) or entity to perform services in connection with a Medicare Product, including any Downstream or Related Entity, Provider agrees that such engagement shall be set forth in a written agreement that requires such other person or entity to assume the same obligations that Provider assumes under this Addendum.

4. **GOVERNMENT RIGHT TO INSPECT.**

4.1 Provider agrees that HHS, the Comptroller General or their designees have the right to audit evaluate, collect and inspect any books, contracts, computer or other electronic systems, (including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of this Addendum or from the date of completion of any audit, whichever is later. *42 C.F.R. § 422.504 (i)(2)(i) and (ii)*

4.2 Provider agrees that HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 4.1 of this Addendum directly from Provider or any other First Tier, Downstream or Related Entity. For records subject to review under this Section 4.2, except in exceptional circumstances, CMS will provide notification to Health Plan that a direct request for information has been initiated. *42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)*

4.3 Provider further agrees that HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any books, contracts, medical records, documents, papers, patient care documentation and other records of the Provider, that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Addendum, or as the Secretary of HHS may deem necessary to enforce the CMS Contract. Provider shall cooperate with and shall assist and provide such information and documentation to such entities as requested. Provider shall retain, and agrees that this right to inspect, evaluate and audit shall extend for a period of ten (10) years following the termination date of this Addendum or completion of audit, whichever is later, unless (i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies Payor at least 30 days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by Payor, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit at any time. This provision shall survive termination of this Addendum. *42 C.F.R. § 422.504 (e)(2).*

5. CONFIDENTIALITY AND ENROLLEE RECORD REQUIREMENTS. Provider shall comply with all confidentiality and enrollee record accuracy requirements, including: (1) abiding by all federal

and State laws regarding the confidentiality and disclosure of medical records or other health and enrollment information; (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoena; (3) maintaining the records and information in an accurate and timely manner; and (4) ensuring timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §422.504(a)(13) and 422.118*

6. HOLD HARMLESS.

6.1 Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of the Payor. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(i).*

6.2 With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. *42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance*

With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. If Provider contracts with Contracted Providers to provide Covered Services to Covered Persons, Provider will inform Contracted Providers of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose, and must prohibit any Downstream Entities from imposing, cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with Company or Payor. Provider shall accept payment from Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

7. COMPLIANCE WITH CMS CONTRACT. Provider shall perform its obligations under this Addendum in a manner consistent with and in compliance with HMO's and Payor's contractual obligations under the CMS Contract. *42 C.F.R. §422.504(i)(3)(iii)*

8. PROMPT PAYMENT. Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance with the Agreement. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Health Plan, Payor or (if Provider contracts with Downstream Entities) Provider, as applicable, at such address as may be designated by Health Plan. *42 C.F.R. §422.520(b)(1) and (2)*

9. COMPLIANCE WITH FEDERAL AND STATE LAWS. Company, Provider, Payor, and any Downstream or Related Entity shall comply with all applicable laws including Medicare laws, regulations and CMS and/or State instructions. *42 C.F.R. §422.504(i)(4)(v)*

10. DELEGATION OF DUTIES. In the event that Company delegates to Provider any function or responsibility imposed pursuant to the CMS Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Addendum shall be subject to the prior written approval of Company and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

10.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment). If such attachment is not executed, no administrative functions shall be deemed as delegated.

10.2 CMS, Company and the Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Company or the Payor determine that such parties have not performed satisfactorily.

10.3 Payor will monitor the performance of the parties on an ongoing basis.

10.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement to this Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by Company, or the credentialing process will be reviewed and approved by Company and Company must audit the credentialing process on an ongoing basis.

10.5 If Company or a Payor delegates the selection of providers, contractors, or subcontractors, Company and the Payor retain the right to approve, suspend, or terminate any such arrangement. *42 C.F.R. 422.504(i)(4) and (5).*

11. NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS. Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of Vision Subcontractorestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42 C.F.R. §422.110(a*).

12. SERVICE AVAILABILITY. Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

13. CULTURAL COMPETENCE. Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R. §422.112(a)(8).*

14. FOLLOW-UP CARE. Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42 C.F.R. §422.112(b)(5).*

15. ADVANCE DIRECTIVES. Provider shall comply with Company's and the Payor's policies and procedures concerning advance directives. *42 C.F.R. §422. 128(b)(1)(ii)(E).*

16. PROFESSIONALLY RECOGNIZED STANDARDS OF CARE. Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R.§422.504(a)(3)(iii).*

17. CONTINUATION OF BENEFITS. Provider shall provide Covered Services as provided in the Agreement and this Addendum: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date

the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Addendum. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3).*

18. **PHYSICIAN INCENTIVE ARRANGEMENTS.** If Provider is a physician or physician group, neither the Payor nor Company shall make any specific payment, directly or indirectly, to Provider as an inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. Provider agrees that, if Health Plan or Payor has a physician incentive plan that places Provider at substantial financial risk (as determined under 42 C.F.R § 422.208(d)) for services that Provider does not furnish itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with the requirements at 42 C.F.R. § 422.208(f). Health Plan*42 C.F.R. §422.208.*

19. **INFORMATION DISCLOSURES TO CMS.** Provider shall cooperate with Company and the Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

20. **NOTICE OF PROVIDER TERMINATIONS.** Company shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

21. **RISK ADJUSTMENT DATA.** Provider shall provide to Company risk adjustment data as required by CMS. *42 C.F.R. §§ 422.310(d)(3), (4).* Upon Company's or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. Provider certifies based on best knowledge, information and belief that the data it submits under 42 C.F.R. § 422.310 are accurate, complete and truthful. *42 C.F.R. §§ 422.310(e) and 422.504(l)(3).*

22. **COMPLIANCE WITH COMPANY AND PAYOR POLICIES.** Provider shall comply with Company's and Payor's policies and procedures. In addition, if Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon Company's request, consult with Company regarding Company's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b).* Provider shall comply with Company's and Payor's quality assurance and performance improvement programs. *42 C.F.R.§422.504(a)(5).*

23. **WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION.** In the event Company suspends or terminates this Addendum with respect to Provider or any physicians employed or contracted with Provider, Company shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by Payor, and (b) the

affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1*)

24. NOTICE OF WITHOUT CAUSE TERMINATION. Company and Provider must provide at least sixty (60) days written notice to each other before terminating this Addendum without cause. *42 C.F.R. §422.202(d)(4).*

25. COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS. Company and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R. §422.504(h)(1).*

26. FEDERAL FUNDS. Provider acknowledges that payments Provider receives from Company or Payor pursuant to this Addendum are, in whole or part, from Federal funds. Therefore, Provider and any of its Downstream or Related Entities are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 84; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of Federal Funds. *Medicare Managed Care Manual, Ch. 11 § 120.*

27. EXCLUDED PERSONS/PROGRAM INTEGRITY. Provider warrants to Company and each Payor that it is not excluded and shall not employ or contract for the provision of health care, utilization review, medical social work, or any administrative services pursuant to this Agreement with any individual or entity (hereafter, "person") whom Provider knows or reasonably should have known is excluded from participation in the Medicare and Medicaid program under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person currently is employed by or under contract with Provider. Provider shall review the Office of Inspector List of Excluded Individuals and Entities and the System for Award Management exclusion list and verify on a monthly basis or as often as required by CMS guidelines, that the persons it employs or contracts for the provision of such services pursuant to this Agreement are in good standing. Provider shall promptly disclose to Company any exclusion, or other event that makes a Provider employee or Downstream or Related Entity ineligible to perform work related to Medicare or Medicaid. *42 C.F.R. § 422.752(a)(8).* Provider shall promptly notify Company in writing in the event that Provider is criminally convicted or has a civil judgment entered against Provider for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services. Provider agrees to be bound by the provisions set forth at 2 C.F.R. Part 376.

28. COMPLIANCE: TRAINING, EDUCATION AND COMMUNICATION. Provider agrees it, its employees, and Downstream and Related Entities who provide services under this Addendum shall receive general compliance training as well as fraud, waste, and abuse ("FWA") training, and that such training shall occur within ninety (90) days of initial hiring and annually thereafter. Unless otherwise agreed to by Company or Payor in writing, such training shall be the general compliance and FWA training modules located on the CMS Medicare Learning Network ("MLN") at: https://learner.mlnlms.com/Default.aspx. Company and Payor shall accept the system-generated certificate of completion as evidence of compliance with the training requirement. The FWA training requirement is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment in Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS. However, compliance with the general training requirement is still required. Provider shall maintain records of Provider's and its employees' training. *42 C.F.R. § 422.503(b)(4)(vi)(C)(3).*

29. COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS. Provider shall cooperate and comply with all applicable State, federal, Company and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to Company and Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

30. OFFSHORE SUBCONTRACTORS. In addition to the applicable requirements of Section 10 of this Addendum, Provider shall disclose to Company in writing, 30 days prior to signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. *Health Plan Management System memos 7/23/2007, 9/20/2007, and 8/26/2008.*

31. SCOPE AND CONFLICTS. Nothing in this Addendum shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, including the Provider Manual, except as stated in this Addendum. In the event of any conflict between this Addendum and any provision of the Agreement, the provisions of this Addendum shall govern. In the event that any provision of this Addendum conflicts with the provisions of any statute or regulation applicable to Company, the provisions of the statute or regulation shall have full force and effect unless such statute or regulation is preempted by federal law.

32. TERMINATION. This Addendum shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. The Addendum may be further terminated by Company immediately upon written notice to the Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or SAM as excluded or is otherwise suspended or excluded from participation in Medicare or Medicaid.

EXHIBIT D-1

STATE-MANDATED REGULATORY REQUIREMENTS

This Exhibit sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to all Medicare Product Types under this Medicare Product Attachment. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Exhibit, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

[INSERT STATE MANDATED REGULATORY REQUIREMENTS]

EXHIBIT E

STATE PRODUCT ATTACHMENT

This State Product Attachment (the "***Product Attachment***") is incorporated into the Provider Participation Agreement (the "***Agreement***") entered into by and between _____ (in this

Product Attachment referred to as "***Provider***") and **Vision Subcontractor**, a vendor of Health Plan ("**HEALTH PLAN**").

ARTICLE I
RECITALS

1.1 State has contracted with the state of State to arrange for the provision of medical services to Covered Persons under the State Program of which Vision Subcontractor is a vendor of HEALTH PLAN.

1.2 Provider has entered into the Agreement with Vision Subcontractor. This Attachment is intended to supplement the Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to Covered Persons as it pertains to the State Program. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern.

1.3 Notwithstanding any provisions set forth in this Attachment, to the extent applicable, Provider shall comply with all duties and obligations under the Agreement, the Provider Manual and this Product Attachment. Provider agrees and understands that Covered Services shall be provided in accordance with the contract between the Provider and Vision Subcontractor, the Provider Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To the extent Provider is unclear about Provider's duties and obligations, Provider shall request clarification from Vision Subcontractor.

ARTICLE II
DEFINITIONS

The definitions listed below will supersede any meanings contained in the Agreement.

2.1 ***Cultural Competency*** or ***Culturally Competent*** means the ability to understand, communicate with, and effectively interact with people across cultures. Cultural competence comprises four components: (i) awareness of one's own cultural worldview; (ii) attitude towards cultural differences; (iii) knowledge of different cultural practices and worldviews; and (iv) cross-cultural skills.

2.2 ***Medical Necessity*** or ***Medically Necessary*** means health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient's medical condition; (ii) compatible with the standards of acceptable medical practice in the United States; (iii) provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; (iv) not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider; (v) there is no other effective and more conservative or substantially less costly treatment service and setting available; and (vi) the service is not experimental, investigational or cosmetic in nature.

2.3 ***Member(s)*** or ***Covered Person(s)*** means Medicaid beneficiaries who have enrolled with HEALTH PLAN in the State Program.

2.4 ***State Program*** means the State's Medicaid program for the following Medicaid eligibility categories: pregnant women, children under the age of one (1) year, and select targeted, high cost Medicaid beneficiaries.

ARTICLE III
PROVIDER CONTRACT REQUIREMENTS

3.1 **Hold Harmless.** Provider agrees to not hold Covered Persons liable for: (a) any and all debts of Vision Subcontractor if Vision Subcontractor should become insolvent; (b) payment for services provided by Vision Subcontractor if Vision Subcontractor has not received payment from HEALTH PLAN for the services, or if Provider fails to receive payment from HEALTH PLAN; and (c) to the extent applicable, the payments to Provider for furnishing Covered Services that are in excess of the amount that normally would be paid by the Covered Person if the services had been received directly from Vision Subcontractor. Provider, agent, trustee, or assignee shall not maintain any action at law against a Covered Person to collect sums owed by Vision Subcontractor. In addition, Provider agrees to honor and be bound by applicable State and federal laws and regulations including, relevant sections of the Balanced Budget Act of 1997, which protect Covered Persons against balance billing.

3.2 **Cultural Competency.** Provider shall promote the delivery of services in a Culturally Competent manner to all Covered Persons including those with limited English proficiency and diverse cultural and ethnic backgrounds.

3.3 **Access to Records.** Provider 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 Medicaid Agency, the State Attorney General, authorized federal or State personnel or the authorized representative of these parties including, without limitation, any employee, agent, or contractor of the Medicaid Agency, the Centers for Medicare and Medicaid Services ("CMS"), and the fiscal agent. Access will be at the discretion of the requesting authority and will be either through on-site review of records or by submission of records to the office of the requester. Any records requested hereunder shall be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) calendar days following a request, for desk audits. Requests may be written or verbal. Provider shall maintain and make records available for review by authorized federal and State agencies during the term of this Agreement and for a period of five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, Provider shall maintain records for a period of five (5) years or until all issues are finally resolved, whichever is later.

3.4 **Termination.** If Provider terminates this Agreement for any reason, Provider shall give Vision Subcontractor at least sixty (60) days prior written notice of such termination**.**

3.5 **State Authority.** Provider agrees and acknowledges that the Medicaid Agency shall have the right to invoke any remedy available under State Contract against Provider through this Agreement that it may bring against HEALTH PLAN, including but not limited to the right to terminate this Agreement. In addition, this Agreement may be terminated immediately upon written notice by HEALTH PLAN and/or Vision Subcontractor upon the entry of a valid order issued by the State Insurance Department or other lawful authority.

3.6 **Non-Assignment.** This Agreement is intended to secure the services of and be personal to Provider, and shall not be assigned, sublet, delegated, or transferred by Provider without the prior written consent of Vision Subcontractor.

EXHIBIT F

PROVIDER PARTICIPATION AGREEMENT AMENDMENT
AND

COMMERCIAL-EXCHANGE PRODUCT ATTACHMENT

THIS PROVIDER PARTICIPATION AGREEMENT AMENDMENT AND COMMERCIAL-EXCHANGE PRODUCT ATTACHMENT (referred to as this "***Amendment and Attachment***") is made and entered into between Vision Subcontractor (***"Vision Subcontractor"***) and ***Provider***.

WHEREAS, a health maintenance organization ("***HMO***") organized, pursuant to the laws of the State, has contracted with Vision Subcontractor to provide or arrange Covered Vision Services to its Covered Persons. As such, Vision Subcontractor and Provider entered into that certain Provider Participation Agreement, including all Attachments, as may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider agrees to provide to Covered Persons those Covered Services described in the Agreement;

WHEREAS, Vision Subcontractor desires to amend the Agreement (i) to include Participating Providers (as hereafter defined) as participating providers in the "***Commercial-Exchange Product***," as defined and described in this Amendment and Attachment, and (ii) to add the Commercial-Exchange Product Attachment (as defined below) as a binding attachment to the Agreement;

WHEREAS, pursuant to the provisions of the Agreement, the Agreement may be amended by Vision Subcontractor providing written notice thereof to Provider, provided that Provider does not object to such amendment by notifying Vision Subcontractor in accordance with the notice provisions in the Agreement of its objection within thirty (30) days of the giving of notice of such amendment by Vision Subcontractor; and

WHEREAS, the Agreement is amended as hereafter provided in accordance with the notice provisions in the Agreement.

NOW THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the Agreement is amended as set forth below.

1. Amendment.

1.1. Effective Date. This Amendment and Attachment is effective as of _____, 201__ ("***Effective Date***").

1.2 Defined Terms. All capitalized terms not specifically defined in this Amendment and Attachment will have the meanings given to such terms in the Agreement.

1.3 Modification to Defined Terms. For purposes of this Commercial-Exchange Product only, Exhibit B of the Agreement is hereby amended by deleting the definitions in the Agreement for the following quoted terms and inserting in lieu thereof the definitions set forth below.

"***Covered Person***" means any individual Member entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

"***Covered Services***" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be medically necessary under the applicable Coverage Agreement.

"***Participating Health Care Provider***" or "***Participating Provider***" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Vision Subcontractor or Payor to provide Covered

Services to Covered Persons, and that is designated by Vision Subcontractor or Payor as a "participating provider" in such Product.

"***Payor***" means the entity that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement.

1.4 New Definitions. For purposes of this Commercial-Exchange Product only, Exhibit B of the Agreement is hereby amended by adding the new defined terms and definitions set forth below to the end of Exhibit B; such quoted terms, when appearing with initial capital letters in this Amendment and Attachment or the Agreement, will have the meanings set forth below.

"***Provider Compensation Schedule***" means at any given time the then effective Provider Compensation schedule(s) of maximum rates applicable to the Commercial-Exchange Product under which Provider and Participating Providers will be compensated for the provision of Covered Services to Covered Persons. Such Provider Compensation will be set forth or described in Provider's fee schedule to the Provider Participation Agreement as Exhibit A-1 and incorporated herein by reference.

"***Commercial-Exchange Product***" means those programs and health benefit arrangements offered by or available from or through HMO, Vision Subcontractor or a Payor that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial-Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which HMO, an Affiliate, or its delegate furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the HMO's, Vision Subcontractor's or Payor's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, employer-sponsored, or other private health insurance exchange. The Commercial-Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

"***Coverage Agreement***" means any agreement, program or certificate entered into, issued or agreed to by a Payor, under which the Payor arranges for the delivery of health care services to Covered Persons through one or more network(s) of providers or other vendor arrangements.

"***Emergency***" or "***Emergency Care***" has the meaning set forth in the Covered Person's Coverage Agreement.

"***Emergency Medical Condition***" has the meaning set forth in the Covered Person's Coverage Agreement.

"***Medically Necessary***" has the meaning set forth in the Covered Person's Coverage Agreement.

"Payor Contract" means the contract with a Payor, pursuant to which HMO or an Affiliate furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of provider networks or vendor arrangements of HMO or an Affiliate. The term "Payor Contract" includes a contract with a governmental authority (also referred to herein as a "Governmental Contract") under which HMO, an Affiliate or Payor arranges for the provision of Covered Services to eligible individuals.

"***Provider Manual***" means the manuals, requirements, policies and procedures adopted by the HMO, an Affiliate, Payor, or its delegate to be followed by Participating Providers, including, without limitation, those relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as the same may be amended from time to time by the HMO, an Affiliate, Payor or its delegate.

"***Product***" means any program or health benefit arrangement designated as a "product" by HMO, Vision Subcontractor or a Payor (e.g., Medicaid Product, Commercial-Exchange Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through HMO, an Affiliate or a Payor that provides Covered Persons in such product with incentives or access to Participating Providers in such product. For purposes of the Commercial-Exchange Product Attachment, "Product" means the Commercial-Exchange Product.

"***Product Attachment***" means an Attachment setting forth certain requirements, terms and conditions specific to one or more Products, including certain provisions that must be included in a provider agreement under the laws of the State, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in the Agreement or the Provider Manual.

"***Regulatory Requirements***" means all applicable statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

"State" means the State of State, unless otherwise defined in an Attachment for purposes of that Attachment.

2. Commercial-Exchange Product Attachment.

2.1 Product Attachment. This Section 2 constitutes the "Commercial-Exchange Product Attachment" ("***Product Attachment***") and is incorporated into the Agreement between Provider and Vision Subcontractor. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation.

2.2 Participation.

(a) Unless otherwise specified in this Product Attachment and as limited by Section 2.2(b) below, all Participating Providers under the Agreement will participate in the Commercial-Exchange Product as "Participating Providers," and will provide to Covered Persons enrolled in or covered by a Commercial-Exchange Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Participating Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Participating Providers, to comply with and abide by the provisions of the Agreement, including this Product Attachment and the Provider Manual.

(b) Provider and Participating Providers may only identify themselves as a Participating Provider for those Commercial-Exchange Products in which the Participating Provider actually participates as provided in the Agreement and this Product Attachment. Provider acknowledges that HMO, an Affiliate or a Payor may have, develop or contract to develop various Commercial-Exchange Products or provider networks

that have a variety of provider panels, program components and other requirements, and that all or certain of HMO's duties with respect to the Commercial-Exchange Product may be delegated to an Affiliate, a Payor or their delegates. Neither HMO, Vision Subcontractor, nor any Payor warrants or guarantees that any Participating Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Commercial-Exchange Product.

2.3 Attachment. This Product Attachment includes, at Exhibit 1, the Regulatory Requirements with which Participating Providers are required to comply in connection with their participation in the Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to Participating Providers are or will be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference.

2.4 Term. The term of the Participating Providers' participation in the Commercial-Exchange Product will commence as of the Effective Date and, thereafter, will be coterminous with the term of the Agreement unless a party or a Participating Provider terminates the participation of the Participating Provider in the Commercial-Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment. In addition to the termination rights in the Agreement, the participation of any Participating Provider as a "Participating Provider" in a Product may terminated by either party giving the other party at least one hundred eighty (180) days' prior written notice of such termination; in such event, Provider shall immediately notify the affected Participating Provider of such termination.

2.5 Conflict and Construction. This Amendment and Attachment modifies, supplements and forms a part of the Agreement. Except as otherwise provided in this Amendment and Attachment, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of any conflict or inconsistency between the provisions of the Agreement (or any other Attachment) and the provisions of this Product Attachment, the terms and conditions of this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by the Commercial-Exchange Product. To the extent Provider or any Participating Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Participating Provider shall request clarification from Vision Subcontractor.

EXHIBIT 1 TO THE COMMERCIAL-EXCHANGE PRODUCT ATTACHMENT TO EXHIBIT F

REGULATORY REQUIREMENTS

This Exhibit sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Commercial-Exchange Product. To the extent that a Payor, Coverage Agreement, or Covered Person is subject to the law cited in the parenthetical at the end of a provision on this Exhibit, such provision will apply to the rendering of Covered Services to a Covered Person of such Payor, to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable. To the extent required by law or as otherwise applicable, the term "Payor" as used in this Exhibit includes Vision Subcontractor.

[INSERT STATE SPECIFIC REGULATORY REQUIREMENTS HERE]

[END OF RESPONSE]

4.2.2.3 CARE MANAGEMENT

4.2.2.3.A Care Management Proposal

1. Describe the Offeror's overview of its proposed Care Management Strategy, including the process and criteria used for Care Management for the Members. Include relevant Performance Measures that will be used to assess the achievement of quality outcomes obtained through the Offeror's process. Address the following issues in the response:

Care Management (CM) Strategy and Overview

Our CM Strategy integrates and coordinates care for our Members across the continuum of services to promote access, health equity, and improved health outcomes. Our Population Health Management Framework, supported by our Health Equity Improvement Model, ensures our CM Strategy and interventions are relevant and customized. CM will operate under a ***local and integrated team-based structure*** designed to enhance access to all covered and non-covered services, meet holistic Member needs, and improve health through:

- **Person-centered, whole-person care** is recovery-oriented, culturally responsive, and encourages personal responsibility and Member engagement.
- **Identification of each Member's needs and strengths**, using a standardized Health Risk Screening (HRS) tool, evidence-based Comprehensive Health Assessment (CHA), and supplemental assessments such as our Social Determinants of Health (SDOH) mini-screen tool.
- **Population-based predictive modeling and risk stratification** incorporates assessments, claims, authorizations, SDOH, and demographic data, to stratify Members into the appropriate CM Risk Level, designing CM interventions and programs to achieve individual and population health.
- **Individualized, person-centered care plan** for Members stratified into Medium and High-Risk CM Levels that documents Member-determined strengths, goals, and clear activities and interventions, designed to meet individual goals and address physical health (PH), behavioral health (BH), functional needs, and SDOH.
- **Integrated Care Teams (ICT)** consisting of CCO staff and external partners, such as Primary Care Providers (PCPs) and Patient-Centered Medical Homes (PCMHs), working collaboratively with Members and families to support personal health and wellness goals, and provide input into the development of the person-centered care and treatment plan. The Member determines ICT participants, which, at minimum, include the Member, the Member's primary Care Manager, PCP/PCMH, and other treating Providers.
- **Collaborative Care Team** is comprised of our physical health and BH medical directors, pharmacists, licensed mental health professionals (LMHPs), registered nurses (RNs), and other internal CCO resources providing multidisciplinary support and consultation to the primary Care Manager for Members with co-occurring, complex needs. In addition, specialized experts help staff our ICTs and programs for complex Members such as individuals with sickle cell disease, BH conditions, substance use disorders (SUD), obesity, cancer and chronic conditions, and foster care children and youth.
- **Care Team meetings** take place regularly in-person, virtually, or telephonically and are driven by Member needs and preferences. Discussions are collaborative and used to recommend interventions to help the Member meet their identified health goals, address barriers that hinder progress toward goals, collaborate on innovative solutions to help meet Member needs, and communicate critical updates.
- **Technology solutions** that support Member engagement, closed loop referrals, coordination and sharing of health information with the Member and the ICT, Providers, and others involved in the care of the Member. Our Clinical Documentation System supports our CM workflow processes and collaboration and our Member, Provider, and Community Partner Portals.

Monitoring and Evaluating our CM Program

We have systems and processes to track and monitor CM services and assess quality outcomes obtained through our CM program. We will leverage our family of integrated decision support and health care informatics solutions for data collection, indicator measurement, analysis, and action. We will capture and analyze data from internal, Subcontractor, delegate, and external sources to evaluate the effectiveness of our CM program. In addition to outcomes, we will use Member satisfaction to gauge program effectiveness, as measured through annual CAHPS surveys and Member CM satisfaction surveys. We will also assess and evaluate the effectiveness of CM programs and processes by looking at population health, quality of life, cost and utilization reports, and dashboards. We will use this combined information to monitor performance expectations and

effectiveness of our CM program and adjust our strategies and processes on a program and Member-level, as necessary. In addition, we have early warning systems in place for critical CM activities and contract requirements that will allow us to expedite the identification and resolution of issues and problems.

Tracking CM Key Performance Indicators (KPIs). We will identify and monitor the value and efficacy of our CM program and processes through a wide range of clinical and health service delivery categories. We develop and track metrics for contractual, operational, regulatory, clinical, and quality requirements, including performance measures required by DOM.

Our reporting and analytics platform includes flexible desktop reporting and various CM KPI Dashboards with drill-down capabilities. For example, our SDOH KPI Dashboard aggregates SDOH data from claims and assessments to analyze Member patterns and trends in social barriers to care. The Dashboard shows Member SDOH need category (e.g., employment, housing, education); associated comorbidities (e.g., cardiac conditions, substance use disorder); and cost and utilization metrics (e.g., average cost PMPM, ED visits). In addition, the platform allows CM staff to identify the correlation between SDOH needs and chronic and acute conditions and identify how SDOH barriers impact Member utilization of services. The Dashboard also allows users to analyze SDOH needs by population segments such as Age, Race/Ethnicity, and Gender. The table below highlights example CM KPIs that will be monitored to assess the achievement of quality outcomes.

Categories	Performance Indicators Tracked
Clinical Indicators	• HEDIS and CAHPS measures • Potentially avoidable ED visits; inpatient length of stay; ED utilization rates; readmission rates, severity & treatment status of co-morbid chronic medical conditions • Member medication adherence, pharmacy over-and under-utilization reports, high volume prescribers of opioids • Utilization patterns, including identification of over- and under-utilization and regional variations
CM Services	• HRS and CHA completion rates • Member CM Risk Levels • Caseloads • Closed loop referrals, number and type of referrals, warm handoffs and receipt of services
Member Experience	• Complaints, Grievances and Appeals • CAHPS and Member CM satisfaction surveys
Disparity Indicators	• Disparities at the HEDIS measure and utilization level using our Health Equity Dashboard

a. The challenges unique to the MississippiCAN and CHIP populations that the Offeror perceives and will target in its Care Management approach;

We know from our national experience serving Medicaid and CHIP Members, and our knowledge of Mississippi and DOM's goals for the next era of the CCO program that there are unique challenges faced by Mississippi Coordinated Access Network (MSCAN) and CHIP populations. Highlighted below are perceived challenges that we will target in our approach to CM.

Members in Rural Areas

We understand over 60% of MSCAN and CHIP beneficiaries live in rural areas of the State. We will tailor our interventions to address the unique challenges and needs of Members living in rural communities. Our interventions will focus on prevalent needs such as primary care access and availability, access to services for Members with complex BH conditions, transportation, and SDOH needs, including access to healthy foods and food insecurity. For example, our CM team, which will include CHWs who live and work in the community, will be strategically located in rural communities where our Members reside. Additionally, we will deploy our virtual and Digital Care Management (Digital CM) solutions to engage Members through Digital CM, remote patient monitoring, and video calls from anywhere. We will also partner with ***Plan A Clinic*** to bring preventive care and health screenings as a solution to address access issues in rural areas of the State.

Members Experiencing SDOH Barriers

The social, economic, and physical environment in which a person lives impacts their overall health and well-being. We understand that MSCAN and CHIP populations face unique challenges like food insecurity, housing instability, and transportation needs. For example, findings from the 2020 Mississippi State Department of Health State Health Assessment indicate the most significant SDOH challenges facing MSCAN and CHIP Members are ***poverty, food insecurity, transportation, and housing***. In response, we will connect Members to culturally responsive services and support system navigation, addressing identified SDOH barriers (including warm handoffs and closed-loop referrals), stigma, literacy, and language and cultural obstacles. Members and

caregivers will have access to our ***Community Resource Support Database*** where they can self-refer to community resources and receive appropriate follow up to ensure their needs were met. Our ***SDOH Help Line*** will be staffed with representatives to assist not just our Members but the needs of the community, and CHWs who reside in the community will provide in-home support. We will leverage existing resources and community partners to help address the social needs of our Members. For example, to address food insecurity for MSCAN and CHIP Members, we will establish a partnership with the local nonprofit ***Extra Table*** to provide a source of healthy food to Members in "hot zones." We will also develop statewide referral partnerships with faith-based food banks and kitchens, the Salvation Army, and Meals on Wheels. We will partner with additional CBOs across the State that provide food assistance, including the Community Action Agencies (CAAs)and the USDA Summer Nutrition Program, which offers hot, nutritious meals for children and their parents during the summer.

Members with Chronic Conditions and Co-Morbidities

Our disease management (DM) programs and interventions are comprehensive and flexible to meet Members' unique needs determined by their conditions, our CM and DM assessments, and individual preferences. Components of our DM programs include supporting and engaging Members, families, and caregivers to be active participants in care planning and condition management by offering self-care management tools. These tools include condition-specific education materials geared to specific populations, such as children, non-English speakers, and Members with low literacy levels, and ***technology solutions*** such as telemonitoring and email, text messaging, and Mobile Applications for information reminders and support. In addition, we will offer DM programs for multiple chronic conditions, including asthma, obesity, diabetes, and smoking cessation. Each program will be designed to support Members and parents/caregivers to proactively manage their chronic conditions and provide better care while reducing care costs.

We will partner with Vigilant to offer a value-based comprehensive health management program in all 82 Mississippi counties for Members with one or more of the following twelve chronic conditions:

- Diabetes
- Hypertension
- Dyslipidemia
- Mental Health
- Chronic Kidney Disease
- Stroke
- Peripheral Vascular Disease
- Ischemic Heart Disease
- Congestive Heart Failure
- Chronic Lung Disease
- Cancer
- Pregnancy

The Vigilant model is designed to integrate the highest standards of medical science, good medical practice, deep insights into human behavior, and population science into a unified whole that is simple in its application for clinicians and powerful in its results for patients and payers. The Vigilant Program will have the following components:

- Community physician participation, leadership, and collaboration
- Clinics for Members in every Mississippi county staffed with dedicated care managers and patient engagement specialists
- Intensive medical management includes customized plans of care for the population as a whole, and each Member developed care navigation and management guided by data analytics and the plans of care
- A technology platform built to measure clinical and economic results, drive performance improvement, guide quality management activities, and manage utilization
- Live patient encounters through remote communications media and technology, including telemedicine.
- Reduction of barriers to access through the elimination of waits for appointments
- Health education and wellness programs

Vigilant has a 22-year track record of clinical and economic results in Mississippi, including disadvantaged individuals in underserved rural and urban communities. The Vigilant program eliminates health disparities in the individuals enrolled in its socioeconomic status, education, neighborhood, physical environment, employment, and social support programs. Their specialized diabetes program has demonstrated decreased medical paid claims of $2,742 per participant and improvements in A1c, blood pressure, and cholesterol control. Severely out of control diabetes (A1c > 9.0) decreased by 73%, hospitalization rates decreased by 50%, and ED utilization rate decreased by 23% among program uses.

We will also partner with the Community Pharmacy Enhanced Services Network ***(CPESN)*** to enhance and expand services in the community. CPESN is comprised of approximately 60 independent pharmacies throughout Mississippi that can support Member-specific care gaps and adherence for chronic conditions. This includes diabetes adherence, gaps in care for diabetic patients that need statin therapy, asthma/COPD adherence, and gaps for Members requiring a maintenance inhaler for better disease control; anxiety and depression adherence and education; ADHD adherence, education, and Provider follow-up visits; and statin use in patients with cardiovascular disease. In addition, CPESN will provide HbA1c point of care testing in CPESN pharmacies, offering Members with diabetes another convenient option to a physician visit. CPSEN will share the HbA1c testing results with the Member, the Member's PCP, and us.

Children and Youth in Foster Care

We have extensive experience serving children and youth in foster care as part of our Medicaid contracts. Our thorough understanding of foster care programs and our approach to developing essential relationships with agency and community partners that help drive desired outcomes are what set us apart. We understand that children/youth in or transitioning from foster care typically have more intensive health care needs than other children and may lack access to regular primary care, dental care, and BH services. We know these children/youth may have been exposed to Adverse Childhood Experiences (ACEs) because of trauma, significant stress, abuse, and neglect and may require care for chronic physical problems. Further, we know these children/youth tend to have more BH problems and need more psychosocial services than other children/youth receiving Medicaid services. Our CM program is child/youth and parent/caregiver-centered. It incorporates trauma-informed and strength-based engagement strategies and community partnerships to address the individualized and holistic needs of each child/youth and young adult. We will provide a variety of CM programs and services, including Care Mangers dedicated to foster care to address the individual needs of our foster care Members and help parents/caregivers enhance skills and resolve problems to promote optimal child development. In addition, we will provide ***Care Kits*** that include essential care items that can travel with children as they transition. The kits will come in a sturdy duffle bag with age and culturally appropriate personal care items, such as a blanket, hot/cold tumbler, dental kit, earbuds, and a journal and pen.

b. How the Offeror plans to ensure that closed-loop referrals and warm handoffs are executed and sufficiently tracked, including details on the community-based referral platform it plans to use to monitor or close the loop on referrals and/or monitor community-based partnership development activities;

Our CM model addresses our Members' PH, BH, and social needs and links them to appropriate community-based resources and services. We will connect Members to community resources and supports through the use of local, field-based CM staff, our ***Community Resource Support Database*** that manages and promotes closed-loop referral processes, and community partners.

Local CM Team

Our CM staff will be available to meet Members where they are, in the home, community, or other care settings, to help coordinate appropriate use of services, including non-covered benefits. We will screen Members for SDOH at every contact and deploy technology resources with closed-loop referral functionality, such as our Community Resource Support Database described below. Our staffing model is based on a high-touch approach that will include ***local CM teams and Community Engagement Specialists*** to provide support and help Members identify community resources such as food pantries, housing, and utility assistance programs to meet SDOH needs. Our CM staff will be equipped to recognize social barriers and strategize effective individual and community interventions**.** Using our person-centered, whole-person approach, we take the time to understand each Member's goals and barriers and facilitate referrals to appropriate resources and provide care coordination and follow-up, as needed. These referrals include coordination of services with the Member's ICT and community programs that assist with food, clothing, utilities, employment, housing and other social determinant needs. We do not just stop at providing a Member with a referral to a community-based organization, Provider or resource in the community. Instead, ***our CM staff will coordinate the delivery of services and provide warm handoffs*** through telephone, secure email, secure fax, and face-to-face approaches to ensure the Member receives the necessary service or community supports to meet the assessed need(s).

Closed-Loop SDOH Platform to Facilitate Referrals and Coordination

Our CM staff, Members, caregivers, and Providers will have access to our ***Community Resource Support Database***, a searchable database of vetted and regularly updated health and wellness resources. The Community Resource Support Database, available in numerous languages, helps connect Members to local programs and resources that best fit their needs, including housing, transportation, and food. The database will be available for Members through our public website, enabling Members and their families and caregivers to locate resources at any time. The data is validated regularly to ensure quality and increase the likelihood that our users are satisfied with the tool and will continue using it to improve their access to social, emotional, and physical health resources. Additionally, our staff will have access to easy-to-read and easy-to-understand reporting, enabling us to track, trend, and report on membership needs and utilization. CM staff can access these analytics and reporting features to gain a deeper understanding of Members' needs at a population and individual level. As an additional layer to this resource directory, our ***SDOH Help Line*** staff will use an internal tool to track needs, referrals, and partnership development activities. Our on-the-ground Community Engagement Specialists will inform this internal tool, who will work directly with community partners.

We will provide Members, their families, and the Care Managers and community organizations that serve them with closed-loop referral tracking and coordination. All CM activities, including Member referrals to Providers for covered benefits and services, are documented in the Member's electronic record in our Clinical Documentation System. The Care Manager can create a task in the individual Member record that enables the Care Manager to follow up to ensure the Member received the service or care needed. The Care Manager will follow up with the Member within seven calendar days of making a referral to confirm the Member could access the resource or service or work with the Member to resolve any issues the Member may have in accessing the referral.

Coordination with Community-Based Resources and Service Providers

We are committed to leveraging existing infrastructure and services across the State and partnering with local stakeholders and entities. For example, to ensure we can link Members and families to needed community services and supports, we will work with transportation programs such as the Holmes County Community-Led Transportation Program local food banks and pantries in communities across the State such as the Mississippi Food Bank Network; Mississippi Shine that provides health and wellness services for individuals in the 21 Delta counties; and the Diaper Bank of the Delta that functions as a central hub for early childhood information and resources. We will also partner with Mississippi's 17 Community Action Agencies to address local needs in each region of the State. Through these relationships, we will gain better visibility to the challenges faced by our Members and access resources needed to support them.

c. How the Offeror will ensure that Care Management is a tool to address health equity concerns;

We have significant experience identifying and prioritizing the reduction of health care disparities through the successful implementation of culturally sensitive and tailored CM interventions. Through our quality management (QM) program, we will identify and assess disparities leveraging data analysis and geographic hot spotting using our ***Health Equity Improvement Model*** detailed in **Figure 4.2.2.3.A.1.c**. Once disparities are identified, we design targeted CM interventions and develop strategic partnerships with community-based organizations (CBOs) and Providers to address all aspects of Member health – PH, BH, and SDOH.

The example in the callout box below highlights how we have successfully used our Health Equity Improvement Model to design a CM program as an effective tool to address identified health equity concerns in our affiliate Medicaid plan that serves populations similar to MSCAN and CHIP. We will employ a similar approach for using CM as a tool to address identified health disparities among the MSCAN and CHIP populations.

Maternal Health CM Program Rooted in our Health Equity Improvement Model. We have prioritized addressing poor health outcomes for Black mothers and infants for several years. For example, in 2015, one of our Medicaid affiliates who serves similar MSCAN and CHIP populations analyzed maternal health-related HEDIS measures, stratified by race/ethnicity. The analysis showed Black Members in one county had lower rates of postpartum care (PPC) visits than the county average and that these rates were even lower in two neighborhoods. Staff performed a barrier analysis on the disparities, revealing transportation issues and a health education gap about the importance of PPC and covered services. Our affiliate implemented interventions to address physical health, BH, and social barriers to engage Members in their care and increase access. Interventions included a transportation program for pregnant and postpartum women, a program addressing isolation and loneliness, education/engagement through CHWs, community events such as baby showers, and Member incentives.

Health Equity Improvements Achieved

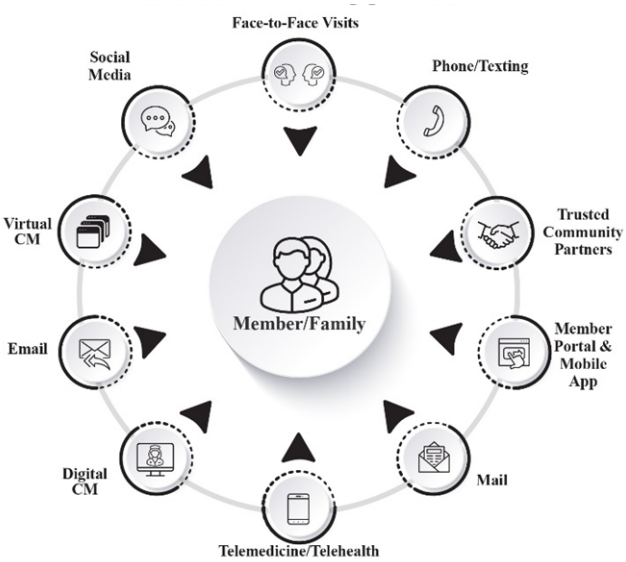
- ***PPC visit rates almost doubled among Black Members between 2015-2018, from 18.6% to 36.2%.*** The gap in PPC visit rates between White and Black birthing families decreased by 40% during that time.
- The success of this program led our affiliate to an additional intervention, hiring licensed doulas from the Members' communities to further health equity efforts for this population in other neighborhoods. This successful program found that ***Members paired with doulas had 26.8% higher PPC rates than those without doulas.***
- The impact of the initial maternal health program has ***continued to improve over time with a 13% increase in prenatal care, 14% increase in PPC, and a 13% decrease in C-section rates*** among participating Members from Q1 2019 to Q4 2020.

d. Creative methods to engage difficult to reach populations or Members who are unresponsive to outreach efforts and/or participation in Care Management; and,

Creative Methods to Engage Members

Our multi-modal methods of Member engagement are ***high-touch and high tech***, with a continuum of strategies honoring varying preferences, learning styles, relationships, available resources, and needs. We deploy a range of engagement activities that meet the Members where they are and create a Member-centric, easy to navigate, and simplified Member experience. Employing our "journey mapping" perspective, engagement starts with our initial outreach and HRS where we first learn of and capture a Member's needs and preferences. We also utilize external data on ***communication preferences, socio-economic, demographic, and geographic indicators***, providing a ***360º view*** of each Member to customize engagement. Combined, we use all available information to tailor outreach and engagement for both content (e.g., smoking cessation materials for Members who smoke) and engagement method (e.g., texting for Members with a cell phone).

Figure 4.2.2.3.A.1.d Multi-Modal Member Engagement Model



Our Member engagement model, depicted in **Figure 4.2.2.3.A.1.d**, encompasses a ***multi-channel approach*** that integrates Member preferences for communication options and accounts for their current health status. Our high-touch, high-tech strategies described below are based on best practices in successfully engaging challenging to reach Members and Members who are unresponsive or resistant to participation in CM.

High-Touch Member Engagement Methods. We are committed to a high-touch Member engagement approach that includes virtual and in-person outreach by our local, regionally based, and culturally adept CM team that meets Members where they live, work and play. As part of our approach, we will partner with State

Agencies such as Child Protective Services, the Mississippi Department of Health, DOM's Perinatal High-Risk Management/Infant Services System, and WIC supplemental food program. We will collaborate and expand engagement efforts with trusted community-based organizations (CBO), including faith-based organizations such as Catholic Charities, Galloway Methodist Church, and But God Ministries; and other CBOs, including Crisis Pregnancy Center and the Diaper Bank of the Delta. We will collaborate with homeless shelters to assist us with case finding, Member outreach, education, and support.

Additionally, as part of our high-touch Member engagement model, we will ***offer every new Member the option of an in-home New Member Welcome Visit within the first 90 days of enrollment.*** The goal of the high touch home visit is to bring services to the new Member who may not know how to navigate the health care system. We will bring the health care system to them to reduce any possible disparities that could emerge. The visit will assess the Member's whole health, including SDOH, ensure the Member is assigned a PCP/PCMH, and provide education on accessing care and services. Additionally, the home visit will be used to engage the member in CM activities, complete screenings and assessments, address health literacy, and facilitate access to services and appropriate programs and interventions.

Our CHWs will help lead Member engagement efforts that include physically locating Members and personally engaging them in services, peer-to-peer coaching, care coordination, and care gap closure outreach. For example, for difficult-to-reach Members, such as those without telephones or with unstable housing or Members who are unresponsive to outreach efforts, our CM staff will be available to meet Members in their homes, at work, or in the community. We will use creative methods, including developing relationships with local police and fire chiefs who can assist us with locating difficult-to-reach Members. We will also host and participate in outreach events to find and engage with hard-to-reach Members. For example, we will support and partner with Shower Power to provide health screenings and mobile hygiene trailer service to assist individuals experiencing homelessness with personal hygiene needs. We aim to conduct targeted outreach and engage our Members who use these services through this partnership.

For Members without telephone access, we will connect Members to and educate them about the Federal SafeLink program, which offers Members with limited or no phone access a free smartphone. In addition, for those who qualify, we will provide members with expanded benefits of up to 1GB per month beyond their SafeLink allowance. Through this expanded mobile phone access program, we will also offer pre-programmed cell phones to Members or their parents/authorized representatives for those engaged in CM who lack reliable phone access. Additionally, our CHWs will work with the Member to pre-program their phone to include numbers for their Care Manager, PCP or PCMH, ICT, Nurse Advice Line, BH/SUD Crisis Line, and other Member supports. We will also work with PCPs, PCMHs, and pharmacy Providers, who may have more up-to-date contact information, or an upcoming appointment or medication fill we can leverage to meet our Members in the community.

Members who are Unresponsive to Participation in CM. Our CM staff, trained in cultural sensitivity and unconscious bias, will use evidence-based practices such as Motivational Interviewing (MI), Trauma-Informed Care (TIC), Person-Centered Care Planning, and the Strengths-Based Model to engage with Members who may be unresponsive to participation in CM. CM staff will meet Members and families where they are by targeting information and interventions to the Member's willingness to engage, level of health literacy, degree of trauma, disparities endured, and cultural preferences.

We will offer a broad array of CM programs that include trusted messengers and peers with lived experiences that have proven effective in engaging individuals who may be unresponsive or resistant to participation in CM. From experience serving Medicaid and CHIP populations, we know that some Members do not trust the system or health plans. In response, we often start with linking Members to social services and supports as an effective method to build trust and openness to engaging in CM. Below is a description of a program we will offer to engage Members who may be hesitant to participate in CM due to the fear of stigma.

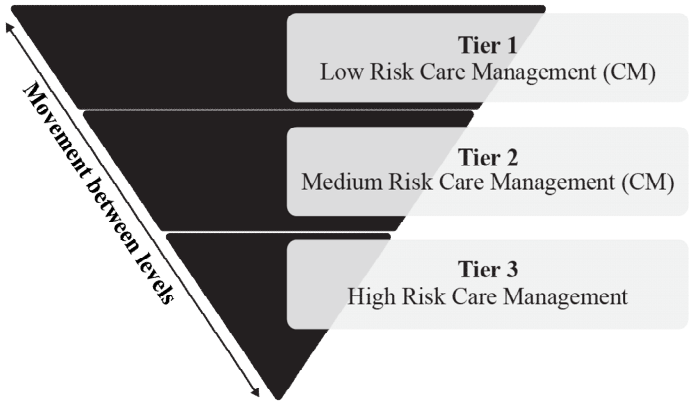
Our ***Perinatal SUD Management program educates and connects pregnant Members with SUD without the fear of stigma*** to appropriate Providers and community resources. We engage Members through ***tailored, personal support***, resources, and education to increase positive outcomes for newborns and to help mothers achieve and maintain the best possible quality of life. Our Care Managers with specialized training in addiction and mental health care, use MI to engage Members in treatment and facilitate behavioral change in partnership with the Member's treating Providers and Integrated Care Team. We will also offer ***Mindoula's Substance Exposed Pregnancy Program,*** a peer support care community that helps Members develop coping mechanisms, build resiliency, access appropriate medication from the right in-network Providers, and address SDOH prior to birth and the critical postpartum stages, without fear of stigma. The program helps opioid and other substance-dependent pregnant women safely stabilize their medications and SDOH prior to birth. Each Member has a Clinical Team that includes a Psychotherapist, ***Certified Peer Recovery Specialist,*** Resource Advocate, and Nurse Educator, which collaborates with the Member's Care Manager and OB/GYN and other Providers to ensure effective Member engagement and coordinated care.

High-Tech Member Engagement Methods. As displayed in the figure above, our multi-faceted digital health management methods (i.e., HIPPA compliant Virtual CM, Digital CM, telemedicine/telemonitoring; texting, social media, and mobile apps) aim to provide a seamless, integrated Member experience. Our tools facilitate Member engagement in the care planning process and communication with the Member and their circle of support, Providers, and others involved in the Member's care. We utilize these platforms to proactively outreach to Members and help drive deeper Member engagement, self-care, and ease of timely completion of assessments and build trust. Members can also receive targeted health education and appointment reminders.

e. The Care Management services the Offeror expects to provide by risk level (e.g., low, medium, high).

Our CM Model is built upon the tenets of achieving health equity and population health and includes three tiers of CM*,* supported by transition of care, discharge planning, and other clinical and social programs targeted to meet the unique needs of special populations. We will assign all Members into one of three Risk Levels for CM.

- **Tier 1: Low-Risk Care Management** is focused on low-risk Members, including healthy children and adults, and provides programs to encourage Member engagement with health promotion and primary prevention activities.
- **Tier 2: Medium Risk Care Management** is focused on Members with ***rising risk*** that require Care Management services and supports to meet their clinical, BH, and SDOH needs.
- **Tier 3: High-Risk Care Management** is focused on addressing the needs of Members with complex physical, BH and/or SDOH needs that require a higher level of staff expertise, intensity, and interventions. This intensive CM tier for high-risk Members aligns with NCQA's Complex Care Management standards and DOM's requirements.



All Members have access to CM, including transition of care and discharge planning. Our CM program accommodates the different levels of care needs exhibited by Members, providing the most appropriate level of CM services for each individual at a specific point in time. Member Risk Level information will be shared and communicated to the State, the Member, the Member's PCP/PCMH, and made available through our Member, Provider, and Community Partner Portals.

Engagement in Tier 1: Low-Risk Care Management. Our model is designed to systematically monitor and support all Members in our CCO. Those identified as healthy or with fewer intensive needs will be assigned to Tier 1, where they will receive tailored health education and access to a variety of population health programs and resources to maintain health and wellness and receive timely preventive care. Members will be assigned to the CCO CM Team and provided with a single point of contact that they can easily access by calling our Member Services toll-free line. Members will be educated on available tools, such as our digital tools, to help them take an active role in improving their health. As care gaps or need for preventive services are identified, a member of the CCO CM team will proactively outreach to the Member to schedule preventive visits and follows up to ensure services are rendered.

Engagement in Tier 2: Medium-Risk and Tier 3: High-Risk Case Management. Members identified as being Medium or High-Risk Levels will be assigned a Care Manager responsible for reaching out to engage them in services. Within 30 days of a Member's consent to enroll in CM, the Care Manager will make contact to complete the CHA. We will make every attempt to reach and engage Members, including telephonic and digital or in-person engagement attempts for those Members who are difficult to engage. CHAs can be completed either telephonically or in person, honoring Member preferences. Care Managers will be trained to identify scenarios and situations when in-person assessments may be appropriate, such as Members with rising or high risk where telephonic outreach has been unsuccessful. Additionally, Members identified as Medium or High Risk will be encouraged to select a PCMH as their PCP.

The Care Manager will work with the Member and the Member's ICT to understand the Member's whole-person needs and to develop a care plan within 30 days of CM Level Assignment for Members who are Medium Risk and within 7 to 14 days for Members who are High Risk. The member's care plan process is driven by aligning their self-identified needs and preferences to appropriate services and interventions based on assessed needs. The care plan is shared with the Member, their Provider(s), and other ICT members.

The Care Manager uses evidence-based practices, such as Motivational Interviewing, Trauma-Informed Care, Person-Centered Care Planning, and the Strengths-Based Model, to foster Members' self-direction through helping them identify and articulate their own goals and preferences. CM staff will "meet Members where they are" to maximize our ability to engage them in care and tailor our interventions for each Member's needs. This also means meeting Members wherever they are in their community settings and targeting information and interventions to their willingness to engage, levels of health literacy, and other factors that affect participation in their care.

The Care Manager monitors the care plan regularly, at least every 30 days, to ensure the Member receives services as outlined and addresses any change in status or care gaps in collaboration with the Member's PCP. CM staff will monitor clinical data at every contact and conduct assessments to determine Member needs, barriers, and progress, updating the care plan as appropriate. For example, if a Member is not taking medications as prescribed, the CM may incorporate medication therapy management into their care plan. Or, if a Member's housing becomes unstable, we will work with the Member to identify a stable residence and include housing supports. Supplementing this hands-on approach, Care Managers use predictive models as a systematic method of assessment to drive the next best action for each Member. For example, our Schizophrenia Inpatient Model utilizes schizophrenia-related claims data to identify Members with increased risk of relapse, such as failure to fill medication prescriptions.

Overview of Care Management Services by Risk Level

A Member's Risk Level for CM drives the intensity, frequency, and type of CM services and activities to best support the Member and their holistic needs. We have established activities, including assessments, interventions, and person-centered planning strategies, assuring each Member is offered CM supports that fit their individual needs. Consistent with our person-centered approach, we honor each Member's preferences for engagement in CM. For example, if requested by the Member or the Member's parent or legal guardian, the frequency and/or method of engagement may be increased, reduced, substituted, or declined. Summarized below are CM services, minimum contact schedules, and sample Care Management programs by Risk Level.

Tier 1: Low-Risk Level	
Member Profile	Healthy adults and children; individuals with less intensive needs.
Method/Frequency of Contact	Based on Member need, but at least annual telephone contact or more frequently upon a change in condition or Member status change
CM Services *(offered to all Members)*	• Initial and annual HRS; SDOH mini screen at every Member contact • Member outreach, education, and engagement, including providing information about the availability of services • Closed-loop referrals to community resources and supports • Care coordination services, including assistance with accessing services, appointment scheduling • Discharge planning and follow up care post inpatient and PRTF discharge

	• Coordinating transitions of care across settings and levels of care and from other CCOs or fee-for-service (FFS), including scheduling follow up appointments and arranging for DME or other supplies • Information and referral services, including referrals and follow up to health and social programs • Monitoring and follow up with Members and Providers • Health promotion and wellness activities and outreach • Self-care management and self-direction supports and services • Care gap closures • Access to Call Center – Member Services
CM Program Examples	• Preventive care campaigns (e.g., flu prevention, mammograms, and dental screenings) • Obesity Program • Healthy Lifestyle programs • Transition of Care Program • Lead Screening CM Program • Tobacco Cessation • Medication review and medication reconciliation • Infant program promoting safe sleep
Tier 2: Medium-Risk Level	
Member Profile	Members with chronic conditions or co-morbidities that are moderately managed; Members with mood disorders; anxiety disorders and all other BH disorders. Members being discharged from an acute inpatient psychiatric stay or PRTF. Members with frequent ED utilization.
Method/Frequency of Contact	Based on Member need and preference, but at least monthly telephonic or face-to-face contact
CM Services	All Care Management services included in the Low-Risk Level, ***and***: • Comprehensive Health Assessments and supplemental assessments • Integrated Care Team meetings and case conferences • Person-centered care plan development • Monitoring, evaluation including progress against care plan goals • Relapse prevention plans for Members with SUD, depression, or other high-risk BH conditions • Medication adherence tools and education • Ongoing monitoring and evaluation of risk factors, BH conditions, rising risk, and unmet needs • Assignment to PCMH as the Member's PCP
CM Program Examples	• Depression, Diabetes, Asthma/COPD, and other DM Programs • Health Coaching and Peer support services • ED diversion program • Readmission reduction program • Care Kits • NICU CM Program
Tier 3: High-Risk Level	
Member Profile	Members with severe and persistent MH conditions; SUD; childhood psychiatric disorders; foster care children; infants and toddlers with an established risk for developmental delays; pregnant Members; Members with persistent and/or preventable inpatient admissions; Members who have high costs; socially complex Members with serious SDOH challenges and Members with diabetes, asthma, cardiovascular diseases, chronic kidney disease, and sickle cell disease.
Method/Frequency of Contact	Based on Member need and preference, but at least weekly to monthly telephonic or face-to-face contact
CM Services	All Care Management services included in the Low-Risk and Medium Level, ***and***: • Interdisciplinary Care/Treatment Team meetings and case conferences to assist with the development of medical treatment plans • Facilitate group visits to support self-care management if SUD, BH and chronic conditions • Information and referrals on community resources (i.e., certified diabetic educators, nutritional support, etc.)
CM Program Examples	• Sickle Cell Program • Behavioral Health Medication Management Program (BHMM) • Substance Exposed Pregnancy program

	• Collaborative Care BH Integration Model • CHF program • Maternal Health Programs

All CM activities, including Member contacts and notes about the interaction, will be documented in the Member's record in our Clinical Documentation System to ensure a seamless Member experience when multiple entities are involved. Reminder tasks are set in the Clinical Documentation System to prompt CM staff of the upcoming contact schedule, assessment due dates, and care plan updates, and track completion per the State's requirements.

4.2.2.3.B Stratification and Assignment

1. Describe the Offeror's proposed initial Health Risk Screening (HRS) for new Members, including questions, methods of seeking answers, and how answers will be used for stratification of Members based on acuity levels and Care Management.

Health Risk Screening (HRS)

We will utilize a standardized HRS to be approved by DOM to assess our members' PH and BH status and SDOH needs. Our HRS tool complies with NCQA standards and includes questions regarding Member demographics, communication preferences, PCMH Provider, current treatment, pregnancy, medication adherence, recent ED visits or inpatient services functional limitations, SDOH needs and non-medical risk factors and urgent issues or barriers to care. Included as **Attachment 4.2.2.3.B.1 Health Risk Screening** is a copy of our proposed HRS that adheres to the third-grade reading level requirement.

Results of HRS Used to stratify Members into CM Risk Level. We will use findings from the Member's HRS to assist us with stratifying the Member into the appropriate Risk Level for CM. Information obtained from the Member's HRS will be combined with other Member-level details such as claims, authorization, SDOH, Provider and Member referrals, eligibility, and demographic data, to stratify the Member into the appropriate CM Risk Level and match with CM interventions and programs to achieve individual health.

No Wrong Door Approach to Complete HRS. Through our national experience serving populations similar to individuals enrolled in MSCAN and CHIP, we have learned that successfully reaching Members to complete the HRS requires repeated attempts using multiple strategies that honor a Member's preferred mode of engagement and communication. We employ a "no wrong door" approach and leverage various methods to successfully engage the Member in completing their HRS and seeking answers to the questions in the HRS tool. CM staff are trained to engage Members in completing health screening and assessment tools through evidence-based methods, such as Engagement Skills Training, Motivational Interviewing, Trauma-Informed Care, and Person-Centered Thinking.

As part of our new Member onboarding process, we will attempt to complete the initial HRS within 30 calendar days of enrollment into the plan and within 90 calendar days for all Members upon contract implementation. We will also complete the HRS within 30 calendar days from the date of a self-referral by a Member or a Provider's referral of a Member. Members can complete the HRS telephonically, in-person, virtually, electronically via the Member Portal or our mobile application or self-completion of the tool via mail. To encourage Members to complete the HRS, we will provide a $25 incentive for completing within 30 days through our Member Incentive Program. Additionally, as described above, as part of our high-touch Member engagement model, we will ***offer every new Member the option of an in-home New Member Welcome visit within the first 90 days of enrollment,*** where we will complete the initial HRS with the Member.

As part of our new Member welcome process, we will make at least three separate outreach attempts by telephone at varying times and days of the week. If we are unsuccessful, we will document all attempts and follow up with a letter with instructions and options for completing the HRS. Our HRS completion efforts are not limited to these formal attempts. We continuously identify opportunities to complete the initial HRS, including engaging Members that call into our Customer Service Center and haven't yet completed the HRS. We will also partner with our Providers, including PCPs and PCMHs, and community-based organizations (CBOs) as trusted partners for Members to assist with completing the HRS.

Difficult-to-Engage Members. For difficult-to-engage Members, such as those without telephones or with unstable housing, our field-based CHWs will be available to meet Members in their homes, at work, or in the

community. We will establish relationships with Providers and partners in local communities across the State, such as Child Protective Services, Head Starts, faith-based organizations, and homeless shelters as ***trusted messengers*** to assist us with Member outreach and engagement to complete the HRS. We will also work with PCPs/PCMHs and pharmacy Providers. They may have more up-to-date contact information or an upcoming appointment or medication fill we can leverage to meet our Members in the community.

2. Describe the Offeror's proposed method(s) for the Comprehensive Health Assessment (CHA) of Members requiring a CHA after the initial Health Risk Screening, including questions, methods for seeking answers, and how answers will be used for stratification of members based on acuity levels and Care Management.

Comprehensive Health Assessment (CHA)

As an integral part of our CM process, we will complete a CHA and supplemental or disease specific assessments, for Members identified that may benefit CM and/or when a Member's HRS answers and findings indicate that the Member's risk level may be Medium or High. The evidence-based CHA is used to:

- Identify a Member's PH, BH, functional, psychological, and SDOH needs
- Identify a Member's potential or existing health care needs and any ongoing conditions that require a course of treatment or regular care monitoring
- Confirm and/or stratify the Member into the appropriate CM Risk Level
- Understand the Member's self-identified goals, desired outcomes, and preferences
- Determine the types of services needed by the Member, including referrals to Providers, State agencies, community-based organizations
- Identify immediate care needs and accessibility requirements
- Inform the development of the Member's care plan/treatment plan

Our CHA includes specific questions that cover the following key domains:

Comprehensive Health Assessment Key Domains	
Demographic information, including race, ethnicity, education, employment status, the Member's preferred language and mode of communications, and cognition	Member's goals and preferences and readiness for change
SDOH needs and non-medical risk factors	Risk assessment, including suicide risk
Health literacy	Sexual Orientation and Gender Identity
Medical and other health conditions, including chronic diseases and prenatal screening	Support system, family and community resources, and home assessments
Indirect supports and caregivers	Current Providers
Recent treatment history	Current medications
ADLs and IADLs	Exposure to ACES or trauma
Current and past mental health and substance use status and/or disorders	Life planning activity- including obtaining information on advanced directives
Quality of life	Behavioral health, including SUD
Environmental Assessment	Safety Assessment

A copy of our proposed CHA tool is included as **Attachment 4.2.2.3.B.2**. The CHA also identifies barriers such as a lack of support system, financial barriers, safety issues, cultural or linguistic challenges, and physical, mental, or cognitive disabilities and evaluates the need for social supports and community resources to improve health and living circumstances. Care Managers will also complete condition-specific supplemental assessments (e.g., sickle cell, diabetes, asthma) and BH screenings (e.g., Edinburgh, PHQ-9, GAD-7) for each identified condition, as appropriate.

Methods for Seeking Answers to the CHA. Our CM team will attempt to complete a CHA within 30 calendar days from the completion of their HRS for Members that are identified as Medium or High Risk, within 30 calendar days after we receive information from any source that a Member's acuity level may have changed, and immediately following a HRS that identifies a Member with a potentially high-risk chronic condition, a Member with a potential BH condition, or a Member who is pregnant. CHAs are tailored to specific populations such as pediatric, adult, and maternal.

To facilitate the completion of the CHA, our CM staff will work with Members and their authorized representatives to schedule a convenient time and location for conducting the assessment. To ensure a seamless process, we attempt to schedule the assessment while we complete the HRS if we know that a Member is Medium or High Risk (i.e., foster care child or youth, Member who is pregnant, etc.). Our CM Team staffing

model includes field-based staff located in communities and regions across the State, who are available to conduct the CHA face-to-face in the Member's home, community setting, residential care setting, or hospital while honoring the preference of the Member. Care Managers will be trained and have access to policies to identify scenarios when a home-based assessment may be appropriate, such as Members that are homebound, Members with significant social and BH needs, and foster care children and youth.

In alignment with the fundamental principles of our CM model, care planning is person-centered, trauma-informed, and strengths-based to empower Members' engagement in their care. Care Managers begin their collaborative relationship with Members and their chosen team, including their Providers, community agencies, and their caregiver/parent via a whole-person assessment and supplemental assessments. Conducted more like a conversation than an interview, these conversations allow their PH, BH, and social needs to be identified and included in the Member goals and intervention plans. The Care Manager, who supports the plan's development, will assist the Member and caregiver/parent with self-identifying their desired outcomes and goals, strategies for accomplishing those goals, and overcoming identified barriers. Care Managers will use various tools to capture a Member's desired outcomes, goals, and preferences, ensuring their needs are addressed as part of the person-centered care assessment and care plan development process. This approach allows Members to identify what is important to them, aligning treatment goals, disease management interventions, and services tailored to their preferences, ultimately encouraging engagement by using motivational interviewing skills and ensuring access to timely services.

Care Managers will leverage the ***Patient Activation Measure (PAM)*** to assess Member activation readiness and capacity for/motivation to self-manage care. Our Care Managers will tailor their engagement methods based on the PAM outcomes and select the health literacy resources and person-centered planning tools best suited to support Members and caregivers through the care plan development process. For example, Care Managers can use our suite of ***Person-Centered Thinking (PCT) and Planning*** tools to capture the Member's desired outcomes and goals/interventions to ensure their person-centered care plan identifies their strengths and needs.

As part of the assessment process, the Care Manager will contact the Member's PCP, PCMH, BH, or OB/GYN Provider to obtain additional clinical information, as appropriate. Supplemental assessments are incorporated to inform interventions and the development of care plans tailored to each individual. These include, but are not limited to condition-specific assessments (e.g., sickle cell, diabetes, asthma); screenings for COVID-19, tobacco/gaming, emergency preparedness, SDOH screenings; Adverse Childhood Experiences (ACEs) as appropriate; and BH screenings (e.g., Edinburgh, PHQ-9, GAD-7).

Results of CHA Used to stratify Members into CM Risk Level. We will use the results and findings from the CHA to further stratify and/or confirm the Member stratification to the appropriate CM risk level. We will also use the results of the CHA, and supplemental assessments, to inform the development of the Member's care plan and provide interventions and services to address assessed and identified needs.

Sharing of Assessment Information. All screening and assessment information will be documented in our Clinical Documentation System. This information will be used to develop and update the care plan and confirm appropriate Risk Level based on additional clinical and social factors identified. Members or their authorized representative/caregivers can access their assessment results and care plan and track their own progress through our secure Member Portal. Our CM team will ensure a seamless and coordinated Member experience and non-duplication of efforts by sharing assessment (including HRS and CHA data) and care plan information with the Member's PCP or PCMH and other treating Providers via secure access to our Provider Portal. We will also share and exchange health information during regular case conferences and ICT meetings.

3. Describe the Offeror's proposed method(s) for reassessment of Members during the life of their enrollment with the Offeror in order to accurately assess that Members are assigned to the correct acuity level. In addition to an overview of the proposed method(s), the Offeror should include how often Members are reassessed; whether reassessment is ad hoc, systematic, or both; and why the Offeror would utilize this timeframe for reassessment.

Reassessments

Our proposed method for reassessment is based on our experience serving Medicaid and CHIP populations in other markets across the country. We will reassess a Member's needs at least annually; upon a significant change in condition or status, such as an inpatient admission, or upon Provider and/or Member request. Needs

are re-assessed during each visit or telephonic contact, and we work with the Member to revise the care plan to include any new goals, interventions, or authorized services. The Care Manager will monitor the care plan regularly to ensure the Member receives services and addresses change in status or care gaps in collaboration with the Member's ICT. CM staff will review clinical data at every contact and conduct assessments to determine ongoing Member needs, barriers, and progress, updating the person-centered care plan as appropriate.

Our CM activities and Member engagement methods are intentional based on CM Risk Level and the acuity of the individual Members as outlined in **Table 4.2.2.3.B.3** below. We have established activities, including frequency and timelines for conducting assessments and reassessments and updating care plans by CM Risk Level. Consistent with our person-centered approach, we will honor each Member's preferences for engagement in Care Management. For example, if requested by the Member, the frequency and/or method of engagement (including assessments and reassessments) may be increased, reduced, substituted, or declined.

Table 4.2.2.3.B.3 Assessments and Reassessments by Risk Level for CM

	Tier 1: Low	Tier 2: Medium	Tier 3: High
Contact Frequency	• At least quarterly as part of preventive care outreach and care gap closure activities	• In-person or telephonic contact (at least monthly) • Quarterly ICT meetings	• In-person contact (at least monthly but may be more frequent based on individual Member need)
Assessments, Reassessments and Care Plan Updates	• Initial HRS within 30 days of enrollment • Annual in-person assessments or upon a change in condition or status	• Initial HRS within 30 days of enrollment • CHA, including home environment and SDOH needs • At least quarterly reassessments/care plan updates	• Initial HRS within 30 days of enrollment • CHA, including home environment and SDOH needs • At least monthly reassessments/care plan updates

4. Describe any other methods the Offeror uses to identify Member acuity levels for assignment and Care Management, including the use of software or other tools.

Methods and Tools to Identify Individuals Who Can Potentially Benefit from CM

We use several tools that include eligibility and enrollment data; screenings and assessments; current and historical claims, authorizations, and utilization trends; State, staff, Provider, and Member self-referrals; and case management reports to identify Member acuity levels for assignment and CM. **Figure 4.2.2.3.B.4** and **Table 4.2.2.3.4** details a description of tools and how the information will be used to identify Members.

Figure 4.2.2.3.B.4 CM Model

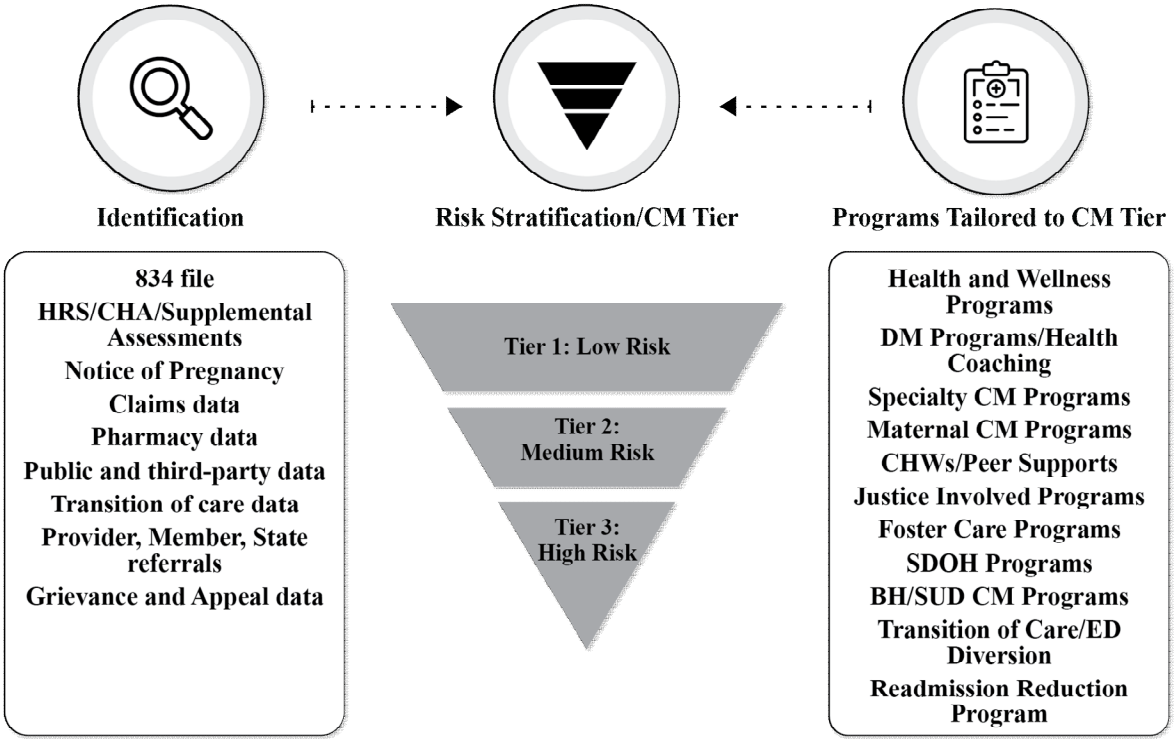


Table 4.2.2.3.B.4 Specific Tools for Identification and Engagement in Care Management

Tools	Description and How We Will Use It
834 File	We use the 834 file to proactively identify Members with specific eligibility code indicators, such as indicator for foster care.
HRS and CHA	We use the HRS and CHA to identify Member's PH, BH, and SDOH needs. Results are scored and used to stratify Members into the appropriate CM Tier. We also conduct age or condition-specific Comprehensive Health Assessment/supplemental assessments.
Stratification Tool Supported by our Algorithms and Data Analytics	Our Stratification Tool synthesizes and analyzes various data inputs to build a comprehensive risk profile for Members. The risk profile allows us to identify and prioritize Members that may benefit from care management services using our proprietary algorithms and advanced predictive analytics. Data inputs include, but are not limited to, the following: • Member demographics, including eligibility and enrollment information • Claims data (Medical, BH, Vision, Pharmacy) and laboratory data and results if available • Electronic Health Records (EHR) feeds, when available • Admissions, Discharges, and Transfer (ADT) feeds • Utilization Management data (e.g., authorization data, concurrent review data) • CM program data, including screenings and assessments, SDOH Mini-Screens, Notice of Pregnancy (NOP) forms and care plans • SDOH data via Z Codes • Historical FFS data from the State and/or transition data from other CCOs
Public and Third-Party Data	We use public and third-party data that includes over 140 data elements from sources such as the CDC Social Vulnerability Index, American Community Survey, Public Health Registries, CDC Chronic Disease Indicators, CDC National Environment Public Health Tracking, Public Safety Reports, USDA Food Atlas, and CDC Behavioral Risk Factor Surveillance System. These data sources create a 360-degree risk profile for each Member indicative of the level and type of CM resources needed.
State, Provider, Member, and Community Referrals	We consider referrals for engagement in Care Management from Members, Member's families; Providers, trusted messengers, community agencies, the judicial system, and State agencies. Our Provider Portal also allows users to make a referral to case management.

Ongoing Systematic Monitoring and Risk Stratification

We will repeat our risk stratification process weekly for our entire population to identify changes in severity or acuity as well as emerging or risking risk. As Members' risk, acuity, needs, and preferences change, they are reassigned to the most appropriate CM Risk Levels. Our approach relies on information we directly learn or validate from our Members. We use leading indicators, such as ADT data received from our network hospitals, to re-stratify Members and ensure we are continuously providing the most effective level of care and support.

We do not stop at stratifying Members based on current assessments and circumstances. Once a Member has been stratified into a CM Risk Tier, we use predictive modeling tools to systematically monitor our Members and identify Members at current or future risk. Our Reporting and Analytics Tool examines large data sets daily, providing a comprehensive array of targeted clinical indicators of future PH, BH, social health, and financial risk and disparities. Our Reporting and Analytics Tool leverages machine learning to detect changes to a Member's condition, re-stratifying as we receive the updated information.

Predictive Modeling Tools. We use predictive modeling to systematically monitor and continuously identify Members at current or future risk. Our predictive analytic models will supply our CM teams and Providers with actionable, forward-thinking Member-centric data to guide decisions and ensure appropriate management of resources. We will monitor clinical information and conduct assessments to evaluate Member needs and progress, using predictive models as a tool to determine the next best action for each Member.

platform. This platform will provide us with cutting-edge technology to drive dramatic improvements in birth outcomes. The platform's enhanced pregnancy identification and risk stratification will help us detect at-risk pregnancies sooner, prevent preterm births, and reduce racial disparities. The maternity analytics platform uses AI-based algorithms to scrub data for more than 3,000 early pregnancy identifiers to detect pregnancies earlier and uncover more data about moms and babies at risk. The platform currently identifies 98% of moms before delivery and 70% in the first trimester. Identifying these moms earlier allows for critical first-trimester prenatal visits, builds more solid doctor-patient relationships, and improves the chances of receiving quality care throughout their pregnancy. ***Use of the platform has shown a 19% reduction in unnecessary C-sections, 10% reduction in preterm birth, and 9% reduction in NICU use***.

5. Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other non-medical risk factors into the HRS and CHA.

Assessment for SDOH, Health Equity Evaluations, and Non-Medical Risk Factors

Our Member-centric assessment tools and processes consider SDOH and health equity data to gain a comprehensive picture of the Member's whole person needs and strengths. For example, our HRS and CHA include standardized questions that routinely assess for SDOH and social risk factors such as educational level, employment status, housing insecurity, access to basic utilities, food insecurity, transportation needs, home environment, safety, trauma, adverse childhood experiences and other risk factors that may impact a Member's health. Examples of questions in our HRS and CHA that assess for SDOH are:

- Do you currently have concerns about having enough money to pay for your basic needs?
- Within the past 12 months, did you worry that your food would run out before you got money to buy more?
- In the past two months, have you lived in stable housing that you own, rent, or stay in as part of a household?
- Do you have any concerns about your home's environment? Are there any hazards that concern you? (Examples include: no heat, no water, unsafe staircase, etc.)
- Do you always feel safe in your home and around all the people in your life?
- Do you ever have any problems with transportation to your medical appointments?

Our tools include questions on RELD (Race, Ethnicity, Language and Disability) information and SOGI (Sexual Orientation and Gender Identity) information to gather information to address health inequities. We

also assess for health literacy in our CHA. We use health equity information obtained from our assessment process and other data sources to identify and address health care inequities and disparities at an individual Member and program level. A few sample questions from our CHA include:

- Do you ever have difficulty understanding what your doctor or health care Provider explains to you about an illness, medical condition, and/or treatment?
- How often do you need to have someone help you when you read instructions, pamphlets or other written material from your doctor or pharmacy, or when you need to fill out medical forms?

SDOH Mini-Screen. In addition to our standardized HRS and CHA tools, our SDOH Mini-Screen is a Member-centric tool we will use to identify changing SDOH needs rapidly. This six-question screen identifies needs such as food, housing, utilities, transportation, safety, employment, and social support. This ***screen can occur at any point in time***. It will allow our staff to identify needs the Member has prioritized and develop interventions to remove barriers that quickly drive the greatest impact. Members can complete the SDOH Mini-Screen on their secure Member Portal or any time they call into our Member Services Call Center. Paired with enrollment and claims data, the HRS, CHA and SDOH Mini-Screen tool helps identify Members with social needs and barriers to care, enabling CM staff to perform timely outreach to assess gaps and resource and target interventions appropriate to the Member.

We also incorporate SDOH-related measures, health equity evaluations, and non-medical risk factors in our risk stratification methodology and algorithms, which identify the appropriate CM Risk Tier and level of CM intensity and interventions. Data is stored uniformly in our Enterprise Data Warehouse and is used to stratify membership based on level of risk, thus allowing for greater insight into existing disparities and factors that may contribute to inequities.

4.2.2.3.C Care Management Services

1. Describe the Offeror's proposed policies, procedures, and processes to conduct outreach to ensure that Members receive all recommended preventive and medically necessary follow-up treatment and medications. Describe how the Offeror's will notify Members and/or Providers when follow-up is due. Address the following issues in the response:

Member engagement is a key component of population health, and our multi-model approach ensures Members have access to information about how and when to access care and services. As illustrated in our Member Engagement Model depicted in **Figure 4.2.2.3.A.1d** above, we meet Members where they are, using a variety of outreach methods (e.g., home visits, community events, texting, social media, trusted messengers) to promote health literacy, health equity, and ensure timely provision of services. Critical to this effort is addressing SDOH, for example, supplying Members who are homeless or at high risk with smartphones to access telehealth services and connect with Providers, Care Managers, our 24/7 Nurse Advice Line and BH/SUD Crisis line. We are also aware of the impact of culture on health, including the role of fear, embarrassment, and lack of motivation in seeking health care. Herein we describe our proposed policies, procedures, and processes for outreach in Mississippi based on proven models and methods in similar markets.

a. Facilitation and monitoring of Member compliance with treatment plans;

Promoting Compliance with Treatment Plans and Follow Up Care

A core function of our CM model is the facilitation and monitoring of treatment plan compliance and progress toward plan goals using a high-touch and high-tech approach. As part of this work, we will have Mississippi-specific policies and procedures and job aides with roles and responsibilities aligned to Contract requirements and best practices to support Member outcomes. Care Managers will jointly develop a care plan with Members and their designated Providers and supports, monitor the plan through frequent outreach, and ensure compliance through direct engagement, including post-visit phone calls and follow-up. Method and frequency of Care Manager engagement is based on Member need, and staff will leverage our clinical documentation system to set tasks for follow-up. For example, we will have processes in place to call pregnant Members with upcoming appointments to facilitate timely access to prenatal care. Care Managers will also conduct home visits for at-risk Members overdue for services that we cannot reach by phone or for Members whose cognitive or BH issues require more intensive support in understanding the importance of receiving care for their health condition.

High Touch Support. CM staff will ensure compliance with care and treatment plans through culturally appropriate Member education and training in self-management and adherence; Provider engagement and

coordination; appointment, transportation, and interpreter scheduling assistance; phone or text reminders; post-appointment follow-up calls; and addressing SDOH barriers. For example, in an affiliate health plan, a Member with COVID-19 had no access to food. Our ***Community Health Worker (CHW)*** went to the local food bank on the Member's behalf and delivered the food along with toilet paper and tissues directly to the Member's home. CM staff will be trained in best-practice techniques such as ***Motivational Interviewing, Trauma-Informed Care, ACEs, Crisis Response, and Cultural and Poverty Sensitivity*** to educate, encourage, and empower Members to manage their care and maintain compliance actively. In coordination with CM, our Child Health Coordinators will call non-compliant Members a month before service due dates to remind them of services due and offer scheduling assistance, including arranging transportation. This includes options for same-day transportation as needed. Staff will call Members on different days and times, including Saturdays. They will also call to verify that appointments are completed, reschedule missed appointments, and problem-solve to address barriers. Automated phone reminders will alert Members due for preventive screenings and immunizations within the next two months and reminders about getting COVID-19 vaccines and flu shots. To address missed appointments, we will receive a no-show list from our transportation vendor, and all Providers will be encouraged to call us when Members miss appointments so we can follow up with the Member to address any SDOH. We will support caregivers in helping to facilitate Member compliance through our ***caregiver partnership program***. As an example of a tool to help caregivers, we provide a caregiver journal to stay organized and keep track of important information and daily routines such as medical history, medication list, contact information for PCPs and other Providers, emergency contact information, and allergies.

High Tech Support. Our HIPAA-compliant ***Digital CM program*** will empower Members to manage multiple chronic conditions, prevent complications, and take control of their health and wellness goals. The tool includes a personalized, interactive daily checklist with reminders, surveys, wellness articles, and tips. As Members engage with the app, data is shared in real-time with Care Managers for timely follow-up. We will use ***industry-leading health engagement software*** for facilitating electronic communication (i.e., email, SMS messages) in compliance with all Federal regulations and recognized best practices for email subscriptions and text message opt-ins. To evaluate impact, we can pull reports that review send volume, delivery rate, open rate, click-through rate, and unsubscribes. Through our secure Member and Provider Portals, Members and Providers will also have access to actionable information, such as health alerts and care gaps. Member Services and all other Member-facing staff have the same real-time access to care gaps that they see any time a Member calls in and will use our ***online appointment scheduling software*** to schedule needed appointments while the Member is on the line. Supporting Members with chronic conditions, we will offer ***remote patient monitoring***. For example, Medicaid Members enrolled in remote monitoring for diabetes in an affiliate plan experienced a 6% average decrease in glucose levels and a 15% reduction in ED visits compared to those not enrolled in the program.

Systematic Monitoring

CM and Quality staff will systematically monitor utilization and outcomes to identify outreach opportunities and push information to Providers. For example, using systematic CM reports, Members seen in the ED will receive outreach to understand the purpose of the visit and be informed of alternatives to the ED. They will also learn how to access our 24/7 Nurse Advice Line and help connect to reliable care through a medical home that meets their geographic, language, and scheduling needs. We will also receive timely alerts on ED utilization through ADT data feeds and no-show reports from our transportation vendor and share that information with Providers and PCMHs for appropriate follow-up care. In addition, CM staff will look for examples of data and reports that will be used to monitor compliance with ongoing care needs, and treatment plans including:

Utilization	Outcomes
• Service Usage (PCP, Specialist, Home Care, DME) • Days/1,000 (total, by product line, by service type) • Average Length of Stay (ALOS) • Admissions and Readmissions • NICU Rate and C-Section Rate • ED visits/1,000 and Outpatient Services/1,000 • Authorizations/1,000 by type • 7-day follow-up after hospitalization visits	• HEDIS measures • Predictive Modeling/Risk Stratification • Nurse advice line call reports • CAHPS Survey • Grievance/Appeals detail • Neonate and Very Low Birth Weight (VLBW) rate • Birth Outcomes, including gestational age • Care gaps

Our Reporting and Analytics Platform is a comprehensive family of integrated decision tools, and provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with drill down capabilities. Through our Reporting and Analytics Platform, we can report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, Performance Improvement Project informatics, and other critical aspects of operations. We will be able to drill down and stratify on all available demographics including geography, race, age, gender, and disability (RELD), ethnicity, and language. The platform includes a suite of industry-leading predictive modeling solutions incorporating evidence-based, care gap/health risk identification applications that identify and report significant health risks at population, Member, and Provider levels. Online care gap notifications through the Reporting and Analytics Platform allow Members and Providers to access actionable health information via our secure Member and Provider Portals. Additionally, using this platform we have the capability to create reports enabling us to identify quality of care concerns.

Notifying Members and Providers Follow Up is Due

We will notify Members when follow-up is due through CM engagement, phone outreach, and other methods as included in our Member Engagement Model and described above and below. For Providers, we will deliver actionable data and reports through the secure Provider Portal and during Provider visits and Joint Operating Committee (JOC) meetings. Through our Provider Portal, we will automatically alert PCPs of EPSDT schedules, care gaps, and required screenings for every Member on their panel, including developmental, vision, hearing, and dental screenings that are due. Care gaps are also displayed on our Provider Portal via a pop-up when a Provider checks eligibility. Care Managers will alert Providers of Members overdue for preventive or follow-up services for chronic conditions by phone and via the Portal. We will conduct peer-to-peer outreach based on identified trends, such as high ED use or opioid prescribing. Our Quality Practice Advisors will go onsite to Provider offices to educate on closing care gaps, leveraging our Provider analytic tools. Provider incentives to promote Provider monitoring and compliance include quality incentives for closing care gaps and non-financial incentives such as streamlined prior authorization for high performers.

b. Partnerships of community-based partnerships and other state agencies; and

Partnering for Health

Collaboration and partnerships are critical to success. This includes using trusted messengers, such as Providers, community-based organizations (CBOs), and community influencers (e.g., barbers, religious leaders, elected officials) to deliver health and wellness information and encourage compliance. This also includes engaging with and understanding the services offered in the community today. For example, we have met with the Holmes County Community-Led Transportation Program, Mississippi Food Bank network, Diaper Bank of the Delta, Mississippi Shine, and Vigilant to partner to improve Member access to all needed services. We will also partner with local housing authorities to coordinate resident health fairs and after-school activities for children, work with schools to promote telehealth services and PCP/PCMH coordination and bring information directly to the community. As part of our Maternal Health and Child program, we will host community baby shower events across the State, collaborating with community agencies such as WIC, MS SIDS & Infant Safety Alliance, and Safe Sleep MS to deliver key prenatal and postpartum education and services. We will also partner with schools and Boys and Girls Clubs to provide onsite support, deliver health information, connect youth with a PCP/PCMH, and leverage Mississippi's Community Action Agencies to identify and address local needs in each region. For example, we will work with the Delta Pregnancy Alliance to connect Members to care and employment. Examples of State agency partnerships we will promote to ensure Members receive needed services include: Child Protective Services, Mississippi State Department of Health (MSDH), and the Perinatal High Risk Management/Infant Services System (PHRM/ISS). For example, we will work with MSDH to certify our staff on home lead level assessments and pay to certify our CHWs to perform car seat safety checks and installation.

Facilitating Communication with Community Partners. We will support communication and coordination with these entities by offering community partners role-based Portal access that maintains personal and protected information security and privacy. Users can check eligibility, current contact information, view risks, care gaps, care plans, up-to-date Member health record data (e.g., immunizations, pharmaceutical information)

upload key documentation and Member assessments, and create free text and structured notes.

c. Coordination with other Providers.

Provider Coordination, Collaboration, and Engagement

Central to our proposed approach, we will support Providers with Member outreach, engagement, and adherence through joint care planning, joint health events, case rounds, integrated care teams, technical and onsite support, and data at the point of care. For example, our Patient Analytics will help Providers identify and prioritize efforts based on clinical needs and opportunities and understand the next best action to improve health. With access to cost, utilization, and quality data, Providers can create custom selections and drill-downs with the ability to export data into their systems. Providers and staff can also gain insight into Member engagement and Provider loyalty. Engagement measures the Provider's efficacy with engaging their assigned Members to be seen for a primary care visit annually, while loyalty measures the Provider's ongoing effort to maintain exclusivity as the PCP. Also available through the Provider Portal, Patient Analytics allows practice managers or Providers access to patient disease registries and critical information, including evidence-based care gaps, and identification of high-risk Members for outreach and engagement.

Our Provider incentives align with our Member incentives to promote quality of care, including proper delivery of recommended preventive and medically necessary follow-up treatment and medications. We will also offer enhanced data sharing capabilities through bi-directional data exchange with Providers' EHRs through multiple strategic partners. This will enhance our ability to address care gaps at the point of care, conduct efficient quality monitoring, and gather additional health information, including Member's social support needs. To help directly connect Members to services, we will work with Providers to offer services in the community through Medicaid-approved mobile units and provide financial and other support to help expand services, such as a proposed partnership with Plan A Mobile Clinic.

2. For Members with special needs, describe how the Offeror will ensure coordination of care across the care continuum and with state agencies. Describe how the Offeror will assist Members with special needs in identifying and gaining access to community resources that may provide services not covered.

Coordination of Care Across Systems and Disciplines

Coordination across the health and social continuum is at the crux of our integrated, whole person CM model. With all Members with special needs enrolled in CM, we will leverage our model and tools for coordination to ensure a holistic and collaborative approach. As part of our assessment and care planning process, we identify other entities and case managers involved in the care of the Member to ensure coordination of care and a seamless experience for the Member. An assessment of each Member's medical, BH, developmental, dental, vision, and social needs will serve as the basis of their shared care plan, including self-determined Member goals and specific services and interventions to meet those goals and remove any barriers. For example, for a child with BH needs, a care plan may include appropriate referrals for BH services, a plan for receiving all necessary EPSDT screenings and services; arrangements for any transportation and/or interpreter needs; a pathway for coordination with schools, including participation in or promotion of an Individual Education Plan (IEP); education and resources for family and caregivers; and connecting to SDOH resources, such as a food bank. If the Member were in foster care or adoption assistance, this would also involve timely communication with the CPS caseworker. Our CM staff will have access to experts across the health plan, including designated staff responsible for maintaining State agency relationships and helping to build SDOH capacity, as described in Section 4.2.3.3. A Care Manager serves as the primary point of contact but works with an ICT with representatives from across the care continuum. Including a team of internal (e.g., Medical Directors, BH clinicians, Social Service Specialists, pharmacists, dieticians) and external (e.g., PCPs/PCMHs, medical and BH Providers, caseworkers, schools, families, caregivers) experts working collectively to address holistic Member needs. The Member's Care Manager is responsible for facilitating information sharing, meetings, follow-up, and ongoing input across the ICT through phone calls, emails, in-person meetings, joint care conferences, and joint assessments. Our web portals, described below, support timely information including assessment results, Member progress and compliance with treatment plans and prescriptions, care plans, new or changed Member needs, including social needs, Provider recommendations, and utilization such as inpatient and ED services.

Communication Tools. Our web portals and coordination tools allow secure access to timely Member

information to authorized users, including treating Providers and external agencies on the ICT. For example, the Member Health Record, available on our secure Provider Portal, provides actionable information to allow Providers to view clinical history and current interventions on their Members as detailed in **Table 4.2.2.3.C.2.a**.

Table 4.2.2.3.C.2.a Member Health Record Features

Member Health Record Features	Description
Overview	Displays Member and PCP information, PCP history, eligibility history, completed EPSDT assessments, care gaps, allergies, and additional clinical information (e.g., recent ED visits, office visits, etc.).
Assessments	All Member assessments, as well as the Notification of Pregnancy (NOP), including completed assessments.
Health Record	Record of visits, medications prescribed to Members, immunizations received (e.g., Hepatitis, Influenza), labs (e.g., metabolic panel, CBC), and allergies (e.g., Codeine, Sulfa) for the Member.
Care Plan	Providers have access to a single care plan for monitoring treatment goals, objectives, milestone dates, and progress in a well-organized, online format. In addition, care plans are available in a consumer-friendly format on the secure Member Portal, further engaging Members in their care and treatment plans.
Authorizations	All processed prior authorization requests submitted within the last 90 days display the status, authorization ID, Member name, date range for services, diagnosis, authorization type, and service.
ADT Data	Displays if a Member has had an ADT event within the last 12 months, including details such as type of visit, facility name, and discharge disposition.
Referrals	Allows Providers to refer Members for Care Management services.

We will allow additional authorized users, such as State and community agencies, on the Member's ICT to share and access essential Member demographic and clinical information bi-directionally via role-based access to our portals. **Table 4.2.2.3.C.2.b** provides examples of our experience coordinating across systems of care.

Table 4.2.2.3.C.2.b - Examples of Coordination Across Systems and Disciplines

Members with Special Needs	External Coordination
Foster Care (FC) and Adoption Assistance	Our local FC Team will establish relationships with CPS caseworkers to ensure timely exchange of information and access to services. For example, we will collaborate with CPS caseworkers to identify Providers for 72-hour screenings and facilitate timely access to the screening for a child entering the foster care system. Our foster care dedicated Care Manager and CPS staff will jointly determine actions to be managed by each person and involve the CPS caseworker in all activities we engage in on behalf of the child. Activities include an assessment to collect placement history, trauma history, and the CPS service plan. We will share the care plan, utilization, and other monitoring information to support any reporting required by the courts and alert the caseworker to due or overdue services, such as EPSDT screens and follow-up services. For Members receiving adoption assistance, our FC Team will provide coordinated support such as educating the adoptive parents about the child's health care needs and care plan. We will also include an assessment of the family's needs and home environment to identify needs such as family counseling to address adjustment issues related to the adoption and non-Member children in the home who are overdue for immunizations, which could impact the Member's health.
Members Experiencing Homelessness	We will serve as a partner and stakeholder on coordinated entry through the State's continuums of care (COC) HMIS, a major innovation in data sharing in Mississippi. The HMIS offers a centralized referral process for chronically homeless Members. We will collaborate with the COC to engage in bidirectional data sharing with their HMIS. Our partnership will help Care Managers identify homeless and housing insecure Members and enhance both our and the COC's ability to identify needs and better coordinate and dispatch resources. An affiliate health plan used their state's HMIS as part of their housing program. After six months, the number of Members at our affiliate who were homeless decreased by more than 24%, and the rate of homelessness decreased by more than 8%.
Pregnant	For pregnant Members, our maternal health CM staff will coordinate with the PHRM/ISS Program to identify, refer, and coordinate care for those who meet program criteria. Our staff will contact the MSDH case manager to provide Member information (with appropriate consent) such as assessment results and determine roles and responsibilities.
Behavioral Health (BH)	For Members with serious BH conditions, our Care Managers will facilitate the integration of BH and medical services, including preventive services. The Care Manager will alert medical Providers of all BH medications the Member is prescribed and share any side effects or compliance issues with all Providers, including treating Providers from inpatient or ED utilization events for both PH and BH issues. CM staff will also coordinate with the Member's external case managers (as appropriate) or Department of Mental Health programs and staff to prevent service gaps or duplication.
School-Aged on IEP	During our initial and ongoing assessment and care planning processes, we will identify children for whom an Individualized Education Program (IEP) has been established or may benefit from establishing an IEP. The Care Manager will ensure ongoing interaction with the local school district to coordinate the IEP-required services and the care covered through our network of Providers to ensure services are coordinated and not duplicative. We may also refer parents/caregivers to community-based agencies to assist the school system and represent the parent at the IEP conference. If a Member does not have an IEP but would benefit, we will help the family work with the school to get an IEP, including coordinating with the Member's PCP. The goal is never to take over for the parent but to equip and empower them to ensure their child's needs are met.

Access to Community Resources. Supporting Members with special needs to maintain maximum functioning and wellness often requires additional assistance with community resources. CM staff will identify needs during our initial assessment and care planning processes and follow-up interactions, including administration of our

SDOH Mini Screen, input through Member Services and from family, informal supports, and Providers. Needs will be documented in the Member's care plan for regular monitoring and follow-up by CM. Our CM staff will still assist with identifying and coordinating with community resources by outreaching to the Provider/agency and making closed loop referrals. Members and caregivers will have access to our ***Community Resource Support Database*** where they can self-refer to community resources and receive appropriate follow up to ensure their needs were met. Our ***SDOH Help Line*** will be staffed with representatives to assist not just our Members but the needs of the community, and CHWs who reside in the community will provide in-home support.

3. Describe the Offeror's proposed process to ensure appropriate communication with the Provider, follow-up communication with the Members' PCP/PCMH, and follow-up care for the Member. Address the following in the response:

While Members are at the center of everything we do, Providers are a key contributor to the care planning process and successful implementation of the care plan. Recognizing the value of the Provider-patient relationship, we will invite Providers to participate in the ICT; provide access to the care plan, assessments, and easy-to-use, actionable information on their patient panel (via the secure Provider Portal); and solicit input and updates on Member progress and compliance with the care and treatment plan.

a. The Offeror's role and the PCP's/PCMH's role in this process;

Offeror Role in Provider Communication

Our role as the health plan is to equip Providers with timely information, support, and oversight to promote optimal health outcomes. This includes a range of activities, from timely and accurate claims payment to onsite CM or Quality staff available to outreach to patients and close care gaps. For our PCP and PCMH practices, we will provide the following information and communication regularly:

- Patient-specific clinical information via the Member Health Record is available on the Provider Portal
- Care plans, assessments, and care plan/assessment updates
- Data analytics and reporting tools that Providers can use to drill down to specific patients, diagnoses, or other variables
- Timely Admission, Discharge, and Transfer (ADT) feeds to notify Providers when their patients present or discharge from the hospital
- Standard and ad hoc reporting to help Providers prioritize outreach efforts, close care gaps, and promote success under value-based payment arrangements
- Provider administrative self-service capabilities (e.g., eligibility inquiry, authorization submission, claim submission /status inquiry, etc.) available through the Provider Portal
- Provider and office staff education about clinical practice guidelines and preventive health guidelines available through our website
- Obtain any needed physician orders, provide authorizations, and contact Provider offices at the Member's request to assist with scheduling appointments and ensure continuity of care

CM Support. Our CM staff is responsible for arranging and facilitating ICT meetings and other care planning activities and actively involving Providers throughout the process. For example, Care Managers will seek direct Provider input into the Member's care plan, keep Providers apprised of progress, and offer Provider support when Members are non-responsive or non-compliant. CM communication occurs in person and via phone, text, fax, secure e-mail, and through the Provider Portal. All CM staff will receive specific training on Provider communication and coordination requirements, and Clinical Auditors will review a sample of care plans monthly to verify documentation of the communication. CM staff will use a ***checklist of NCQA-required activities*** (CM elements), including Provider engagement. For Members transitioning between settings, Care Managers will engage the Member's PCP in transition planning, including notification of admission and discharge and scheduling appropriate post-hospitalization visits. Care Managers can also accompany high-risk Members to office visits to facilitate access and support communication with the Provider. Our Medical Directors will outreach to Providers on complex cases for peer-to-peer discussions.

Provider and Member Education. As part of Provider onboarding and ongoing education, we will train on contract requirements, including those related to communication and follow-up, such as the role of the PCP;

follow-up responsibilities for missed appointments; follow-up Member care; and cultural and disability competency. We will provide training within 30 days of the Provider's active status, through the Provider Manual, and ongoing as needed or requested, including weekly email blasts on updates, workshops, and ad-hoc training and webinars. Our Quality team will provide ***onsite support*** to help Providers improve quality outcomes. We will monitor compliance through medical record reviews, appropriate utilization and care gap reporting, and Care Manager oversight of the care plan for Members in CM. Providers identified as non-compliant receive additional training and monitoring, including a corrective action plan as appropriate. We will educate Members about the importance of follow-up care during Welcome Calls and through our Member Handbook, Call Center, and CM process, including our ***New Member Welcome Visit*** within 90 days of enrollment into the plan and our Transitions of Care program. For example, we stress the importance of the seven-day follow-up visit for inpatient BH utilization. We will support our Members through tools and resources such as a ***Personal Health Record Booklet*** that helps inpatient Members track information on medications and post-discharge care, including a checklist of what they need to know prior to discharge. To improve patient-Provider communications, we will train our Providers on evidence-based interventions, including the teach-back technique. We promote ***Ask Me 3®,*** intended to help patients better understand their health conditions, including what actions they need to take to stay healthy, asking three specific questions during Provider visits: 1) What is my main problem?; 2) What do I need to do?; 3) Why is it important to me?

PCP/PCMH Role in Care Management Communication

As highlighted below, we expect our Providers to participate in care planning and share information with other Providers to help coordinate care across Providers and disciplines. Including providing care plan recommendations, evaluating recommendations from other treating Providers, including BH Providers, making and following up on referrals for specialty care, providing necessary clinical information to specialty Providers, and being available for consultations with Providers and health plan staff. When we identify non-compliance through reporting or complaints, Provider Relations staff will contact the PCP to reinforce requirements. We will also ask Providers to share assessment information and submit Z-codes, providing SDOH insights.

b. Examples of information that the Offeror will provide to Providers;

Information we will make available to our Providers includes, but is not limited to:

- Actionable data made available through our Provider Portal and Provider and Patient Analytics, including dashboards with drill-down capabilities, disease registries, care gap reports, and progress toward Provider quality incentives
- Provider educational materials distributed through our Provider Newsletter with seasonal and relevant articles about how to better care for their Members and how to refer to health plan services; leave-behind and education campaign materials that Providers can share with Members, such as the importance of getting a flu shot or COVID-19 vaccine; and our on-line Provider Resource Center including clinical practice guidelines and other health plan program materials and condition specific content
- Access to health plan policies and procedures, our Provider Manual, and Provider Quick Reference Guides to help Providers meet and exceed contract requirements, understand programs and benefits, and promote quality health care for their membership

c. Interaction between Care Manager and Members, Members' PCP/PCMH, family, other physicians, and other relevant parties; and,

Serving as the Member's single point of contact, the Care Manager is responsible for facilitating communication with Members, their PCP, family, other treating Providers, and other relevant parties, such as schools or caseworkers. Care Managers will outreach to Members and Member families through Member-preferred and condition-indicated channels and frequencies, including in-person contact, phone, text, email, and mail. For example, a high-risk Member with co-occurring BH conditions may be seen in person monthly, along with weekly phone contact. A low-risk Member with controlled chronic conditions may receive quarterly phone outreach with targeted health information mailed, emailed, and sent via text between phone contact. Families, caregivers, and other relevant parties will be engaged in the care planning process as directed by the Member or as required based on the Member's age, including participating in initial and ongoing Member assessments and ICT meetings. As appropriate, authorized parties on the ICT will also have role-based access to our Portals. As

described above, Care Managers will actively engage PCPs/PCMHs and other treating Providers through regular phone calls, emails, in-person meetings, joint care conferences, and joint assessments.

d. Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time of Contract implementation.

Continuity of Care

We have extensive experience ensuring seamless transitions for Members during new contract implementation. As part of our approach, we will ensure our transition of care policy is available on our website and via Member and Provider training materials, including clear instructions for accessing continued services upon transition, including services from out-of-network (OON) Providers. As part of our policy, we will promote seamless access to OON Providers in compliance with Section 7.8.7 of Appendix A, Draft Contract. Components of our transition planning approach for Members receiving covered services from OON Providers at the time of contract implementation include:

- Proactive identification of new Members with existing services from OON Providers
- A system of care approach to transition planning which includes the Member, family, and Providers
- Continuation of such services for up to 90 calendar days or until the Member may reasonably be transferred to a Network Provider without disruption of services, whichever is less
- Honoring any authorizations of existing services, regardless of Provider Network status, and never denying any authorization throughout the 90-day continuity of care period
- Continuation of authorizations with OON Providers beyond 90 days, when clinically appropriate, to protect Member health and safety, or when required to ensure continuous care without disruptions
- Collaboration with relinquishing and receiving systems for Members transitioning between our health plan and another CCO to ensure timely transfer of information about open authorizations
- Development of a transition plan and coordination with the Member, family, and Providers including attempting to contract with OON Providers - if we are not able to contract with the OON Provider, we will work collaboratively to transition the Member to a contracted Provider that meets their needs
- A network built around Providers who have traditionally served Medicaid and CHIP populations

Transition Coordinator. Leading this effort will be a designated Transition Coordinator. The role of the Transition Coordinator is to ensure continuity of care and Member and Provider communication through all contract transitions, including ensuring the transfer and receipt of all outstanding prior authorization decisions, utilization management (UM) data, and clinical information such as disease management, Care Management and complex case management notes. Our Transition Coordinator will coordinate the sharing of information, pulling in the appropriate plan staff, including CM, Utilization Management (UM), and Network staff, to meet the individual needs of each Member or situation. The Transition Coordinator will also serve as a single point of contact with other CCOs, programs, and plan staff to coordinate the secure exchange of appropriate medical, BH, dental, vision, and NET information on a timely basis when Members transition.

Data Sharing. Supporting successful transitions is the timely sharing and receipt of information, including claims, authorizations, and care planning information. We can both receive and send data to ensure a seamless transition. Upon receipt of information from DOM or other CCOs, we will process and store the information in a usable manner via our Enterprise Data Warehouse.

e. The Offeror's Care Management processes and specific communication steps with hospital inpatient Providers to ensure post-discharge care is provided to Members. The Offeror's response should address review of potential Member inpatient readmission by diagnosis and the Offeror's plans for readmission reduction through coordination with hospital Providers and other relevant parties.

As described in our response to Section 4.2.2.3.D Transition of Care below, our evidence-based Transition of Care program (TCP***)*** incorporates proactive outreach to identify hospitalized Members prior to discharge, coordinate services, and connect Members to the post-discharge care they need to prevent readmissions.

Processes and Communication Steps with Hospital Inpatient Providers

We understand the importance of established systems that support timely notification of inpatient admissions and communication protocols that support bi-directional sharing of information and coordination between the health plan and hospital. Upon admission, we begin discharge planning and coordination with hospital discharge planning staff and inpatient providers. Our TCP team will utilize ADT feeds from hospitals and our daily census report to identify Members with an inpatient admission. Upon identification or notification from the hospital, our TCP staff will reach out to the designated hospital discharge planners to begin coordination and collaboration. We will conduct concurrent review activities to ensure coordinated and timely discharge care. We will establish weekly meetings with each hospital in our network to review complex cases, discuss opportunities for process improvements, and improve CCO CM coordination with our hospital partners to prevent future readmissions. We will also support hospitals in reducing preventable readmissions through our collaborative processes and programs described below.

Readmission Reduction Program

We will use our predictive modeling system as our "radar" to quickly detect and intervene with at-risk Members and Members with rising risk, such as Members with advanced illness or sickle cell disease. We will generate daily reports that identify Members who have been admitted to an inpatient setting, including information on their readmission risk score, the number of readmissions in the last 30 days and within the past year, and the name of their Care Manager and PCP/PCMH. Our TCP team will use this information to provide pre- and post-discharge coordination and assistance to ensure a successful transition, reduce readmissions, and improve Member health care outcomes and overall health care status. The interdisciplinary nature of our approach maximizes our ability to identify and address barriers that may have led to the admission, harnessing the varied backgrounds of our UM, CM, pharmacy, and network staff and Medical Directors through direct conversations, structured case rounds, and information sharing. We document this information in our Clinical Documentation System so all involved have a complete, current picture of Member needs and care. Additionally, an essential aspect of our discharge planning and Readmission Reduction Program includes coordination and collaboration with hospital discharge planning staff, hospital Providers involved in the treatment and care of the Member, and the Member's PCP or PCMH. Using our predictive modeling tools, as part of our process, we will stratify Member risk for readmission to effectively target resources and quickly intervene with at-risk Members and Members with rising risk. [redacted] This process maximizes TCP staff/Care Manager efficiency by directing resources to Members most in need. As part of our Model, our Golden Four Readmission Prevention Standards include:

Strong Readmissions Outcomes

An analysis of the effectiveness of the Readmissions Reduction Program across our affiliate health plans found that Members enrolled in the program had a statistically significant lower rate of potentially preventable readmissions (PPR) compared to Members who were not enrolled in the program (11.61% PPR and 13.12% PPR, respectively).

- Follow-up appointments within 30 days for physical health and seven days for behavioral health
- Medication reconciliation
- Addressing DME, home health, private duty nursing, and therapy needs
- Effective communication with the Member's ICT that includes the Member, the Member's PCP or PCMH, hospital Provider and other treating Providers involved in the Members' care, and care integration that includes addressing a Member's whole person needs

Members at High or Moderate Risk of Readmission. CM staff will conduct a face-to-face visit with the Member in the hospital (or a phone discussion if a face-to-face visit is not possible) to assess status and needs and provide education. As part of our process, CM staff communicate with the Member, caregivers, attending physicians and inpatient Providers, PCP/PCMH, and any outpatient Providers to look beyond the discharge orders. This information is used to determine the Member's holistic needs post-discharge, and develop a plan to return the Member to the optimal setting for health and wellness. Specific hospital discharge and transitional

support activities will include:

- Evaluating physical health, BH, and social support needs and coordinating appropriate care and service after discharge from one level of care to another
- Assessing transition needs and document in a transition plan (further described below)
- Supporting referrals and scheduling assistance for follow up appointments, including the seven-day follow-up appointment, specialty care, transportation, medical supplies and equipment, and other supports
- Verifying medications prior to discharge and confirming there are no barriers for the Member
- Conducting medication reconciliation, as appropriate
- Transferring Member records in compliance with HIPAA privacy and security rules, including providing a copy of discharge plan to the PCP/PCMH and other treating Providers
- Contacting the Member within 72 hours of discharge to assess status, confirm receipt of services, and evaluate the effectiveness and appropriate use of supplies and equipment
- Arranging same-day hospital discharge transportation assistance
- Arranging post-discharge meals for Members who are food insecure or with certain post-discharge dietary needs
- Providing Members with NICU Kits and Sickle Cell Kits, as appropriate, based on the Member's situation to prevent readmissions. Sample contents in our NICU Kit include newborn clothing and essentials (e.g., baby onesie, socks, bibs, diapers and baby wipes, suction pump, pacifier, and thermometer), and delivery/ postpartum educational materials such as safe sleep practices. Contents in the Sickle Cell Kit include Member materials on understanding Sickle Cell Disease, a digital thermometer, hot/cold pack, water bottle, color-coded arm bands, and bracelets that help adults and children communicate their pain levels.

Developing a transition plan specific to the transition period is a best practice in reducing readmissions. Incorporating all elements described above, we will develop a transition plan for every Member identified as at-risk of readmission. The transition plan reflects Member strengths, preferences, and post-transition goals. The transition plan will remain in place until all post-discharge needs and barriers have been addressed.

Members at Low Risk of Readmission. For inpatient facility admissions, we will coordinate the discharge plan with hospital staff inpatient and attending Providers and help identify network Providers to deliver post-discharge services. Prior to discharge, CM staff will assist with setting up post-discharge PCP and specialist appointments or required follow-up tests and reinforce with the Member and applicable caregivers the importance of:

- The discharge orders and the need to take them home/share with follow-up Providers
- A seven-day follow-up appointment and assistance to make the appointment(s)
- Listing all medications with the name of the drug, dosage, frequency, and prescribing physician
- Filling any newly prescribed medication(s) and asking attending physicians for clarification on taking previously prescribed medication(s)
- Arranging same-day hospital discharge transportation assistance
- Informing the Provider or plan if ordered services have not been provided timely

4.2.2.3.D Transition of Care

1. Describe the Offeror's overall approach to Transition of Care, including the process and criteria used for Transition of Care for Members. Include relevant Performance Measures that will be used to assess this process.

Transition of Care Approach

A key component of our CM program is our evidence-based Transition of Care Program (TCP). Our holistic, high-touch, Member-centered TCP facilitates access to needed health and recovery services, including social and community supports, to ensure safe transitions to the most integrated community setting possible and continuity of care for Members transitioning from FFS to managed care. Our approach considers needs related to barriers and the Member's social context to be on par with clinical conditions. We provide intensive support after discharge for those at high risk for readmission. Our TCP and UM activities are aligned with and fully compliant with Appendix A, Draft Contract requirements, including policies and procedures, staff training, and compliance reporting to ensure all timelines are met, Members are assessed, and needs and barriers are

addressed. Fundamental aspects of the TCP program can be applied to all transitions, such as when a Member moves from one setting of care (hospital, nursing facility, primary care physician care, home health care, or specialist care) to another, including:

- Timely assessment of Member and family needs and barriers
- Coordination and collaboration with Providers, facilities, and community agencies
- Caregiver engagement, assessment, and support that includes our caregiver support program that provides information and tools to our Member's informal caregivers
- Ensuring appropriate physical and BH follow up and assistance with referrals, scheduling appointments, interpreter, and transportation services
- Monitoring to ensure the health and safety of Members in the least restrictive setting
- Linking Members with a PCP/PCMH and ensuring ongoing care, including prevention and wellness care, and preventing potentially preventable events, including admissions, readmissions, and ED visits
- Medication reconciliation and non- adherence monitoring
- Identifying Providers and ensuring continuity of care and services, including arranging for single case agreements as appropriate to promote seamless care and treatment
- Identifying the need for and connecting Members with appropriate community services
- Documentation of TCP and other CM services in our Clinical Documentation System, made available to authorized users involved in the Member's care via our secure Provider, Member, and Caregiver Portals
- Ongoing Member and family/caregiver education, including self-care management tools and resources

Transition of Care Staff. Our transition of care activities will be implemented with coordinated and integrated CM and UM teams designed to address the holistic needs of the Member and ensure a successful transition and continuation of services that improve Member outcomes, regardless of the type of transition. For Members assigned to Medium or High-Risk CM Level who already have a Care Manager, that Care Manager will lead the transition process, receiving support and assistance from the applicable interdisciplinary transition of care team staff located in Mississippi. The Care Manager is the patient advocate and is charged with engaging the clinical team in sharing the Member's needs and preferences. This minimizes handoffs and reinforces the Member-Care Manager relationship. The Care Manager functions as the Member advocate and engages the clinical team and the Member's PCP/PCMH to ensure successful transitions. With an understanding that poor transitions contribute to hospital readmissions, medical error, and miscommunication, the Care Manager works with the Member to improve adherence with medications and treatment and helps to ensure the Member and any family caregiver(s) are informed and understand what they need to do. An integral part of the team includes our UM staff responsible for concurrent review and authorization of services, such as DME, home health, and private duty nursing. For ease of reading, throughout this response, we use the term "Transitions of Care Program team (TCP team)" to refer to the CM and UM staff carrying out transition activities.

Performance Measures. We will identify and monitor the efficacy of our TCP and processes through a wide range of performance measures and metrics that include, but are not limited to:

- Potentially preventable readmission rates and trends
- Potentially preventable ED visits
- Psychiatric Residential Treatment Facility (PRTF) transitions back to the community
- Member medication adherence, pharmacy over-and under-utilization reports
- Follow-up appointments within 30 days for physical health and seven days for behavioral health
- TOC program timeliness of sharing information with other CCOs
- Monitoring of continuity of care – (i.e., out of network utilization, use of single case agreements)
- Closed-loop referrals, including number and type of referrals made, warm handoffs, and receipt of services
- Member experience, including CAHPS surveys, Member CM surveys, and Grievance and Appeals data

2. Describe how the Offeror will provide Transition of Care to Members after discharge from an institutional clinic or inpatient facility, including:

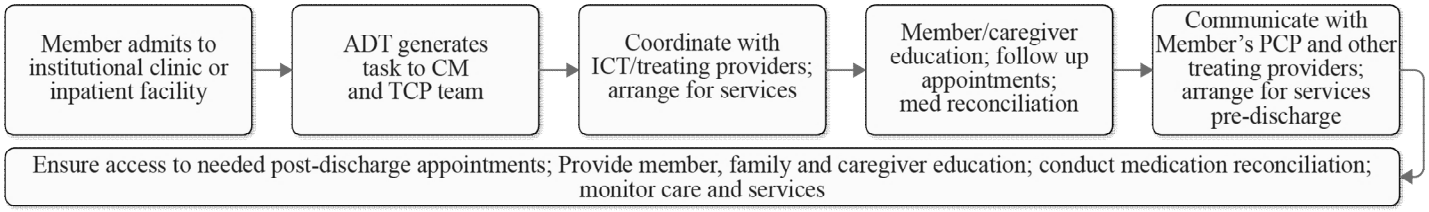
We emphasize prevention, continuity of care, and coordination of services for all Members transitioning from one setting to another. We have adopted evidence-based and emerging best practices for care transitions using

Care Transition interventions developed by Dr. Eric Coleman. These best practices incorporate onsite clinical resources, Member and Provider engagement and education, coordination of care and services, and promotion of self-management skills. Our TCP model, inclusive of care transition and diversion activities, considers SDOH, such as housing needs, to evaluate risk and identify services needed to address well-being and prevent unplanned or unnecessary readmission, ED visits, and adverse health outcomes. Our approach to managing transitions involves a holistic person-centered approach designed to meet each Member's PH, BH, and SDOH in the least restrictive setting possible. As described in our response to Section 4.2.2.3.D.1 above, our TCP team will include a multidisciplinary focus on interventions to support a safe transition to the Member's next setting and focus on reducing avoidable readmissions. We will incorporate proactive outreach to identify hospitalized members prior to discharge, enhancing our ability to plan, coordinate services, and connect Members to the post-discharge care they need to prevent readmissions.

We approach the Member care transitions to coordinate services, facilitate continuity of care, and ensure the Member is stabilized post discharge. Our transition of care processes, depicted in **Figure 4.2.2.3.D.2** below, includes, but is not limited to:

- Timely identification of Members needing transition of care through ADT feeds and the use of our daily census reports
- Assessment and summary of Member's needs (current PH, BH/SUD, and SDOH), including short- and long-term goals
- Development of transition plan based on assessed needs
- Communication with all Providers including the PCP/PCMH, treating BH Provider and SUD Provider, and other Providers involved in the Member's transition
- Ensuring timely access to needed post-discharge appointments that may include transportation assistance and assistance with scheduling appointments
- Providing Member, family, and caregiver education to ensure an understanding of the health condition and how to manage the health condition, including reviewing their discharge planning report to support health literacy and educating the Member on early recognition of symptoms and actions steps to be taken. We will offer our Caregiver program that provides caregivers with tools and resources, including a journal that caregivers can use to keep track of important information and daily routines such as medical history, medication list, allergies, PCP and other Provider contact information, and emergency contact information.
- Conducting medication reconciliation
- Providing Member and parent/guardian support by phone or in-person as needed
- Providing a Care Kit with a medication planner, stress ball, essential phone numbers sheet, Member tip sheet, and transportation brochure for our Members who are being discharged and transitioning from a PRTF, inpatient psychiatric, or rehabilitation facility
- Providing information and warm handoff referral and coordination with community agencies for needed non-covered services and community resources such as making accommodations for housing and home delivered meals
- Monitoring of services and care, including the use of closed-loop referrals to ensure continuity of care and stabilization and provision of uninterrupted access to covered benefits and services

Figure 4.2.2.3.D.2 Transition of Care Processes



Our TCP Team will provide discharge planning and coordination for hospitalized Members to ensure a safe transition. We will utilize a daily census of inpatient and institutional clinic Members and work closely with the Member's ICT to close care gaps identified by the discharge planner. To support self-management and medical

care adherence, we will also provide our ***Personal Health Record booklet*** to Members and their families/caregivers post-discharge. We will also utilize our ***Discharge Coordination Form*** to coordinate with hospital and institutional clinic staff to facilitate collaboration and ensure the Member's discharge needs are met. In addition, our TCP staff will outreach to psychiatric facility Providers to build collaborative relationships that support our ability to obtain information about our hospitalized Members and participate in facility rounds and discharge planning. Our staff will work with the Member to identify and address SDOH and/or environmental risk factors that might result in a readmission. To ensure a holistic approach that captures all Member needs, our TCP team will complete the ***Post Hospital Outreach Member assessment*** to manage readmission risk, medication compliance, DME and PDN requirements, and follow-up appointments.

a. Scheduling outpatient follow-up and/or continuing treatment prior to discharge for Members receiving inpatient services;

Upon hospital admission, our TCP Team will immediately begin working with the hospital discharge staff, Providers, and the Member/family/guardian, as appropriate, to coordinate care, ensure a safe discharge, and reduce readmission risk. TCP staff will contact the Member's PCP/PCMH, BH/SUD, or other treating Providers to schedule needed outpatient appointments. Once appointments are made, our staff will notify the hospital discharge planner and then document the appointment in our Clinical Documentation System. Additionally, we will provide the Member with the ***Personal Health Record booklet*** as part of the in-person visit or mailed to the Member to document details of their appointments, such as date, time, and Provider names and addresses. TCP staff will call the Member within 72 hours after discharge to educate them on post-discharge care. Our staff will assist, as needed, with scheduling appointments per discharge instructions, arranging for DME, private duty nursing, home health services, environmental adaptions, equipment, and other technology and transportation services as well as addressing other social and caregiver support needs. Our process includes making closed-loop referrals to Providers and CBOs for follow-up care, as appropriate.

b. Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff;

Upon admission notification, our staff will immediately outreach to the hospital discharge planner to obtain the discharge plan and quickly authorize and arrange for needed post-discharge services. If the hospital does not complete our ***Discharge Coordination Form***, our staff will inquire about the reason for the hospitalization, services the Member received, medications provided, and needed refills. TCP staff may request that hospital staff and/or Providers participate in a case conference to discuss the Member's care and discharge needs. Our team will share information from hospital staff and Providers with the PCP/PCMH and other treating Providers, such as BH Providers and staff, to support clinical oversight by the Member's medical home. This ensures an integrated approach to services and allows us to obtain discharge planning support such as physician's orders for certain home care services. If the treating Provider offers recommendations on the discharge plan, TCP staff will share this information with hospital staff and Providers. As with needed physical health follow-up care, our staff contact BH Providers and staff to schedule appointments and notify the facility and/or acute psychiatric hospital staff of the appointments for incorporation into the discharge plan. TCP staff strives to ensure that BH outpatient follow-up appointments and/or continuing treatment are arranged prior to discharge.

Additionally, our TCP team will collaborate with Community Mental Health Centers (CMHCs) and BH Providers to ensure quality care through an integrated process that addresses the Member's BH and PH needs. Through our collaboration, we will directly address barriers to care as we coordinate with a designated BH point of contact. An example of coordination with the BH Provider staff and point of contact may be notifying the CMHC of the Member's discharge date prompting the CMHC to submit a request for Day Treatment services for child and adolescent Members ensuring they are set up with services.

c. Arranging for the delivery of appropriate home-based support and services in a timely manner; and,

As described above, upon notification of admission, TCP staff outreach to the hospital or facility discharge planner to obtain the discharge plan and quickly authorize and arrange for needed post-discharge services, including appropriate home-based services and support. As part of our process, we will assess DME, private duty nursing, home health needs and supplies, authorize services, and document in the Member's transition care plan, as appropriate. If the Provider/facility arranged for services prior to discharge, the TCP staff will obtain the Provider or DME company name and contact number to ensure the appropriate home-based support and services are in place. If the Care Manager identifies a home health need during Member assessment, they will

work collaboratively with the Member and the Member's PCP/PCMH to confirm and to facilitate an appropriate referral.

One of the overarching goals of our TCP is to ensure the Member receives needed supports to live in the most integrated community setting possible. As such, our TCP staff will assist with arranging for services and support the Member needs to successfully transition from an institutional or inpatient setting back to the Member's home or community setting. This may include an assessment and authorization for PDN services and medically tailored meals as well as conducting environmental and home safety assessments, as appropriate. We also recognize issues may arise after hours. In response, our Nurse Advice Line is available 24/7/365, and our UM team will be available 24/7 for urgent matters.

d. Implementing medication reconciliation in concert with the PCP/PCMH, Behavioral Health Provider, and network pharmacist to assure continuation of needed therapy.

Medication Reconciliation is one of our Golden Four Readmission Prevention Standards. Medication reconciliation and non-adherence monitoring are key components of our TCP to assure the continuation of needed therapy and prevent readmission due to medication error or adverse event when a Member has polypharmacy, low health literacy, or communication barriers. We will provide medication reconciliation activities as part of our post-discharge process in collaboration with the Member's ICT. We will complete a medication review and medication reconciliation after inpatient stays and every 30 days and communicate timely with the Member's PCP, BH Provider, and Pharmacist to resolve any medication discrepancies. Within 72 hours of discharge, the Member's Care Manager will outreach to complete a medication reconciliation of newly prescribed medications and existing medications to identify potential issues, such as duplication or contraindications. They will identify barriers to access and compliance with taking the medications, educate on why the medication is needed and the appropriate way to take it, and assist in resolving any issues. The Care Manager will assist the Member promptly with prescription refill needs post discharge and perform medication review with the Member to determine dosage changes, identify discontinued medications, and compare the medication list with our pharmacy and predictive modeling system and any hospital-provided information.

Working in collaboration with the Member's PCP/PCMH, BH Provider and pharmacist as appropriate, our process includes checking the accuracy of medication lists, identifying changes in medication regimen and potential interactions with previous medications including over the counter drugs, and assuring the Member understands changes and side effects that should be reported to their prescribing Provider and PCP/PCMH. The Care Manager also communicates the discharge medication regimen to the PCP/PCMH if they were not the treating Provider during the inpatient admission. We also educate the Member and caregiver on their medications, communicate with the treating Providers, and, when applicable, coordinate with our pharmacy staff to assure the continuation of needed therapy. To support the Member with medication adherence, we will provide each Member with a seven-day ***Medication Planner*** (prescription medication box) and instruct the Member and/or caregiver on using it. Some Members may also benefit from an in-home assessment to identify all medications, including over-the-counter drugs and supplements, what reminders they use, and any barriers. To remove barriers, we will educate the Member and provide medication reconciliation and prescription support through mail and weekly or monthly outbound calls. TCP staff and/or the Member's Care Manager may also assess for the use of appropriate equipment such as inhalers, pediatric spacers, and self-administration of injectable drugs, such as insulin.

3. Describe the Offeror's proposed transition plan and policies for ensuring continuity of care for Members who are currently receiving covered services from Non-Contracted Out-of-Network Providers at the time of Contract implementation.

We will have systems and processes to ensure continuity of care and non-disruption of services or treatment for new Members who are entering from the Medicaid FFS system or transitioning from another CCO at the time of Contract implementation. Using national Medicaid and CHIP best practices, we will ensure Members needs are met upon enrollment with us, including Members who are currently receiving covered services from non-contracted out-of-network (OON) Providers. Members transitioning from FFS or another CCO at the time of Contract implementation will receive continuity of care to prevent disruption or delay in services, particularly Members in active treatment or whose health could be placed in jeopardy if services are interrupted.

We will use our best efforts to complete the HRS for all new Members within 30 days of enrollment. As part of

this process, we will identify any immediate needs and active courses of treatment. For Members requiring continuity of care, this information will be transferred to UM to ensure the appropriate prior authorization information is loaded into our system, with follow-up by a Care Manager, as appropriate. We will authorize a Member's existing OON Providers for medically necessary services until the Member's records, clinical information, and care can be transferred to a network Provider. We will authorize all medically necessary covered services without any form of prior approval and without regard to whether such services are being provided by in-network and OON Providers. We will provide for the continuation of these services that comply with the contract requirements, including providing a continuation of medically necessary services for up to 90 calendar days or until the Member may be reasonably transferred to a network Provider without disruption of services whichever is less. Additionally, suppose the OON Provider does not wish to contract with us. In that case, our CM staff will work with the Member to find a qualified alternative in-network Provider to facilitate the transition. For Members in their second or third trimester of pregnancy, we will support continuity of care. Specifically, we will allow continued access to the Member's prenatal care and any Provider currently treating the Member's chronic, acute medical, or BH/SUD condition through the postpartum period.

Our approach to ensuring continuity during transitions between and among delivery systems will include using many and varied data sources to proactively identify new Members who may need assistance transitioning into our CCO from another CCO or the FFS system. Our Reporting and Analytics Platform integrates these data sources and applies state-of-the-art analytics to identify Members who are or may be receiving covered services from non-contracted Providers at the time of contract implementation that needs to be continued during a transition. It also identifies potential risk factors that may require individualized assistance to ensure continuity and care coordination through a transition. This systematic approach will ensure our ability to outreach to Providers, authorize services, and provide coordination and other support promptly during transitions. Additionally, our Clinical Data and Interoperability Gateway will offer enhanced data sharing capabilities through bi-directional data exchange with Providers' EHRs. Our interoperability capabilities will allow us to automate data extraction from Providers' EHRs to proactively identify members who may be accessing OON Providers to ensure continuity and non-disruption of care and services.

Transition Planning. Components of our transition planning approach for Members receiving covered services from non-contracted Providers at the time of contract implementation include:

- Proactive identification of new Members with existing services from non-contracted Providers
- A system of care approach to transition planning which includes the Member, family and Providers
- Honoring authorizations of existing services new Members are receiving at the time of enrollment, regardless of the network status of their service Provider
- Continuation of authorizations with OON Providers beyond the transition period, when clinically appropriate, to protect Member health and safety, or when required to ensure non-disruption of care
- Collaboration with relinquishing and receiving systems for Members who are transitioning between our CCO and another CCO or FFS to ensure timely transfer of information about open authorizations
- Develop a transition plan for Members and coordinate with their family/caregivers and Providers. If we are not able to contract with the non-contracted Provider, we will work collaboratively with the Member and family to transition the Member to a contracted Provider while honoring Member choice

4.2.2.3.E Staff

1. During the next contracting cycle, it is required that Care Managers be located in the state. Describe the Offeror's requirements for Care Managers, including but not limited to the following:

CM Staffing Model

All CM staff will be located in Mississippi. Our CM staffing model is based on a high-touch approach that includes regionally located CM teams available to provide face-to-face support and coordination with other entities, Providers, and systems of care involved in the care of MSCAN and CHIP individuals and families. Our CM Teams will include local, boots-on-the-ground staff comprised of Care Managers, Program Coordinators, Social Service Specialists, Community Health Workers (CHWs), Directors, Managers, and Supervisors.

A defining element of our person-centered CM program is one Care Manager working with a Member for all needs – PH, BH, SDOH, and coordination of services. The ***Care Manager is the member's primary point of***

contact and performs screenings and assessments, develops and monitors care plans, provides educational resources, warm hand-offs, and closed-loop referrals, and makes care and service connections. Depending on the primary diagnosis, the Member will either be assigned to a registered nurse for physical health diagnoses or a licensed BH clinician for BH diagnoses. Should a Member have co-morbid physical and BH conditions, the appropriate Care Manager is assigned based on the prevalent needs and preferences of the Member. Additionally, all foster care children will be assigned to a dedicated Care Manager for foster care. CM staff are crossed trained on PH, and BH. Each Care Manager will be supported by a Collaborative Care Team representing all Member needs, including SDOH.

a. Education and training required for Care Managers;

Our CM program description specifies the type of staff responsible for the functions of CM. All CM Job descriptions define the qualifications, education, training, and professional experience required for the position. Education and training required for Care Managers and CM staff are described below.

- ***Nurse Care Manager***: licensed nurse, Certified Care Manager (CCM) preferred. 2+ years of CM experience and recent nursing experience in an acute care setting, particularly in medical/surgical, pediatrics, or obstetrics. 2+ years of related experience in a managed care environment.
- ***BH Care Manager***: Master's degree in BH and an unrestricted license as an LCSW, LMFT or LPC, or a PhD, PsyD or RN with experience in psychiatric, substance use disorder, and/or medical health care settings. Knowledge of utilization review procedures and familiarity with BH community resources. 3-5 years of CM and or Utilization Management (UM) experience.
- ***Social Services Specialist:*** Bachelor's degree in social work, nursing, health, behavioral science or equivalent experience. 2+ years of community experience in directly managing and integrating the social/community needs of Members. Experience in a managed care environment preferred.
- ***Program Coordinator***: High school diploma or equivalent; 2-3 years managed care or physician's office experience. Customer service, utilization review or claims processing experience in a managed care environment and operation of office equipment such as a personal computer.
- ***Community Health Worker (CHW):*** High school diploma or equivalent. 2+ years of social services, community outreach, or education experience. Bilingual ability or Certified Peer a plus.
- ***Health Coach:*** Licensed clinical staff (respiratory therapist, certified diabetes educator, registered dietician, exercise physiologist) with at least one year of experience in a clinical setting for DM programs. Health Coaches are certified for tobacco cessation through a program based on the University of Arizona's tobacco cessation certification program.

b. The Offeror's Care Manager hiring process, including how the Offeror plans to recruit and retain Care Managers;

Care Manager Recruitment

Our organizational philosophy is centered on hiring and staffing local, qualified Care Managers with experience serving populations similar to individuals eligible for MSCAN and CHIP. Our Care Manager job descriptions include a summary of the role, responsibilities, and required education, experience, and desired skills for the position we are recruiting for to assist us with finding qualified Care Manager and CM staff candidates. As part of our hiring process, our Talent Acquisition team screens all potential candidates against job qualifications and position requirements to ensure we have qualified candidates for consideration. We are intentional in our recruitment and hiring practices, and our diversity and inclusion policies will be followed by all hiring managers within the organization. Our approach for the recruitment and hiring of local CM staff includes:

- **Promote from within our organization.** We will leverage word of mouth and our employees as a recruitment strategy. We find this to be an impactful recruitment strategy since internal staff understands the roles and responsibilities of the position and individuals who may be a good fit for the job. Recognizing the value of this recruitment strategy, we will offer referral bonus programs for our employees.
- **Post job openings online.** We will recruit candidates through multiple channels, including posting job openings on our website and at other sites such as LinkedIn and the Mississippi Board of Nursing.
- **Professional organizations, colleges, and universities.** We will leverage professional clinical organizations such as the Mississippi Nurses Association and local colleges and universities, such as Hinds

Community College, Jackson State University, and Mississippi College, to recruit CM staff. We will also attend college job fairs to recruit CM staff.

Retention Strategies

To address and prevent turnover, we will implement a comprehensive retention strategy based on best practices to retain knowledgeable and experienced CM staff, including:

- **Initial interview.** Testing probable candidates for basic computer skills, critical thinking, ethics, empathy, and commitment to our mission, making a difference in our Members' lives.
- **Career pathway.** Identified career goals CM staff wishes to achieve, with pathway development in collaboration with CM staff and leadership.
- **Flexible schedules.** Care Managers can work a flexible schedule. For example, to successfully reach Members after normal business hours, we will allow some of our CM staff a later start time.
- **Tuition and license reimbursements.** After one complete year of regular full-time employment, employees in good standing will be eligible for tuition reimbursement, as well as other specified costs, such as textbooks and lab fees. Additionally, all clinical staff will be reimbursed for their professional license renewals.
- **Continuing education support.** Clinical staff are encouraged and supported in obtaining certifications, including training courses, certification exams, and tuition reimbursement. For example, we will financially support ongoing professional development and help prepare our staff by teaching classes and reimbursing our Care Managers to take the Certified Care Manager (CCM) exam to obtain their CCM credential. Additionally, we will support our CHWs to become certified CHWs. Additionally, we will work with the Mississippi Department of Health (DOH) Lead Screening Council to certify our CHWs on lead screening to provide evaluations and assessments for our Members. Similarly, as part of our commitment to professional and career path development, we will also work with the Mississippi DOH Kids First program to certify our CHWs in car seat safety and installation. We will financially support our CHWs to participate in the three-day training and certification. We will also equip our staff with the most current clinical informatics needed to grow our Teams' clinical knowledge such as use of Micromedex, UpToDate), etc.
- **Continuing Education Units (CEUs).** We will offer CEUs and training opportunities for our clinical CM staff at no cost through our parent company's established program. The program is jointly accredited by the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education, and the American Nurses Credentialing Center. It provides interprofessional continuing education through research-informed educational activities, equipping Providers to deliver current therapies and better health outcomes. As part of the program, our CM staff participates in interprofessional educational activities through a series of monthly clinical rounds that include obstetrical rounds, sickle cell disease rounds, diabetes rounds, NICU rounds and SUD in pregnancy rounds designed to educate Care Managers on current CM and clinical best practices for a variety of chronic disease topics.
- **Culture of Transparency.** We provide a culture of transparency supported by our Leadership Team that, for example, will include a comment and suggestion box that promotes a positive work environment.
- **Culture of Connection.** Our culture of connection ensures CM staff have a connection to the community and populations they are serving, which impacts employee satisfaction.

c. How the Offeror will ensure that Care Managers are culturally competent and aware of implicit biases;

Ensuring a Diverse and Culturally Sensitive Staff

Culture includes linguistic, socio-economic, and disability-related needs plus beliefs, expectations, assumptions, and preferences due to race/ethnicity, race, religion, or cultural background. We are committed to ensuring all our CM staff are culturally competent and aware of implicit bias.

Comprehensive training. We will train all CM staff using a comprehensive curriculum that includes assessing cultural considerations and incorporating them into care planning. We have a Diversity and Inclusion Committee, and we require all staff to take Cultural Sensitivity Training. As just a few examples, we will engage our Provider partners and experts from the community, such as the Mississippi Coalition for Citizens with Disabilities and the National Alliance of Mental Illness, to ensure our training is comprehensive and

effective. All CM staff are also trained in Person-Centered Thinking training. Additionally, all CM staff are trained on the use of our language assistance line and in-person interpreter services.

Use of evidence-based practices. CM staff trained in cultural sensitivity and unconscious bias use evidence-based practices such as Motivational Interviewing (MI), Trauma-Informed Care (TIC), Person-Centered Care Planning, and the Strengths-Based Model to engage with Members. CM staff meet Members and families by embedding staff in the community and targeting information and interventions to the Member's willingness to engage, level of health literacy, degree of trauma, disparities endured, and cultural preferences.

Hiring from and contracting within local communities. Our hiring practices are inclusive and non-discriminatory, including recruiting and retaining a diverse workforce that attracts individuals from diverse cultural backgrounds, speak prevalent languages, and have relevant life experiences. This includes bilingual staff and staff with direct experience serving pregnant women and children, individuals with disabilities, behavioral health and substance use disorders, children, youth, and young adults involved in the child welfare system, and medically and socially complex individuals.

d. An overview of the Offeror's continuing education and training plan for its Care Managers; and

Our approach to CM staff education and training is rooted in our expertise gained over the past 10 years deploying CM training across 30 State Medicaid managed care programs. We design our training to provide optimal service and outcomes for Medicaid and CHIP populations. We specifically hire Care Managers who have a passion for serving vulnerable populations. Our dedicated health plan Clinical Trainer, coupled with our parent company's nationwide training team, comprised of master's level staff, developed and will provide a comprehensive training curriculum for our Care Managers. CM Training topics include:

- CM program and Care Manager responsibilities
- CM information systems, documentation, processes, workflows
- Covered benefits and services
- Disease Management
- SDOH and Health Equity Improvement Model
- Transitions of Care
- Motivational Interviewing
- Informed consent
- Abuse, Neglect and Exploitation
- Social isolation and loneliness
- Trauma-Informed Care
- Suicide Prevention and Crisis Training
- Person-centered service planning
- Cultural competency
- Motivational Interviewing
- Mental Health First Aid
- Foster care stakeholders
- Co-management of PH and BH conditions
- Poverty Training
- Managed Care 101
- Fraud, Waste, and Abuse

We employ best practice adult learning principles and use varied training modalities to support diverse learning styles. Training modalities will include in-person training, self-directed digital training, virtual instructor-led training, and training delivered by peers. Ongoing trainings are based on micro-learning research, which delivers the curriculum in manageable "bite-size" pieces for those with limited time to complete longer education.

Onboarding. We will provide four weeks of classroom training, which begins with new employee orientation, CM tools, best practice engagement techniques (e.g., motivational interviewing, recovery and resiliency model), and MSCAN and CHIP program information. Following classroom training, new CM staff will participate in a minimum of four weeks of shadowing and mentoring with seasoned staff. New staff will be closely monitored and coached during this on-the-job training. Shadowing includes both observations of and supervised practice with completion of health screenings and assessments.

Continuing Education and Ongoing Training. Continuing education and ongoing training ensure our CM staff hone skills and keep abreast of new approaches, best practices, and policy developments both in Mississippi and nationally. We will provide ongoing training at least quarterly. CM staff will also receive annual Person-Centered Thinking and Trauma-Informed Care training.

Evaluating Training Competencies. All trainings include competency measurement assessments. In addition, our initial curriculum contains knowledge transfer checks, including embedded quizzes, practice interviews

with corrective instruction, formal testing, and critique of care plans and motivational interviewing skills.

Following the initial training, we will monitor the ability of CM staff to integrate post-training knowledge into their practice through our preceptorship program and routine audits for the first 90 days. If post-learning assessments suggest gaps in knowledge transfer, the individual will be retrained and offered coaching. Once the individual has successfully demonstrated competence, CM Supervisors will monitor individual performance by conducting monthly quality performance audits, which will measure the performance related to the workflow process, timeliness, appropriateness of care plans, and contacts with children and their caregivers.

To ensure that all CM staff stay current on training requirements, our CM and Human Resources Departments will maintain documentation of orientation, training dates, attendance, and post-learning assessments for CM staff. If an individual fails to successfully complete required ongoing training, the Clinical Trainer electronically notifies the individual and his or her supervisor to perform follow-up and completion. Supervisors will monitor knowledge transfer via coursework quizzes, monthly audits, and review of care plans. Our online training courses will track, trend, and report to supervisors/trainers on each individual's learning activities.

e. Expected wages to be paid to Care Managers (hourly/salary and what amounts).

We will offer competitive wages and benefits for our Care Managers that will be hired and located in Mississippi. All of our Care Manager job descriptions define the qualifications, education, training, and professional experience in medical or clinical practice required for the position. Summarized below are salary ranges for each of the CM positions we will hire in Mississippi. Our salary ranges take into account number of years of experience, specialized trainings, licensure and other expertise and capabilities.

[redacted]

4.2.2.3.F Hypotheticals

1. Describe the Offeror's approach to providing Care Management in the following scenarios:

a. Member who had been stratified as low risk has had four (4) emergency department visits in the previous five (5) months;

Our integrated approach to CM ensures Members receive the right care, at the right time, in the right setting. We will identify Members who have changing needs and have systems in place to detect Members who demonstrate rising risk. This Member's frequent ED use indicates a rising risk level and makes them eligible for enrollment in our ***ED Diversion Program*** for outreach, education, and engagement. Seeking care from the ED is often a learned behavior, which the COVID-19 pandemic has exacerbated. Below is our approach to providing CM services for this Member, including educating the Member on appropriate ED use, addressing why they frequent the ED, linking them to a PCP/PCMH, and other appropriate services and supports.

Proactive Outreach and Engagement
Our ED High Utilization Model examines large data sets daily, interprets Members' clinical data, and delivers actionable insights that will allow our CM team to identify, outreach, and engage this Member proactively.

Outreach and Engagement. The ***predictive analytics*** component of our Reporting and Analytics Platform identifies this Member for outreach based on their probability of high utilization within 365 days following an initial ED visit. We will share this predictive modeling data with the Member's Providers via our Provider Analytics tool in the secure Provider Portal to assist in providing tailored services to the Member. Within seven days of identification, we will outreach and engage this Member by deploying a member of our locally-based, integrated CM team. The Care Manager will partner with a CHW who lives in the Member's community. By using the Member's most updated contact information, the CHW will meet the Member where they are in their home, community, or setting of care and establish a trusting relationship with the Member and gain an understanding of their needs by engaging them in discussions about their ED utilization.

Screening and Assessment. The Member's ED visits frequency indicates they may be experiencing barriers to care or have needs that require resources and support. ***Ensuring the Member's basic needs are met will improve their overall health and well-being and reduce their ED utilization***. As a trusted messenger, the CHW will address the Member's SDOH needs by leveraging our ***SDOH Mini Screen*** and connecting them to community resources tailored to their needs using our ***Community Resource Support Database***. Although the Member was stratified as Low Risk, the frequency of their ED visits demonstrates a rising risk. In addition, many individuals utilize the ED for non-emergent or primary care needs. Unless the Member presents with a complex condition that would require a High-Risk tier of CM, we will re-stratify the Member as Medium Risk and assign a Care Manager who will ensure the Member's PH, BH, and SDOH needs are met through preventive measures and access to the appropriate level of care. To avoid duplication of effort, the assigned Care Manager will collaborate with the CHW and obtain information from the discussions the CHW has already had with the Member. The Care Manager will perform additional root cause analysis by reviewing the Member's medical records, claims data, medications, HRS, SDOH Mini-Screen, and other information within our Clinical Documentation System. Next, the Care Manager will outreach to the Member to complete a CHA with the Member and their circle of support to assess the Member's PH and BH needs and discuss why they are utilizing the ED, such as potential barriers to preventive care. The CHA will also capture the Member's goals and preferences for care and assess the Member's educational level, health literacy, and financial situation to determine if these or other factors contribute to their ED use.

Health Equity Screening

The SDOH Mini-Screen creates opportunity for our staff to identify and address social barriers to good health at any Member touchpoint.

CM Services and Interventions. The Care Manager will work with the Member and the Member's ICT to develop a person-centered care plan that reflects needs identified from the CHA and aligns with the Member's self-identified goals and preferences. The Care Manager will ensure the Member is connected with a PCP/PCMH, provide education, and connect the Member to additional services to reduce their ED utilization. The Care Manager will confirm the Member feels comfortable with and trusts their PCP/PCMH, and that the Provider aligns with any cultural preferences they may have. The Care Manager will help the Member schedule a PCP appointment through a three-way call or our online appointment scheduling software. The Care Manager will contact the Member to remind them of their appointment and ensure transportation. The Care Manager considers the Member's primary language and communication preferences and will arrange for onsite or telephonic interpreter services if needed. If the Member feels they need additional support, the Care Manager will offer to attend Provider visits with them. The Care Manager will complete medication reconciliation, identify needed specialty care Providers, and coordinate referrals and DME with the Member's PCP. Additional CM services and interventions include:

Improved Health Outcomes for Members

From 2017-2019, our affiliate reduced ED and inpatient visits and increased PCP visits among Members.

4%	Decrease in ED visits.
17%	Decrease in inpatient admissions.
11%	Increase in PCP visits.

Member Education. Having partnered with the CHW to establish and maintain the Member's trust, the Care Manager understands the issues faced by the Member and knows that fear or embarrassment often prevents Members from seeking preventive health care. Rather than lecturing the Member, the Care Manager will meet the Member where they are to maximize our ability to engage them in care by offering tailored education based on their needs. For instance, if the Member has a chronic condition, the Care Manager will help the Member understand their diagnosis by reviewing how to manage their condition and prevent complications. The Care Manager will also discuss the role of their PCP/PCMH and other Providers and the importance of preventive care. To support the Member's health literacy and empower them to be a voice for their health, the Care Manager will engage in self-management planning with the Member. This self-management planning includes guiding the Member to verbalize their needs and plan for

Diverting Unnecessary ED Visits

In 2020, two of our affiliates began offering our Virtual PCP Program to Members. Twelve months before the launch, Members showed an 11% non-emergent ED rate. After the launch, the same Member cohort had a non-emergent ED visit rate of 3%, indicating that the program helped reduce inappropriate ED use by 72%.

Provider visits by helping them list out key questions, issues, and concerns. The Care Manager will discuss how and when the Member should seek care from their PCP, specialist Providers, or Urgent Care instead of the ED and provide information on our 24/7 BH/SUD Line and 24/7 Nurse Advice Line (NAL).

Virtual PCP Program. The Care Manager will offer to connect the Member to our Virtual PCP Program, offering primary care access in the Member's home, eliminating transportation barriers, reducing wait times, and enhancing Member engagement to reduce ED visits. The Member can choose to continue receiving care from their local PCP or connect to a virtual PCP. The Care Manager will co-manage the Member's care with a Care Advisor from the Virtual PCP Program to provide care coordination, plan benefits, and community resources. The Care Manager will also ensure the Member has access to a reliable phone to connect regularly with the Care Manager and their Providers by offering our expanded phone access program. Similar to a SafeLink phone, the Member has free immediate access to 3 GB of data, unlimited text/talk, and calls to our Member Services, BH/SUD Line, NAL Line, and 911.

Member Incentive Program. To encourage the Member's use of preventive care and reduce their ED use, the Care Manager will educate the Member about our Member Incentive Program that offers financial rewards for healthy behaviors. The Care Manager will remind the Member that our health plan automatically enrolled them in the program to start earning rewards immediately by attending their annual doctor visits, obtaining annual cancer screenings and flu vaccinations. In addition, the Care Manager will remind the Member that they can apply their rewards toward purchases at Walmart and services like utilities, rent, transportation, education, telecommunications, and childcare.

Disease Management (DM) Programs. Obesity, hypertension, depression, and smoking can lead to more complex conditions like diabetes, heart failure, stroke, and cancer. Understanding that there is a lack of a culture of health that prevents the prioritization of health and well-being in many Mississippi communities[1], the Care Manager will connect the Member to healthy lifestyle coaching offered through our DM Programs. The Member will receive telephonic outreach and support services that promote treatment adherence, health literacy and education, condition self-management, and improved outcomes through these DM Programs.

Monitoring and Follow Up. The Care Manager will monitor the Member's progress based on their care plan and the Member's preference. The Care Manager will continue to review weekly hospital reports and bi-weekly pharmacy reports to identify any new ED visits and to confirm the Member fills their prescriptions. The Care Manager will contact the Member by phone monthly to discuss their health status, ask about medication and appointment adherence, and complete an SDOH Mini Screen to identify any new or changed SDOH needs they may have. As the Member's condition stabilizes, the Care Manager will reduce the frequency of contact to monthly calls. The Member transitions to Care Coordination and/or DM health coaching once their condition has stabilized and ED use decreases.

b. Member with diabetes and attention deficit hyperactivity disorder has been identified as high risk, but the Care Manager has been unable to reach the Member by phone and face-to-face, and mail has been returned as undeliverable;

We understand the importance and urgency of providing integrated and comprehensive High-Risk CM for this Member with attention deficit hyperactivity disorder (ADHD) and diabetes. Below, we describe how we will locate and engage this Member by leveraging a CHW and partnering with Providers and community partners to engage the Member at the point of care. We will also discuss how we will meet the Member's ongoing PH and BH needs through CM services and interventions.

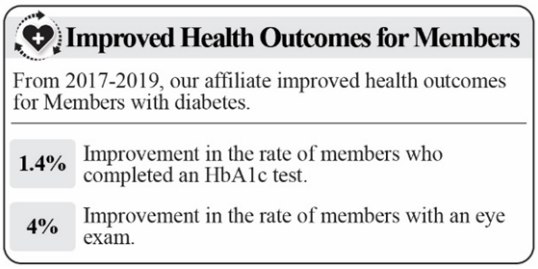
Outreach and Engagement. Within five days of identifying this Member through our ***Diabetes Predictive Modeling tool***, we take a high-touch "boots on the ground" approach to outreach and engage the Member.

Remember the Member. A Member at an affiliate health plan had several inpatient readmissions and three ED visits related to COPD, heart failure, hypertension, asthma, and sleep apnea. The Member also struggled with nicotine dependence and health literacy. Our Care Manager coordinated with the Member, Provider, and DME company to obtain a CPAP, asthma supplies, and a nebulizer. The CM educated the Member on how to use these supplies, keep their nebulizer clean, and connected the Member to our Smoking Cessation DM program. To ensure access to needed care, the Care Manager scheduled appointments for the Member with a Cardiologist and a PCP and confirmed the Member was able to attend these visits. To date, the Member remains engaged in CM, has not had an inpatient or ED visit in 123 days, and has remained tobacco free.

[1] Mississippi State Department of Health 2019 Community Themes and Strengths Assessment

Having already reviewed available claims data, authorizations for DME, and reached out to the Member's Provider or pharmacy to obtain the Member's most recent contact information, the Member's assigned Care Manager partners with a CHW who lives in the Member's community. The CHW leverages trusted community partners such as local churches, police and fire stations, and community centers to outreach and locate the Member; to engage Members under the age of 19, we will partner with a Mississippi youth-serving organization. The CHW will meet the Member where they are in their home, community, or setting of care and develops a rapport with the Member based on shared experiences from living in the same community. The CHW will partner with the Care Manager to establish a trusting relationship with them and engage them in the High-Risk tier of CM services.

Screening and Assessment. The CHW and Care Manager will utilize Motivational Interviewing strategies to engage the Member and their circle of support in screening and assessment to understand the Member's needs. Using our Clinical Documentation System, the Care Manager will determine if the Member previously completed an HRS, CHA, or had a person-centered care plan in place. If not, the Care Manager will partner with the CHW to complete an HRS during the CHW's in-person meeting with the Member. Because the Member is identified as High Risk based on their diabetes and ADHD, the CHW and Care Manager will work with the Member to arrange a time for the Care Manager to conduct a CHA. They confirm the Member's need for High-Risk Care Management by evaluating the Member's physical, behavioral, social, psychological, and SDOH needs, including access to utilities, nutrition, and transportation. During the CHA, the Care Manager will perform medication reconciliation, evaluate the Member's home environment and safety, and ask if the Member has a PCP who manages their diabetes and a BH Provider who manages their ADHD. The Care Manager asks the Member if they feel comfortable with and trust their Providers and, if not, offers to help the Member find alternative Providers based on their preferences. The Care Manager will also help establish a relationship between the Member and pharmacy to screen for drug-drug interactions and to assist the Member with gaps in care and drive medication adherence conversations. The Care Manager will help the Member locate a local pharmacy partner that can engage the Member to provide additional support for medication adherence and education.



CM Services and Interventions. After completing the CHA, we will place the Member at the center of an ICT, comprised of the assigned Care Manager, additional BH CM support, the Member's PCP/PCMH and other treating Providers, and the Member's identified supports. We will develop a person-centered care plan that reflects the Member's needs, self-identified goals, and CM services and interventions outlined below.

Member Education. As a trusted messenger, the Care Manager will have an honest conversation with the Member about how important it is for the Care Manager to reach the Member at their current address or phone number so the Care Manager can connect the Member to services on their needs. The Care Manager will also ensure the Member knows how to contact the Care Manager moving forward. Managing co-occurring diabetes and ADHD can be challenging, so the Care Manager will educate the Member on ways to best manage these conditions. This includes reviewing diabetic healthy eating habits and helping the Member learn how to monitor and track their blood sugar using a glucometer. The Care Manager will help the Member understand when to seek care from the Member's PCP or specialists instead of going to the ED and educate them on our ***24/7 BH/SUD Line and 24/7 NAL***. The Care Manager will inform the Member about our Member Incentive Program and explain how the Member can earn financial rewards for healthy behaviors like attending their annual Provider visits and engaging in comprehensive diabetes care.

Diabetes Management and Ongoing Care. The Care Manager will reinforce that the Member's PCP/PCMH is central to managing the Member's diabetes and other whole health needs. The Care Manager will evaluate the need to arrange home health for additional diabetic teaching and use our care gap analysis tool to identify if the Member needs any preventive screenings and services (i.e., HbA1c). If so, the Care Manager will help the Member schedule a PCP appointment through a three-way call or by using our online appointment scheduling

software. The Care Manager will provide a Personal Health Record Booklet for the Member to bring to Provider appointments and will offer to attend these visits with the Member as an added layer of support and help clarify information the Member may find confusing. If the Member is a child or adolescent, the Care Manager will communicate with the nurse at the Member's school to ensure they understand and can manage the Member's diabetic needs during the school day. The Care Manager will connect the Member to integrated diabetes programs including:

- **Vigilant Health.** Through our proposed partnership with Vigilant Health, the Care Manager will connect the Member to real-time, face-to-face diabetes education and coaching, a diet and exercise plan, medication management, and other tools designed to support their diabetes self-management. Vigilant's patient-centered practice is integrated with local community-based resources and fits well with the PCMH model.
- **Diabetic DM Program**. As the Member continues to engage with the Care Manager and their diabetes stabilizes, we will transition them to our diabetic DM program for ongoing healthy lifestyle coaching. The Care Manager is mindful of the services the Member is receiving through Vigilant and will work closely with the DM coach to reduce the Member's diabetic complications, improve their self-management skills and compliance with HbA1c monitoring, and optimize the Member's physical activity, nutrition, and healthy eating behaviors.

Supporting ADHD Needs. Understanding how to manage their ADHD can directly impact the Member's ability to manage their diabetes and other health outcomes. We support the Member's ADHD needs through our integrated ADHD CM and DM Programs. If the Member is a child or adolescent, the Care Manager will actively engage the Member's parent/caretaker by educating them on ADHD, how to manage the Member's symptoms, and the importance of Provider follow-up. The Care Manager will determine if the Member has an Individualized Education Plan (IEP) and partners with the special education staff at the Member's school to ensure they are connected to recommended accommodations and treatment interventions for their ADHD and that PH, BH, and SDOH services and supports are integrated within the IEP. The Care Manager will connect the Member to community resources such as an ADHD support group, review self-care management strategies with the Member's circle of support, and provide a support guide with tips for individuals with family members with ADHD. The Care Manager will ensure the Member is connected to a Provider who will manage their ADHD symptoms and medications. For instance, if the Member is in foster care, the Care Manager will connect the Member's PCP to the UMMC Childhood Access to Mental Health and Psychiatry (CHAMP) program that provides consultation and educational service for PCPs. Through this program, the Member's PCP can receive support related to ADHD diagnostic clarification, medication adjustment, or treatment planning.

Ensuring Continuity of Care for Members with ADHD

Since 2018, our affiliate has consistently exceeded the 95% Quality Compass threshold for the Continuation and Maintenance Phase for Follow-Up Care for Children Prescribed ADHD Medication.

Monitoring and Follow-Up. The Care Manager will monitor the Member's overall health status, diabetes management, ADHD medication adherence, Provider follow-up, and ongoing compliance with their person-centered care plan. Moving forward, the Care Manager will contact the Member and caregiver by phone weekly, as determined by the care plan, and then at least monthly to identify any new or changing needs.

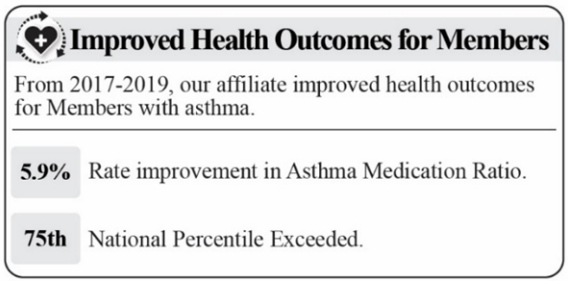
Remember the Member. At an affiliate plan, a Member in foster care was discharged to a shelter following an acute inpatient BH stay due to a lack of available foster care placement options. Knowing shelters struggle with these situations, the Care Manager reached out to assist. The Member had no follow-up scheduled prior to discharge, so we worked quickly to schedule an appointment with the Member's BH Provider within 7 days. The Care Manager completed a medication reconciliation and ensured the Member's prescriptions were filled, including a new ADHD medication. The Care Manager educated the Member on these medications, scheduled an EPSDT exam to ensure the Member's immunizations were up to date, and helped the Member obtain new glasses after an eye exam. The shelter was grateful for the support and swift interventions. The Member has since remained stable, experienced no readmissions or ED visits, and has attended all scheduled appointments.

c. The Offeror's Care Management System identifies that a fourteen (14) year old Member with behavioral health needs was admitted last night to a local inpatient facility after presenting with an asthma attack;

Hospitalizations for asthma bring added stress to adolescents and families and place a considerable burden on the health care system. Through our Transition of Care Program (TCP) services, we improve outcomes for Members who are hospitalized and identified as high risk, such as those with asthma and BH needs, by

addressing their whole person needs. Below we describe how we will partner closely with hospital discharge planning staff and Providers to ensure continuity of care for this Member, improve their asthma management, and reduce their risk of readmission.

Identification and Notification of Admission. We identify that this Member has been admitted to a local inpatient facility when our integrated UM and CM staff review our daily real-time inpatient activity reports. Tools in our Reporting and Analytics Platform will flag child and adolescent Members, allowing us to quickly alert and engage our interdisciplinary team. The UM team will leverage our Clinical Documentation System to complete an initial clinical review based on information obtained from the hospital that determines the Member's appropriate level of care and medical necessity for admission. Based on the Member's BH needs, asthma, and admission, we will stratify the Member into our High-Risk level of CM and assign them to our integrated TCP team. Through our secure Provider Portal, the Member's PCP will receive the notification of the Member's inpatient admission.



Outreach and Engagement. To minimize handoff and reinforce the Member-CM relationship, the TCP team includes the Member's assigned Care Manager, who will lead outreach, discharge planning, and TCP activities. The Care Manager will contact the Member and their parent/caretaker to coordinate a time to meet in person at the hospital. The Care Manager will explain the role of the TCP team and that the Care Manager will remain their primary point of contact at the health plan. Because the Member is stratified as high-risk, the CM asks the Member if they are feeling well enough to complete a CHA that confirms the Member's need for High-Risk CM by evaluating the Member's physical, BH, social, and psychological needs as well as the Member's SDOH needs, including access to utilities, nutrition, and transportation. During the CHA, the Care Manager will ask the Member and their parent/caretaker what triggered the Member's asthma attack and assess if the Member may benefit from an environmental assessment or visual walk-through of their home to help identify asthma triggers and discuss ways to reduce or eliminate those triggers. The Care Manager determines if the Member has a Medication Planner for their asthma and BH medications as well as an adolescent-sized spacer for their inhalers. Based on the information obtained during the CHA and from discussions with the hospital discharge planning team, the Care Manager will confirm that the Member remains appropriate for High-Risk CM.

CM Services and Interventions. The Care Manager continues to engage the Member and their parent/caretaker throughout the admission by answering questions about the Member's needs, helping them navigate the discharge planning process, and identifying preferences they have for the Member's care so the Care Manager can link them with culturally appropriate services and Providers. To improve the Member's asthma and BH outcomes and reduce the risk of readmission, the CM bridges the gap between hospital and home. The Care Manager partners closely with the hospital discharge planning team to jointly develop a transition plan that considers the Member's safety, PH, BH, and SDOH needs to ensure services and supports are in place before discharge. The Care Manager will help identify any limitations, barriers, or other factors that may affect the Member's discharge, follow-up, and continuity of care by using our ***Discharge Coordination Form*** which details the reason for the Member's admission, treatment and services received while inpatient, medications provided, and needed refills. Using our Clinical Documentation System, the Care Manager will review any existing person-centered care plan that the Member may have had in place before admission. If so, the Care Manager will update the Member's person-centered care plan to reflect details related to this admission and integrate the Member's transition plan.

Safe Discharge and Provider Follow-up. The Care Manager will reduce the Member's risk of readmission by ensuring a safe discharge and Provider follow-up. The Care Manager will address any SDOH needs identified during the CHA and will use our Community Resource Support Database to connect the Member and their family to local resources. The Care Manager will coordinate Provider follow-up by scheduling an appointment with the Member's PCP/PCMH within 30 days of discharge. The Care Manager will also inform the Member and their caregiver that asthma increases the Member's risk for developing complications from the flu and

COVID-19 and will ensure the Member is up to date on immunizations. If the Member is not already connected with a specialist to help manage their asthma needs, the Care Manager will coordinate an appointment with a specialist such as a pulmonologist who may have cared for the Member during their hospitalization.

Member and Caregiver Education. Asthma attacks can be incredibly scary, so the Care Manager will help calm any fear or anxiety the Member may have about potentially experiencing another asthma attack. The Care Manager will discuss that improving the Member's asthma management will allow the Member to participate in the activities they enjoy and live a healthier life. The Care Manager will provide the Member and parent/caregiver with simple, easy-to-understand asthma education and resources such as our ***Member Health Guides*** that support health literacy through age-appropriate videos, digital books, and parent guides that will increase their asthma knowledge. Through our free ***Online Health Library*** available on our public website, the Member and parent/caretaker can also access over 4,000 additional health-related topics in multiple languages, including those for asthma management. The Care Manager will discuss how to proactively manage the Member's asthma by discussing the triggers and symptoms identified during the CHA and will review effective environmental control measures with the Member and parent/caretaker, such as frequent dusting, vacuuming, and washing of pets, sheets, and rugs. The Care Manager will help the Member and parent/caretaker understand how and when to seek care from the Member's PCP, specialists, or local urgent care center and emphasizes our 24/7 NAL as an added resource.

Prioritizing Asthma Needs. An asthma attack resulted in the Member hospitalization, so the Care Manager will coordinate with the Member's PCP to develop an ***asthma action plan*** integrated within the Member's person-centered care plan and documented in our Clinical Documentation System. The Care Manager will partner with our pharmacy team to assess the Member's inhaler medications, authorize and arrange for a nebulizer and home equipment, and ensure the Member has both a controller medication and rescue inhaler. As part of our Asthma DM Program, the Care Manager will provide the Member with an adolescent-sized spacer and a medication planner to use at home and school. The Care Manager will also provide an instructional video on how to use their inhalers for better outcomes appropriately. In addition, our pharmacy team monitors claims data to identify Members who may have uncontrolled or repeated asthma exacerbations based on frequent use of rescue inhalers and will alert the Care Manager so they can provide additional education, follow-up, and support to the Member. We will also leverage our Medication Therapy Management Program and partner with CPESN, a community-based pharmacy network to improve medication adherence and close gaps in care for Members with asthma.

BH Services and Supports. Once the Member's immediate asthma needs are addressed, the Care Manager will focus on connecting the Member to BH services and supports. Members with asthma are at increased risk for anxiety and depression which can lead to poor asthma control and increased hospitalizations[2]. Our CM model includes BH Care Managers who support the Member's primary CM as needed to ensure the Member's BH needs are met. The Care Manager will use evidence-based tools approved for use with adolescents, including the GAD-2, PHQ-9, and NIDA-Modified Assist V2.0 to assess the Member's BH needs. The Care Manager determines if the Member is connected with a BH Provider, such as a therapist or psychiatrist, provides the Member with a medication planner, and confirms if the Member has an IEP in place at school. As part of our whole-person approach, the results of these tools will help inform recommendations for BH services and supports that are included in the Member's person-centered care plan. These include our 24/7 BH/SUD Line that is fully staffed by BH licensed clinicians and access to our digital BH resource application which is a customizable self-care tool that enables the Member to learn more about their diagnoses, track their symptoms, and receive motivational ideas and support to work toward solutions. The Care Manager will also encourage the Member's

Asthma Program

Our Asthma Program reduces in-home exposures to asthma attacks, improves quality of life and decreases the need for ED and other physical and/or behavioral health visits, with an estimated cost savings of $1,184 annually. As a value-added benefit, the Member is eligible to receive:

- $100 allowance for hypoallergenic bedding
- Medical masks
- Carpet cleaning services

[2] Rodriguez, Tori. The Asthma-Mental Health Connection: Expert Clinicians Weigh In. Pulmonology Advisor, 28 June 2019, https://www.pulmonologyadvisor.com/home/topics/asthma/asthma-and-mental-health-disorders-may-share-connection/.

parent/caretaker to utilize our digital BH resource application to support themselves and better understand the Member's BH diagnoses.

Monitoring and Follow-up. Within 72 hours of discharge, the Care Manager will contact the Member and their parent/caretaker by phone to complete a medication reconciliation and ***Post-Hospital Outreach Assessment*** to manage the Member's readmission risk, medication compliance, DME needs, and follow-up. The Care Manager will leverage our ***Digital CM*** web- and mobile-enabled solution to deploy customized asthma and BH programs and communicate directly with the Member and their parent/caretaker through HIPAA-secure messaging. The Member's PCP will receive a copy of the Member's care plan, which includes the Member's transition plan, and is notified of updates and changes as they occur. The Care Manager will contact the Member weekly to review the Member's adherence with their asthma action plan, discuss recent and upcoming PCP and specialist appointments, and identify any needs. The Care Manager will update the person-centered care plan as appropriate, including new recommendations for environmental asthma control measures.

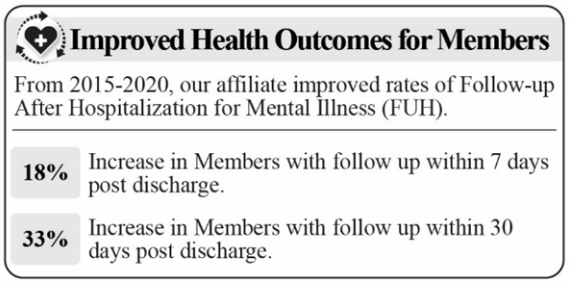
Remember the Member. At an affiliate health plan, an adolescent Member with depression was recently taken to the ED for complications related to asthma. Following the Member's discharge, our Care Manager contacted the Member's parent and completed a medication reconciliation. In doing so, the BH CM recognized that one of the medications was not the appropriate size, dose or color. The Care Manager contacted the pharmacy and sent the Member's parent back to the pharmacy to have the medication checked. The pharmacy informed the Care Manager that an error had occurred and that the medication dispensed was not the Member's prescribed psychotropic medication but was instead a diuretic. The Care Manager and pharmacy notified the Member's Provider who evaluated the Member. The Member's parent was grateful our Care Manager caught this issue before complications could occur. The Member has since remained stable with no further ED or inpatient visits related to their asthma or depression.

d. Member with behavioral health needs is taking multiple psychotropic medications and will be discharged from an acute psychiatric hospital and returning to his home next week;

We meet the holistic needs of this Member through our integrated, person-centered approach to CM and by deploying BH Care Manager staff from our interdisciplinary TCP team to coordinate discharge planning and follow-up. We will partner closely with the psychiatric hospital discharge planning staff and Providers to reduce the Member's risk of readmission and ensure the Member receives treatment and services in the least restrictive environment. We will ensure continuity of care to improve the Member's outcomes by connecting the Member to appropriate BH services and supports and ongoing monitoring of the Member's psychotropic medications.

Outreach and Engagement. We will begin discharge planning and TCP services upon notification of the Member's admission to the psychiatric hospital through our daily notification reports. Because the Member is discharging from an acute inpatient psychiatric stay, we will automatically enroll them into our High-Risk level of CM and assign them to a Care Manager and TCP team. To minimize handoff and reinforce the Member-CM relationship, the integrated TCP team includes the Member's assigned BH Care Manager who will support the Member's return home by leading Member and facility outreach and engagement, discharge planning, and TCP activities with assistance from our non-clinical support staff. The BH Care Manager will outreach to the psychiatric hospital to establish a relationship and obtain information related to the Member's admission, including the reason for admission, the Member's prescribed psychotropic medications, treatment received during the admission, discharge recommendations, and information related to the Member's social supports, housing, food insecurity, and other SDOH needs. The BH Care Manager will document all information in our Clinical Documentation System.

Ensuring Appropriate Discharge. The BH Care Manager will coordinate closely with the psychiatric hospital discharge planning team and our UM staff to ensure the Member is stable for discharge and transitions to an appropriate level of care. For instance, if the Member has stabilized in the acute setting but still requires daily group therapy, monitoring, and medication oversight by a psychiatrist, the Member may benefit from transitioning to a step-down level of care for continued evidence-based psychiatric care. This may include a Psychiatric Residential Treatment Facility (PRTF) if the Member is under the age of 18. If the Member is clinically stable to return home, the BH Care Manager will ensure services and supports are in place before the Member discharges. The Care



Manager partners closely with the psychiatric hospital discharge planning team to jointly develop a transition plan that considers the Member's safety, BH, and SDOH needs. The BH Care Manager will provide the Member with a Care Kit that includes a psychotropic medication planner, contact information for the BH Care Manager, information on our 24/7 NAL, and suicide prevention resources like our 24/7 BH/SUD Line that BH licensed clinicians fully staff. The BH Care Manager will engage in the ***"Golden Four"*** readmission prevention standards by: **(1)** Ensuring the Member has a priority BH follow-up appointment scheduled within seven days of discharge and providing the Member with appointment reminders; **(2)** Completing a psychotropic medication reconciliation; **(3)** Coordinating needed DME and screening the Member for SDOH needs; and **(4)** Determining/confirming the appropriate level of CM.

Screening and Assessment. Within 72 hours of the Member's discharge, the BH Care Manager will outreach to the Member telephonically to conduct a ***Post Discharge TOC Assessment*** to manage the Member's readmission risk, medication compliance, DME needs, and follow-up. Because the Member was automatically enrolled into our High-Risk level of CM, the BH Care Manager will obtain permission from the Member to engage them in High-Risk CM services. The BH Care Manager will complete a CHA within seven days via telephone or in-person if needed, that captures the Member's strengths, physical, BH, and psychological needs, medications, functional ability, cultural considerations, and information about the Member's SDOH, including education level, employment, housing status, access to nutrition, transportation, and any other social stressors the Member has. The BH Care Manager will use evidence-based tools like the ***GAD-2, PHQ-9, and NIDA-Modified Assist V2.0*** to assess the Member's BH needs, including the Member's risk of suicide and if the Member is experiencing symptoms like homicidal ideation or audio/visual hallucinations. The BH CM will also conduct an ***SDOH Mini-Screen*** to rapidly identify the Member's SDOH needs and use our Community Resource Support Database to provide the Member with tailored SDOH resources.

CM Services and Interventions. The BH Care Manager will partner with the Member to develop a person-centered care plan that reflects the Member's self-identified goals and integrates the Member's transition plan. To address the Member's physical health needs, the BH Care Manager will ensure they have a follow-up appointment with a PCP/PCMH. To coordinate care and avoid duplication of services, the BH Care Manager will share the Member's care plan with the Member's PCP. Additional services and interventions include:

Member Education. The Member's psychotropic medications increase the risk for diabetes and metabolic syndrome, so the BH ***Care Manager*** will explain this to the Member in simple terms and emphasize the importance of reporting side effects such as weight gain. The BH Care Manager will provide educational materials on the Member's BH condition and directs the Member to our online BH resources. The BH ***Care Manager*** will discuss the importance of self-care and additional health plan covered benefits and services, such as peer supports and family counseling if needed.

Continued BH Care and Support. The Member's transition plan will include a priority BH follow-up appointment scheduled within seven days of discharge with the Member's BH Provider or preferred Community Mental Health Center (CMHC). The Care Manager will confirm the Member attended this appointment and helps the Member schedule future appointments for ongoing evidence-based BH care. To avoid duplication of services and coordinate care, the BH Care Manager will share the Member's person-centered care plan with the BH Provider. If the Member is under the age of 21 and not enrolled in CHIP, the BH Care Manager will determine if the Member may be eligible for ***Mississippi Youth Programs Around the Clock (MYPAC)*** offered through DOM. The BH Care Manager also provides the Member access to our digital BH resource application, a customizable self-care resource that helps the Member learn more about their diagnoses, track their symptoms, and receive motivational ideas and tools to work toward solutions. To enhance Member engagement and encourage self-management, the BH Care Manager will use our ***Digital CM*** web- and mobile-enabled solution to communicate with the Member through HIPAA-secure messaging and deploy customized BH and post-discharge related programs.

Monitoring Psychotropic Medications. Given the Member's risk for potential medication contraindications due to taking multiple psychotropic medications, our ***Behavioral Health Medication Monitoring*** program educates and supports both the Member and their Providers. Our integrated pharmacy team will monitor our Drug

Utilization Review reports for interactions, duplications, and other potentially dangerous or inappropriate prescribing practices. The pharmacy team will then reach out to the prescribing Provider to educate and inform them of the issue and discuss steps to ensure the Member's safety.

Monitoring and Follow Up. As the Member is enrolled in our high-risk level of CM, the BH Care Manager will follow up with the Member via telephone weekly to support their ongoing needs. The BH Care Manager will discuss the Member's continued medication adherence and appointment attendance and identify new or changing needs. The BH Care Manager will remind the Member to contact them with questions about their medications, Provider follow-up, or other needs or concerns. The BH Care Manager will monitor hospital reports and pharmacy reports to identify any ED visits or inpatient hospitalizations and to verify the Member is filling their prescriptions. Subsequent monitoring and follow-up will continue at a method and frequency driven by the Member's goal progress, PH, BH, and SDOH needs until the Member can transition to a lower level of CM for ongoing SDOH support for long-term maintenance and continued stabilization.

e. Hospital staff are resistant to having you assist with coordinating discharge and Transition of Care activities for a Member.

Through our Transition of Care program (TCP), we reduce the Member's risk of readmission by closely coordinating with hospital staff and Providers, notifying the Member's PCP/PCMH of the admission, connecting the Member to appropriate post-discharge care and services, and conducting timely outreach and follow-up. Based on the scenario presented, below is our approach to coordinating discharge and TCP activities for a Member while facing resistance from hospital staff.

Outreach and Engagement. Our integrated UM and CM staff will identify the Member was admitted to an inpatient hospital through a facility authorization request and our daily inpatient activity reports. We assign the Member to our interdisciplinary TCP team and notify the Member's PCP or PCMH of the Member's inpatient admission via our secure Provider Portal to engage them in the TOC planning process. The TCP team includes the Member's assigned Care Manager, who will lead outreach, engagement, and TCP activities. This involves communicating with hospital staff and the Member's PCP/PCMH and other Providers to understand the Member's conditions and documenting this information in our Clinical Documentation System. The Care Manager will also partner closely with the hospital discharge planning staff and the Member and caregiver (s) to develop a transition plan, including information on their discharge plan and the importance of outpatient follow-up. As the Member was not enrolled in CM before admission, the Care Manager will attempt to visit the Member in the hospital. If the Member's acute condition prevents them from participating, the Care Manager will engage the Member's family, designated decision-maker, and/or durable power of attorney. The Care Manager explains the role of the TCP team, discusses the Member's condition, helps the Member understand why they were admitted, and begins planning for the Member's discharge needs. However, given this scenario, the hospital staff respectfully requests that the Care Manager conduct their business post-discharge. The Care Manager will again offer to assist with discharge planning, but the hospital declines, so the Care Manager escalates the situation to our CM supervisor.

Key Educational Messages. The CM supervisor will reach out to the director who oversees the hospital discharge planning team to discuss our shared interest in reducing the Member's risk of readmission and educate them on the importance of coordinating with our CM staff, as failure to properly transition care is a leading cause of readmission. The CM supervisor will emphasize we will not replace the role of the hospital staff but are here to actively partner with them to coordinate the Member's discharge needs from start to finish. The CM supervisor will share our Member-centered TCP process and explain how we can help identify and address discharge barriers and streamline the TCP process by using our ***Discharge Coordination Form,*** which indicates the reason for the Member's hospitalization, treatment, and services received while inpatient, medications provided, and needed refills. The CM supervisor will also highlight our focus on the ***"Golden Four"*** readmission prevention standards and emphasize the resources, services, and supports we can offer the Member, such as conducting an ***SDOH Mini Screen*** to identify the Member's SDOH needs and connecting the Member via closed-loop referrals to resources using our Community Resource Support Database. The CM supervisor explains that our TCP team can reduce the administrative burden on hospital staff by arranging DME, home health, and other services the Member may need. Therefore, the Member's dedicated CM and TCP team will:

- Work with the Member and family to obtain relevant information
- Reduce administrative burden on hospital staff by ensuring the Member has prior authorizations for medications or DME in place before discharge
- Ensure Provider follow-up visits are scheduled and completed post-discharge
- Confirm the Member's prescriptions are filled, and ensure the Member remains adherent
- Connect the Member to tailored resources for identified SDOH needs
- Help the Member and family understand all discharge instructions and address health literacy issues

Promoting Increased Coordination. The CM supervisor acknowledges the Readmission Reduction Quality Improvement Plan issued by DOM and discusses that the most effective results come from increased coordination and collaboration. This involves working with the hospital to address quality of care concerns and partnering with hospital social workers or other staff to build trust with the Member and ensure their whole-person needs are met. To reduce preventable readmissions, we will embed a Member of our integrated CM team at UMMC and actively partner with other health systems and hospitals in the State. Monthly, we will proactively meet with hospitals with high readmission rates to provide training on frequent causes of readmissions, discuss specific Member cases, and educate them on our ***Readmission Reduction Program*** which reduces preventable readmissions by optimizing transitions of care.

Reducing Potentially Preventable Readmissions

Members enrolled in our Readmission Reduction Program across affiliate health plans had a statistically significant lower rate of potentially preventable readmissions compared to Members not enrolled.

CM Services and Interventions. If the hospital remains resistant to the Care Manager's discharge and TCP assistance, the Care Manager will complete the Discharge Coordination Form with input from the Member and their family, PCP and ICT to develop a transition plan that addresses the Member's PH, BH, and SDOH needs. The Care Manager reaches out to the Member's PCP within 72 hours of discharge to obtain information to ensure continuity of care by coordinating needed services and ensuring authorizations are in place. Our UM program and partnerships with DME and home health agencies will enable the Care Manager to quickly arrange these services. If the hospital has not already done so, the Care Manager will also arrange follow-up appointments with the Member's PCP and other Providers.

Screening and Assessment. Within 72 hours of discharge, the Care Manager will contact the Member by phone to complete a ***Post Discharge TOC Assessment*** to manage the Member's readmission risk, medication compliance, DME needs, and Provider follow-up. The Care Manager will also ensure the Member's HRS is completed and/or updated by assessing the Member's needs based on their hospitalization. Knowing that medication error is the top reason for hospital readmission in adults, the Care Manager will complete a medication reconciliation and reviews the hospital discharge instructions with the Member to ensure they understand and can follow them.

Monitoring and Follow-up. The Care Manager will monitor the Member's progress to ensure all necessary post-discharge services have been provided and that the Member attends their follow-up appointments. The Care Manager will update the Member's care plan and level of CM, as appropriate, and works with the Member and their circle of support to understand the Member's root cause for admission, identify barriers and issues the Member is experiencing, and work together to prevent readmission. Moving forward, the frequency of follow-up is determined by the Member's preferences and outlined in the care plan. To address the hospital's ongoing resistance, our CM team will continue to emphasize the key educational messages described above and encourages the hospital to engage in our efforts to promote increased coordination.

Remember the Member. Our Care Manager from our affiliate health plan completed a TOC assessment with a Member with major depressive disorder who was discharged from an acute inpatient psychiatric facility following a suicide attempt by overdose. The Member was discharged without a follow up appointment scheduled so the Care Manager helped the Member contact their BH Provider. However, staff at the Provider office reported they were unable to schedule a visit because they had not received information from the discharging facility regarding the Member's inpatient treatment. The Care Manager educated the staff on the importance of timely follow up within 7 days of discharge and the office staff agreed to schedule a telehealth visit. The Member successfully completed their telehealth visit within the required 7-day timeframe, maintains ongoing therapy sessions and medication management appointments, and has not been readmitted.

ATTACHMENT 4.2.2.3.B.1 PROPOSED HEALTH RISK SCREENING

One (1) appendix response to B.1 limited to five (5) pages. Describe the Offeror's proposed initial Health Risk Screening (HRS) for new Members, including question, methods of seeking answers, and how answers will be used for stratification of Members based on acquit levels and Care Management.

HEALTH INFORMATION FORM

Please take a few minutes to fill out the form below or fill it out on our **website**. This will help us identify any extra needs or services you may require. Please place this form in the provided postage paid envelope and drop in the mail when complete.

If you have questions, please call our **Member Services Call Center** or visit our **website**.

If you are currently having any problems (physical, social, behavioral) that you would like to talk to a staff person at the Health Plan please call our Member Services Call Center. We will use the information on this form to help you get health care services. Your information will be kept private and confidential as required by State and Federal law. For more information, please see the Notice of Privacy Practice section of your Member Handbook or call us at our Member Services Call Center.

ONE MEMBER PER FORM

Member First Name:_____ Last Name:_____

Medicaid ID*_____ Member Date of Birth (mm/dd/yyyy)_____

Caucasian Black/African American Hispanic/Latino American Indian/Native American

Hawaiian/Pacific Islander

Name of Person Answering Questions:_____

Relationship to Member: Parent Guardian Spouse Friend Lawyer
Provider Other

If we would need to return a call to you, what is the best time and telephone number to reach you?

Morning (Y/N)?____ Telephone Number _____-_____-_____

Afternoon (Y/N)?___

Evening (Y/N)?____

Member Height:_____Feet___inches Member Weight:_____Pounds

1. Do you know who your PCP (Doctor) is? Yes / No

PCP's Name:_____

PCP's Phone Number:_____-_____-_____

When did you last see your PCP? Less than 3 months ago More than 3 months ago Never

Do you have an appointment scheduled with your PCP? Yes / No

If yes, when?_____

2. Are you having a problem with any of your medication that prevent you from using them the way your doctor ordered them? Yes / No

3. Have you been to the emergency room more than once in the last six months? Yes / No

Have you been admitted to a hospital in the last 12 months? Yes / No

If yes, what was the reason?_____

4. Are you currently pregnant? Yes / No

If yes, please answer the following and complete a pregnancy form. The form is on our website and included in the Member Welcome Packet.

Name of the doctor caring for you during this pregnancy:_____

Your Baby's Due Date (mmddyyyy):_____

5. Do you currently have any of the following conditions? (Circle all that apply)

Alcohol or Substance Abuse	High Blood Pressure
Asthma	HIV/AIDS
Cancer	Kidney Disease
COPD	Mental Health Condition
Depression	Transplant (On waiting list or received a transplant past 12 months)
Diabetes	Tobacco
Heart Disease	Other Medical Condition(s):_____

Do you have any special needs (such as hearing, vision, or mobility problems)? Yes / No

Please List:_____

6. What is your housing situation today? (Circle One)

I have housing

I do not have housing (stay with others, hotel, shelter, live outside, in a car)

I do not want to answer

7. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

Yes No Already shut off

8. In the past 3 months, how often have you worried that your food would run out before you had money to buy more?

Never Sometimes Often Very often

9. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Yes No Unknown

10. Which of the following would you like to receive help with at this time? (Circle all that apply)

Food	Housing	Transportation	Utilities (heat, electricity, water, etc.)
Medical care	Medicine	Medical Supplies	Dental services / Vision

Applying for public benefits (WIC, SSI, SNAP, etc.)

Understanding health information or completing medical forms

ATTACHMENT 4.2.2.3.B.2 PROPOSED COMPREHENSIVE HEALTH ASSESSMENT

One (1) appendix response to B.2 limited to five (5) pages. Describe the Offeror's proposed method(s) for the Comprehensive Health Assessment (CHA) of Members requiring a CHA after the initial Health Risk Screening, including questions, methods for seeking answers, and how answers will be used for stratification of members based on acuity level and Care Management.

Name: **DOB:** **Gender:**

Member ID: **Age:**

BHP:

Complex Care Management Assessment - Adult V2

Start Date: Provider Name:

Complete Date: Provider Specialty:

Case#: Case Name:

Score:

MEMBER INFORMATION

NOTE: MANY OF THE QUESTIONS IN THIS ASSESSMENT MAY BE PRE-POPULATED FROM THE MOST RECENT RESPONSES GIVEN IN ANOTHER ENTERPRISE ASSESSMENT. PLEASE REVIEW AND UPDATE, AS NEEDED.

What is your preferred name?

Race

Are you Native American?

Ethnicity

Preferred Language

What is the highest level of education you have completed?

What is your marital status?

What is your gender identity?

What is your sexual orientation?

Do you have any religious or spiritual beliefs that impact your health care?

Do you ever have difficulty understanding what your doctor or health care provider explains to you about an illness, medical condition, and/or treatment?

How often do you need to have someone help you when you read instructions, pamphlets or other written material from your doctor or pharmacy, or when you need to fill out medical forms?

Do you have any problems with your hearing, vision, or speech requiring special services?

HEALTH STATUS

In the past 12 months, has your overall health stayed about the same, improved, or worsened?

On a scale from 0-10, how ready are you to make changes for your health?

Do you have a doctor or health care provider?

Have you ever been told by a doctor or health care provider that you have any of these conditions? (check all that apply)

Name: **DOB:** **Gender:**

Member ID: **Age:**

BHP:

Arthritis

Asthma as an Adult

Cancer

Chronic Kidney Disease

COPD/Emphysema

Diabetes, Type 1

Diabetes, Type 2

Pre-diabetes

Heart Disease

Heart Failure

Hepatitis

High blood pressure

High cholesterol

HIV

Learning Disability

Sickle Cell Disease (not trait)

Stroke

Transplant

Do you have any other conditions not listed above?

Please include details about all diagnoses above, including dates of onset.

If member has none of the above, please type N/A.

Has a doctor or other health care professional told you that you suffer from memory loss, cognitive impairment, any type of dementia, or Alzheimer's disease?

Have you ever had any serious injuries to your head or neck in your lifetime?

Do you have a personal history of substance misuse?

Have you been diagnosed with a behavioral health disorder like anxiety, depression, bipolar or schizophrenia?

Please list details about all previous ER or hospitalizations due to a behavioral health condition.

If none, type N/A.

How many times have you been in the hospital in the last 3 months?

Please list details about all previous hospitalizations.

If none, type N/A.

How many times have you been in the Emergency Department in the last 3 months?

Member ID: **Age:**

BHP:

Please list details about recent ED use.

If none, type N/A.

Have you had any surgeries? (Check all that apply and enter date and details.)

Adrenal Gland Surgery

Appendectomy

Bariatric Surgery

Bladder Surgery

Breast Surgery

Cesarean Section

Cholecystectomy

Colon Surgery

Coronary Artery Bypass Graft

Esophagus Surgery

Gastric Bypass Surgery

Hemorrhoid Surgery

Hernia Repair

Hysterectomy

Kidney Surgery

Neck Surgery

Prostate Surgery

Small Intestine Surgery

Spine Surgery

Stomach Surgery

Thyroid Surgery

Other Surgery

Please list any other previous significant past illnesses, surgeries, or procedures not already noted.

Have you and your healthcare provider discussed elective surgery for any current condition(s)?

How many medicines are you currently taking that were prescribed by your doctor or health care provider?

Please list all current and past medications. (Include schedules and dosages ONLY for current medications.) Document here and/or in the Medication Module.

Complete medication reviews if needed. If none, type N/A.

Name: **DOB:** **Gender:**

Member ID: **Age:**

BHP:

On a scale of 0-10, where 0 = Health problems had no effect and 10 = Health problems had an effect, how much did your health problems affect your ability to do your regular daily activities (other than work at a job) during the past 7 days?

BEHAVIORAL HEALTH SCREENING

In general, how satisfied are you with your life?

Is there anything you would like to learn, change, or achieve to live your life the way you want?

During the past month, have you often been bothered by feeling lonely?

ACTION: If member answered "Yes" to "feeling lonely" question, complete Three Item Loneliness Scale questions.

During the past month, have you often been bothered by feeling down, depressed, or hopeless?

During the past month, have you often been bothered by little interest or pleasure in doing things?

ACTION: If member answered "Yes" to "feeling down" and/or "little interest" questions, complete PHQ-9 questions for members under age 65 or complete GDS questions for members age 65 and older.

Do you feel that stress in your life is affecting your health?

ACTION: If member answered "Yes" to "stress affecting their health", complete GAD-2 questions.

During the past year, how often did you have 5 or more alcoholic drinks in one day?

During the past year, how often did you use tobacco products?

During the past year, how often did you use prescription drugs for non-medical reasons?

During the past year, how often did you use illegal drugs?

ACTION: If member reports any prescription misuse or illegal drug use in the last year, complete NIDA Modified Assist questions.

How many hours of sleep do you usually get a night?

Do you often have trouble falling or staying asleep, or sleeping too much?

PAIN

During the last month, have you had pain that interfered with completion of housework or your ability to work outside the home?

ACTIVITIES OF DAILY LIVING

Do you need help with any of the following daily activities: Walking, getting out of a chair, eating, bathing, dressing, or going to the bathroom?

Do you currently have any open wounds? (ex: bed sore, accident wound, etc.)

Name: **DOB:** **Gender:**

Member ID: **Age:**

BHP:

Do you use any assistive devices?

Do you receive any home health services?

Have you fallen in the last year?

PREVENTATIVE CARE

When was the last time you saw a dentist?

What is your height (enter in feet/inches)?

in Feet

in inches

What is your weight (enter response in pounds)?

Have you or a health care provider been concerned about your weight?

Do you eat a healthy diet, such as eating fruits, vegetables and whole grains every day and limiting your sugar and saturated fats?

Do you eat at least 2 meals per day?

Do you have problems with your teeth or mouth that make it hard for you to eat?

Do you participate in regular physical activity?

Have you received a flu shot in the last 12 months?

Do you always use a seatbelt when you drive or ride in a car?

Are you female or male?

ACTION: For women of childbearing age, consider reproductive life planning questions from the Maternal Health Assessment.

SOCIAL DETERMINANTS OF HEALTH

Do you have a paid or volunteer job in the community?

Do you currently have concerns about having enough money to pay for your basic needs?

Within the past 12 months, did you worry that your food would run out before you got money to buy more?

Within the past 12 months, did the food you bought just not last and you didn't have money to get more?

In the past 2 months have you been living in stable housing that you own, rent or stay in as part of a household?*

Which of the following best describes your current living situation? (Select ONE only)

Do you have any concerns about your home's environment?

Are there any hazards that concern you? (examples include: no heat, no water, unsafe staircase, etc.)

Do you always feel safe in your home and around all the people in your life?

Name: **DOB:** **Gender:**

Member ID: **Age:**

BHP:

Do you have access to a safe, reliable telephone?

Do you ever have any problems with transportation to your medical appointments?

Do you have a primary caregiver who helps you on a regular basis?

What resources (caregiver/community support/paid support) are you currently receiving?

If member has a caregiver, does their caregiver need any additional training or support services?

Are you the primary caregiver for someone in your life?

LIFE PLANNING

Do you have an Advanced Directive or a Living Will?

Do you have a Health Care Representative and/or Health Care Power of Attorney?

Do you have Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms?

Has the Advance Directive, Living Will, MOLST or POLST form been shared with the PCP, treating provider(s) and caregiver(s)?

Are you interested in participating in care team meetings to discuss your health care needs?

CARE MANAGEMENT CONCLUSIONS

Did member report poor health status on HRA, HRS, or other assessment?

Please summarize the event or diagnosis that led to identification of this member for complex care management.

Please summarize your conclusions about the member's physical health status including presence/absence of comorbidities and their current status, compliance with medications, and CM next steps.

In your clinical opinion, would you be surprised if the member expired within the next 12 months?

Please summarize your conclusions about the member's behavioral health status including cognitive functions, mental health, compliance with medications, substance use disorders and CM next steps. Please summarize your conclusions about the member's hearing, vision and/or speech needs and their impact on effective communication, care or acceptability of specific treatments and CM next steps.

Please summarize your conclusions about the member's cultural and linguistic needs and their impact on effective communication, care or acceptability of specific treatments and CM next steps. Please summarize your conclusions about the member's functional status (ADL needs) and CM next steps. Please summarize your conclusions about the member's economic and social conditions and CM next steps.

Name: **DOB:** **Gender:**

Member ID: **Age:**

BHP:

Please summarize your conclusions about the member's adequacy of caregiver resources and family involvement and CM next steps.

Please summarize your conclusions about member's life planning activities and CM next steps.

Please summarize your conclusions about the adequacy of the member's health benefits and whether they are sufficient to fulfill the treatment plan and CM next steps.

Please summarize your conclusions about the member's eligibility and access to the following community resources and CM next steps.

Which community resources will you be referring the member to?

Community Mental Health

Transportation

Wellness Organizations

Palliative Care Programs

Other

Which agencies/services will you be referring the member to?

Behavioral Health Provider

PCP

Specialist

In-home Visiting Providers

Disease Management

Telemedicine

Waiver Program

WIC

Please list any additional referrals completed.

INTERNAL CARE MANAGEMENT

Assessment Completed Date

Assessment Completed By (Name)

Credentials of staff completing assessment?

Name of health plan, vendor, or delegated entity completing assessment?

By what method was the information obtained?

Was information obtained from a member's representative/caregiver/POA?

ATTESTATION: I have reviewed the Member Demographics module. The member's General Information section and Contact Information section have been transcribed and updated with the information obtained in this assessment.

Name: **DOB:** **Gender:**

Member ID: **Age:**
BHP:

ATTESTATION: I have reviewed and updated the Member Contact Summary with caregiver/POA information if applicable.

ATTESTATION: I have reviewed the Provider Contacts Summary module and the information is up to date and accurate.

ATTESTATION: I have reviewed the Member's Diagnosis module and the member's information is up to date and accurate.

ATTESTATION: I have reviewed all of the Member's Care Alerts.

OSU TBI Identification

I am going to ask you about injuries to your head or neck that you may have had anytime in your lifetime.

In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?

In your lifetime, have you ever injured your head or neck in a fall or from being hit by something?

Have you ever injured your head or neck playing sports or on the playground? (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)

In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?

In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat- or training-related incidents.

Interviewer Instruction: Ask the following questions if any of the previous questions were answered YES.

If more injuries with LOC, how many?

Longest knocked out?

How many over 30 minutes?

Youngest age when the LOC occurred?

Interviewer Instruction: Ask the following questions if all previous questions were answered NO.

Have you ever had a period of time in which you experienced multiple, repeated impacts to your head (e.g. history of abuse, contact sports, military duty)?

INTERPRETING FINDINGS

A person may be more likely to have ongoing problems, if they have any of the following:

WORST - One moderate or severe TBI

Member ID: **Age:**
BHP:

FIRST - TBI with loss of consciousness before age 15

MULTIPLE - 2 or more TBIs close together, including a period of time when they experienced multiple blows to the head

RECENT - A mild TBI in the last weeks or a more severe TBI in the last months

OTHER SOURCES - Any TBI combined with another way their brain function has been impaired

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Three-Item Loneliness Scale

How often do you feel that you lack companionship?

How often do you feel left out?

How often do you feel isolated from others?

Is the total score 6 or above?

PHQ-9

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

Feeling down, depressed, or hopeless

Trouble falling or staying asleep, or sleeping too much

Feeling tired or having little energy

Poor appetite or overeating

Feeling bad about yourself - or that you are a failure or have let yourself or your family down

Trouble concentrating on things, such as reading the newspaper or watching television

Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety

or restless that you have been moving around a lot more than usual.

Thoughts that you would be better off dead, or of hurting yourself

Total Score/Depression Severity

Geriatric Depression Scale

Choose the best answer for how you have felt over the past week:

Are you basically satisfied with life?

Have you dropped many of your activities and interests?

Do you feel that your life is empty?

Do you often get bored?

Are you in good spirits most of the time?

Are you afraid that something bad is going to happen to you?

Do you feel happy most of the time?

Do you often feel helpless?

Name: **DOB:** **Gender:**

Member ID: **Age:**

BHP:

Do you prefer to stay at home, rather than going out and doing new things?

Do you feel you have more problems with memory than most?

Do you think it is wonderful to be alive now?

Do you feel pretty worthless the way you are now?

Do you feel full of energy?

Do you feel that your situation is hopeless?

Do you think that most people are better off than you are?

Total Score/Depression Severity

Is the total score >5 and <10?

Is the total score >or =10?

GAD-2

Over the last two weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious or on edge.

Not being able to stop or control worrying

Total Score/Anxiety Severity

NIDA-Modified Assist V2.0

In your LIFETIME, which of the following substances have you ever used?

Cannabis (marijuana, pot, grass, hash, etc.)?

Cocaine (coke, crack, etc.)?

Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?

Methamphetamine (speed, crystal meth, ice, etc.)?

Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?

Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)?

Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?

Street opioids (heroin, opium, etc.)?

Prescription opioids (fentanyl, oxycodone (OxyContin, Percocet), hydrocodone (Vicodin), methadone, buprenorphine, etc.) for Non-Medical Use?

***** Please record NON-MEDICAL USE ONLY: Non-medical use refers to using a substance either not prescribed to the patient or used in ways or amounts not prescribed by their doctor.**

Other drugs?

Have you ever used any drug (including steroids) by injection for Non-Medical Use?

NOTE: The patient should not indicate "No" for all of the above drugs since they indicated they used an illegal or prescription drug for non-medical reasons in the past year.

Total Score

Maternal Health Assessment

***Thinking about your goals for having or not having children is called a reproductive life plan. Let's discuss some questions you may want to think about.**

Are you considering getting pregnant in the next year?

Program Enrollment

Enroll Member in Program now?

Member/guardian agrees to participate in program?

[END OF RESPONSE]

4.2.2.4 QUALITY MANAGEMENT

4.2.2.4.A Quality Management Program
1. Describe the Offeror's proposed quality management program, including:

Continuous quality improvement (CQI) is a core pillar of our organization. We are committed to ensuring access to high-quality and equitable care for Members through the provision of an effective Quality Management (QM) Program. The goal of our QM Program is to provide continuous performance of quality of care studies, health service delivery studies, and other monitoring activities using objective, measurable and current standards to ensure that services provided by our health plan improve the health status and outcomes of our Members. A highly qualified team will lead our proposed QM Program with local experience and the necessary subject matter expertise to serve both the MSCAN and CHIP populations. Our QM Program is founded on decades of experience serving Medicaid and CHIP beneficiaries across multiple markets.

We propose a QM program that directly aligns with the Mississippi Division of Medicaid's (DOM) Comprehensive Quality Strategy (CQS). Our QM program will meet all State, Federal, NCQA, and Appendix A, Draft Contract requirements. We have the infrastructure and experience to respond quickly and appropriately to future guidance on QM from DOM and the Centers for Medicare and Medicaid Services (CMS). Our quality initiatives will directly support the Mississippi Medicaid Access to Physician Services (MAPS), the Quality Incentive Payment Program (QIPP), and the Coordinated Care Value-Based Withhold Program by aligning incentives and designing training and technical assistance to support success under these initiatives.

Our QM Program will support improved health, address health disparities, improve access, and achieve cost savings through the delivery of high-value care and the meaningful use of data. We respect Member and Provider feedback and will be accountable to their experiences by incorporating feedback into our QM program. We will use innovative approaches, evidence-based practices, incorporate the voice of the Member, leverage community partnerships, and apply CQI principles to drive quality improvement focus areas and design our quality initiatives and PIPs. Our QM Program will focus on the health priorities defined by a combination of the DOM CQS, CDC 6|18 Initiative, Healthy People 2030, the National Institutes of Health, and other evidence-based sources. Through dashboards; daily, weekly, monthly, and quarterly reporting; and our quality committee structure, we will monitor HEDIS and CMS Core Measure Sets for adults and children, as well as performance measures that are aligned to specific priorities and goals used to drive quality improvement and operational excellence.

Quality Management Program Scope

In alignment with Section 8 of Appendix A, Draft Contract**,** our comprehensive QM program scope will include but is not limited to, assessment of access to care, barriers to care, quality of care, Care Management (CM), and continuity of services for the MSCAN and CHIP populations. Our QM policies and procedures incorporate all demographic groups, lines of business, benefits packages, and care settings. Our QM activities include preventive, emergency, primary, behavioral health (BH), specialty, acute, short-term care, and ancillary services. Areas subject to quality oversight include Member safety; credentialing and re-credentialing of Providers; delegate oversight; adoption and compliance with preventive health and clinical practice guidelines; acute and chronic CM; vision and dental health care; pharmacy benefit utilization and oversight, under- and over-utilization; continuity and coordination of care; appointment availability/network access; Member/Provider satisfaction; Grievances and Appeals; departmental performance and service; cultural competency; confidentiality; and Member rights and responsibilities.

Health Equity Lens

As a deliberate focus of who we are and what we do, our organization is establishing the foundation for advancing health equity and social justice, developing and modeling solutions to our most challenging health inequities. ***We will work with Jackson State University in collaboration with DOM and the other CCOs to develop a Health Equity Guide to align health equity efforts across the State***. As a further demonstration of our commitment to health equity, we will pursue ***NCQA Health Equity Accreditation***. Health Equity Accreditation includes the continuous quality improvement necessary to advance health equity and symbolizes the importance for all organizations to work toward a more equitable health care system. These efforts will inform

our Health Equity Plan and align with Population Health Management and quality goals. This fixed focus starts with listening and embedding the perspectives and voices of the community. It involves a restructuring of our governance; realignment of policies and procedures; a purposefully trained and diverse staff and Provider network; integrated data systems that stratify quality performance, utilization metrics, and disease prevalence by race, ethnicity, language, and disability data to identify social inequities; and culminating this work into meaningful partnerships and investments in our Members and communities we serve. It means leading by example and confronting the root causes of long-standing social and health inequities starting with our health plan.

a. The program's infrastructure, including coordination with subcontractors/corporate entities, if applicable;

Our QM Program infrastructure will be compliant with all requirements in Appendix A, Draft Contract. A culture of CQI is woven throughout our infrastructure and day-to-day operations. We will coordinate with our corporate entity for CAHPS surveys, accreditation processes, and HEDIS operations, but ***all responsibility for the QM program will be retained at the local health plan***. The people, processes, and technology that make up our QM Program infrastructure include:

People

Our QM Program is administered by dedicated, local QM staff and a QM Committee (QMC) with a thorough subcommittee structure.

Processes

Our QM staff leverage proven processes to deploy programs and initiatives to improve Member outcomes. This includes Plan, Do, Study, Act and Lean Six Sigma.

Technology

Our processes are enabled by cutting edge technology to identify opportunities for quality improvement before they become issues.

Dedicated, Local Quality Staff and Committees

As a quality-driven, NCQA accredited organization, our affiliates have adopted CQI as a core business strategy across all markets. Our executive and management teams apply data-driven decision-making in strategic planning and daily operations. Set up ***with local leadership, local decision-making, and local operations*** in every market, we ensure each functional area has defined service metrics aligned to the market's needs and with accountability to the local Senior Quality Leadership team. This will include a VP of Population Health and Clinical Operations and a Director of Health Equity. These and other key leadership roles are accountable to the QMC, focusing on quality and health equity across the organization. The QM department will serve MSCAN and CHIP Members by ensuring high-quality care through a team of local and qualified experts. The team will consist of registered nurses, licensed practical nurses, and non-clinical staff. QM will be led by a Certified Professional in Health Care Quality (CPHQ) and certification will be encouraged for all quality staff. All staff will receive annual training related to QM. Additionally, all Quality employees and plan leaders will be trained on QM methodologies during a 2-day Quality Boot Camp. This annual training includes a refresher on topics such as NCQA, HEDIS measurement, CQI, and will be expanded to include extended Health Equity trainings beyond the required CLAS Standards and Cultural Competency.

We will have several core committees to perform oversight of our QM Program and activities. Below is a brief description of each committee and its purpose.

Title	Purpose	Description
Quality Management Committee (QMC)	Review and direct clinical and non-clinical services provided to Members through comprehensive, ongoing, objective, and systematic monitoring, identification,	A multidisciplinary oversight committee of local executive leaders and participating external Providers. The QMC receives regular reports from all subcommittees that are

	evaluation, and resolution of process problems; identification of opportunities to improve Member outcomes; and education of Members, Providers, and staff about CQI.	accountable to the committee.
Health Equity Governance Committee (HEGC)	Provide oversight for Health Equity activities.	A multidisciplinary leadership committee responsible for the execution of the Health Equity strategy to reduce health disparities. The HEGC will review input and recommendations from our Community Impact Councils and report to the QMC.
Credentialing Committee	Ensure network Providers are qualified, properly credentialed, and available for access by our Members.	We will follow DOM's guidance and be compliant with the Centralized Credentialing Process. The Credentialing Committee will be responsible for reviewing the credentialing and re-credentialing Provider portfolios created by DOM's Credentialing Verification Organization (CVO). The Credentialing Committee will meet monthly to facilitate timely review and expedite network development. The Credentialing Committee reports to the QMC.
Pharmacy and Therapeutics Committee (P&T)	Review pharmaceutical management practices and align with preferred drug lists and make recommendations regarding drug utilization review activities.	The P&T Committee is a multidisciplinary team of network Providers and health plan pharmacy operations staff that meets annually. We recognize that DOM has a uniform preferred drug list and will comply with and support that list. The P&T Committee reports to the QMC.
Utilization Management Committee (UMC)	Monitor appropriateness of care and guard against over- and under-utilization of services.	A multidisciplinary team that meets quarterly and reports to the QMC.
Clinical Policy Committee (CPC)	Ensure that clinical policies provide a guide to medical necessity, are reviewed and approved by appropriately qualified Mississippi licensed physicians and are available to all Providers serving our Members.	A committee of internal and external physicians, nurses, and pharmacists that is led by the Chief Medical Director. The CPC is authorized by the QMC to make all decisions related to local Mississippi clinical policies.
Peer Review Committee (PRC)	Review alleged inappropriate or aberrant service provision by a Provider, including quality of care concerns, adverse events, and sentinel events where initial investigation indicates a severe adverse outcome has occurred.	An ad hoc committee that will include peer representation and report to the QMC.
Performance Improvement Team (PIT)	Responsible for gathering and analyzing data, identifying barriers to QI, resolving problems, and making recommendations for performance improvements.	An internal, management level, cross-functional QM team. The PIT will meet monthly and report to the QMC for focus area approval and further recommendations.
Quality Task Force (QTF)	Responsible for monitoring and improving HEDIS and Performance Measure rates for physical and behavioral health.	A multidisciplinary, internal, management-level committee. The QTF will review and establish benchmarks and performance goals, review and analyze monthly trends to determine areas of improvement, and direct Member and Provider CQI to improve performance rates. The QTF meets monthly and will report directly to the QMC.
Joint Oversight Committee (JOC)	Ensure that delegated entities carry out activities according to State and NCQA guidelines.	JOC meets quarterly and reports to the QMC.
Member Advisory Committee (MAC)	Solicit Member input for the QM Program and review Member satisfaction survey results and service-related issues.	A group of Members, Parents, guardians, and health plan staff that will review and report on a variety of quality improvement issues. The MAC will meet no less than semi-annually and reports to PIT.
Community Advisory Committee (CAC)	Make recommendations for health plan performance from a community-based perspective.	A statewide advisory committee that will provide the health plan with feedback on the QM Program and performance from community representatives. The CAC reports to PIT.
Hospital Advisory Committee (HAC)	Address concerns of network hospitals regarding prior authorization, concurrent review, discharge planning, and coordination of care and payment.	An advisory group made up of key administrative hospital leaders and health plan staff. The HAC will meet annually and reports to PIT.
Provider Advisory Committee (PAC)	Communicate health plan programs and processes to the Provider network, obtain feedback, identify issues, and allow Providers to make recommendations.	The PAC will meet annually and report to PIT.

Processes

Our CQI philosophy encourages us to ask ourselves: How are we doing? Can we do it better? Can we do things more efficiently? Can we be more effective? Can we do things faster or in a more timely way? As standard

practices, we use rapid cycle process improvement and apply plan-do-study-act (PDSA) cycles and LEAN/Six Sigma models to guide our CQI processes to evaluate each intervention and test high priority interventions on a small scale, then modify them as needed before full implementation.

Technology

We use data, including structure, process, and outcome measures, to monitor the success of interventions and appropriately modify, refine, or replace them as indicated. We will share data with our Providers, including PCMHs, FQHCs, and RHCs, through the Provider Portal. We will work with a diverse group of Mississippi stakeholders and Providers to evaluate the right State Health Information Exchange (HIE) partners to enhance bi-directional data sharing between our organization and Providers. We are committed to expanding on this existing infrastructure within Mississippi with data partners. This collaboration will drive innovation that improves Member quality of care and enhances the quality expertise driving the CQI process.

Our local staff and network Providers in Mississippi will have access to timely and actionable data to assess outcomes, identify disparities, determine improvement focus areas, drive clinical quality interventions, and evaluate results. Our Reporting and Analytics Platform of integrated decision support tools supports this critical function, highlighted with brief descriptions below.

- Our **Care Gap Analysis Tool** provides automated prospective clinical interpretation data daily, compared to the industry standard of weekly or monthly.
- Our **Reporting and Analytics Platform** supports predictive modeling and risk stratification solutions to inform quality initiatives and incorporate hot-spotting technology to identify and report risks and disparities at the population, individual Member, and Provider levels.
- **Health Equity Dashboard** is used to identify disparity reduction opportunities and track our quality performance related to promoting equity.
- **SDOH KPI Dashboard** aggregates social data with drill-down capabilities to analyze social determinants of health (SDOH) and their impact on Member health outcomes.

b. The program's lines of accountability;

Every department and function across our organization is responsible for and accountable for quality, with oversight through our quality team and committee infrastructure. The main lines of accountability for the QM program are illustrated in **Figure 4.2.2.4.A.1.b** below.

Local Board of Directors

Our local, physician-led Board of Directors will ultimately be accountable for oversight of the quality of care and services provided to our Members. Our Board of Directors will have authority, responsibility, and oversight of the development, implementation, and evaluation of the QM program. The Board of Directors will delegate the operating authority of the QM Program to the Quality Management Committee (QMC) and ensure the QMC has the resources and infrastructure necessary to follow through with recommendations. The BOD will be responsible for reviewing QMC meeting minutes at least bi-annually.

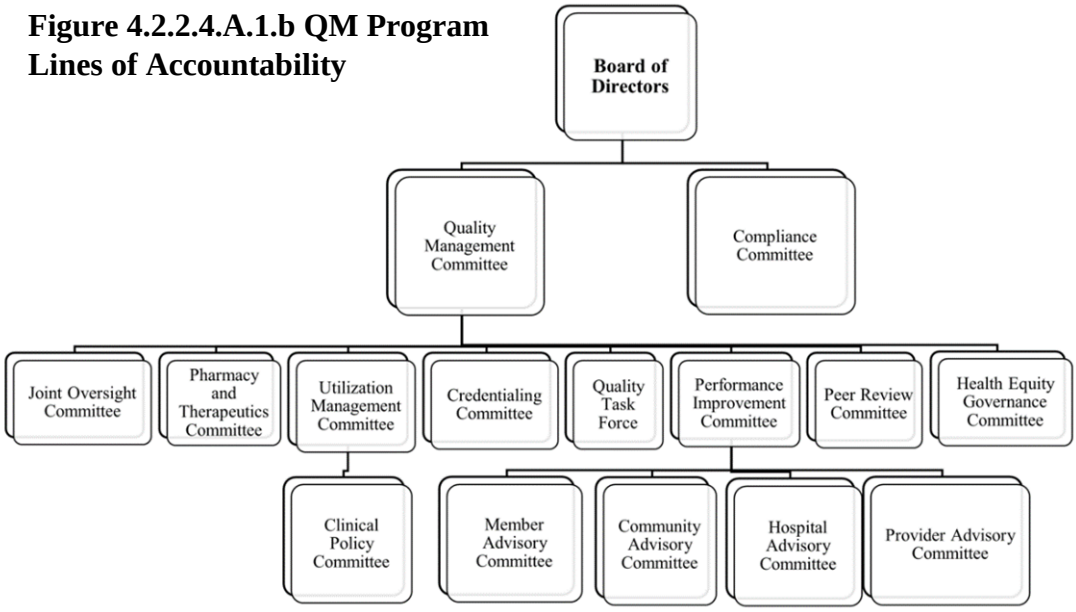
Executive Leadership

Our executive leadership team will serve as QM champions and foster an organizational culture that considers CQI integral to all health plan operations. Through steadfast commitment from leadership, a culture of listening, thoughtful education, and meaningful innovation, we will carry out our mission to provide meaningful, Member-centric opportunities for all Members to live their healthiest, most fulfilling life possible. The Chief Medical Director (CMD) will oversee the QM Program. The Vice President of Quality will report to the CMD and be responsible for the direction of day-to-day activities of the quality staff in monitoring and auditing the plan's health care delivery system, including, but not limited to, internal processes and procedures, CQI, Provider network(s), service quality, and clinical quality. Additionally, the VP of Quality will coordinate the QMC proceedings with the CMD.

Cross-functional Committee Oversight

QM will be integrated throughout the health plan, and the accountability for quality will be monitored through key operational areas and supported by our local committee structure. We will have a QM Committee Structure, illustrated in **Figure 4.2.2.4.A.1.b**, to monitor and support the QM program. We will establish subcommittees and workgroups based on our Members' needs and regulatory and accreditation requirements. These subcommittees and workgroups will report up to QMC and the Board of Directors.

Figure 4.2.2.4.A.1.b QM Program Lines of Accountability



c. Process for selecting areas of focus;

We will align with the Mississippi Comprehensive Quality Strategy (CQS) and utilize the three year CQS document to select areas of focus. We will use the CQS, data about our membership and program performance, and community partnerships and insights to inform our selection and prioritization of focus areas. We will choose topics that are evidence-based, relevant to the population served, impactful over time, and are aligned with Appendix A, Draft Contract. Development of focus areas may occur through committee input and collaboration with DOM, other CCOs, and community partners. We will incorporate the following focus areas into our QM program to improve health outcomes:

- Preterm births
- Maternal and Child health
- Child and adolescent health (increasing immunizations)
- Health Equity (relating to Member satisfaction with Providers)
- Chronic conditions related to cardiovascular, diabetes, and respiratory illnesses
- Behavioral health including schizophrenia and bipolar disorder

In addition, our process for selecting areas of focus will include:

Data Analysis. We understand the importance of using data to make decisions. We will leverage a data-driven approach to understand our Member's and Provider's needs and identify and recommend QM Program areas of focus. Our Enterprise Data Warehouse (EDW) is used to integrate data from both internal and external, clinical, and non-clinical sources. Data is combined from multiple systems and sources (e.g., claims, Provider data), across care sites (e.g., inpatient, community-based Providers), and across domains (e.g., social, clinical). We will use our Reporting and Analytics Platform and integrated decision support tools to determine trends, most prevalent issues, prioritize issues, conduct barrier analysis, and determine health disparities and SDOH.

Collaboration with Key Stakeholders. In addition to data, we will leverage our advisory committees to identify potential areas of focus. Our Member, Provider, and Community Advisory Committees provide valuable insights related to identifying and prioritizing quality initiatives. For example, in a market like

Mississippi, the Member Advisory Committee identified that Members did not understand the differences between Medicaid Managed Care and Medicaid Fee for Service benefits. In addition, Members did not realize they had unlimited PCP visits and often used the ED for primary care. This discovery led to an initiative to educate Members about their benefits and a complete revision of the Member Handbook. ***This initiative contributed to an increased Member PCP engagement resulting in a 42% decrease in ED visits.*** We will also participate in the Mississippi Coordinated Care Quality Workgroup to collaborate with DOM and other CCOs to select areas of focus and coordinate quality improvement initiatives to maximize impact.

Quality Committee Review and Recommendation. Our various internal quality committees, such as the HEGC and UMC, will review the above data and input from key stakeholders as it relates to each committee's purpose within our organization to develop Member and Provider centric strategies and programs that will improve Member health outcomes. These quality committees will present relevant findings to the QMC for feedback and approval on the selection of priority areas.

Development of Quality Improvement Initiatives and Performance Improvement Projects (PIPs). Following quality committee review and recommendations, we will develop quality improvement initiatives and PIP topics based on the selected focus areas. Our QM program will include PIPs that evaluate clinical and non-clinical areas, collection and submission of performance measurement data, mechanisms to detect both underutilization and overutilization of services, and mechanisms to assess the quality and appropriateness of care furnished to Members. As part of our CQI model, we will use our annual evaluation of program effectiveness to identify and implement modifications to achieve performance improvement. We will also look to the CQS and Appendix A, Draft Contract for quality improvement initiatives and PIP topics. We will utilize Mississippi specific data and/or the Member population data to identify disparate Member quality outcomes and the study aim for the project.

d. Process for using evidence-based practices;

We will use evidence-based practices for developing performance indicators, setting benchmarks and performance targets, developing clinical practice guidelines, and designing projects and programs to improve Member health outcomes. Guidelines are based on the health needs of Members and opportunities for improvement identified as part of our Quality Management Program as well as valid and reliable clinical evidence or a consensus of health care professionals in the particular field. Our process for using evidence-based practices will include:

Identification of Evidence-Based Practices and Industry Standards

We will leverage our corporate entity's national resources and expertise to identify and monitor evidence-based practices and industry standards on an ongoing basis. Our clinical and preventive health guidelines are evidence-based, consistent with national standards for prevention and management, and reflect specific recommendations published in peer-reviewed literature and by nationally recognized organizations including the American Cancer Society, U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, and the American Society of Addiction Medicine (ASAM).

Incorporating Evidence-Based Practices Throughout our Organization

We will comply with NCQA's standardized, nationally recognized, evidence-based standards for health plan operations and services. Our health plan policies and procedures will reinforce these standards. All utilization management criteria, coverage decisions, clinical programs, Member and Provider educational materials, and benefits information will be consistent with evidence-based guidelines.

Sharing Evidence-Based Practices with Network Providers

Supporting Providers with the correct information, resources, and guidance is perhaps the most effective tool in encouraging them to incorporate the best practices of their respective disciplines into their everyday provision of care. We value Provider input and recommendations in our decisions about which evidence-based guidelines we will ultimately disseminate. ***Our Clinical Policy Committee (CPC) is authorized by the QMC to make all decisions related to local Mississippi clinical policies and consists of internal and external physicians, nurses, and pharmacists that is led by the Chief Medical Director***. The CPC will ensure that clinical policies

provide a guide to medical necessity, are reviewed and approved by appropriately qualified Mississippi licensed physicians and are available to all Providers serving our Members. To best meet the learning needs and preferences of our network Providers we will share evidence-based practices with Providers through multiple modalities such as our Provider Portal, Provider Workshops, webinars, and newsletters (see response to Section 4.2.2.4.B.1 of the RFQ).

Continued Monitoring and Oversight

We will consistently monitor evidence-based practices to identify newly published guidelines as a result of scientific evidence changes and invite feedback from Providers about new guidelines prior to adoption through our committee structure. We will incorporate recommended changes into our organization and send them to Providers for adoption. Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma, EPSDT (Early and Periodic Screening, Diagnostic and Treatment), and pediatric preventive health guidelines. We will annually measure Provider compliance with the implementation of preventive and clinical practice guidelines. We use multiple means to show our Providers how their clinical performance compares to their peers. Within the Provider Portal, Providers can receive individualized analytic scorecards with information about their membership, opportunities for addressing gaps in care performance in key clinical areas, and their patients' care utilization through claims data. They can benchmark against other Providers within the same specialty to learn how well they are meeting the needs of their patients. This data gives them timely feedback on whether their patients are going to the hospital and emergency department or failing to have annual exams at higher rates than patients in similar practices. This information prompts Providers to reflect on how they care for their patients and serves as a powerful catalyst for better aligning with evidence-based practices that will result in improved Member health outcomes.

e. How the Offeror will comply with and support the Mississippi Managed Care Quality Strategy;

To elevate quality and ensure access to affordable, high-quality health care for Members, we will comply with and support the Mississippi Managed Care Quality Strategy by aligning our QM Program with the aims, goals, and objectives outlined by DOM.

Accountability

We will demonstrate good stewardship of public resources by ensuring the delivery of high-value, efficient services. We will adhere to DOM's performance measures, including CMS Core Measure Set for MSCAN and CHIP Members, State Withhold measures, HEDIS measures, and CAHPS measures to support the CQS. We will meet or exceed the specific performance requirements outlined in the Performance Measures Manual. We will cooperate with DOM's technical and regulatory monitoring, including the External Quality Review Organization (EQRO) and compliance audits as specified in Appendix A, Draft Contract, including timely document submission and onsite review. The CQS will be a standing agenda item for each QMC meeting. We will seek to make care more affordable through:

High-Value Care. Our organization has extensive experience providing high-value, evidence-based care using progressive approaches to support QM program requirements, including proposed innovations to address SDOH and health disparities that impact our Members. ***We will make health care more person-centered, coordinated, and accessible, empowering the Member to actively participate in their care.*** We will develop Member incentives for preventive care and chronic disease management in support of the CQS. We promote effective prevention and treatment of chronic disease using evidence-based interventions that address physical, behavioral, and social needs by supporting and educating our Members and Providers. We incentivize providers to deliver high-value high-quality care and improved outcomes through value-based purchasing (VBP) contracts with measures aligned with the CQS.

VBP Drives High-Value Care

All of our affiliate Medicaid health plans offer Provider participation in VBP contracts, resulting in up to 25% higher quality scores; 3% lower costs; 15% lower IP admissions; and 20% lower ED utilization rates.

Active Participation and Communication. To maintain compliance with State and Federal regulatory

requirements, we will actively participate in the DOM's quality initiatives and maintain strong communication with DOM staff. Our QM leadership and staff will participate in the Mississippi Coordinated Care Quality Workgroup, sharing ad hoc reports and updates on improvement activities collaborating with the DOM and peer CCOs.

Consistency/Sustainability

We will improve the health of Members through prevention, treatment, and evidence-based interventions that address their physical health, behavioral health (BH), and social needs. In addition, we will promote effective prevention and treatment of chronic disease and make care safer by reducing the harm caused in the delivery of care through:

Integrated Care. We will invest in partnerships and technology to promote access to BH/SUD services and communication and coordination of care between physical health and BH/SUD Providers. We will work towards advancing the use of PCMH in Mississippi to support integrated and coordinated care and improved communication. Through our Medicaid-specific experience across the nation, we recognize the importance of integrating care across the entire continuum. We understand the intricacies of coordinating with entities and State agencies involved in different components of the Member's care. We will coordinate services and supports required to address Members' needs and goals, regardless of which program or State agency provides the benefit or service. We will educate our PCPs and provide them with tools to better prepare them to identify, diagnose and manage BH/SUD conditions. We will continue to invest in telehealth and virtual solutions to strengthen our BH/SUD access. Our Members will be able to initiate two-way video and/or audio consultation for BH/SUD services, including talk therapy and psychiatric care. For coordination of care, virtual visit and follow-up care information is shared with the Member's PCP. We will partner with Mindoula to offer targeted interventions for high-risk populations with co-occurring BH/SUD and medical conditions. Initiatives will optimize and enhance our BH Provider network and include but are not limited to 24/7 team-based care, psychosocial education and skills training, and care coordination and navigation support. ***Mindoula's population health interventions have proven to decrease hospital admissions, readmissions, and avoidable ED utilization.***

Focus on Integration

From 2017 to 2019, 93% of Providers that were incentivized by a Medicaid affiliate to become PCMHs achieved improved overall HEDIS gap closure rates.

Local and Community Involvement and Collaboration. We will seek out collaborative partnerships with Providers, community-based organizations, and other CCOs to improve access to health care using innovative solutions to create a no wrong door approach for our Members. We will address maternal health inequities through a tailored program that address the diverse needs of Black mothers to decrease preterm births. This program will offer culturally competent maternal health solutions to connect Black expectant mothers with critical resources, including virtual and in-person access to peer support, Community Health Workers (CHWs), and doulas to drive positive pregnancy outcomes. In addition, the program will offer a symptom monitoring and analytics platform with curated content and lifestyle tips that speak directly to the experience of Black expectant mothers.

Respect

Our person-centered, integrated approach empowers Members to be an active participant in their care. We understand that ensuring accessible and well-coordinated care leads to improved health outcomes.

Focus on Member and Provider Experience. We engage and partner with Member's to improve their experience as we understand Member satisfaction with Provider Services directly correlates with Members' engagement in their care and health outcomes. Our organization's experience with improving Member satisfaction will support the CQS's aim to increase Member engagement with care and improve experience outcomes. For example, an affiliate in a similar market achieved ***Adult CAHPS summary rates greater than 90%*** across several composites, including Customer Service and How Well Doctors Communicate and ***Child CAHPS summary rates greater than 90%*** across several composites including How Well Doctors Communicate, Getting Needed Care, Customer Service,

Member Satisfaction

A Medicaid affiliate's 2021 Adult and Child CAHPS summary rates reflect Member satisfaction with Providers in the following composites:

- How Well Doctors Communicate 93.3%
- Rating of Personal Doctor 93.8%

Rating of Health Care, Rating of Personal Doctor, and Rating of Specialist.

f. Use of data to design, implement and evaluate the effectiveness of the program;

Use of Data to Develop and Implement the QM Program

We will use a data-driven QM approach to design, implement, continuously evaluate, and improve our programs, services, and Member health outcomes. We will develop and implement our QM program after an exhaustive analysis of demographic and epidemiologic data. Our quality staff will use the data and apply CQI principles to drive quality improvement focus areas and design our quality initiatives and PIPs. Data allows us to be agile and make quick decisions in the PDSA cycle, lends confidence to the decision-making process, and improves transparency. Data includes qualitative and quantitative information and is used to select and evaluate initiatives. We will use data to identify and select improvement opportunities relevant to our population, establish performance measures and goals (in alignment with DOM performance measures and goals), develop and implement interventions, measure improvement, and develop post-measurement activities. We will employ our integrated EDW and Reporting and Analytics Platform to monitor key performance indicators and Coordinated Care Program Performance Measures and track our progress in meeting initiative, QM Program, and DOM goals.

In alignment with Section 8 of Appendix A, Draft Contract, our QM program incorporates an ongoing documentation cycle that applies a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and evaluation. Annually, we will make DOM-approved information about the QM program and our progress in achieving program goals available to Members and Providers via our public website, Member and Provider newsletters, and Provider Portal.

The annual QM Program Evaluation will identify outcomes and areas of accountability through evaluation of the following:

- Analysis and evaluation of the overall effectiveness of the QM Program, including progress toward influencing network-wide safe clinical practices
- Completed and ongoing quality activities that address quality and safety of clinical care and quality of service
- Trending of measures collected over time to assess performance in quality of clinical care and quality of service
- Interventions implemented to address performance improvement projects and focused studies
- Measurement of outcomes
- Measurement of the effectiveness of interventions
- Whether there have been demonstrated improvements in the quality of clinical care and services
- Identification of limitations and barriers to achieving program goals
- Recommendations for the upcoming year’s QM Work Plan
- An evaluation of the scope and content of the QM Program Description to ensure it covers all types of services in all settings and reflects demographic and health characteristics of the Member population
- Adequacy of resources and training related to the QM Program
- Communication of necessary information to other committees when problems or opportunities to improve Member care involved the intervention of more than one committee

At the end of the QM Program cycle each year, the Quality Department will prepare the QM Program Evaluation. The evaluation will assess progress in implementing the quality management and improvement strategy and the extent to which the strategy promotes the development of an effective QM Program designed to serve our Members and Providers. Recommended enhancements to the program strategy or administration and commitment of resources that the QMC has considered will be included in the evaluation. In addition to providing information to the QMC, the annual QM Program Evaluation, or an executive summary as appropriate, will be used to provide information to accrediting agencies, regulators, stockholders, new employees, and the Board of Directors.

g. Assurance of separation of responsibilities between utilization management and quality assurance staff; and

We will ensure consistent separation of responsibilities between QM and Utilization Management (UM) staff through a separate reporting structure along with separate program descriptions, work plans, and policies. QM staff will report to the Chief Medical Director (CMD) and are responsible for quality assessment, data analysis, identification of opportunities and interventions that promote improvement, and evaluating the effectiveness of those interventions. UM staff will report to the VP of Population Health and approve authorization requests that meet medical necessity, utilization review, and discharge planning. These responsibilities are clearly outlined in their job descriptions. UM staff will follow established procedures and work processes to refer to designated QM staff to investigate any case for which they have information suggesting substandard quality of care. QM staff will monitor UM data to evaluate over- or under-utilization of programs and services, the turnaround times for prior authorizations, and UM denials that are reversed on appeal.

h. How the Offeror will address health access and equity in its quality management program

We will use our data-driven ***Health Equity Improvement Model*** (as captured in our response to Section 4.2.3.3 of the RFQ) which prioritizes improving health access and equity and includes quality improvement initiatives and programs designed to improve health care disparities. This model incorporates cultural sensitivity and awareness into CQI and the delivery of care to Members, their families, and the communities we serve.

Data Analytics

[redacted]

Oversight and Accountability

We will obtain NCQA HEA and will foster a culture that values health equity, addresses implicit bias, and increases cultural proficiency, health literacy, and education. We will align our CLAS and health equity standards, policies, and procedures and our CLAS and health equity initiatives to align with NCQA's Health Equity Accreditation (HEA). We will be accredited within six months of the contract initiation and are undergoing a comprehensive review of our current policies and procedures to assess alignment with the HEA standards and guidelines. Four of our affiliates currently have NCQA Multicultural Health Care Distinction (MHC), and ten affiliates are on track to receive MHC or HEA by the end of 2022. QM leadership will work with the Director of Health Equity who will be hired as a dedicated position to oversee strategic design, implementation, and evaluation of initiatives to improve health equity, reduce disparities, and increase cultural sensitivity. The QM Department will collaborate with the Director of Health Equity to ensure that the health equity lens is applied to all QM strategies and activities. Our accountability model aligns with National CLAS Standards and CQI, infusing health equity into all we do, including ***honoring the voice of Members, Providers, staff, and our communities***. Throughout these efforts, our HEGC, Community Impact Councils, Director of Health Equity, and team will ensure health equity best practices are woven throughout our population health programs and Member engagement strategy to reduce disparities and improve health access across the State.

Health Equity Tools

[redacted]

Network Access and Diversity

We will monitor network access and availability no less than quarterly and conduct audits to ensure Providers have adequate business hours, have a plan for meeting after-hours Member needs, and whether or not they are accepting new patients. We will audit the accessibility of Provider and Specialist appointment times for routine and sick visits. This information will be integrated with disparity data to identify specific areas in our network with Provider access issues and specific Member populations at risk. Periodically, we conduct a gap analysis to ensure we maintain an adequate network of PCPs, BH and specialty care Providers that meets the cultural needs and preferences of our Members. To increase the percentage of Mississippi Providers that meet minimum Federal and State disability access standards, our Provider Relations Specialists will conduct Accessibility Site Reviews. After the review, PCP/PCMHs can apply for a grant to carry out their improvement plan which could include wheelchair ramps and equipment such as accessible exam tables.

Health Equity Training

Training on healthy equity, cultural humility, and unconscious bias is critical to the success of our health equity initiatives and QM strategy. We offer training in Person-Centered Thinking, Trauma-Informed Care, and ACEs to build staff skills. The Quality team, including senior leaders, will participate in comprehensive training geared towards gaining a deeper understanding of our Members preferences and needs to improve access and health outcomes. We will use the information to guide initiatives and CQI to improve Member health outcomes. This training aligns quality improvement and health care transformation through a lens of health equity.

Provider Health Equity Education. We not only train our health plan staff, but we will provide training for our Providers and partners to create a common understanding of the root causes of inequities and foster a collaborative approach to address equity issues. We will include mandatory training on cultural competency, health equity, and implicit bias in our Provider orientation given by our Mississippi-based Provider Relations Specialists and through Community Based Organizations. For example, we will partner with the March of Dimes to provide “Breaking Through Bias” implicit bias training for OB Providers. Our Provider Partnership Associates will also provide training on cultural humility and implicit bias when meeting with Providers regarding clinical quality measures. Initial education and training for Providers will be conducted no later than 30 days before implementation of Appendix A, Draft Contract. In addition, the Quality team will support Providers by providing resources on health equity in the Provider toolkit.

2. Provide models of the following documents: Annual Program Evaluation and Annual Program Description/Work Plan that meet the requirements of Section 8, Quality Management, of Appendix A, Draft Contract (no more than 10 pages).

Please see **Attachment 4.2.2.4.A.2 Quality Management Program Models** for models of the Annual QM

Program Evaluation, QM Program Description, and QM Work Plan.

4.2.2.4.B Clinical Guidelines and Compliance

1. Describe the Offeror's proposed process to notify Providers of new practice guidelines and to monitor implementation of those guidelines.

We will engage in a formal review process of clinical guidelines annually but are constantly monitoring and updating as new guidance emerges. We ensure that utilization management criteria, coverage decisions, clinical programs, Member and Provider education materials, and benefits information are consistent with adopted CPGs. Our organization understands and will comply with all DOM requirements for CPGs and all other applicable State and Federal requirements. We will seek to coordinate the development of CPGs with other willing CCOs to present Providers with consistent CPGs across CCOs.

We will notify all Providers about new or revised CPGs relevant to their specialty and those against which their performance will be measured. Our website provides access to all adopted physical and BH clinical practice and preventive health guidelines by links or printable copies, and hard copies are available upon request. We distribute (or advise how to access) CPGs in orientation and training materials, Provider and Member Newsletters, Provider Manual, and when appropriate, by e-mail blast and/or mailings to Provider offices. Our Provider facing quality staff will personally distribute and meet with Providers to discuss new or revised CPGs to Provider offices with a panel of 100 or more Members. We will disseminate CPGs through regional Provider Summits and Provider workshop webinars, and other group settings, as our network Providers prefer in-person or face-to-face dialogue. CPGs update notifications are published in quarterly Provider Newsletters, toolkits, on the public website, and in the Provider Portal.

We will seek Physician Champions to personally advocate CPG compliance with contracted Providers. These champions will be high-performing contracted Providers or respected regional specialists who agree to share their best practices with their colleagues, professional organizations, and other Providers and, upon request, support the improvement activities of under-performing Providers. For example, at local Mississippi chapters of the American Association of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), or the Mississippi Academy of Family Practice (MSAFP). They will also advocate inside their clinical practices with colleagues and peers. Physician Champions will be selected by reviewing quality data and must have a high-quality, low-cost clinic to be eligible.

Our strategies for effective CPG implementation focus on motivating Providers and facilitating their use of guidelines. By involving Providers in the selection and adoption of CPGs, we obtain valuable input on guideline structure and presentation to maximize buy-in and acceptance by the Provider community. We motivate Provider improvement efforts by distributing performance data to Providers via secure email, in-person delivery, and on the Provider Portal.

Our Provider facing quality staff provide monthly HEDIS rate reports to PCPs with a panel of 100 or more Members and bi-monthly reports to PCPs with a panel of less than 100 Members. Annually, we will conduct randomized reviews of practitioners' individual HEDIS rates with Quality Compass benchmarks to verify implementation of guidelines. We will incentivize providers to adopt electronic health records, which include clinical support systems inclusive of clinical guidelines, to drive decision-making. Our value-based programs will enable us to monitor and encourage implementation by rewarding providers who successfully adopt clinical guidelines. Our pay-for-performance model incentivizes Providers for meeting certain HEDIS quality metric thresholds and those Quality Measures based on evidence-based criteria. We will recognize Providers with the highest quality scores for the year with Annual Quality Awards for Excellence in Care.

2. Provide a list of the behavioral health/substance use disorder clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines.

BH/SUD CPG List. Our organization will adopt CPGs following the Mississippi CQS, Appendix A, Draft Contract, evidence-based practices, and relevant to the Mississippi population. As a fully integrated organization, the proposed CPGs will consist of both physical and BH/substance use disorder (SUD) and apply to both adults and children. The proposed BH/SUD CPGs are listed below.

Table 4.2.2.4.B.2 Proposed BH Clinical Practice Guidelines

BH/SUD Conditions	Guideline Title	Recognized Source
Antipsychotic Prescribing for Children and Adolescents	Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents	Substance Abuse and Mental Health Services Administration (SAMSHA)
Attention–Deficit / Hyperactivity Disorder in Children and Adolescents	Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents	American Academy of Pediatrics
Anxiety Disorders	Generalized Anxiety Disorder and Panic Disorder In Adults: Management	National Institute for Health and Care Excellence (NICE)
Autism	Practice Parameter for the Assessment and Treatment of Children and Adolescents With Autism Spectrum Disorder	American Academy of Child and Adolescent Psychiatry (AACAP)
	Identification, Evaluation, and Management of Children with Autism Spectrum Disorder	American Academy of Pediatrics
Bipolar Disorder	Treatment of Patients With Bipolar Disorder	American Psychiatric Association
Depressive Disorder	Management of Major Depressive Disorder	United States Department of Veteran Affairs (VA) and the Department of Defense (DoD)
	Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts	American Psychological Association
Eating Disorders	Initial Evaluation, Diagnosis, and Treatment of Anorexia Nervosa and Bulimia Nervosa	American Academy of Family Practice
	Practice Parameter for the Assessment and Treatment of Children and Adolescents With Eating Disorders	American Academy Of Child And Adolescent Psychiatry (AACAP)
Gender Reassignment and Transgender Issues	Guidelines for Psychological Practice with Transgender and Gender Nonconforming People	American Psychiatric Association (APA)
Obsessive Compulsive Disorder (OCD)	Obsessive Compulsive Disorder	American Psychiatric Association (APA)
	Practice Parameter for the Assessment and Treatment of Children and Adolescents with Obsessive-Compulsive Disorder	American Academy of Child and Adolescent Psychiatry (AACAP)
Opioid Use Disorder and Treatment	National Practice Guideline For the Treatment of Opioid Use Disorder	American Society of Addiction Medicine (ASAM)
	Federal Guidelines for Opioid Treatment Programs	Substance Abuse and Mental Health Services Administration (SAMHSA)
	Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants	Substance Abuse and Mental Health Services Administration (SAMHSA)
	VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain	United States Department of Veteran Affairs (VA) and the Department of Defense (DOD)
Oppositional Defiant Disorder	Practice Parameter for the Assessment and Treatment of Children and Adolescents With Oppositional Defiant Disorder	American Academy Of Child And Adolescent Psychiatry (AACAP)
Posttraumatic Stress Disorder and Acute Stress Disorder	Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder	United States Department of Veteran Affairs (VA) and the Department of Defense (DOD)
Schizophrenia	Practice Guideline for the Treatment of Patients with Schizophrenia	The American Psychiatric Association, American Academy Of Child And Adolescent Psychiatry (AACAP)
	Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia	American Academy Of Child And Adolescent Psychiatry (AACAP)
Substance Use Disorders Management	Clinical Practice Guideline for the Management of Substance Use Disorders	Department of Veterans Affairs
Suicidal Behavior	Assessment and Management of Patients at Risk for Suicide	Department of Veterans Affairs and the Department of Defense (VA/DoD)

Provider Adherence Monitoring. As obligated by contract, Providers are expected to adhere to our organization's published guidelines to improve Member health outcomes. We will monitor CPGs monthly by reviewing HEDIS rates. Annually, no less than four CPGs (both physical and BH/SUD) will be reviewed, analyzed, and evaluated against Provider clinical data. Our organization uses HEDIS measures with national,

validated benchmarks to monitor network and Provider-level compliance with adopted CPGs. For example, for population-based analysis, adherence is assessed via claims or HEDIS rates. For practice-based analysis, a sample of medical records will be evaluated for adherence to specific guidelines. This information will be collected by Quality Improvement Coordinators and Providers will be informed of the outcome. The adherence analysis will be included in the QM Program Evaluation along with recommendations for the upcoming year. The QMC will also track other quality indicators, such as adverse events, Member complaints, and peer review outcomes.

If performance measurement rates fall below our internal and/or State goals, corrective action plans and/or interventions will be implemented for improvement, as applicable. All Provider CAPs are tracked through the QMC. We promote CPG documentation and offer continuing education to Providers as appropriate. When we identify Providers with persistent CPG noncompliance, Provider facing quality staff provide targeted education about adherence to CPGs, HEDIS measures, and proper coding. In addition, Medical Directors and Provider Relations staff may consult with select Providers to develop corrective actions. Provider adherence to the CPGs is emphasized during new Provider Orientation, Provider Workshop Webinars, and other Provider Quality training sessions throughout the year. Targeted education that includes CPGs relevant to specific Providers underscores the importance of compliance.

Opioid Use and Misuse Program Outcomes

A Medicaid affiliate saw the following improvements in quality outcomes:

- Decrease in % of opioid fills/total fills from 5.45% to 3.31%
- Decrease in % of opioid users (>30 days) from 3.95% to 1.7%

Provider Incentives to Promote Adherence. Our Provider quality incentives are aligned with the CQS objective to incentivize innovation by advancing value-based payment arrangements. We incentivize our Providers through value-based arrangements to encourage and recognize evidence-based, quality health care, including appropriate delivery of preventive care and screenings and follow-up treatment and services. For example, our VBP program rewards providers for achieving preventive care and condition management measures benchmarks.

Practice Management Support and Tools. The use of practice management support and tools can improve the practicality of CPG compliance. Our Provider Portal offers network Providers access to practice-level clinical quality reports so they can self-monitor guideline compliance. The Provider Portal displays Member-level Care Gaps with practice-level summaries that identify panel members needing recommended preventive care and treatment for chronic conditions. Providers can access these reports at any time. Our Care Management (CM) programs are consistent with, and support compliance with, approved CPGs, and our CM staff provide education and guidance on CPGs when interacting with Providers serving Members who have conditions relevant to our CPGs. Using our Reporting and Analytics Platform including our integrated suite of predictive modeling applications, they keep PCPs updated on Member-level utilization, risk, service, and CM data.

Our online Provider Resource Center (PRC) supports Providers in implementing CGPs. The PRC is available on our public website and provides a set of interactive tools and content such as reproducible patient education materials, flow sheets for tracking the management of individual Members, copies of assessment tools, physical and BH CPGs, and action plans for Members, Parents, or caregivers. It is organized so that Providers can find the best practice, evidence-based information they need, when they need it, across a broad range of topics from clinical practice through administrative operations to the use of information technology. We carefully vet all PRC content and functionality to deliver vibrant, searchable, targeted information with detailed citations to widely recognized sources and full attributions (or links) to copyrighted materials (such as source guidelines).

3. Describe the Offeror’s proposed process for compliance with the SUPPORT Act.

Through current programming and capabilities, we will adhere to Sections 4.1.4 and 4.2.4 of Appendix A, Draft Contract and all related C.F.R.s and references, including but not limited to the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act). This includes compliance with Drug Utilization Review (DUR) requirements, the implementation of an antipsychotic medication monitoring program for children, and Fraud, Waste, and Abuse identification requirements related to the use of controlled substances in Medicaid.

Opioid Use and Misuse Program. We will employ a quality-based integrated care program to support Members with opioid and substance use disorders (OUD/SUD). The program leverages collaboration with Providers and community support to promote best practices, including enhanced treatment and ancillary medical service access; monitoring evaluation and interventions surrounding prescribing and care patterns; engagement and recovery plans outside of the formal treatment setting; and coordination of care through Care Management interventions.

The program's primary goal is to enhance the scope of treatment and recovery continuum for our Members, with a focus on the whole person. Initially, Members will be identified and stratified by risk-level and impactability, using the Opioid Risk Model and comprehensive assessments. Identified Members are supported by Care Management staff and encouraged to participate and progress through the continuum, with service planning and coordination to acquire needed resources and address multiple aspects of their lives. Success is achieved by assisting members in accessing appropriate, cost-effective services to meet their individual health needs, and facilitate the arrangement of appropriate services. Both Quality and Pharmacy staff will monitor several performance metrics for improvement including but not limited to those in **Table 4.2.2.4.B.3.a**.

Table 4.2.2.4.B.3.a Examples of Opioid Misuse Program Metrics

Pharmacy Metrics	Quality Metrics	Clinical Metrics
• % Opioid prescriptions • % Monthly opioid utilizers • % Opioid utilizers >30 days • Medication Assisted Treatment (MAT) claims per 1000	• Use of opioids at high dosage • Use of opioids from multiple Providers • Risk of Continued opioid use	• Number of opioid-related ED, IP, and readmissions • Number of Neonatal Abstinence Service (NAS) • NAS births per 1000 live births • Length of NICU duration of NAS births • Opioid-related comorbidities and infections

Provider Capacity and Proficiency. We will build Provider capacity and proficiency to screen, engage, refer, and treat SUD and co-occurring disorders. Part of building Provider capacity and proficiency, particularly in primary care, is ensuring our network Providers can effectively identify and screen for potential SUD issues, have the ability and resources to treat/manage SUD and co-occurring conditions if appropriate, and refer to the right setting as needed. We will provide technical assistance and partner with PCPs, FQHCs, and RHCs to expand screening through the adoption of Screening, Brief Intervention, and Referral to Treatment (SBIRT) and utilizing standardized screening tools such as the PHQ-9, GAD-2, and AUDIT-C. We will provide network Providers with tools for providing brief interventions and treatment, including Motivational Interviewing techniques and Shared Decision-Making templates to communicate and facilitate access to the right services for each Member. We will further equip providers through the dissemination of CPGs onsite and web-based training, remote case review, and telehealth physician consults. We will also provide actionable data, such as alerts around the need for screening and follow-up, opioid misuse and Medication Assisted Treatment (MAT) prescribing practices.

4. Provide a list of the physical health clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines.

Our organization will adopt CPGs following the Mississippi CQS, Appendix A, Draft Contract, and evidence-based practices. All CPGs will be reviewed and approved by the QMC annually. As a fully integrated organization, the proposed CPGs will consist of PH and BH and apply to both adults and children. The proposed physical health CPGs are listed in **Table 4.2.2.4.B.4** below.

Table 4.2.2.4.B.4.a Proposed Physical Health Clinical Practice Guidelines

Physical Health Conditions/Diseases	Guideline Title	Recognized Source
Adult Preventive Care	Morbidity and Mortality Weekly Report (MMWR)	Centers for Disease Control and Prevention (CDC)
	U.S. Preventive Services Task Force Recommendations.	U.S. Preventive Services Task Force (USPSTF)
Asthma	Asthma Care Quick Reference: Diagnosing and Managing Asthma. Guidelines from the National Asthma Education and Prevention Program	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)

Physical Health Conditions/Diseases	Guideline Title	Recognized Source
	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma and 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)
	2020 GINA Report, Global Strategy For Asthma Management and Prevention	Global Initiative for Asthma (GINA)
Back Pain	Clinical Practice Guideline for Diagnosis and Treatment of Low Back Pain	Department of Veterans Affairs and the Department of Defense (VA/DoD)
	Low Back Pain, Adult Acute and Subacute	Institute for Clinical Systems Improvement (ICSI)
	Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians	American College of Physicians
	Diagnosis and Treatment of Low Back Pain	North American Spine Society (NASS)
Cancer	ASCO Guidelines by Clinical Area	American Society of Clinical Oncology American Society for Radiation Oncology (ASTRO) National Comprehensive Cancer Network (NCCN)
Chlamydia Screening	Final Recommendation Statement Gonorrhea and Chlamydia: Screening	U.S. Preventive Services Task Force (USPSTF)
Chronic Obstructive Pulmonary Disease	Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease	The Global Initiative for Chronic Obstructive Lung Disease
	Clinical Practice Guideline for the Management of Chronic Obstructive Pulmonary Disease	United States Department of Veteran Affairs (VA) and the Department of Defense (DoD)
Congenital Disorders	The Care of Children With Congenital Heart Disease in Their Primary Medical Home	American Academy of Pediatrics (AAP) and the American College of Cardiology (ACC)
	Guideline for the Management of Adults With Congenital Heart Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines	American Heart Association (AHA) and the American College of Cardiology Foundation. (ACC)
Coronavirus Disease 2019 (COVID-19)	Overview of Testing for SARS-CoV-2 (COVID-19)	Centers for Disease Control and Prevention (CDC)
Coronary Artery Disease	Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents. The Report of the Expert Panel	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)
	ACC/AHA Prevention Guideline: ACC/AHA Guideline on the Assessment of Cardiovascular Risk	American College of Cardiology (ACC) and American Heart Association (AHA) Task Force
	Routine Assessment and Promotion of Physical Activity in Health Care Settings; A scientific statement from the American heart association	American Heart Association (AHA)
	AHA Scientific Statement: Secondary Prevention of Atherosclerotic Cardiovascular Disease in Older Adults	American Heart Association (AHA)
	AHA/ACC/ASH Scientific Statement Treatment of Hypertension in Patients with Coronary Artery Disease	American Heart Association (AHA), American College of Cardiology (ACC), and American Society of Hypertension
	AHA/ACCF Guideline: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease	American Heart Association (AHA) and American College of Cardiology Foundation (ACC)
	2019 AHA/ACCF Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines	American Heart Association (AHA) and American College of Cardiology Foundation (ACC)

Physical Health Conditions/Diseases	Guideline Title	Recognized Source
Critical Care	Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock:	Society of Critical Care Medicine and European Society of Intensive Care Medicine.
Diabetes	AACE/ACE Consensus Statement: Consensus Statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm-2020 Executive Summary (Endocrine Practice 2020; Volume 26, No.1)	American Association of Clinical Endocrinologists and American College of Endocrinology
	Standards of Medical Care in Diabetes-2021 (Diabetes Care 2021, Volume 44, Supplement 1)	American Diabetes Association (ADA)
Epilepsy	Guidelines by Topic: Epilepsy	American Academy of Neurology and American Epilepsy Society
Frailty and Special Populations	American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults	American Geriatrics Society (AGS)
	Managing Medicines for Adults Receiving Social Care in the Community	National Institute for Health and Care Excellence (NICE)
General Evidence-Based Medicine	Choosing Wisely	Choosing Wisely; American Board of Internal Medicine Foundation
Heart Failure	Guideline for the Management of Heart Failure: A Report of the ACC, AHA, and HFSA	American College of Cardiology (ACC) Foundation, American Heart Association (AHA) Task Force on Practice Guidelines, and the Heart Failure Society of America (HFSA)
HIV/AIDS	Human Immunodeficiency Virus (HIV) Infection: Screening	United States Preventive Services Task Force (USPSTF)
	Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis	United States Preventive Services Task Force (USPSTF)
	Routine Human Immunodeficiency Virus Screening	American College of Obstetricians and Gynecologists (ACOG)
	Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States	National Institutes of Health (NIH)
	Diagnosis and Management of Acute HIV Infection (2018)	AIDS Institute
Hyperlipidemia	Lipid Management in Adults	Institute for Clinical Systems Improvement (ICSI)
	ACC/AHA Prevention Guideline: Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults.	American College of Cardiology (ACC), American Heart Association (AHA) Task Force on Practice Guidelines
Hypertension	2ACC/AHA/AAPA/ABC/ACPM/ AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults; A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines	Journal of the American College of Cardiology (ACC)
Immunizations	Recommended adult immunization schedule for ages 19 years and older	Advisory Committee on Immunization Practices (ACIP)
	Recommended child and adolescent Immunization Schedule for ages 18 years or younger	Advisory Committee on Immunization Practices (ACIP)
	Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the ACIP —Influenza Season	Advisory Committee on Immunization Practices (ACIP)
Kidney Disease	National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NFK KDOQI)	National Kidney Foundation
Lead Poisoning	CDC's Childhood Lead Poisoning Prevention Program	Advisory Committee On Childhood Lead Poisoning Prevention (ACCLPP)

Physical Health Conditions/Diseases	Guideline Title	Recognized Source
	Recommendations for Blood Lead Screening of Medicaid-Eligible Children Aged 1-5 Years: an Updated Approach to Targeting a Group at High Risk	Advisory Committee on Childhood Lead Poisoning, Division of Environmental and Emergency Health Services, and National Center for Environmental Health
Opioids for Chronic Pain	CDC Guideline for Prescribing Opioids for Chronic Pain	Centers for Disease Control and Prevention (CDC)
Osteoporosis	Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis.	American Association of Clinical Endocrinologists (AACE)
	ACOG Practice Bulletin N. 129. Osteoporosis.	American College of Obstetricians and Gynecologists (ACOG)
Palliative Care	Palliative Care for Adults	Institute for Clinical Systems Improvement (ICSI)
Pediatric Preventive Care	Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents	American Academy of Pediatric Dentistry
	Periodicity Schedule: Recommendations for Preventive Pediatric Health Care	American Academy of Pediatrics Bright Futures
Perinatal Care	AFP by Topic: Prenatal AFP by Topic: Labor, Delivery, and Post-Partum Issues	American Academy of Family Physicians (AAFP)
	Guidelines for Perinatal Care, Eighth Edition (2017)	American College of Obstetricians and Gynecologists (ACOG)
Pneumonia	Management of Adults With Hospital-acquired and Ventilator-associated Pneumonia: Clinical Practice Guidelines by the Infectious Diseases Society of America and the American Thoracic Society (2016	Infectious Diseases Society of America (IDSA)
	The Management of Community-Acquired Pneumonia in Infants and Children Older Than 3 Months of Age: Clinical Practice Guidelines by the Pediatric Infectious Diseases Society and the Infectious Diseases Society of America (2011)	Pediatric Infectious Diseases Society (PIDS) and the Infectious Diseases Society of America (IDSA)
Respiratory Illness	Adult and Pediatric treatment recommendations	Centers for Disease Control and Prevention (CDC)
	AFP by Topic: Respiratory Tract Infections	American Academy of Family Physicians (AAFP)
	Diagnosis and Treatment of Respiratory Illness in Children and Adults	Institute for Clinical Systems Improvement (ICSI)
Rheumatoid Arthritis	American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis (2021- Update in progress)	American College of Rheumatology (ACR)
Sickle Cell	Sickle Cell Disease, Recommendations	Centers for Disease Control and Prevention (CDC)
	Evidence-Based Management of Sickle Cell Disease: Expert Panel report	National Institutes of Health Heart, Lung, and Blood Institute
Special Health Care Needs of Adolescents	Standards for Systems of Care for Children and Youth with Special Health Care Needs	Association Of Maternal And Child Health Programs and the National Academy For State Health Policy
Tobacco Cessation	Tobacco and Nicotine Cessation During Pregnancy	American College of Obstetricians and Gynecologists (ACOG)
	Smoking and Tobacco Use Cessation	Centers for Disease Control and Prevention (CDC)
	Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons	United Preventive Services Task Force (USPSTF)
	Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions	United Preventive Services Task Force (USPSTF)
Traumatic Brain Injury (TBI)	Management of Concussion-mild Traumatic Brain Injury (TBI).	United States Department of Veteran Affairs (VA) and the Department of Defense (DoD)
Weight Management	Adult Weight Management (AWM) Guideline	Academy of Nutrition and Dietetics
	Clinical Report: Preventing Obesity and Eating Disorders in Adolescents.	American Academy of Pediatrics (AAP)

Physical Health Conditions/Diseases	Guideline Title	Recognized Source
	Managing Overweight and Obesity in Adults: Systematic Evidence Review from the Obesity Expert Panel	U.S. Department of Health and Human Services, National Institute of Health, National Heart, Lung, and Blood Institute
	Final Recommendation Statement Obesity in Children and Adolescents: Screening	U.S. Preventive Services Task Force (USPSTF)
	Clinical practice guideline for multicomponent behavioral treatment of obesity and overweight in children and adolescents	American Psychological Association (APA)

Provider Adherence Monitoring. As part of our QM program and to improve Member health outcomes, we will monitor Provider adherence to our CPGs. We will monitor CPGs monthly by reviewing HEDIS rates. Annually, no less than four CPGs (both PH and BH/SUD) will be reviewed, analyzed, and evaluated against Provider clinical data. Providers will be informed of the outcome, and this analysis will be included in the QM Program Evaluation along with recommendations for the upcoming year. See our response to Section 4.2.2.4.B.2 of the RFQ for a full description of Provider adherence monitoring.

5. Describe the Offeror's proposed policies, procedures, and processes to conduct Provider profiling to assess the quality of care delivered.

Provider Profiling Process to Assess Quality of Care Delivery

We have established policies, procedures, and processes that outline how our local organization will systematically assess the quality of care delivered to MSCAN and CHIP Members by our network Providers. These policies and procedures are integral to our QM and network performance strategy for PCPs to improve compliance with preventive health and clinical practice guidelines and clinical performance indicators. By providing quantitative feedback on clinical measures, the health plan promotes Providers' success and the health outcomes of Members. Our profiling system is developed with input from network Providers to ensure the process has value to both Providers and Members.

Table 4.2.2.4.B.5 Provider Profiling Program Policy

Policy Name	Purpose	Description
Provider Profiling Program	To outline the process by which we develop, implement, monitor, and distribute Provider-profiling reports to Providers.	To describe the process and distribution of Provider profiling reports to Providers.

Ongoing Assessment of Provider Performance. Provider profiles will include a multidimensional assessment of a PCP or other Provider's performance using indicators such as PMPM cost and utilization data, peer group comparisons, patient engagement analysis, quality performance measure trends, and readmissions by disease state. Provider profiling allows us to identify Providers delivering high-quality care, as well as Providers with opportunities for performance improvement. Profiling is conducted through claims data, and results are shared during monthly in-person meetings as well as electronically via dashboards available in the Provider Portal. Multiple data sources populate the dashboard, including but are not limited to the following:

- Claims and encounter data
- Pharmacy data
- Immunization registries
- Lab value data
- HEDIS measures

Provider Quality Performance Engagement and Support. Our quality and network teams work side by side with Providers to build useful, understandable, and relevant analyses and reporting tools to improve Provider quality performance and Member outcomes. These analytic reporting tools provide quantitative and actionable analyses of the Providers' Member panel. The data is visible and helps Providers recognize opportunities for improvement. For example, from a practice level, they can see which Providers in the practice are performing well. This type of information helps Providers establish and leverage best practices for operational efficiencies.

Annual Assessment of PCPs. Annually, our Quality Practice Advisors and Provider Relations Specialists will collaborate to assess all PCPs. Teams will meet with Providers whose performance is out of range from their

peers in-person to discuss dashboard results, identify any performance barriers, and determine what interventions are needed for performance improvement. Interventions may include but are not limited to, Provider education, sharing of best practices and/or documentation tools, assistance with barrier analysis, development of corrective action plans, ongoing medical record reviews, and potential termination of network status. For Providers identified as significantly outside the norm, re-measurement at six-month intervals may be required. If a Provider does not correct their issues, the case is reported to QMC then Compliance Committee. If necessary, the case will go to Peer Review for recommendations. Providers who meet or exceed established performance goals and demonstrate continued excellence or significant improvement over time will be recognized in publications such as Provider and Member Newsletter, bulletins, and press releases. High-performing Providers will receive preference for Member panel auto-assignment.

6. Describe methods the Offeror will use to ensure the quality of care delivered by Non-Contracted Providers.

We will ensure that the quality of care delivered by non-contracted Providers complies with all contractual and regulatory requirements. First, ***we will work with any Non-Contracted Provider to become a credentialed network Provider***. When a Member does receive care from a Non-Contracted Provider, for example, if a Member requires very specialized expertise unavailable in the network, they will need to access services from a non-contracted Provider. When this occurs, we will ensure the quality of care delivered by Non-Contracted Providers through education about quality standards, monitoring compliance with established standards, and dissemination of performance data.

Educating Non-Contracted Providers about Quality Standards. We will ensure that Non-Contracted Providers understand our expectations regarding quality. During the Single Case Agreement contracting process, we will educate non-contracted Providers about all relevant CPGs when Members are referred for service and/or when Members new to our plan are continuing a course of treatment with a Non-Contracted Provider. Printable copies and links to all adopted physical, and BH clinical practice and preventive health guidelines are available on our public website. Hard copies are available upon request. Provider Relations staff personally distribute CPGs to Provider offices if requested. Our Care Managers will recommend applicable CPGs to Providers during care planning and implementation for medium and high-risk Members.

Monitoring Non-Contracted Providers Compliance with Quality Standards. We require Non-Contracted Providers to comply with our quality standards as a condition of receiving authorization. We monitor compliance through our QM program by reviewing Non-Contracted Provider reports for identification of any Member safety concerns; quality of care issues; and Member or Provider Grievances and Appeals. Those reports also include any compliance issues identified by CM staff during care plan development and monitoring. As with network Providers, QM staff monitor, Grievances and Appeals, and quality of care indicators (such as unscheduled return to surgery, transfusion reaction, nosocomial infection, or unexpected death) for non-contracted Providers. QM staff focus on Providers with more than one occurrence or indicator during the previous six months.

The QM Department, with the support of the CMD and assistance from Provider Relations, investigates and reports findings and recommended actions to the Quality Management Committee (QMC) and, if necessary, the Peer Review Committee. Recommended action may include continued monitoring, education letters, phone calls, and potentially, restriction from providing services to our Members. In the event of service restrictions, UM, CM, and Provider Relations staff will cooperatively identify all Members currently under that Provider's care. CM staff will arrange for their transition to a network Provider, or to another Non-Contracted Provider if necessary. All such actions will be reported to the appropriate agencies per State and Federal requirements.

Dissemination of Performance and Outcome Data to Non-Contracted Providers. Our QM program will comply with all Federal rules and regulations for managed care entities regarding the interpretation and dissemination of performance and outcome data to contracted and non-contracted Providers approved for primary and specialty care referrals. We will disseminate performance and outcome data, as requested by the Provider, through our Provider Relations staff.

If Non-Contracted Providers establish relationships with our plan and serve significant numbers of our Members but choose to remain outside the established network of any MSCAN and CHIP, we may include

these Providers in profiling activities when sufficient Member volume and utilization exists to generate statistically significant information. Our annual profile report includes the Provider's individual score for each measure and a weighted composite score, with a benchmark for each score showing the average of like Providers and, as applicable, the NCQA Medicaid Mean.

In addition, we will make the Annual QM Program Report available to Non-Contracted Providers through the Provider Portal and make hard copies available upon request. The Provider Newsletter instructs Providers how to request a hard copy.

7. Describe the Offeror's proposed policies and procedures for reducing Provider Preventable Conditions, including Never Events. Describe the Offeror's process for precluding payment to Providers and reporting to the DOM via encounter data in accordance with 42 C.F.R. § 438.3.

As part of our commitment to providing the highest quality and most cost-effective care, we have policies and procedures (**see Table 4.2.2.4.B.7**), staff training, and Provider education in place for reducing Provider Preventable Conditions (PPC). The policies include our procedures for reporting PPCs and include processes for identifying, investigating, and implementing corrective action to reduce PPC and Never Events. We have system configurations in place that prevent payment for charges associated with Hospital Acquired Conditions (HACs) and other preventable Never Events that can be devastating for Members.

Table 4.2.2.4.B.7 Provider Preventable Conditions Policy

Policy Name	Purpose	Description
Provider Preventable Condition Payment Preclusion and Reporting	To define the requirements of the Preventable Provider Condition (PPC) initiative DOM reporting requirements. To detail conditions upon which reimbursement may be denied per CMS and State regulations.	We identify and investigate PPCs and Never Events through claims and clinical review activities. Staff are educated on definitions of and indicators for identifying these types of events and conditions and are instructed to report potential concerns to the QM Department within one business day for investigation and follow-up. Our claim processing system is programmed to process claims based on Present on Admission (POA) indicators to preclude payment to providers. We will report PPCs and Never Events to DOM via encounter data submission.

Compliance with Federal and State Requirements. We will follow the definitions and policies governing non-payment of HACs and PPCs described in the regulations and bulletins summarized below. Our policies and procedures are consistent with this guidance and are revised as updates are released.

- DOM Administrative Code Part 200 General Provider Information Part 200 Chapter 2 Benefits 2.2 Non-Covered Services
- 42 CFR 438.3(g) regarding compliance with the requirements mandating Provider identification of Provider-preventable conditions as a condition of payment
- 42 CFR 447.26, which also mandates that State Plans must require that Providers identify Provider-preventable conditions that are associated with claims for Medicaid payment and 42 CFR 447.26(d), requiring that as a condition of payment, all Providers agree to comply with the reporting requirements in 42 CFR 447.26(d)
- 42 CFR 434.6(a)(12), which prohibits payments to a Provider for Provider-preventable conditions
- Our organization shall require all Providers to comply with the reporting requirements in 42 CFR 447.26(d) as a condition of payment from our organization

Exceptions. We will follow all Centers for Medicare & Medicaid Services (CMS) and State guidance regarding exceptions, including deep vein thrombosis and pulmonary embolism following total knee replacement or hip surgery in pediatric and obstetric patients.

Payment Preclusion Process. Our claims processing system is programmed to process claims based on Present on Admission (POA) indicators. We will comply with Mississippi Administrative Code regarding POA indicators that are mandatory for inpatient claims submission, except exempt diagnosis codes. HACs and PPCs shall not be reimbursable as identified through self-reported POA indicators "N" or "U" as described in **Table 4.2.2.4.B.7** listed below and in our written policies. Our current policy is in full accordance with current Medicare National Coverage Determinations. It is reviewed and updated at least annually to account for any changes to national drug codes or other guidance adopted or issued by the State Medicaid agency in the State we are operating in.

Table 4.2.2.4.B.7 Reimbursable and Non-Reimbursable Present on Admission Indicators

Indicator	Description	Payment
Y	Diagnosis was present at time of inpatient admission.	Payment will be made when a HAC is present.
N	Diagnosis was not present at time of inpatient admission.	No payment will be processed on a HAC diagnosis. The diagnosis will be suppressed from the DRG pricing. Any other diagnosis with a POA indicator will be considered for the DRG pricing.
U	Documentation is insufficient to determine if the condition was present at the time of inpatient admission.	No payment will be made on a HAC diagnosis. The diagnosis will be suppressed for payment.
W	Clinically undetermined. The Provider is unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment will be made when an HAC is present.
1	Exempt from POA reporting. This code is the equivalent of a blank on the UB04.	Exempt from POA reporting.

PPC and Never Event Reduction Processes. We exceed minimum contract requirements by administering additional steps to ensure compliance, including promotion of Member safety through education of Members and Providers and processes to proactively identify and investigate potential PPCs and Never Events. We will review The Leapfrog Group and Hospital Compare data annually to identify areas of deficiencies so we can proactively educate Providers on our expectations Member care and safety.

Identification of PPCs and Never Events. Member safety is a key focus of the QM program. Monitoring and promoting Member safety is integrated throughout many activities, including through the identification of potential and/or actual quality of care events and critical incidents, as applicable. Potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of Member care, is not compliant with evidence-based standard practices of care, or signals a potential sentinel event, up to and including the death of a Member. All local plan staff across all operational areas, independent facility and ancillary providers, Members, Medical Directors, and the Board of Directors may advise the Quality Department of potential PPCs. Staff and Providers will be educated on the definitions of and indicators for identifying these types of events and conditions and will be instructed to report any potential concerns to the Quality Department within one business day for investigation and follow-up. PPCs and Never Events are identified through the following channels:

- Claims Review and Analysis
- Grievances and Appeals
- Medical Record Reviews
- Utilization Management Activities

Investigation of PPCs and Never Events. All potential Never Events and PPCs forwarded to or identified by the QM staff will be investigated by a clinical Quality Improvement (QI) Coordinator. The QI Coordinator will conduct a preliminary review of the identified or reported event to determine if it warrants further clinical investigation. If the event or PPC occurred in a facility, this review would be performed in collaboration with the facility's quality review process. The QI Coordinator will confirm that the facility Quality staff is aware of the event in question. The QI Coordinator will cooperate with the facility's quality management procedures. If the event background information reviewed does not meet the definition of a quality-of-care event or PPC, and is an expected clinical event, we will not conduct an investigation. If further investigation is needed, the QI Coordinator will prepare a confidential case file to summarize the investigation for presentation to the Medical Director for review. The Medical Director may request a consult from a board-certified practitioner with experience in diagnosing and treating cases similar to the case under review. The Medical Director can assign a severity level or refer the case to the Peer Review Committee for review and determination. The committee will discuss the case and come to a consensus on recommended final severity level and corrective action. The committee will assign an appropriate action, ranging from no further action required or the development of a corrective action plan to suspension or termination for cause from network participation.

Provider Corrective Action. Following the determination of appropriate action, the Provider in question will be notified of the recommendations, including corrective actions and timeframe for completion.

- The Medical Director may conduct informal education such as telephonic counseling or send an educational letter to the Provider regarding the specific event.
- More intensive actions will include formal oral or written counseling, requiring Medical Director Review of authorization requests, proctoring by a designated physician, or mandatory skills training. For the most serious Never Events and PPCs, the most intensive actions will include probation or termination of participation in the Provider network.
- For Never Events and PPCs involving facility staff or functions, the Medical Director will contact the facility risk management department to develop an action plan for the facility-based parties involved in the incident, in addition to the individual network practitioner. The Medical Director will assess any education or other action that has been taken by the facility and determine if the action meets the requirements of the Peer Review Committee decision.
- In the case of suspension or termination, we will follow the Practitioner Disciplinary Action and Reporting Policy, including notification to the National Practitioner Data Bank or other appropriate agency. We will inform the provider of any applicable appeal process.
- All Providers identified with quality-of-care events will be monitored for trend analysis regardless of severity level assigned. Provider-specific outcomes will be forwarded to the credentialing staff to be included in the Provider's credentialing file.
- The QMC will review aggregated peer review actions quarterly and may also initiate corrective action.

Provider Communication and Education. Provider communication and training are key tools that we use to ensure nonpayment for HACs and Never Events. Our Providers receive policy training for these conditions and events during Provider orientation, receive updates during regular meetings, and discuss these topics during ad hoc training and education sessions. All Providers have access to our policy on non-payment of HAC and Provider-preventable conditions via our website. We reinforce State and CMS guidance through our public website, email blasts, newsletters, and verbal reinforcement through telephonic or in-person communications with our Network Managers and our PR staff. Our Claims Liaisons and Analysts proactively review denied, rejected, claim pends, and other claim activity weekly. If a trend is found with a specific Provider through any of our quality checks, PR is notified with the details and a conversation to educate the Provider will take place.

Member Education. The QM program will support Member safety initiatives and the education of Providers and Members about safe practice protocols and procedures. These initiatives include utilizing the Member Handbook, website, and Member Newsletter articles to communicate information regarding Member safety.

PPC and Never Event Reporting. We currently build and submit these reports in other Medicaid markets and will comply with DOM's reporting requirements.

8. Describe how the Offeror will encourage Providers to use electronic health records and e-prescribing functions.

We will support the DOM in increasing the use of health care data and supporting meaningful use of health information technology to lower overall costs and foster improvements in quality of care, transparency, and outcomes. Through our enterprise Management Information System (MIS), we can support DOM's goal of sharing clinical data with Providers throughout Mississippi to improve quality, timeliness, and cost of care. Based on our experience, we know that the key to encourage the adoption and use of electronic health records (EHRs) and e-prescribing is to offer Providers the ability to receive actionable information, displayed in the manner the Provider needs to support automated workflows that relieve costly administrative burdens.

Our approach to encouraging EHR use and e-prescribing is based on our Provider engagement efforts and recognition that Providers have varying technology capabilities. We will "meet Providers where they are" technologically and encourage Providers to use EHRs/e-prescribing to connect and stay connected with us and share in the ongoing cost savings gained from EHRs/e-prescribing while employing technology for impactful applications.

Identifying and Engaging Providers

We will conduct a survey of our Provider network to target engagement efforts and determine which Providers are currently using EHRs and e-prescribing platforms and which platform they use. The information collected will inform how we engage Providers with education and tools to encourage EHR use and e-prescribing. Our

Quality Practice Advisors and Provider Relations staff will identify Providers' use of EHRs during routine Provider contact (e.g., service inquiries, site visits) and Provider training sessions. We will also analyze pharmacy data which contains information on the use of e-prescribing. This will allow our pharmacy team to reach out to Providers that have e-prescribing capabilities but elect to utilize traditional prescribing methods.

Encouraging EHR Use

We will support Providers to adopt EHRs through:

VBP Arrangements. We will incent Providers to adopt EHRs by encouraging technological advancement through VBP arrangements. For example, an affiliate developed an Alternative Payment Model (APM) in collaboration with FQHCs to improve quality performance, assist FQHCs with infrastructure development and practice transformation, and reduce costs. Participating FQHCs were eligible to earn a $9,000 infrastructure bonus for establishing a method of electronic data sharing, such as through an EHR. We will make similar investments to participating Providers in support of their EHR adoption efforts.

Tailored Communication. We will engage Providers through our Provider Newsletters which will discuss a variety of topics including issues about Health Information Technology (HIT) such as the benefits of EHRs and HIE connectivity and the importance of EHRs and HIEs in enabling Providers to take on VBP arrangements and enhance incentives. Our Provider Relations team will engage in high-touch, personalized outreach to our network Providers to keep them informed on upcoming trainings and conduct Provider surveys to assess connectivity level and technology needs.

Transdisciplinary Partnerships. We will identify unique partnerships and collaborations to increase the use of EHR technology among all Provider types. For example, our Subcontractor for vision benefit management partnered with an optometric association in an affiliate market to develop a Diabetic Eye Care Alliance. This initiative identifies eye care Providers committed to diabetic eye care, care team coordination, and information exchange. To participate in this program, Providers must use EHR technology. Although current EHR systems do not universally communicate, participation in this Alliance highlights the vitality of information exchange and Providers committed to care team coordination

Encouraging E-Prescribing

To reinforce Provider education and facilitate timely access to needed and appropriate preferred drugs, we will encourage network Providers' use of e-prescribing. In partnership with DOM's Pharmacy Benefit Administrator (PBA), we will give existing e-prescribers near real-time access to our patient-specific medication history, eligibility information, and Preferred Drug List (PDL) coverage, so that prescribers can easily identify medications on the PDL and alternatives for medications that require prior authorization. For those without current e-prescribing capabilities, our PR staff will engage Providers, where plausible, by encouraging e-prescribing through training and education.

For Providers who are ready to and capable of successfully participating in value-based purchasing (VBP) arrangements, we have the capability to offer incentives to encourage e-prescribing. In addition, Providers who currently have e-prescribing capacities will receive financial bonuses aligned with VBP efforts for demonstrated improvements in prescriptions filled electronically. A Medicaid affiliate is currently supporting this incentive through a Provider agreement amendment.

Resources for Providers Not Currently Using EHRs

For Providers with no EHR and/or new to the use of EHRs in their day-to-day work, our secure Provider Portal is a no-cost and low-risk tool to engage Providers on the topic of EHRs. Providers can demonstrably see the value of EHRs (e.g., medication history, Care Plans), which helps spur their interest in obtaining their EHR for their entire Member panel. Our online Provider Resource Center (PRC) is a well-organized, searchable collection of best practices documentation, multi-media content, and tools to help Providers address the challenges of their practices. The PRC will include educational resources to support EHR and e-prescribing adoption. Training materials will also address topics such as incorporating e-prescribing into Provider workflows, expanding the use of EHRs, using prescription history to support medication management, and connecting to State Health Information Networks/Exchanges.

4.2.2.4.C Quality Measurement
1. Describe the Offeror's data analytics and data informatics capabilities and how the Offeror will use those capabilities to drive performance improvement and quality management activities. Provide up to ten (10) pages as appendix to this response of excerpts from or full sample reports that the Offeror proposes to use for this Contract.

Advanced Data Analytics and Informatics to Transform Quality Management

Our organization has robust data analytics and data informatics capabilities. We will utilize data in all decision-making processes and add credibility to the information at our disposal. As part of our data-driven approach to QM, our Quality team will leverage multiple technology resources to support quality analytics and drive performance improvement and quality outcomes.

We use multiple integrated data sources housed in our Enterprise Data Warehouse (EDW) to identify and select improvement opportunities that are relevant to our Member population, establish performance measures and goals (in alignment with State Custom Performance Measures and goals as referenced in Section 8.5 and the Performance Measure Manual) and develop, implement, and evaluate interventions using CQI processes. Through our EDW and Reporting and Analytics Platform, our staff and Providers will have access to actionable data reporting to monitor KPIs, such as MSCAN and Mississippi CHIP quality performance measures, and track our progress in meeting QM program and DOM goals, drive clinical quality interventions, and evaluate results.

We will monitor over and underutilization of services, Care Management services, behavioral health services, and any delegated vendor services. We will use a cutting-edge maternity analytics platform to supplement our analytic capabilities. This enhanced pregnancy identification and risk stratification will help us detect at-risk pregnancies sooner, prevent preterm births, and reduce racial disparities. ***The platform currently identifies 98% of moms before delivery and 70% in the first trimester, allowing for critical first-trimester prenatal visits, stronger doctor-patient relationships, and higher quality care throughout their pregnancy.***

Reporting and Analytics Platform Capabilities. Our Reporting and Analytics Platform is a comprehensive family of integrated decision support tools. The platform provides flexible desktop reporting and online KPI Dashboards with drill-down capabilities. These capabilities enable our internal staff and network Providers to access actionable data reporting to assess outcomes, determine improvement focus areas, drive clinical quality interventions, and evaluate results. We have the ability to report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, Performance Improvement Project informatics, and other critical aspects of our operations. We drill down and stratify all available demographics, including geography, age, gender, and RELD. The platform includes a suite of best-in-class predictive modeling and risk stratification solutions incorporating evidence-based, care gap, and health risk identification applications that identify and report significant health risks at the population, Member, and Provider levels***. Our Diabetes Predictive Model has a positive predictive value of 93%, and our Readmissions Prevention model has a positive predictive value of 80%.***

Use of Data for Quality Initiatives. Data is used at a high level to inform Member centric strategies and programming to address the management of chronic and acute conditions and reduce health disparities. Our QM and PR Teams use reports to identify high-performing Providers and use their initiatives to disseminate local best practices across the network. Member-facing staff can view care gaps and areas of health risk during each Member interaction and arrange for follow-up services and referrals to close care gaps, including preventive services, cancer screenings, and chronic condition management. PCPs can see care gaps via the Provider Portal when they check eligibility and close gaps during upcoming visits. Real-time data enables our staff and PCPs to quickly identify and prioritize care needs and address emerging health issues at the earliest clinically appropriate time. ***As a result of our efforts, we continue to make a direct impact on Member outcomes, including improvements in quality. Using the data in the PDSA cycle, an affiliate Medicaid plan met or exceeded the 75th percentile for 13 HEDIS measures between CY 2019 and CY 2020.***

Assessment of Provider Performance. Using the Reporting and Analytics Platform, we have the capability to create reports that enable us to track Provider performance on quality measures. We profile Providers using a multidimensional performance assessment across clinical and administrative care indicators.

Our Providers receive quantitative and actionable analyses of their Member panel via analytic tools on our Provider Portal so they can optimize each Member interaction and focus on care gap closure to improve quality outcomes.

Annual QM Program Evaluation. We will conduct a comprehensive QM Program Evaluation that documents our analyses and evaluation of system performance and the effectiveness of clinical and non-clinical initiatives and other components of our QM program. As in other States, we are committed to publicly sharing the report results of our QM program to promote transparency and excellence. We will make DOM-approved information about the QM program and our progress in achieving program goals available to Members and Providers in newsletters and on our public website annually.

Sample Reports

Sample reports demonstrating our data analytics and data informatics capabilities are provided in **Attachment 4.2.2.4.C.1 Sample Reports**.

a. Describe the type of build necessary to create these types of reports.

Accurate and Flexible Reporting Capabilities. We currently build and create these reports in other Medicaid markets. Our EDW produces high-quality, reliable data to enable better decision making. We have the capability and tools to build and create quality reports to monitor and track performance. Report Builder powered by our EDW provides our analysts with access to a library of over 12,000 existing Medicaid reports covering administrative, operational, clinical quality, service delivery, compliance, and financial aspects of our health plan activities. This library of pre-built report templates allows our team to have the flexibility and easily create their custom reports by subject area in a guided fashion, which they can then save for ongoing use.

The Report Builder allows our analysts, including those with no previous coding background, to quickly respond to ad hoc requests in the timeframe specified by a State. Report Builder enables analysts to access our comprehensive dataset, data dictionary, and library of report templates, via an easy-to-use graphical interface, for rapid report creation. If the DOM requests a new report or our staff needs to run an ad hoc report for a regular interval, our analysts can save report logic to easily reproduce upon returning to the platform.

2. Describe any innovative approaches the Offeror plans to use to ensure that Quality Measurement is both accurate and evidences efficacy of programs.

Quality Measurement Approach

Our organization explores and uses innovative approaches to quality data measurement to support our approach to quality improvement. The following data analytics tools and processes exemplify how we ensure accurate quality data measurement and demonstrate the overall effectiveness of the QM program. We will meet or exceed the specific performance requirements outlined in the Performance Measures Manual.

Systematic Validation to Ensure Data Quality. Within our EDW, we perform many validation processes to ensure the completeness and timeliness of data. If errors occur during these validation processes, alerts are sent to our EDW support teams, who immediately triage the data issues for prompt resolution. For example, our EDW performs quality checks horizontally, vertically, referentially, and temporally (trending) to ensure data quality. Additionally, our data quality controls include multiple levels of accountability, from data lineage tracking to active data cataloging, helping to ensure that valid, reliable, and accurate data are obtained. Our EDW provides the master cross reference of our data names and formats and systematically maps each data element name, and contextual use information with equivalent metadata for each production application. Through the EDW's centralized repository of code lists, we enforce all industry-standard code sets and formats, including HIPAA-mandated sets. For data formats not governed by industry standards, we enforce formats used in the system of record of that data element.

Ensuring Effectiveness of Programs

Our organization ensures the effectiveness of a program by using accurate, timely, consistent, standardized, and actionable data. Our Care Gap Analysis Tool has been enhanced to provide daily updates on performance measures. This near real time data provides valuable insights for our team and will be used to design and implement rigorous outreach and engagement activities and inform programming to meet the PH, BH/SUD, and social needs of our Members. Combined with our Health Equity and SDOH KPI Dashboards, this will allow for

a person-centered approach and interventions that will likely achieve better health outcomes for both the individual and the population. This process supports our commitment to CQI and the rapid cycle PDSA models, allowing us to easily evaluate the effectiveness of our interventions, be agile in making data-driven decisions, and identify if interventions will lead to sustainable improvement over time. QM tools are integrated throughout our QM program and applied to test our program's effectiveness. We will utilize standardized QM tools such as scatter diagrams, run charts, and control charts to test the effectiveness and follow up when appropriate with testing for statistically significant probability testing.

Identification of Disparities. To implement effective interventions, it is critical to identify underlying reasons for variations in the provision of care to Members. We will use predictive modeling and risk stratification solutions, including hot-spotting technology, Health Equity, and SDOH KPI Dashboards, and SDOH Predictive Analytic Tool to identify and report significant health risks and disparities at the population, Member, and Provider levels and analyze results across sub-populations, geographies, races, and ethnicities. ***A Medicaid affiliate identified a racial disparity in their asthma control HEDIS data and were able to eliminate the disparity through focused regional Provider engagement and targeted Member education.***

Identification of Barriers. When we design a PIP and plan interventions intended to improve Member outcomes, it is critical to identify and remove barriers. We use our Reporting and Analytics platform, Care Gap Analysis Tool, KPI Dashboards, including our Health Equity and SDOH KPI Dashboards, to monitor, track and analyze care gaps to identify barriers to care. First, we make sure we understand the data and what it is telling us. Then the data is used to facilitate validated QM tools such as but not limited to Five Why's, Driver Diagrams, Cause, and Effect Matrices, Fishbone Diagram, and process mapping for cause-and-effect analyses. In addition, the Voice of the Customer (Member and Provider feedback) is essential to identify underlying reasons for variations and informs our approach to reducing variation in the provision of care to Members. These tools allow for a Root Cause Analysis which assists in removing barriers. These tools also help analyze SDOH and the correlation to health outcomes or risk. After barriers and or risks are identified, actions will be taken to remove barriers to clear the way for a successful project and the ultimate goal of improved Member health outcomes.

Actionable Performance Data. Our internal Quality and Provider engagement teams use performance data daily and monthly to monitor and track performance.

- **Daily Action.** Our Care Gap Analysis tool allows our Quality and Provider engagement teams to monitor and track performance on measures including HEDIS and EPSDT services. This enhanced data platform is updated daily when it allows for near real-time action. We do not have to wait on data to make decisions. We have actionable data at our fingertips. The Care Management (CM) and Quality staff have access to the KPI dashboard. The CM team can discuss options to close care gaps in real-time with Members on the phone. The Quality team can review performance rates to determine if interventions are working or not and make real-time data-driven decisions on the results. This tool is available to our Providers via the Provider Portal. Providers can review open care gaps while a Member is in the office and help the Member close care gaps as applicable. This data is used daily to focus improvement efforts, including Provider education, quality initiatives and outreach, and inform changes to Member and Provider programs.
- **Monthly Action.** HEDIS and performance measures are calculated monthly, allowing us to review month-over-month or year-over-year data for analysis. This depicts trends over time, assists in determining the effectiveness of interventions, and determines if the project is sustainable. We will also be able to project the rates in the future based on innovative predictive modeling tools. This data provides actionable information to inform short-term actions to meet long-term goals.

Provider Care Gaps. By delivering prospective care gaps to our Providers that are updated in near-real-time, compared to traditional weekly or monthly cycles, we enable them to identify and address emerging health issues at the earliest clinically appropriate time before they become significant concerns. Available to Member Services staff via our Customer Relationship Management (CRM) platform, Care Managers via the Clinical Documentation System, and to Providers through our secure Provider Portal, users can view care gap data at the Member, Provider, and practice levels, with drill-down functionality for Member-specific and clinical

details. The ability to see care gap data offers our Providers and Quality, Member Services, and CM staff a more purposeful approach to every interaction with Members by integrating actionable data into their daily workflows, acting upon Member specific data, and prioritizing outreach.

Performance Monitoring. We will track and trend quality performance metrics to assess our performance in the quality of clinical care and service to Members. We use our annual QM Program Evaluation as a tool to describe completed and ongoing QM activities and identify and track issues longitudinally for both Members and Providers. The Quality Task Force (QTF) is a multidisciplinary committee, including internal physical and BH Medical Directors. The QTF is responsible for monitoring and improving performance measures. The QTF meets monthly to review rate trending and identify quality performance concerns. The QTF will direct Member and Provider initiatives, both clinical and non-clinical, to improve performance.

Data Sources and Benchmarks. We will combine data from multiple internal and external sources, including physical health, BH, and pharmacy claims/encounters; electronic health records; UM and CM activities; lab and immunization data; and advanced sources such as ADT feeds, all-payer claims databases or health information exchanges, and census data. We will integrate data from our Health Equity and SDOH Dashboards to analyze outcomes measures across demographics such as language, race, and ethnicity. We will establish thresholds for selected measures and set targets based on historical trends, DOM goals, the Mississippi CQS and national benchmarks. For example, we will target the NCQA 75th Percentile (or 2% improvement year over year) for prioritized HEDIS measures. We will publish a performance scorecard with specific annual benchmarks and goals that include disparity reductions and align with DOM Performance Measures. The scorecard will create transparency related to performance to be used by our teams to focus improvement efforts.

Identifying Areas of Opportunity. Our proposed QM strategy framework will transform our delivery model to a more comprehensive approach. We will perform ongoing assessments and surveys of local health trends and needs to identify areas of opportunity to improve quality outcomes. We will also leverage input from our network providers, Member, Provider, Community Advisory Committees, and physician-led Board of Directors to identify areas or opportunities. We will then use the CQI process to prioritize areas for improvement. ***The Performance Improvement Team (PIT)*** will implement the selected health plan performance improvement efforts. The PIT will meet monthly to review performance data and is responsible for gathering and analyzing data, identifying barriers to quality improvement, resolving problems, and making recommendations for performance improvements.

ATTACHMENT 4.2.2.4.A.2.a ANNUAL PROGRAM EVALUATION, DESCRIPTION, WORK PLAN

One (1) in response to A.2. Each appendix is limited to ten (10) pages. Provide models of the following documents: Annual Program Evaluation and Annual Program Description/Work Plan that meet the requirements of Section 8, Quality Management, of Appendix A, Draft Contract (no more than 10 pages)

Quality Management Program Description

Report Period: January 1, 20[xx]-December 31, 20[xx]

INTRODUCTION TO QUALITY EVALUATION

Introduce the health plan Quality Management (QM) Program. State the mission, philosophy, and how these are incorporated into your QM Program. Include background information of health plan and product, the purpose and scope of the QM program. Describe how the QM program encompasses both Medicaid and CHIP (Children's Health Insurance Program) programs and physical and behavioral health. No Data goes here (May use a table, or bullet out the indicators).

QUALITY PROGRAM OVERVIEW

Quality Program

Assessment of the QM Program Structure: authority, accountability, staffing, resources, committees, and work plan. Describe any changes in the health plan during the evaluation year. Describe tracking of data and issues over time, conduct a barrier analysis as applies, interventions both completed and ongoing, and recommendations for the coming year.

Quality Management Evaluation Process

Each program is evaluated using the QM Evaluation Process. This process includes both physical and behavioral health but is not limited to analyzing data using a qualitative and quantitative approach and trended over time to assess performance. Charts, graphs or the applicable QM tool is used to demonstrate data. Completed and ongoing interventions are assessed, and a barrier analysis is conducted. Based on the analysis, recommendations are made for the coming year are based on the analysis.

Compliance Program Description

Describe how you monitor for fraud and abuse and regulatory compliance with NCQA and state requirements.

QUALITY PROGRAM OVERALL EFFECTIVENESS

Assessment of the overall effectiveness of the QM program. Describe the accomplishments for the reporting year. Illustrate the health plans strengths and accomplishments and opportunities for improvement. May use bulleted lists. Priorities and recommendations will be implemented within the 20[XX] QI Program based on aspects of this evaluation. These recommendations and opportunities are addressed in the 20[XX] Quality Improvement Program Description and Work Plan for 20[XX].

POPULATION CHARACTERISTICS

Describe, in detail, the health plan membership (age, gender, and other important demographics), population characteristics, language, cultural, and ethnicity. Evaluate the top diagnoses affecting your health plan's membership for both physical and behavioral health. Complete the evaluation using the QM Evaluation Process.

QUALITY PERFORMANCE MEASURES AND OUTCOMES

Healthcare Effectiveness Data and Information Set (HEDIS)

Describe, in detail, health plan approach to HEDIS and HEDIS Hybrid measures including but not limited to: systems used, system validation, auditor, auditor results, measure validation, timeframes committee input. Illustrate the most recent HEDIS rate results. Complete the evaluation using the QM Evaluation Process.

State Withhold Measures

Describe, in detail, [health plan] approach to the State Withhold measures including but not limited to: systems used, system validation, auditor, auditor results, measure validation, timeframes and committee input. Illustrate the most recent rate results. Complete the evaluation using the QM Evaluation Process.

Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Measure Sets Describe, in detail, [health plan] approach to the Adult and Child Core Measure Set measures including but not limited to: systems used, system validation, auditor, auditor results, measure validation, timeframes. Illustrate the most recent rate results. Complete the evaluation using the QM Evaluation Process.

QUALITY IMPROVEMENT ACTIVITIES

Consumer Assessment of Healthcare and Provider Services (CAHPS) Member Satisfaction Survey

Describe the annual Consumer Assessment of Healthcare and Provider Services (CAHPS) member satisfaction survey process. Description will include program and adherence to guidelines established by NCQA. Illustrate the most recent rate results. Rates will be displayed and compared to a set benchmark or Book of Business to gauge performance. Complete the evaluation using the QM Evaluation Process.

Experience of Care and Health Outcomes (ECHO) CAHPS Mental Health Survey

Describe the annual ECHO mental health member satisfaction survey process. Description will include program and adherence to guidelines established by NCQA. Illustrate the most recent rate results. Rates will be displayed and compared to a set benchmark or Book of Business to gauge performance. Complete the evaluation using the QM Evaluation Process.

Provider Satisfaction Survey

Describe the annual Provider satisfaction survey process. Illustrate the most recent rate results. Rates will be displayed and compared to a set benchmark or Book of Business to gauge performance. Complete the evaluation using the QM Evaluation Process.

Performance Improvement Projects (PIP)

For each PIP, describe the approach to the topic, population, stratification of population with a Health equity lens, data measurement cycles, Complete the evaluation using the QM Evaluation Process.

PATIENT SAFETY

Describe the patient safety program. Evaluate Never Events, Peer Review Actions, and Potential Quality of Care Issues. Complete the evaluation using the QM Evaluation Process.

NETWORK

Describe structure and resources, committee participation, number of Practitioners in network stratified by PCP and Specialist categories. Evaluate the credentialing and re-credentialing process, effectiveness of the provider network adequacy, Patient Centered Medical Home (PCMH), access and availability of providers, provider adherence to medical record requirements, and coordination between providers. Complete the evaluation using the QM Evaluation Process.

CLINICAL PRACTICE AND PREVENTVE HEALTH GUIDELINES (CPG, PHG)

Provide a description of the adopted CPG and PHG. Describe how the information was made available to your Practitioners. Monitor for provider adherence to the CPG and PHG. Complete the evaluation using the QM Evaluation Process.

CONTINUITY AND COORDINATION OF CARE

Evaluate how members are managed across the continuum of care for physical and behavioral health. Complete the evaluation using the QM Evaluation Process.

CARE MANAGEMENT

Include the Care Management Effectiveness Evaluation which includes a description of each program, barrier analysis, interventions, and results/impact on the delivery of service and quality of care. Programs included but not limited to: Behavioral Health, Substance Use Disorder, Acute and Chronic Physical Health programs, Disease Management Programs, Special Populations such as EPSDT, Sickle Cell, Maternal and Infant Health, Foster Care, Closed loop referrals, Community based organization partnerships, Readmissions and SDOH. Complete the evaluation using the QM Evaluation Process.

UTILIZATION MANAGEMENT (UM)

Evaluate the effectiveness of the UM program. Include medical necessity criteria, inter-rater reliability testing for medical necessity, timeliness of decision making, denials, and over and under-utilization monitoring. Complete the evaluation using the QM Evaluation Process.

PHARMACEUTICAL MANAGEMENT

Describe programs/services related to pharmacy. Include statistics for medications (top prescribed meds, generic vs. premium, etc.), and adherence to the Uniform Preferred Drug List. Complete the evaluation using the QM Evaluation Process.

MEMBER SERVICES

Describe customer service telephone access, call center statistics and language line utilization. Complete the evaluation using the QM Evaluation Process.

GRIEVANCES AND APPEALS

Describe the member and provider grievance and appeal process. Illustrate all rates for the measurement year. Complete the evaluation using the QM Evaluation Process.

INCENTIVE PROGRAMS

Describe the member incentive program and provider value-based agreements. Complete the evaluation using the QM Evaluation Process.

DELEGATION OVERSIGHT

Describe all delegated vendor arrangements. List exactly what areas are delegated concerning UM, Credentialing, Claims, Network, and Disease Management. Annual audit results are included as well as any issuances of corrective action plans. Complete the evaluation using the QM Evaluation Process.

Health Equity and Social Determinants of Health (SDOH)

Describe the Health Equity, SDOH and Health Literacy program and interventions for disparities in health care. Health Equity accreditation efforts. Include committee and Community Council involvement. Complete the evaluation using the QM Evaluation Process.

REVIEW AND APPROVAL

The 20[XX] Quality Improvement Program Evaluation was reported to the following QI committees:

Committee Name	Meeting Date	Committee Actions or Recommendations
Quality Improvement Committee		
Board of Directors		

The 20[XX] Quality Management Program Evaluation has been reviewed and approved as follows:

Name	Title	Date
Name	Title	Date
Name	Title	Date

Quality Management Program Description

Report Period: January 1, 20[xx]-December 31, 20[xx]

PURPOSE

[Health plan] is committed to the provision of a well-designed and well-implemented Quality Program. [Health plan] culture, systems, and processes are structured around the purpose and mission to improve the health of all enrolled members which includes a focus on health outcomes as well as healthcare process measures, and member and provider experience.

SCOPE

Explain how the QM program scope is comprehensive. Provide an all-inclusive list of the scope of the QM program (may include a grid or bulleted points).

GOALS and OBJECTIVES

Define and provide a detailed list of health plan goals and objectives with timelines to reach goals.

CONFIDENTIALITY

Describe health plan defines confidential information and include the definition, regulations, what is considered privileged and confidential, and adopted confidentiality standards.

CONFLICT OF INTEREST

Describe how the health plan defines and process for conflict of interest.

HEALTH EQUITY and Social Determinants of Health (SDOH)

Describe the Health Equity/SDOH program design to provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual members and protects and preserves the dignity of each.

AUTHORITY and ACCOUNTABILITY

Describe in detail the authority, accountability, and responsibility of the QM Program. Describe how the Board of Directors (BOD) has authority, responsibility, and oversight of the development, implementation, and evaluation of the Quality Program and is accountable for oversight of the quality of care and services provided to members. Describe how the BOD supports the Quality Program, how it delegates operating authority, the responsibilities of the delegate, and an explanation of how information about activities and outcomes are reported to the BOD. Include how the health plan executives support the QM program.

QUALITY PROGRAM STRUCTURE

Describe the QM program structure. Describe how QM is integrated throughout the health plan and applies to both physical and behavioral health care and services for members. Provide the framework for each health plan committee structure including but not limited to the description of committee, purpose, scope, role, chair, composition, voting and quorum requirements and committee roster including name, title, specialty, internal and external providers and voting members.

QUALITY DEPARTMENT STAFFING

Describe the QM staffing model required to support the QM program.

QUALITY PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

Describe the [Health plan] technology infrastructure and data analytics capabilities and how each is used to support goals for quality management.

DOCUMENTATION CYCLE

Define the continuous quality improvement model for the health plan with timelines for the model. **Include the overview of the contractors review requirements in the annual QM Program Evaluation.**

PERFORMANCE MEASUREMENT

Explain the assessment, analysis, monitoring and reporting of performance measures both clinical and nonclinical and preventive and acute/chronic conditions. This includes but is not limited to the **timely, accurate, and analysis** of Health Effectiveness Data and Information Set (HEDIS), CMS Adult and Child Core Measure Sets, and State Withhold Measures.

MEMBER SATISFACTION

Describe the process for coordinating the Consumer Assessment of Healthcare Providers and Services (CAHPS) surveys and the timely, accurate, complete collection, analysis of the findings, and reporting the results. Include the timelines for the survey and how the findings are used to improve member experience.

PROVIDER SATISFACTION

Describe the process for coordinating the Provider Satisfaction survey and the timely, accurate, complete collection, analysis of the findings, and reporting the results. Include the timelines for the survey and how the findings are used to improve member and provider experience.

PROMOTING MEMBER SAFETY AND QUALITY OF CARE

Describe the health plan patient safety program including but not limited to Quality of Care, Provider Profiling, Provider Preventable Conditions, and Never Events.

MEMBER ACCESS TO CARE

Describe how the health plan monitors, assesses, analyzes, and reports on member access to care including timelines. This will include but is not limited to network adequacy, appointment availability (PCP and Specialist), continuity and **coordination of care** and monitoring utilization patterns.

POPULATION HEALTH MANAGEMENT

Explain how the Population Health Management (PHM) strategy for care management and care coordination and how the PHM strategy is closely aligned with the Quality Program priorities and goals. Include Behavioral Health, Substance Use Disorder, Physical Health, Closed Loop Referrals, and Community Based Organization Partnerships.

BEHAVIORAL HEALTH SERVICES

Describe the mechanisms for assessment, analysis, and reporting of the health plan Behavioral Health (BH) services including Substance Use Disorder services and the SUPPORT Act. Describe the process for the survey and the timely, accurate, complete collection, analysis of the findings, and reporting the results of the BH member satisfaction survey.

INPATIENT HOSPITAL

Describe the mechanisms for assessment, analysis, and reporting of transitional care, discharge planning, and readmission program.

PROVIDER SUPPORTS

Describe how the health plan collaborates with and supports providers. Including but not limited to Value Based Agreements, Patient Centered Medical Home, Clinical Practice Guidelines, and Provider Profiling.

PERFORMANCE IMPROVEMENT ACTIVITIES

Explain the health plan approach to and the framework for performance improvement activities. Describe the process for selecting areas of focus, using evidence-based practice, and QM tools. Include the mechanisms for assessment, analysis, and reporting of activities as well the timelines.

PERFORMANCE IMPROVEMENT PROJECTS

Explain the approach to and the framework for performance improvement projects. Include details and timelines for each performance improvement project separately. Describe the process for selecting areas of focus, using evidence-based practice, and QM tools.

GRIEVANCE AND APPEAL SYSTEM

Describe the member and provider grievance and appeal process and how that process is used for continuous quality improvement.

COMMUNITY-BASED ORGANIZATIONS

Describe the partnerships with community-based organizations and the assessment, monitoring, analysis and evaluation of these partnerships.

REGULATORY COMPLIANCE AND REPORTING

Describe how the health plan complies with all regulatory and reporting requirements.

NCQA HEALTH PLAN ACCREDITATION

Describe the health plan's commitment to delivering high-quality care and service for members through NCQA accreditation and how the health plan supports it.

DELEGATED SERVICES

Describe the health plan's delegated services and the oversight process.

WORK PLAN

AIM			MEASURE				LEADING CHARGE				
Scope	**Objective**	**Objective Detail**	**Data Source**	**Start Date**	**Status**	**Timetable**	**Planned Improvement Initiatives**	**Activities**	**Responsible Party**	**Process Measures**	**Completion Date**
Department Scope	How to achieve goal	Details on how to achieve goal	N/A	1/1/2023	**On Track**	Annual	overall initiative	details to monitor	director/manager/	how to measure success	Date
Quality Management	QM Program Description	Develop/revise a comprehensive document that describes the Quality Program structure, operational processes, responsibilities, etc. The Quality Program Description is updated annually to incorporate findings from the annual evaluation.	N/A	1/1/2023	**Not Started**	Annual	Develop/revise a comprehensive QM Program Description annually in accordance with NCQA, CCO Contract, Federal and State Regulations	• Review current regulatory and accreditation standards • Review CCO Contract •Create/Update the Program Description, incorporate findings from the annual QM Program Evaluation • Obtain DOM, Committee, and BOD approvals	Quality Management Director	DOM and Committee Approval in Meeting Minutes	3/31/2022

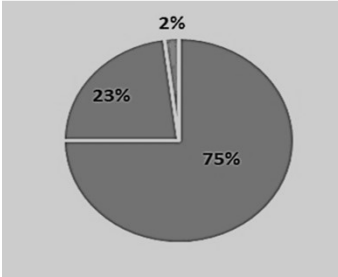
LEADING CHARGE							
Analysis Q1	**Analysis Q2**	**Analysis Q3**	**Analysis Q4**	**Remedial Actions as applicable**	**Evaluation of QIP or CAP as applicable**	**Comments**	**Recommendations for Next Year**
update	update	update	update	N/A	N/A	Implemented timely, no issues identified	Continue to monitor in 2024
							To be completed after a measure/initiative is or in the annual assessment

QUARTERLY SUMMARY

CCO 2023 Quarter 1 QM Work Plan Summary Date Range: 1/1/2023-3/31/2023	
Quarterly Submission to DOM date:	XX/XX/XXXX
Metric Analysis Summary	**Total**
N/A	
Met Expectations	
Partially Met	
Not Met	
Number of Corrective Actions Implemented	

Quantitative Analysis:

Sample 2023 Analysis of QM Work Plan Metrics



Qualitative Analysis:

Metrics Partially Met	Reason	Remedial Action	Responsible Party	Q2 Evaluation of Action

ANNUAL SUMMARY

Metric Annual Analysis Summary	Total End of Year
N/A	
Met Expectations	
Partially Met	
Not Met	
Number of Corrective Actions Implemented for Year	

Quantitative Annual Analysis:

Qualitive Annual Analysis:

Run Chart, Pie Chart, other chart(s) as applicable

Metrics Partially Met at End of Year	Reason	Remedial Action	Responsible Party

[Health Plan] QMC has reviewed and adopted this document, including the Quality Management Work Plan.

ENDORSEMENT OF THE Quality Management Program Description
The Quality Management Program Description has been reviewed and endorsed by the quality senior leadership effective this day of _____, month of _____, 20[XX].

_____
Vice President of Quality

_____
Chief Medical Director

ENDORSEMENT OF THE Quality Management Program Description
The Quality Management Program Description has been reviewed and endorsed by the Board of Directors effective this day of _____, month of _____, 20[XX].

_____
Board of Directors Chairman

ATTACHMENT 4.2.2.4.C.1 EXERPTS FROM SAMPLE QUALITY REPORTS

One (1) appendix in response to C.1, limited to ten (10) pages of excerpts from or full sample reports that the Offeror proposes to use for this Contract.

TIN	TIN Name	Primary Region	Number of PCPs	Panel - Current Membership	Panel Size Tier	Number of Pediatric Members - All	Number of Pediatric Members - $100K+ Annual Spend	Number of Adult Members - All	Number of Adult Members - $100K+ Annual Spend	Total Number of Members	Member Months	TIN Average Risk	TIN Normalized Risk
				94	5	95	-	54	1	149	1,029	1.227	1.223
				176	5	226	-	65	-	291	2,212	1.576	1.143
				4,689	3	6,354	7	1,969	9	8,323	71,079	0.974	0.940
				92	5	126	-	51	-	177	1,424	1.310	1.232
				1,920	3	2,408	-	34	-	2,442	19,207	0.959	0.980
				182	5	214	-	47	-	261	1,919	1.096	1.032
				1,928	3	2,851	1	819	2	3,670	30,368	0.997	0.952
				92	5	92	-	19	-	111	795	0.760	0.818
				4,931	3	6,023	5	2,686	10	8,709	69,252	1.042	1.000
				876	4	1,015	1	222	-	1,237	9,774	1.053	1.022
				182	5	235	2	2	-	237	1,974	1.141	1.256
				176	5	214	1	30	-	244	1,596	1.297	1.121
				182	5	209	-	115	2	324	2,685	1.238	1.104
				4,979	3	5,739	7	1,226	10	6,965	57,927	1.166	1.073
				845	4	888	1	309	-	1,197	10,152	0.859	0.983
				380	5	424	-	64	-	488	3,085	0.953	0.955
				3,634	3	4,535	2	1,584	13	6,119	51,325	1.050	0.965
				375	5	421	-	88	1	509	4,773	1.079	0.985
				176	5	224	-	88	1	312	2,514	1.044	0.914
				94	5	95	0	65	0	160	1290	1.0563238	1.0187721

PCP Visits per 1000 Member Months	Specialist Visits per 1000 Member Months	ED Visits per 1000 Member Months	Admits per 1000 Member Months	Outpatient Visits per 1000 Member Months	Other Visits per 1000 Member Months	II Quality Peer Definition	II Quality Score	II Peer Quality Index (actual/peer)	Potential Savings (low)	Potential Savings (high)	Average Membership	Loyalty Score	Engagement Score
301	349	195	13	261	55	Non-Physician PCP	0.4	0.784313725	$ 10,120	$ 17,843	86	0.120	0.066
398	252	221	9	185	48	PCP (Family)	0.630573248	1.205259313	$ 188,292	$ 204,309	184	0.385	0.283
261	235	163	7	159	67	Non-Physician PCP	0.855456172	0.999471212	$ (259,883)	$ 180,138	5,923	0.448	0.298
416	270	194	8	219	82	Non-Physician PCP	0.888888889	1.009888491	$ (7,876)	$ 2,539	119	0.364	0.286
389	136	121	2	174	20	Non-Physician PCP	0.69379015	1.028255879	$ (157,666)	$ (75,890)	1,601	0.711	0.624
560	304	183	5	164	19	Non-Physician PCP	0.794425087	0.936556512	$ 2,909	$ 12,745	160	0.595	0.531
305	230	126	6	196	81	PCP (Family)	0.38028169	1.516640921	$ (407,326)	$ (230,255)	2,531	0.278	0.200
682	202	94	2	254	27	Non-Physician PCP	0.777777778	1.071975498	$ (23,363)	$ (19,323)	66	0.560	0.491
439	349	200	8	191	96	PCP (Family)	0.777036588	1.030300594	$ 269,995	$ 751,606	5,771	0.484	0.384
429	247	204	5	342	61	Non-Physician PCP	0.713709677	0.989748369	$ 119,925	$ 175,838	815	0.770	0.654
472	108	119	4	185	31	PCP (Pediatric)	0.630188679	0.96682684	$ 153,900	$ 162,045	165	0.504	0.427
375	434	129	3	162	213	Non-Physician PCP	0.814696486	1.028184347	$ 91,670	$ 100,100	133	0.091	0.064
502	300	171	9	295	96	PCP (Family)	0.773743017	1.025697993	$ 107,220	$ 125,164	224	0.363	0.265
456	325	136	5	168	109	PCP (Pediatric)	0.549555411	1.058156869	$ 487,965	$ 818,832	4,827	0.686	0.586
315	270	170	5	164	58	Non-Physician PCP	0.832901554	0.997796468	$ (311,250)	$ (247,989)	846	0.542	0.394
410	216	114	4	116	18	Non-Physician PCP	0.805084746	1.025945625	$ (33,219)	$ (18,958)	257	0.095	0.066
373	291	157	8	153	62	Non-Physician PCP	0.749777382	1.009193005	$ 165,558	$ 484,184	4,277	0.485	0.371

408	231	165	3	149	36	PCP (Family)	0.781704782	1.025920873	$ (39,804)	$ (15,257)	398	0.314	0.248
334	221	129	4	149	33	PCP (Internal Medicine)	0.808823529	0.932835821	$ (94,736)	$ (76,698)	210	0.273	0.210
417.6744186	252.09302	172.09302	2.790698	261.395349	48.37209	PCP (Internal Medicine)	0.930041152	1.06433079	-28166.858	-18876.447	107.5	0.409895	0.304316

Non-Inpatient Leading Indicators

Line of Business: Medicaid Plan: All Plans Product: All Products Regions: All Regions

Non-Inpatient Leading Indicators

3 Month Average Same Month Prior Year

Cost Categories

All Medical Cost Categories
Emergency Room
Hospital Outpatient
Other Medical
Primary Care
Specialist

Claims Per Member

-3%
-3%
4%
-14%
1%
2%

Dollars Per Member

-4%
-8%
-1%
-7%
-3%
1%

All Sub Cost Categories Claims Per Member Dollars Per Member Cost Per Claim

Monthly Claims Per Member

1.20
1.16
1.12
1.08
1.04
1.00
.96
.92

Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec Jan

Through Current Day Claims Per Member

Daily Claims Per Member Received

1.40
1.20
1.00
.80
.60
.40
.20
0.00

1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31

Current Membership

Current 3 Mth Avg. Prior Year

The Basics

Main Menu: Return to project home page or select a subfolder

Filter Panel: Contains dashboard filters and applicable reports

Reports Button: Links to reports associated with this dashboard

Info Button: Navigate supporting documents about this dashboard

Help Button: Email with a question

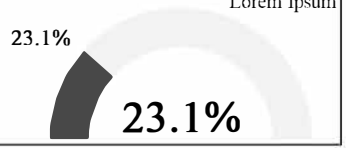
1. Header information lets you know which filter selections have been made
2. Top graphs show performance against 3 month average or previous year by medical cost category
3. The filter button allows for changing selection between LoB, Plan, Product, Region, Communication Method, and Received Lag
4. Lower graphs display Claims per Member, Dollars per Member and Cost per Claim at a daily and monthly level
5. Clicking on the lower graph icon provides a grid view of the data

Summary by Data Plan

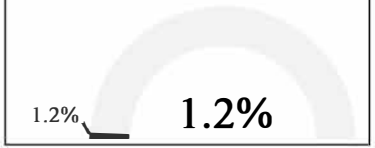
Plan	IRS Number	IRS Name	County
Multiple	Multiple	Multiple	Multiple

C-Section Rate

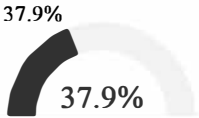
Lorem Ipsum



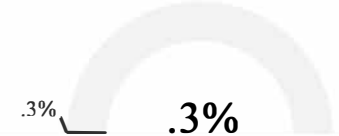
NICU Rate



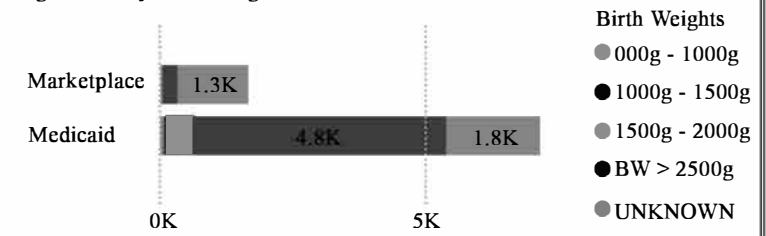
NOP Rate



Provider NOP

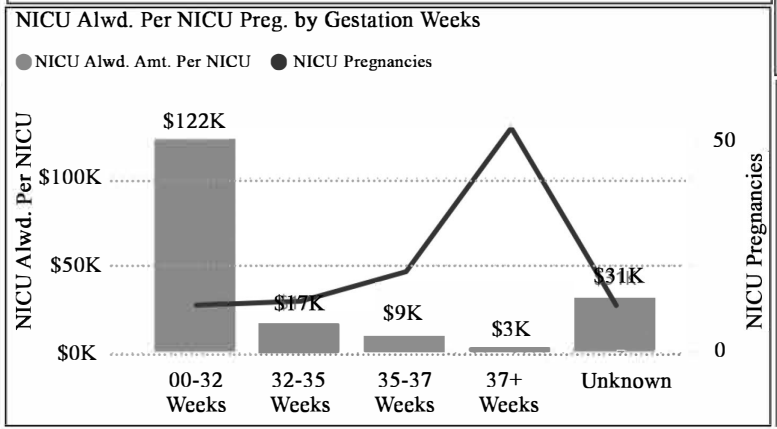


Pregnancies By Birth Weight



Start Date	9/1/20
End Date	8/31/21
HBR Run ID	100
Pregnancy Months	32.70K
Pregnancies	8,865
Med. Alwd. Amt. Per Preg. Month	$1,705
Med. Alwd. Amt. Per Preg.	$6,289
Preg. Alwd. Amt. Per Preg. Month	$417.28
Preg. Alwd. Amt. Per Preg.	$1,539
NICU Alwd. Amt. Per NICU	$20,888

NICU Alwd. Per NICU Preg. by Gestation Weeks



Med Claims Alwd. Amt. Per Preg.

Preg.Claims Alwd. Amt. Per Preg. Month

Number of Pregnancies By Mother's County

NICU Claims Alwd. Amt. Per NICU Preg.

Average Member Risk

Plan	Number of Pregnancy Months	Number of Pregnancies	Number of Attributed OBs (NPI Count)	Total Med Allowed Per Preg. Month	Preg. Claim Alwd. Amt. Per Preg. Month	RX Claim Alwd. Amt. Per Preg. Month	NICU Allowed Amt. Per NICU Pregnancy
Marketplace	4,369	1,669	211	$2,099	$504.38	$123.91	$460
Medicaid	28,326	7,196	265	$1,645	$403.84	$75.49	$23,743

[END OF RESPONSE]

4.2.2.5 UTILIZATION MANAGEMENT

4.2.2.5.A. Approach

1. Describe the Offeror's proposed approach to utilization management, including:

Our Utilization Management (UM) Program will encompass structures and processes to promote fair, impartial, and consistent utilization decisions and coordination of care for our MississippiCAN and CHIP Members in full compliance with Appendix A, Draft Contract and all NCQA Health Plan Accreditation UM guidelines. The mission of our UM department and related programs is to assure Members are receiving clinically appropriate services at the most appropriate level of care while improving health and quality of life for all. The goals and objectives of our UM program focus on quality care, safety, clinical effectiveness, appropriateness, and meeting Member needs in the least restrictive setting. Ensuring a health equity lens, our ***Director of Health Equity*** will review UM data to identify disparities and advise on potential inequities in utilization. This information will help inform our UM program and routinely account for health equity in our decision-making processes.

a. A description of the utilization management program;

UM Program Description

As part of Population Health and Clinical Operations, our UM Program encompasses prior authorization, concurrent review, discharge planning, transitions of care, Care Management, disease management, and utilization monitoring and oversight. Formally defining the structures, accountabilities, and processes to meet our UM goals and objectives is our UM Program Description (UM Description) that will meet or exceed all State, Federal, contract, and accreditation requirements; the Mississippi Administrative Code, Medicaid State Plan, and CHIP State Health Plan; and formal memorandums and policies promulgated by the DOM. We will submit the UM Description to DOM annually for written approval. Building on national best practices and lessons learned, key components of our UM Program are described below.

Program Accountability. Our local Board of Directors (BOD) will have ultimate authority and accountability for oversight of the quality of care and services provided to Members, including UM. The BOD will delegate oversight and operating authority for UM activities to the Quality Management Committee (QMC). The UM Committee (UMC) reports up through the QMC and reviews all UM issues and related information and makes recommendations. The Chief Medical Director (CMD), who will be a Mississippi licensed physician, and a Mississippi-based Vice President of Population Health and Clinical Operations (VP of Population Health) will be the accountable executives overseeing the UM Program. Appropriate specialists will be involved in implementing, monitoring, and directing the UM Program's specialty health and service aspects, such as a behavior health (BH) practitioner, dentist, and pharmacist. As part of program oversight and accountability, we will not structure compensation to individuals or entities that inappropriately incentivize denying, limiting, or discontinuing medically necessary services to any Member. All UM staff involved in the authorization process will be required to sign an annual Affirmative Statement regarding compensation.

99.8%

Our policies and procedures, management oversight, and systems will work in concert to ensure timely determination of requests. In 2021, in our affiliate plan in a similar market, we met our ***service level 99.8% of the time for Inpatient Initial and Outpatient Authorizations***.

Program Staffing. Under the direction of the VP of Population Health, we will appoint a Mississippi-based UM Coordinator responsible for the day-to-day management of the UM function. Staff carrying out UM activities will include non-clinical Referral Specialists and appropriately licensed Concurrent Review Nurses, Prior Authorization Nurses, and licensed BH clinicians. Any personnel employed by or under contract to perform utilization review under this contract will be appropriately trained, qualified, and Mississippi-licensed, with all UM decisions made by licensed nurses, BH clinicians, pharmacists, and physicians. Only a Mississippi-licensed physician or other appropriately Mississippi-licensed health care professional with appropriate clinical expertise in treating the Member's condition or disease will be permitted to make any decision to deny or reduce an authorization request. For example, for all BH requests, only a Mississippi-licensed psychiatrist can make adverse determinations. All UM decisions will consider the regional and cultural characteristics of our Members and the local practice patterns of our Providers.

Program Linkage. Our UM, QM, CM, Credentialing, and Fraud Waste and Abuse (FWA) Programs will be closely linked in function and process. UM staff will track trends to monitor for over-or under-utilization of

services. As nurses perform UM functions, they will screen for quality and other indicators and forward identified issues to the QM team for review. UM staff also identify Members with CM needs and refer directly to CM staff for outreach. Our Medical Directors review trends for possible review by the Credentialing Committee or inclusion in a Provider's recredentialing process. To ensure a link between the Grievance and Appeals processes and the QM and UM Programs, our Grievance Coordinator and Clinical Appeals Coordinator will review and report Grievance and Appeal data to our QMC quarterly. UM policies and processes serve as integral components in preventing, detecting, and responding to FWA among Providers and Members. The VP of Population Health will work closely with the Compliance Officer to resolve any potential issues that may be identified.

Coordination and Collaboration

Our cross-functional UMC promotes coordination and collaboration across functions and completes quarterly reviews of UM trends, including PA trends, over-and under-utilization, and access to services.

Provider Satisfaction. Based on experience in affiliate plans with a similar UM Program, UM's Provider satisfaction scores have historically met or exceeded all UM goals. For example, in one affiliate, satisfaction survey results in 2020 exceeded goals in the following survey questions: Access to knowledgeable UM staff; Procedures for obtaining pre-certification/referral/authorization information; Timeliness of obtaining pre-certification/referral/authorization information; The health plan's facilitation/support of appropriate clinical care for patients; and degree to which the plan covers and encourages preventive care and wellness.

Utilization Oversight and Monitoring Process

As a key function of our UM Program, we will continuously monitor and address inappropriate utilization, as fully described in our response 4.2.2.5.B to the RFQ. This includes systematic and ongoing review of trends by UM, CM, Member, and Provider Services staff; quarterly cross-functional review and analysis at our UMC; and follow-up review at our QMC. We will also promote real-time monitoring and oversight through our ***weekly and bi-weekly UM rounds***, including private duty nursing (PDN), NICU, and readmission IP rounds, facilitating direct collaboration between Medical Directors, UM, and CM staff. Based on these collaborative review processes, we will develop and design individual and population level interventions to address negative trends. Including education and training for staff, Members, and Providers; process improvement in UM policies and processes; clinical programs; and community partnerships to help promote Member engagement and address SDOH. For example, a Medicaid affiliate was concerned with trends in readmissions. In response, they implemented a readmissions reduction program that ***decreased potentially preventable readmissions by 11%*** over two years, with a 14.7% readmission rate for Members that completed the program compared to 21.3% for those that did not participate.

Authorization Review Process

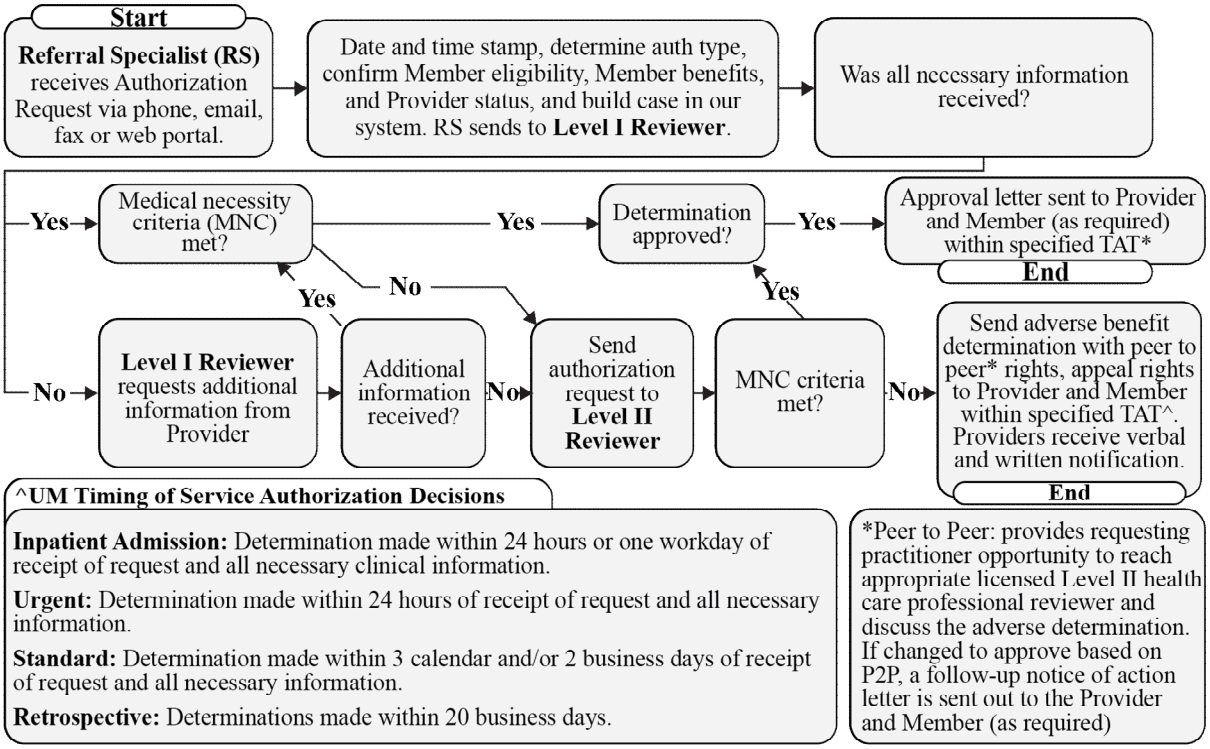
The UM process includes 24-hour nurse triage, referrals, second opinions, prior authorization/pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning, transition of care, and care coordination. Authorization, prior authorization, and prepayment review processes will include two (2) levels of review, as described in **Table 4.2.2.5.A.1** below.

Table 4.2.2.5.A.1 Levels of UM Review

Levels of UM Review		
Level	**I**	**II**
Type of Review	• All initial requests sent to Level I for review after Referral Specialist has validated and set up case in our Authorization System	• Requests that do not meet medical necessity criteria sent up from Level I reviewer • Services that do not have existing medical necessity criteria
Reviewer	• Nurse Reviewer (Physical Health) • BH licensed clinicians or RNs with BH experience	• Medical Director or Licensed Practitioner, depending on request, e.g., BH, Dental. May be licensed MDs, DOs, DDSs
Determination	• If medical necessity criteria is met, approval issued. • At no time can issue an adverse benefit determination. If lack of standard, referred to Level II	• All Adverse Benefit Determinations (reduction, denial, etc.) • Medical Necessity Determinations for reviews without existing criteria, and that do not contain supporting clinical information

The clinical decision process begins when a request for authorization of service is received at the health plan. The process is complete when the requesting practitioner and Member (when applicable) have been notified of the determination. UM criteria are provided in response to Section 4.2.2.5.A.1.d of the RFQ. **Figure 4.2.2.5.A.1** below provides an overview of our proposed authorization process workflow.

Figure 4.2.2.5.A.1 Authorization Process



Prior Authorization (PA). Providers may submit standard and expedited PA requests as well as supporting information via phone, fax, secure e-mail, and our ***web-based PA request system*** on our secure Provider Portal using HIPAA ASC X12 278 Transaction. Our secure Provider Portal allows users to quickly find PA information by Member name, authorization number, or Medicaid number. We will create "smart" electronic authorization request forms customized for each service that requires authorization. These forms will ease Provider administrative burden in the authorization request process and reduce chances of technical denials. We will promote use of the secure Provider Portal through workshops and will offer incentives for participation in trainings on submitting authorizations through the Portal. ***Our PA Call Center will be open from 8 a.m. to 5 p.m. Central Standard Time, Monday through Friday (excluding State declared holidays)***. Our flex scheduled UM staff and 24/7 Nurse Advice Line will be available to accept PA requests by phone after hours. Our public website also includes a ***PA Check Tool where Providers can input the specific codes to check if the procedure or service requires a PA***.

Review Process. Our Referral Specialists will receive and complete the process for PA requests for covered services not requiring clinical review. They will forward clinical requests electronically through our integrated Clinical Documentation System to a UM clinician (licensed nurse or licensed BH clinician) who conducts a Level I medical necessity review using appropriate criteria, guidelines, and available information about the Member's condition and circumstances. PA will never be required for emergency services, by either participating or non-participating Providers, as documented in our UM Description and associated UM policies.

Requests That Meet Criteria. If the request meets clinical criteria, the UM clinician will notify the Provider and issue an authorization number as expeditiously as the Member's condition requires, not to exceed contractual timeframes. For phone requests, the ***UM clinician conducts the Level I review in real-time*** while interacting with the Provider, issuing an authorization number during the call if the request meets criteria.

Requests That Do Not Appear To Meet Criteria. In compliance with 42 C.F.R. § 438.210 (b)(3), any adverse determinations will be made by the appropriately licensed and qualified individual, as described above under

Program Staffing. If an adverse determination is made, the peer-to-peer review process can be employed by the requesting practitioner. Based on a best practice to acknowledge Provider schedules and needs and **help drive provider satisfaction**, we have increased the standard time for a peer-to-peer review to at least fourteen calendar days from notification. To further reduce Provider administrative burden, we will have an **easily accessible, standardized peer-to-peer request form** available through the Provider Portal.

Requests with Insufficient Information to Make a Determination. If clinical information needed to make a determination is not provided at the time of the request, the UM clinician will notify the requesting Provider that additional clinical documentation is required. The UM clinician must allow three (3) calendar days and/or two (2) business days for the requesting Provider to submit the required information. If the additional information is not received, the UM clinician will make a second attempt to notify the requestor of the additional medical information needed and must allow one (1) business day or three (3) calendar days for the requestor to submit the required information. If we do not receive the information or receive information but it is insufficient to meet criteria, the UM clinician will refer the case through our Clinical Documentation System to the Medical Director for a Level II review.

Notifications. We will provide appropriate verbal and written notice to Members and Providers of any UM decisions. Denials or reductions will be processed in accordance with 42 CFR 438.404, with a "Notice of Action." Member notices are written in plain language and will not exceed a 3rd grade reading level. Determination letter templates will be individualized for each denial case and reviewed and approved by DOM prior to use, addressing all requirements in Section 4.3.1.10 of the Draft Contract and NCQA standards. Notifications will be delivered within the timeframes described in Section 4.3.1.10 of the Draft Contract, including Table 4.1 and 4.2, and 42 CFR 438.404(c). Turnaround times (TATs) are tracked for timely determination and notification. Reports are run daily to verify TAT, and performance is monitored by UM supervisory staff. In instances where TATs are not met, a corrective action plan will be generated. Interventions may include increased staffing; UM-specific process improvements, using Six Sigma and other quality-control methods; increased and innovative automation, including ADT feeds and our web-based PA system; increased chart auditing; enhanced reporting capabilities specific to UM; and provider and staff education.

Specialty PA Reviews

A Specialty Therapy Advisor (STA) will be a Member of our UM team. The STA may review all therapy (for Members 13 yrs and older) and DME requests that do not meet first level review criteria and makes recommendations to the Medical Director such as a partial approval of six visits with a discharge plan instead of denying the 12 visits requested. Providers in affiliate plans have responded favorably to directly discussing treatment options with the Specialty Therapy Advisor.

Second Opinion. A Member or individual within the Member's health care team may request second opinions from within the network for the purpose of evaluation of a condition and to ensure that diagnosis and treatment is based on the most recent evidence-based guidelines. If there is not an appropriate Provider within the network, and the requested service is medically necessary and appropriate, we will authorize the second opinion from an out-of-network Provider at no cost to the Member.

b. Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures;

UM Policies and Procedures (P&Ps)

As noted above, our VP of Population Health will be responsible for overseeing the UM Program, including developing, implementing, and monitoring compliance with UM P&Ps. Our UM P&Ps will address UM processes such as PA, retrospective review, concurrent review, discharge planning, transition of care, and UM monitoring.

Development. Our UM P&Ps will be developed to comply with current NCQA Health Plan Accreditation UM criteria, applicable State and Federal UM guidelines, and all contract requirements. The UMC and QMC are responsible for the review and appropriate approval of medical necessity criteria and UM P&Ps, including annual review and periodic updates to incorporate changes in standards or guidelines. Our VP of Population Health and UM Coordinator will review and electronically sign upon QMC and DOM review and approval.

Implementation. We will submit all PA criteria and P&Ps to DOM for approval prior to implementation. The UM Coordinator will ensure implementation of through appropriate posting, training, education, and auditing,

in accordance with the UM Description. This includes initial and ongoing training of staff, Members, and Providers, in coordination with other departments. For example, Provider education will cover all aspects of our UM Program, such as medical necessity criteria and guidelines; clinical practice guidelines; PA requirements and processes; forms and instructions; determination timeframes; and Grievance, Appeal, and State Fair Hearing processes. Our Provider Relations staff will provide training in Provider offices, through webinars, and telephonically when we update UM processes, identify Providers who may need extra support, and upon Provider request. We will provide a Quick Reference Guide that includes a summary of PA information in the Provider Manual, on our public website, and on the Provider Portal. Similarly, Members can access PA information through the website, Member Portal, and Member Handbook.

Monitoring. The UMC will monitor and analyze relevant data to evaluate appropriate implementation and impact of UM P&Ps on a quarterly basis, including impact on health care services, coordination of care, and appropriate use of services and resources. This analysis and the status of any corrective action plans will be reported to the QMC on a quarterly basis. The UM Coordinator will also monitor compliance with UM P&Ps through our auditing processes described in response to Section 4.2.2.5.A.1.j of the RFQ. For example, they will audit P&Ps against contract requirements and PA reviews, pulling random samples to ensure the P&P is followed, and monitor TAT reporting for compliance with timely notifications. In addition, on an annual basis, we will complete a Medicaid UM Evaluation in accordance with NCQA, including a review of the effectiveness of the program and P&Ps, and an internal audit by our Compliance department to validate P&P implementation and alignment with the contract.

c. Data sources and processes to determine which services require Prior Authorization and how often these requirements will be re-evaluated;

Prior Authorization (PA) Services

To reduce the administrative burden for our Providers, we will limit PA requirements to only those services or procedures for which the quality or efficiency of care can be favorably influenced by our management. Our PA List manages services with significant quality of care, financial, or FWA risk. We will collaborate with other MCOs to align PA requirements and promote consistency for Providers and Members.
We will routinely review the PA list in alignment with DOM guidelines, Provider feedback, recommendations from staff, national best practices, utilization data, and approval rates.

Data Sources. Data sources to determine which services require PA will include claims volume and cost data, clinical practice guidelines, evidence-based and best practices, volume and types of approvals and denials, reversals of appeals, DOM's Comprehensive Quality Strategy, and internal and external stakeholder input.

Processes. Our CMD and VP of Population Health will review the PA List annually and make recommendations to the QMC. Reviews and proposed revisions to the PA List will include a review of the above data sources and direct input from QM, CM, Member and Provider Services, Health Equity, and Provider Relations staff. We will take into consideration Member and Provider feedback and CCO alignment.

Re-Evaluation Frequency. Re-evaluation occurs annually as part of the UM Program Evaluation and during quarterly review of the data sources above, as further described in response to Section 4.2.2.5.A.1.f of the RFQ.

Preferred Provider Partnership. We will have a preferred Provider program to waive authorizations and remove administrative burden when Providers demonstrate high quality. For example, we will waive certain authorization requirements for preferred Providers who commit to entering value-based contracts.

d. Process and resources used to develop utilization review criteria;

Process and Resources to Develop Utilization Review Criteria

UM criteria for reviewing each authorization, PA, and prepayment review request for medical necessity determination will be based on standard, evidence-based clinical decision support solutions or, if not available, nationally recognized standards, as approved by the Division. Our evidence-based criteria will be specific to the characteristics of our Members; consider our Members' conditions, diagnoses, and needs; and will be based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.

Process for Developing Criteria. Our Clinical Policy Committee, comprised of both internal and external Providers, will develop, review, and recommend the adoption of criteria for MississippiCAN and CHIP. The QMC will review and approve final criteria before submitting to DOM at least ninety (90) calendar days prior to

implementation of the Contract for approval. In addition to State required criteria, such as for hospice and PDN, we will use InterQual® Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Long-Term Acute Care, Inpatient Rehabilitation, Home Care, Outpatient Rehabilitation and Chiropractic, DME, Procedures, Molecular Diagnostics, and available BH criteria to determine medical necessity and appropriateness of care. We will also use the American Society of Addiction Medicine (ASAM) criteria for inpatient and outpatient chemical dependency care. Our UMC and QMC will review all criteria at least annually including updates to criteria (such as annual InterQual updates) when revisions are published.

Internal Criteria. For services where the State or InterQual do not have criteria, or local practice patterns do not align with InterQual, our Corporate Clinical Policy Committee, which includes Medical Directors from each of our affiliate health plans and will include our Mississippi health plan, develop criteria in the form of clinical policies. With this national input, our local Clinical Policy Committee, including local practitioners to inform policies in their areas of expertise, will review proposed clinical policies for relevance to local practice patterns and State requirements. In addition, our Medical Directors will work with DOM to ensure proposed clinical policies/UM criteria address the specific characteristics of our Members and local communities.

Resources. Resources we will use include nationally recognized, reputable organizations that establish standards for clinical decision management; local clinical practice, including DOM's definition of medical necessity and MississippiCAN and CHIP Program requirements; input from local Providers; and internally developed clinical policies and guidelines in the absence of nationally recognized review criteria. For example:

- Government sources such as the CMS Coverage Determinations and the Food and Drug Administration
- Biomedical literature and life science journals
- Professional sources such as U.S. Preventive Services Task Force, American Diabetes Association, American College of Obstetrics and Gynecology, American Academy of Pediatrics and American Psychiatric Association
- Consultation with relevant specialists with expertise in the procedure or technology

Disseminating Criteria. Once DOM approves criteria or updates, we will distribute them to UM staff, including Medical Directors, who attend mandatory training before using criteria in reviews. We will inform Providers during initial, annual, and ad hoc training. We will disseminate updates as they occur to impacted Providers through our Provider Newsletter, electronic alerts on our Provider Portal, updates to our website, and during onsite visits by our Provider Relations staff. We will also provide criteria to Providers upon request. We will inform our Members about requesting criteria through the Member Handbook, Member Newsletter, Member Portal, Notices of Adverse Benefit Determination, and health plan staff. In addition, we will provide written copies of our clinical criteria to Members upon request related to specific Member cases.

e. Expected Prior Authorization clinical criteria by program area;

UM Clinical Criteria

Part of ensuring appropriate utilization of services is ensuring our staff are well trained and aligned, adhering to standard decision-making criteria. All UM staff will use clinical decision criteria, including local clinical policies, to determine medical necessity in alignment with the State's definition. Clinical review criteria are based on nationally recognized criteria reflecting evidence-based clinical practice, along with MississippiCAN and CHIP program requirements. Reviewed no less than annually, the criteria described in **Table 4.2.2.5A.1.e** will drive our UM decisions and be embedded within our integrated Clinical Documentation System. All individuals involved in UM decisions will be required to attest annually, via our "Affirmative Statement about Incentives," that UM decisions are based on appropriateness of both care and coverage using approved criteria.

Table 4.2.2.5A.1.e Standard UM Criteria

Service Type	National Criteria Used (unless specifically identified)
Medical Services including but not limited to Acute IP Hospital Admission, Home Health, Hospice, DME, Genetic Testing, Physical Therapy, Occupational Therapy, Speech Therapy, Private Duty Nursing, Prescribed Pediatric Extended Care, Auditory Services	InterQual Level of Care and Care Planning, Clinical Policy, and DOM Administrative Code

Service Type	National Criteria Used (unless specifically identified)
Behavioral Health Services including but not limited to Psychiatric Residential Treatment Facility, Partial Hospitalization Program, IP Hospital Admission, Community Based Services, Day Treatment, Intensive OP Therapy	InterQual Level of Care and Care Planning, American Society of Addiction Medicine (ASAM), Clinical Policy, and DOM Administrative Code
High tech imaging, such as CT scan, MRI/MRA and PET scans	Internally developed criteria as developed by our high technology imaging Subcontractor and approved by DOM

f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need for updates;

Ensuring Ongoing Effectiveness of Prior Authorization Requirements

As described above, the UMC and QMC will review and revise our PA List no less than annually. This will include ongoing reviews based on DOM guidelines, Provider feedback, recommendations from local and national experts, utilization data, and approval/denial rates. Our CMD and VP of Population Health will review the data sources identified in 4.2.2.5.A.1.c, such as clinical practice guidelines and reversals, in addition to input from Member and Provider-facing staff to gain a complete perspective on utilization and Member and Provider needs and identify any disparities in access. For instance, understanding the impact of SDOH. Based on this ongoing analysis, recommendations for PA requirements are brought to the UMC for review and approval. For example, if we identify a service with a low denial rate, we may remove it from the PA List. Through an affiliate, based on a review of Physical, Speech Therapy, and Occupational Therapy utilization, it was determined that most PAs for therapy services for children ages twelve and under were for developmental delays. In response, PA was removed for these therapies for children in this age cohort. Providers also bring suggestions and recommendations to the CMD or QMC, which are validated and reviewed for potential changes to the PA list.

Minimizing Provider Burden

Our PA processes will be designed to minimize Provider burden and enhance Member access to the right services, including analysis of our PA list. For example, in an affiliate plan in 2020 alone, they removed over 900 codes from their PA list.

g. Prior authorization processes for Members requiring services from non-participating Providers or expedited Prior Authorization;

Ensuring Timely Authorizations for Out of Network (OON) Providers

Our goal is always to minimize the likelihood that Members will require services from OON Providers. We achieve this by employing proven network development approaches that maintain and improve capacity, diversity, and access to Providers that match the needs of Members. If required services are not available through a participating Provider, we will authorize care with the appropriate non-contracted Provider.

Transition of Care. For Members actively receiving medically necessary services upon enrollment, we will cover the costs of continuation of such services, without PA and without regard to network status. As part of our Transition of Care policy, we will provide coverage for up to 90 calendar days from the date of enrollment or until care may be reasonably transferred without disruption, with additional exceptions for defined services, such as pregnancy and post-partum, hospice, chemo, transplant, and outpatient BH and SUD services. When our UM and CM staff identify existing services, they will contact the OON Provider to obtain information about the care and any existing authorization. They will enter PAs into our Clinical Documentation System and provide the PA information to the Provider. For requests for services from OON Providers beyond the 90-day transition period, we will use the same criteria to review for medical necessity that we use for in-network services. For services available within our network, our Medical Directors and UM and CM staff will work with the Member and OON Provider to safely transition the Member to a contracted Provider when the transition will not disrupt care or jeopardize the Member's health. If transition would likely disrupt care or jeopardize health, we will authorize the OON Provider appropriate for the Member's needs for the appropriate period.

Non-Participating Provider PA. Existing Members may request services from an OON Provider for any medically necessary services. Written policies and procedures will allow for referral and payment to OON Providers based on PA. Providers may call our Provider Services Call Center for assistance finding an available in-network specialist or, if not available, finding an OON alternative and securing a single case agreement (SCA). Our UM and CM staff and Medical Directors will assess the information within the context of availability of the Provider's expertise within our network and approve the PA as indicated. If an OON Provider is willing to accept Medicaid rates, no SCA is required, and the PA serves as notification and approval for payment. Providers and Members are notified of our process to access OON Providers via the Provider Manual

and Member Handbook. We will coordinate with OON Providers to ensure they fully understand how to bill for services, when and how to obtain authorization, and that they are not permitted to balance bill. Provider Network staff will also extend an invitation to contract as appropriate. We will authorize and reimburse for medically necessary services not available in-network until those services are available in network.

Expedited Authorization

We will provide an expedited authorization process when a Provider requests or it is determined 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. For OON services, our UM staff and Medical Directors will follow the same process as described above in Section 4.2.2.5.A.1.a to determine whether the request meets criteria and necessary information was submitted at the time of the request. If the determination results in a denial, reduction, or termination, our Medical Director will notify the Provider orally the same day of the determination and issue a written or electronic notice of the decision to the requesting Provider, servicing Provider, and Member and their parent/guardian. The notice will include the reason, right to a peer-to-peer discussion, right to an appeal, and the appeal process.

99.9%

In 2021, in our affiliate plan in a similar market, we met our ***service level 99.9% of the time for Urgent Outpatient Authorizations***.

h. The Offeror's approach to reducing the number of Prior Authorizations required;

Reducing Prior Authorization Requirements

In an effort to reduce Provider administration burden and barriers to accessing timely medically necessary services, we will continually review the PA List for potential requirements to be removed. As described, if a PA requirement is not demonstrating value or impact, it will be excluded from the PA List. Our UM staff will submit any services that meet these criteria to the UMC, recommending that they be removed from the PA list, as appropriate. For example, policy memos from DOM would not require UMC approval prior to PA removal. We will also collaborate with other CCOs to align PA Lists to support consistency across the system. Examples of services our affiliate plans have withdrawn from the PA List include, but are not limited to, observation, podiatrist services, sterilization procedures, laboratory chemistries, and therapy services for children ages 12 and under. For Providers meeting pre-defined quality and performance thresholds, we will also waive authorizations requirements and review retrospectively to monitor continued appropriateness.

i. How the Offeror will ensure that Prior Authorization does not delay treatment in an emergency; and

Ensuring Timely Services

PA will never be required for emergent or post stabilization services. Providers will simply be required to provide notification of inpatient admission within one business day to inform us of the need for continued inpatient care. To directly assist the UM process, we will have established mechanisms and written P&Ps for a plan clinician or representative to respond within one hour to all ED Providers 24 hours-a-day, 7 days-a-week. Should the Provider need support outside of business hours, our on-call nurse will be available 24/7 through the nurse advice line. To streamline the process and reduce administrative burden, our ***Clinical Data & Interoperability Gateway*** will allow for auto-authorization based on our ability to integrate with a Providers' EHR.

j. Processes to ensure consistent application of criteria by individual clinical reviewers.

Processes to Ensure Consistent Application of Criteria by Individual Clinical Reviewers

Initial and Ongoing Audits. We will conduct audits to ensure appropriate application of criteria consistent with all health plans and other applicable standards as described. Our Auditor(s) will conduct audits on five or more randomly selected cases for new UM staff each month until competency is demonstrated, and at least two cases monthly for each reviewer thereafter. The Auditor(s) will use our UM Audit Tool in conjunction with InterQual or clinical policies to determine whether staff applied UM criteria appropriately and complied with all health plan and NCQA UM standards. The Auditor(s) and/or UM Supervisors will discuss results with each reviewer following the audit and consider audit results as part of the annual employee performance review.

Ensuring Consistent Application of Criteria. Annually, we will perform Inter-rater Reliability (IRR) testing to monitor the consistent application of criteria for all staff who participate in medical necessity reviews. A score of 90% must be obtained by all personnel in each subset on which they are tested. Retraining is conducted

for staff failing to achieve 90%, followed by re-testing. UM staff and clinical reviewers will complete IRR testing within 30 days for new hires and annually thereafter to evaluate the consistency with which staff apply UM criteria. We will use the McKesson IRR test that is applicable for InterQual criteria. The test evaluates the consistent application of medical necessity criteria by comparing decision making among clinical reviewers against the standards provided by InterQual. We will review and develop reports summarizing results and program impact on performance evaluations, retraining, orientation training, and the IRR review process. We will also conduct IRR testing for Medical Directors, and our corporate entity's Chief Medical Officer will review results and address identified issues. The UMC and QMC will review these reports at least annually to identify potential trends or patterns and require corrective action or additional training as needed.

Physician Peer-Reviews. Quarterly, Medical Directors from our affiliate health plans will complete peer review audits of our Medical Directors to determine accuracy in terminating, suspending, reducing, or denying requests. Reviews must demonstrate decision making competency based on our UM guidelines and criteria. If improvement opportunities are identified, the QMC develops and oversees corrective actions.

Staff Training. Our local, full-time Auditor(s) will provide training for all UM and CM staff and Medical Directors on topics that include but are not limited to UM criteria and P&Ps, how to apply criteria, and how to document medical necessity in our Clinical Documentation System. Training includes new hire training, initial job-specific training, monthly in-service training, lunch and learn sessions, seminar opportunities, and targeted training to address issues identified during monitoring of UM Program performance. Our UM leadership will maintain an "open door" approach, creating a user-friendly environment that facilitates consultation with peers and leadership for any questions, challenges, or ideas for improving our processes.

Monitoring Delegated UM Functions. For any UM delegation, we will contractually require these vendors to comply with all criteria, P&Ps, NCQA, contract, State, and federal requirements related to UM. We will conduct pre-delegation and annual audits to evaluate the delegate's ability to perform delegated activities and compliance with delegation agreements and all requirements. We will require regular reporting with specific format, content, and timeframes to systematically monitor performance. At our quarterly Joint Oversight Committee meetings, we will review performance and identify and address compliance or performance issues.

4.2.2.5.B Methods

1. Describe the methods the Offeror will use to manage unnecessary emergency room utilization, avoidable hospitalization, and readmissions. Include information regarding how the Offeror will use its telehealth policy in this response, as well as how the Offeror will utilize PCP visits and PCP assignments in its strategy.

Managing Unnecessary and Avoidable Utilization

Referring back to the mission of our UM Program, including the provision of clinically appropriate services at the most appropriate level of care, UM plays a key role in identifying inappropriate utilization and promoting a Member's ability to obtain timely preventive services, diagnosis, and treatment.

Emergency Department (ED). We will manage unnecessary ED utilization through our ED Diversion Program. CM staff will follow a unique ED Management Playcard, a best practice in affiliate Medicaid health plans, which outlines all required CM activities for supporting the Member. Our weekly ED High Utilizers Report will identify Members with two or more ED visits in a rolling 90 calendar day period for outreach. Staff will outreach to these Members by phone or home visit within 72 hours to establish the reasons for the utilization, provide education about appropriate ED use, the importance of routine PCP/PCMH visits, and the availability of our 24/7 nurse advice line. Staff will assist the Member, as needed, to schedule a follow-up appointment with the PCP and arrange transportation. The CM may accompany the Member to PCP appointments to assist them in voicing issues, concerns, and fears to the PCP and understanding needed follow-up or self-management strategies. ***Our Care Managers will assist in developing***

ED Diversion Success Story

The UM team in an affiliate health plan, through the weekly ED High Utilization Reports, identified a 28 year old female Member with a diagnosis of Anxiety Disorder who had eight ED visits in the past two months. A Social Services Specialist provided education to the Member on the importance of preventive measures, using their PCP for non-emergencies and urgent care center if after hours, and use of the nurse advice line. Since engagement, the Member has not had an ED visit within the last two months and has been following up with her PCP. The Member has completed 100% of HEDIS prevention measures as of last report.

agreements between the Member and the PCP guaranteeing that the PCP will see the Member if they call before going to the ED for non-emergent care. In affiliate plans, our PCPs have reacted very positively to this approach. We will also address the needs of Members at risk for unnecessary ED utilization to prevent or reduce emergent needs. Our DM programs and other specialized CM programs, such as for sickle cell disease and high-risk pregnancy, will provide condition-specific education and coaching to improve Member self-management and prevent or reduce exacerbations. For example, we will educate Members with asthma to identify triggers and use spacers to avoid acute episodes. Additionally, CM staff will review cases monthly to discuss strategies for reducing inappropriate ED use, including identifying and addressing SDOH or BH needs contributing to the ED visit. Employing similar strategies, a Medicaid affiliate saw a ***30% decrease in non-emergency ED visits*** from 2017 to 2020.

Avoidable Hospitalizations. We will manage avoidable hospitalizations collaboratively between our UM and CM Programs which integrate disease and health management to prevent complications and ensure treatment of chronic conditions. We will identify Members at risk for hospitalization through clinical and financial analysis of claims data, Health Risk Screenings (HRS) and Comprehensive Health Assessment (CHA), Member demographic information, and utilization patterns for preventive, secondary, and tertiary care. We can also identify Members from biweekly predictive modeling reports, monthly Trigger Diagnosis reports, ED High Utilization reports, after-hours call reports, and referrals. Members identified as Medium or High-Risk or needing additional support will be assigned a Care Manager, who leads an Integrated Care Team comprised of the Member, other clinical and non-clinical CM staff, the PCP, treating Providers, and family/informal supports. For those with certain conditions, such as high-risk pregnancies and sickle cell disease, we will offer CM staff with special expertise in these conditions. Care Plans will incorporate all PH, BH, social and other covered and non-covered services the Member needs, including preventive care, to meet their goals and prevent exacerbations requiring hospitalization. CM staff will educate Members about their condition(s), self-management, appropriate access, and symptoms to watch for and how to report them. CM staff will monitor Member utilization, treatment adherence, and care gaps to identify and address barriers to compliance, self-management, and appropriate utilization. For Members without access to a cell phone who are enrolled in CM and do not qualify for SafeLink, we will provide a phone through our expanded mobile phone access program and program the phone with numbers for the CM, Providers, and the 24/7 Nurse Advice Line, BH/SUD Crisis Line, and SDOH Help Line, enabling Members to report symptoms, ask questions, and make appointments. We will partner with facilities to support the Medicaid QIPP PPHR program, as further described in response to Section 4.2.2.5.B.2 of the RFQ. We will make monthly calls and follow-up care coordination support to specific readmitting Members in both BH and PH through these partnerships.

Readmissions. Our Transition of Care Program (TCP) will use near real-time analytics and proactive outreach to identify hospitalized Members prior to discharge, coordinate services, and connect Members to the post-discharge care they need to prevent readmissions.

Readmission Reduction Program. We will use our predictive modeling system as our "radar" to quickly detect and intervene with at-risk and rising risk Members, generating daily reports that identify Members who have been admitted to an inpatient setting. This includes a readmission risk score, number of readmissions in the last 30 days and in the past year, and the name of their Care Manager and PCP/PCMH and is used to provide pre- and post-discharge coordination and assistance. The interdisciplinary nature of our approach maximizes our ability to identify and address the barriers that may have led to the admission, harnessing the varied backgrounds of our UM, CM, pharmacy and network staff and Medical Directors through direct conversations, structured case rounds, and information sharing and tasking through our Clinical Documentation System. The Member's readmission risk level takes into consideration the Member's diagnosis, SDOH needs and other non-medical risk factors, drives which staff are involved in transition planning and follow up, coordination with hospital Providers and other treating Providers, as well as intensity of service.

TCP Program. Our TCP activities will be implemented through coordinated and integrated CM and UM teams. For Members assigned to Medium or High-Risk CM with a Care Manager, that Care Manager will lead the transition process. An integral part of the team includes our UM staff that are responsible for concurrent review

and authorization of services, such as DME, home health and PDN. Our TCP team will coordinate with hospital staff to assess Member conditions, needs, and discharge potential. They will share information about the Member's care with the PCP and other treating Providers to ensure an integrated approach to discharge planning. We will obtain support, such as physician's orders for certain home care services; coordinate with the PCP and outpatient Providers for scheduling post-discharge appointments and tests and connect the Member to value-added services or community agencies to help access non-covered services and address SDOH needs, such as medically tailored meals. Staff will review the final discharge plan and instructions with the Member and assist in developing actions to prevent avoidable ED and inpatient use, including a Personal Health Record booklet and Discharge Coordination Form to track information such as medications, diagnoses, post-discharge needs, Provider contact information, and questions or concerns to discuss with the Provider. In addition, with medication reconciliation, we will collaborate with the PBA to adjust prescription limits to avoid re-hospitalization. TCP staff will coordinate with our Maternal and Child Health Program to educate moms with babies in the NICU about critical post-discharge care. The NICU kit we will provide to these moms includes the American Academy of Pediatrics book Your Baby's First Year, a double electric breast pump, and education about reducing readmission risk such as hand washing, safe sleeping habits, avoiding smoking, and exposure to others with colds or flu. For Members with a BH admission, we will work with the Member, PCP, and outpatient BH Provider to develop a plan to prevent symptom recurrence, working with Members until they meet CM discharge criteria.

$130 PMPM in Savings

Through a Medicaid affiliate's similar TPC program, they experienced a $130 Per Member Per Month (PMPM) average savings and readmissions per 1,000 Members fell by 17%.

Post-Discharge Follow Up. For Members at risk for readmission not in CM, we will conduct a follow-up call post-discharge and, if unsuccessful, make three attempts at three different times of the day on three consecutive days. During the call, we will review discharge instructions and provide additional education and support on the Member's condition(s), ensuring timely follow-up and support services are in place.

Telehealth and Telemonitoring Solutions

In addition to providing regularly scheduled telehealth visits throughout our network, we will offer telehealth services that offer 24/7 care, including urgent care, BH crisis intervention, and 24/7 population-focused CM to ensure our Members have access to care when they need it. Our solutions also support Members by promoting virtual access in non-traditional settings like school-based care.

Reducing ED Use by 72%

A telehealth technology partner helped reduce inappropriate ED use by 72% in a Medicaid affiliate similar in size and scope to Mississippi, with 98% of Members reporting high satisfaction.

Virtual Care Platform. To improve access and quality, increase health literacy, and promote health equity, we will offer Members access to a virtual care platform with leading-edge digital technology and artificial intelligence symptom checking tools to help triage and determine the best point of care. Through this platform, Members can initiate two-way video and/or audio consultation for pediatric and adult urgent care needs as well as BH services, prescription management, and preventative care. In addition, our virtual care platform will assist Members in finding and scheduling an appointment with network Providers and refer the Member to the appropriate next point of care. For coordination of care, virtual visit and follow-up information is shared with the PCP/PCMH.

To reduce SDOH barriers and increase Member engagement and access to primary care for Members in identified disparity areas, we will pilot a ***virtual PCP program***. Through this program, Members are engaged in care where they are, including PCP services in their homes. For example, we will use claims data to monitor low PCP engagement and provide outreach recommendations to the virtual PCP to increase Member engagement and efficacy. Our virtual PCP program will employ a team of practitioners who have applied for and received an MS Medicaid Provider ID number. A similar pilot conducted by one of our affiliate plans has resulted in a three percent decrease in non-emergent ED visits, which is attributed to our virtual PCP program assistance in helping Members navigate through non-emergent situations.

Specialty e-Consults. Providers can access specialty expertise via e-Consults from over 120 specialties and sub-specialties. For rural practices relying on mid-level practitioners to deliver primary care, this resource

enables them to expand their scope beyond primary care and meet Members' needs for specialty care. Providers can use e-Consults for all their patients, not only our plan patients, to help reduce unnecessary ED visits, acute inpatient admissions, and referrals, which decreases overutilization.

Crisis Support. Through our toll-free BH/SUD line we will provide crisis intervention 24 hours a day, 7 days a week, and 365 days a year to connect Members to the most appropriate level of care based on the presenting situation. BH clinical personnel will assess, triage, and address Members' immediate needs for safe and timely disposition of BH/SUD emergencies and identify longer-term supports. Calls to the BH/SUD line will always receive a live answer due to the number of redundancies in place, including overflow staff and additional BH clinical personnel during periods of high call volume.In addition, we will deploy ***cellular-enabled tablets*** to allow medical practitioners, hospitals, EDs, first responders, and schools without telehealth capabilities to reach a BH clinician immediately on-demand, delivering real-time BH crisis stabilization and therapy services.

School-Based Telehealth. With a large school-aged population, we recognize the value of school-based care, which can help alleviate parent challenges and SDOH barriers to timely access to preventive and chronic condition care. We will collaborate and partner with UMMC to help develop and implement their school-based telehealth program designed to bring telehealth services to Mississippi students. We will partner with a Trauma-Informed Care telepsychiatry group that has provided virtual services to hospitalized children since 2018. Its roster includes more than 100 psychiatrists and other BH professionals that provide sensitive outreach to hospitalized children to promote timely post-discharge follow-up visits.

Mobile Devices and Broadband. We recognize the need for Members to connect to health care services through phone or internet. Through our expanded mobile phone access program, we will provide pre-programmed cell phones to Members enrolled in CM who lack reliable phone access and do not qualify for Safelink. Many rural communities have long faced barriers to high-speed internet. This is often a limiting factor for the PCPs in these areas to use telehealth to treat patients remotely or provide access to virtual specialists from their practice. Through partnership with AT&T, we will support Providers with the application process for expedited access to Federal FirstNet, a nationwide wireless broadband service featuring highly competitive rates and faster, more reliable internet service. An affiliate plan in 2020 outreached to more than 355 Providers, including 34 FQHCs, about signing up for FirstNet. We hope to establish a relationship with C Spire in Mississippi to offer Members discounted equipment for home wifi. Through these efforts, we will help Mississippi FQHCs and rural Providers offer telehealth services more effectively and maintain pace with the evolving methods of care delivery.

Remote Patient Monitoring. Our remote monitoring program for diabetes will provide real-time glucose readings and automatic refills to deliver the right service at the right time. Program goals include improving glycemic control, reducing preventable healthcare utilization, promoting Member adherence to treatment guidelines, and improving self-management skills. Medicaid Members in a similar market experienced a 6% average decrease in glucose levels and a 15% reduction in ED visits compared to those not enrolled in the program. We will also partner with UMMC to offer a ***technology-driven chronic condition self-management program*** to Members living with diabetes, hypertension, and/or congestive heart failure. For each participating Member, the program provides continuous monitoring of disease-specific biometrics, care coordination, daily educational sessions, and medication management with clinical information shared electronically with PCPs.

Promoting the PCP/PCMH-Member Relationship

Provider Notification and Follow Up. We will actively engage our Provider partners in decreasing avoidable ED visits by notifying PCPs when their Members have been seen in the ED. We have ED Flag functionality on our Provider Portal that will inform Providers of Members accessing the ED the previous day. Providers can also view Member ED visit history on the Provider Portal. We will encourage Providers to contact Members using the ED for follow-up care and refer the Member to CM if not already receiving assistance. For Members not engaged with their Provider, we will outreach to ensure Members are satisfied with their assigned PCP and, if not, connect to a PCP/PCMH that meets their geographic, ethnicity/language, and clinical needs. Members who trust that their assigned Provider is managing their care effectively will adhere to the Provider's course of treatment, not rely on EDs for care, and improve their overall health.

PCMH Referrals. Studies have shown that the PCMH team approach to coordinated care is highly effective at improving health outcomes for Members managing chronic diseases. PCMHs have also demonstrated their effectiveness at reducing ED utilization and hospital readmissions through their transformational practice activities, such as extending primary care office hours, coordinating after-hours care, coordinating in discharge planning, and ongoing patient education about where and when to seek hospital-based care. Therefore, we will offer a PCMH to all medium and high-risk Members.

Member Engagement. We will educate Members, their families, and their caregivers about the importance of preventive and follow-up care through our Member and Provider Handbooks, Member Services Call Center, and CM process, assisting with appointment scheduling and transportation as needed. We will further support our Members with tools and resources such as a Personal Health Record booklet that will help Members track information such as medications and needed post-discharge care and questions to ask their Provider.

2. Describe how the Offeror will cooperate with hospital providers regarding post-discharge efforts in relation to the QIPP PPHR program.

Coordination and Collaboration on Post-Discharge for QIPP PPHR

Through our years of experience across our affiliate plans, we know that common hospital readmission causes are patients' lack of understanding, lack of resources and support, and low health literacy. Our dedicated Transitional Care Team will work with partner hospitals to address these issues through discharge planning and post-discharge efforts. In response to DOM's QIPP PPHR initiative, we will conduct monthly calls with our partner facilities to look at specific readmitting Members in both BH and PH. Through these calls, we will identify Members needing medication adjustments, care management outreach, and other engagement strategies. We will also have dedicated CMs for our partner hospitals to address identified barriers and work to reduce preventable readmissions. Additionally, our CM staff make post-discharge calls within three days of discharge to provide medication education, identify needed resources, provide assistance with scheduling appointments and transportation, and ensure home health and DME needs are met. For affiliates with similar markets, this initiative has resulted in a 2% decrease in readmissions in partner hospitals.

3. Describe how the Offeror will identify and address trends in over- and under-utilization.

Promoting Appropriate Utilization

We continuously monitor under- and over-utilization as part of our UM program in direct and deliberate coordination with CM, Quality, Provider Relations, and Member Services staff. Reports are run daily, weekly, monthly, quarterly, and annually for comprehensive monitoring of UM trends. Examples of reports include high risk CM, ED trends, readmissions, pharmacy, BH medication management, and gaps in care. As described below, systematic reporting is one of many processes we will employ in Mississippi to identify and address inappropriate utilization and gaps in care across the delivery system.

Monitoring Utilization. We will identify over-, under-, and inappropriate utilization patterns by continually monitoring and analyzing UM data from clinical processes, activities, and programs including PA, adverse benefit determinations, CM, preventive care, and drug utilization review. These analyses will allow us to identify opportunities for improvement, assess plan and Provider level compliance with our UM guidelines, and monitor program integrity and authorization accuracy. We will monitor and analyze data at aggregate and detail levels by Member, Provider, specialty and type of service, diagnosis, place of service, region, and services authorized versus services received. We will also offer tools that help Providers identify and monitor Members with over-, under-, and inappropriate utilization through the Provider Portal.

Responding to Utilization Trends

Based on identification of overutilization of private duty nursing (PDN) services in an affiliate plan, they implemented PDN rounds, adopted as a best practice. Through bi-weekly rounds with UM, CM, and Medical Directors, the team works with parents and caregivers to provide education and support and successfully transition off of a dependence on non-indicated PDN services.

Addressing Over-, Under- and Inappropriate Utilization. Strategies to address inappropriate utilization include Member and Provider education, outreach, and engagement. For example, based on findings, our Medical Directors or Provider Relations staff will meet with Providers whose utilization metrics fall outside of specific thresholds to develop an action plan for improving identified measures. QM staff will re-evaluate the Provider's performance every three to six months until an acceptable level of performance is achieved. If performance falls below thresholds, the Medical Director or Provider relations staff will meet with the Provider to discuss performance, provide education, and establish a corrective action plan. When we identify Members

who may be over-, under-, or inappropriately utilizing services, we outreach via mail, phone, and in-person to provide education, assist with scheduling appointments and transportation, and connect with CM supports. For example, our HEDIS Program targets Members under-utilizing recommended preventive services. In addition, we provide specialized CM programs and interventions to target specific types of inappropriate utilization. For example, Members with Sickle Cell Disease (SCD) will be enrolled in our SCD program to develop and improve self-management strategies, connect them to a PCP with expertise in managing SCD, and remove barriers to care. We will also educate Providers about SCD and best practices for treatment and address cultural stigmas often associated with SCD and promote Member adherence with hydroxyurea to reduce pain crises through our Hydroxyurea Medication Adherence Program. We will educate Providers on DOM's documentation requirements through mailings, e-mail blasts, phone calls, and workshops, as well as peer-to-peer conversations with the Medical Director.

Addressing Health Disparities. We share DOM's commitment to health equity and providing healthy opportunities to Members by addressing social barriers that affect wellness and quality of life. As a natural output of our whole-person approach and purpose-driven culture, our Director of Health Equity will serve as a resource to our UM and other health plan staff to connect Members to all needed services and remove barriers to care. UM staff will also participate in our onboarding and training programs that include a poverty simulation and person-centered thinking to help staff recognize social barriers and strategize effective interventions. Through cross-functional coordination, oversight, and mechanisms such as screenings, referrals, and technology, we will identify and address social barriers to care. Our goal is to identify Members with barriers to seeking care before they experience an acute event, such as an ED visit or inpatient admission. In doing so, we can help remove barriers and provide our Members with the tools they need to improve their lives, thus enabling them to make their health a priority in their life.

4. Describe how the Offeror will analyze pharmacy utilization patterns to improve care and reduce costs. In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members.

Analyzing Pharmacy Utilization Patterns to Improve Care

Our clinical pharmacy team will manage our statewide drug utilization review (DUR) and clinical pharmacy programs. Our Reporting and Analytics Platform will support pharmacy operations and a multi-disciplinary team of Mississippi-based expert leaders. Our clinical teams will all work cross-functionally alongside our Provider partners to inform and drive integrated solutions that consider the Member's entire health journey. Our pharmacy team will be staffed by licensed pharmacists who lead our DUR program. The pharmacy team will analyze claims and utilization patterns to identify inappropriate prescribing practices. Medication reconciliation is a key strategy to improve care and reduce costs. We will collaborate with DOM on prescriber engagement strategies to educate and monitor our network Providers regarding compliance with the preferred drug list, PA requirements, billing requirements, and appropriate prescribing practices.

DUR Activities. Our pharmacy team will use claims data provided by the PBA to conduct drug reviews and performance monitoring. Our reviews will identify potential overutilization, such as overuse of short-acting beta-agonists with no controller medications and therapeutic duplications (antidepressants, benzodiazepines, Long-Acting ADHD medications, ACE/ARB) as well as overuse of opioids. The reviews will also identify underutilization, such as statin use in diabetic Members and Members with cardiovascular disease. Additionally, reviews will focus on identifying potential drug-age contraindications, drug-drug interactions, and other medication combinations that may jeopardize Members' safety and prevent positive health outcomes. We will use the Mississippi Prescription Monitoring Program database, in addition to other available resources (e.g., claims data), to monitor utilization and prescribing patterns of controlled substances and other drugs.

Identifying and Addressing Member Overuse or Misuse. Identifying inappropriate pharmacy utilization by Members will be a key objective of our DUR program. For example, one of our Retro DUR overutilization reports identifies Members using acetaminophen (APAP) containing product(s) with doses of APAP over 4000mg per day. Leveraging our Opioid Action Council, we will use an evidence-based, multi-disciplinary approach to develop and enhance opioid-specific programs identifying Members misusing opioids and include interventions to educate them on safe utilization and connect them with care. For example, we will refer a Member identified through our Opioid Oversight Program to pain management services and/or substance use

disorder (SUD) screening.

How We Use Pharmacy Data to Improve Care and Reduce Costs

We will use data from utilization reports and PBA activities to improve Member outcomes, care, quality, and safety, up to and including identifying Members and prescribers who may benefit from additional intervention. Steps to ensure quality Member care and reduced costs are below:

- The Pharmacy Director or Medical Directors will contact prescribers with outlier prescribing trends to address issues and offer a Peer-to-Peer prescribing practice consultation
- We will develop a Continuing Medical Education component to address cost-ineffective or inappropriate trends; for example, to share best practices and current clinical guidelines in prescribing ADHD stimulants
- Will refer Members to CM, including our CM programs
- We will provide pharmacy staff assistance to Care Managers to tailor CM approaches based on trends in a Member's pharmacy use, such as managing the benefit limit, medication noncompliance, or recent changes in Providers, to improve Member outcomes and reduce pharmaceutical costs
- We will report findings to the UMC and QMC to make operational and program enhancements, for example, by identifying opportunities to improve cost-effective prescribing through Providers

5. Describe the process for ensuring medication continuity of care upon Enrollment and ongoing. In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all of its Members.

Processes for Ensuring Medication Continuity upon Enrollment

Upon enrollment into our plan, Members will be able to access existing prescriptions, including those not on the Mississippi PDL, for continuity of care (COC) during an initial period up to 90 calendar days. We ensure this continuity for a seamless transition into our plan through the following activities.

New Member Welcome Packet. Our orientation materials, such as our New Member Welcome Packet, will educate Members about the MississippiCAN and CHIP pharmacy benefits and encourage continued use of medication therapies. We will also inform Members about seeking help with pharmacy questions from Pharmacy and CM staff, who immediately transfer clinical questions to clinical staff. We inform Members that they can obtain needed medications even after hours through a three-day emergency supply provision. We will support PCP oversight by encouraging new Members to schedule a PCP appointment as soon as possible and ensure PCPs receive notice through our secure Provider Portal of new Members and associated pharmacy and medical claims histories.

New Member Welcome Calls and Visits. CM staff will ask Members during an initial Health Risk Screening whether they have any problems taking their medications. Members who report problems will be referred to a Care Manager who can further evaluate their medication use and identify steps to address concerns. As needed, the Care Manager also assesses for other conditions, such as BH issues and SDOH needs, to evaluate continuity. We will conduct New Member Welcome Visits for all new Members during the first 90 days of enrollment

Medication Therapy Management. We will implement an agreement with pharmacies across the state of Mississippi as well as an internal polypharmacy program to support medication continuity and decrease ED admissions. For example, by monitoring antivirals, antibiotics, asthma/COPD inhalers and diabetic medication adherence, we can reduce overall costs of care. The polypharmacy program will identify Members with eight or more chronic conditions to capture potential drug-related problems. Provider and Member outreach will be made to address and resolve any issues identified (i.e., dangerous drug combinations, therapeutic duplications, deprescribing).

Medication Continuity as a CM Focus

Care Managed Transitions. For Members with special needs transitioning from another plan, our CM staff will coordinate with the Member's former plan to ensure services, including all medication therapies, are not interrupted. CM staff will also contact the Member's Providers to educate them about our CM program as well as verify the Member's medical, BH, medication history, and Care Plan information.

Targeted Programs. We will design targeted programs based on Members' needs in Mississippi, such as our Hydroxyurea Medication Adherence Program for Members with SCD. Through our ADHD Initiative, we will provide CM services to Members ages 6 to 12 with an ADHD diagnosis who are prescribed an ADHD

medication. A Care Manager will follow up with Member and their parent/guardian to ensure the quality of care and medication continuity. We will educate the Member's parents/guardians about ADHD, the management of symptoms, and the importance of follow-up appointments. We will track each Member's appointment attendance and assist with scheduling follow-up appointments as needed. Through this program, our affiliate plan has made continuous improvements on the HEDIS ADHD maintenance measure since 2013, increasing the rate from 55% to 72% in 2021, surpassing the NCQA 50th Quality Compass Benchmark.

Ongoing CM. Our CM team uses our enterprise Reporting and Analytics Platform to identify Members whose clinical data, including pharmacy claims data, indicates they may be at risk of medication care gaps, therapy duplications, or noncompliance. We will enroll those Members in CM for enhanced oversight, education, and assistance. Our DUR and our ED Diversion programs will be used to identify Members for CM. For example, our ED Diversion program analyses will identify Members whose conditions have deteriorated due to medication noncompliance or ineffective drug therapies. Our CMs support continuity by doing one or more of the following:

- Reviewing a Member's prescription claims history and asking the Member, at each contact, whether they are taking their medication as prescribed, and whether there are any problems, such as with refills, side effects, or a medication's directions.
- Educating Members and caregivers about the importance of medication adherence and compliance.
- Encouraging and assisting Members to complete baseline and periodic medical screenings and other visits, thereby assuring appropriate, periodic medical evaluation of a prescribed regimen.
- Inviting prescribers to participate in care planning and updating them about Care Plan changes or medication-related issues as reported by Members.
- Providing select high-risk Members with a cell phone to support medication adherence by helping Members report side effects or ask questions about their medications. In addition, pharmacy contact information may be pre-programmed to provide Members with refill reminders when a prescription supply runs low.
- Working with hospital discharge planners and conducting post-discharge follow-up on medication use and potential problems. We will also offer Members a Personal Health Record booklet to help them record the name and purpose of their medications and how to take their medications appropriately.

Community Health Worker (CHW) Support. We will deploy local CHWs to assist Members in the community. CHWs can help discover potential medication issues or questions and forward those concerns to appropriate clinical staff. For Members being discharged from the hospital, CHWs can provide resources and connect Members to services in the community to help support medication adherence, such as pillboxes.

[END OF RESPONSE]

4.2.2.6 INFORMATION TECHNOLOGY

4.2.2.6.A Claims Processing

1. Describe the Offeror's claims processing system including:

We are committed to continuous improvement in our claims payment operations, including our system capabilities and Provider education and outreach activities. We process payment to in-network and out-of-network Providers, and view claims processing as a critical opportunity to offer superior service to Mississippi Coordinated Access Network (MSCAN) and Children's Health Insurance Program (CHIP) Providers through timely and accurate payment. Our strategy for achieving superior service to our Providers centers on our ability to maintain a high rate of automatic adjudication and electronic claims submission. Each plan is under the oversight of a Claims Administrator/Management Information Systems Director. ***Each month we process on average over 780,000 behavioral health and over 9.4 million medical Medicaid claims nationally, meeting and exceeding timeliness and Provider payment turnaround requirements***. As a CCO, we will provide the same level of service to the MSCAN and the CHIP population to meet and exceed all contractual requirements outlined by the Mississippi Division of Medicaid (DOM). As required in Appendix A, Draft Contract Section 9.1.1 Claims Payment, and we have the capability to pay at least 90% of all Clean Claims for covered services within 30 calendar days of receipt and pay at least 99% of all Clean Claims within 90 calendar days of receipt, except when an alternative payment schedule has been agreed upon. All other claims except for Providers under investigation for fraud, waste, and abuse (FWA) will be paid within 120 calendar days of receipt. Our Claims Processing System diagram below describes its major functions, how our Claims Processing System will support major functional areas of the MSCAN and CHIP Programs, how our system will be modified to meet requirements, claims operations, Medicaid Fee for Service Program standards, and how we handle compliance issues, correcting claims, and correcting deficiencies and variances.

125.5 Million Claims

In 2021, our parent company's Claims Processing System processed over 125.5 million Medicaid claims.

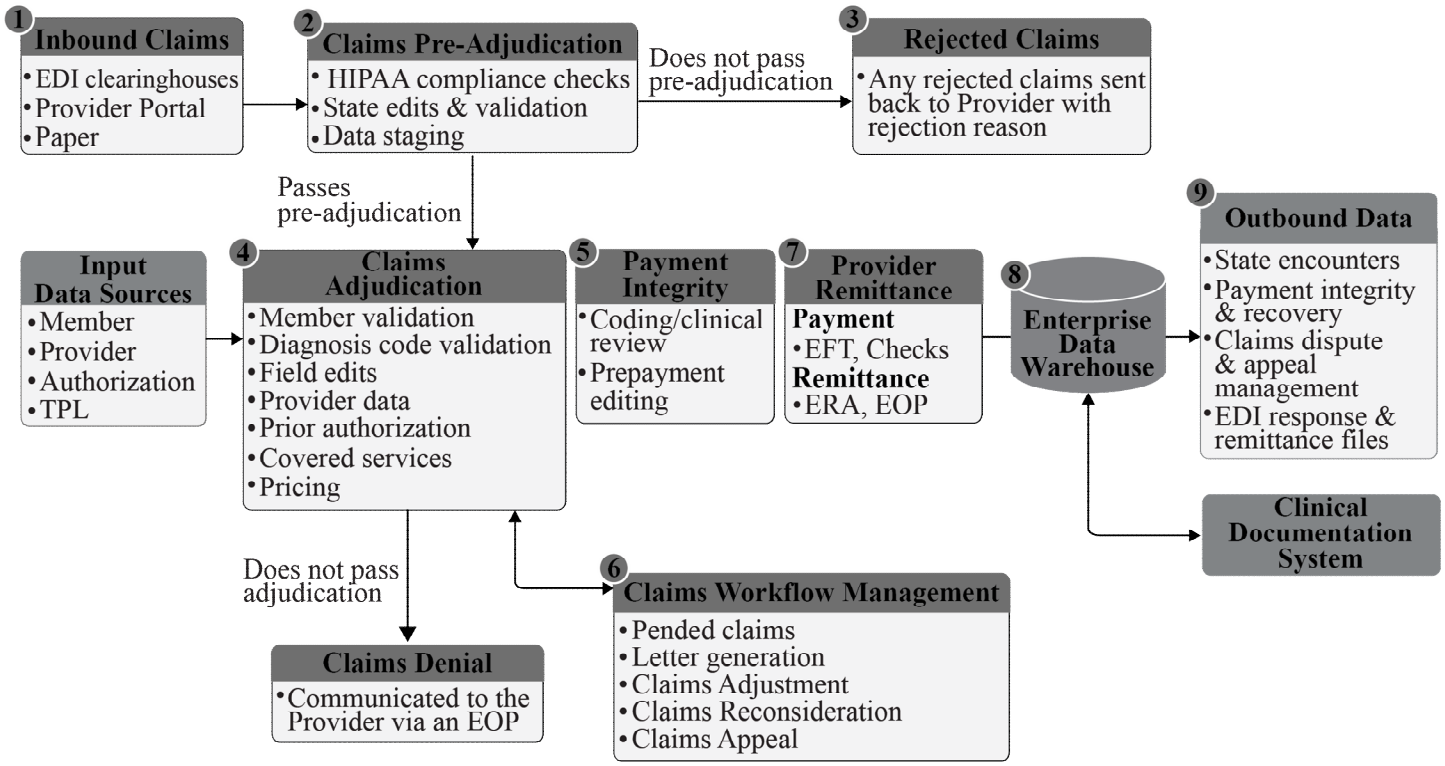
a. A systems diagram that describes each component of the claims processing system and the interfacing or supporting systems used to ensure compliance with Contract requirements, and

Claims Adjudication Process

Our Claim Processing System capacity has grown year after year and has the capacity to continue to meet growing claims processing needs. For effective claims processing and payment, we provide a Medicaid-focused HIPAA compliant claims adjudication process and systems which are integrated end-to-end: from Provider claim submission to Provider payment. Our Claims Processing System, as described in **Figure 4.2.2.6.A.1.a** processes both medical and behavioral health claims enabling a uniform approach to coordinated benefits administration. Our flexible system allows us to configure complex Provider reimbursement models, including value-based payment structures, clinical edits, and advanced FWA edits to ensure accurate and timely claims payment. We have the capability to process claims consistent with timeliness and accuracy requirements identified in contract Section 9.1.2 Claims Processing and Information Retrieval Systems to make any updates to our Claims Processing System within 60 calendar days of notice by the DOM. We will implement all subsequent updates using the same date requirements as the DOM. Unless otherwise approved by the DOM, we will implement changes in State Plan Amendments by the effective date of those Amendments. Our system diagram describes each component of our Claims Processing System and how its capabilities will support the MSCAN and CHIP Programs. The diagram further describes how we will handle the claims receipt and adjudication process, including pre-adjudication, rejected claims, ensuring payment integrity, claim workflow management, Provider payment, and outbound data. Our Claims Processing System is an essential part of our integrated Management Information System (MIS), and we describe in detail below how our MIS works to provide added functionality to our Claims Processing System.

Claims Processing Growth	
2021	125.5 million
2020	106.7 million
2019	103.1 million
2018	88.4 million

Figure 4.2.2.6.A.1.a Claims Processing System



Claims Receipt and Adjudication. We will offer Providers training and technical assistance on the different modalities they can use to submit and track claims. Through our Electronic Data Interchange (EDI) subsystem (Item **(1)** in **Figure 4.2.2.6.A.1.a),** we collect and adjudicate claims submitted via HIPAA-compliant electronic formats and paper formats. Providers can also utilize an automated clearinghouse to submit claims electronically and to request and receive electronic funds transfer (EFT) for claims payment, as described below. Our multiple claim receipt options are outlined below in **Table 4.2.2.6.A.1.a.**

Table 4.2.2.6.A.1.a Claims Receipt Methods

EDI Claims Clearinghouses	We support receipt of HIPAA 837 EDI and Institutional, Professional, and Dental via over 80 clearinghouses.
Multi-Payer Portal	Providers can also submit claims through the multi-payer portal, allowing Providers to use a single portal to interact securely with multiple payers for checking eligibility and benefits, claims submission and EFT for payment.
EDI Batch File Submission (Provider Portal)	Providers can submit HIPAA EDI 837 files through our secure Provider Portal. If a Provider is new to EDI, they have access to our Ramp Manager claims testing portal. This tool allows Providers to onboard through file testing and certification of EDI claims submissions with assistance from our Claims team. Providers can track the status of submitted claims and e-mail us through the Provider Portal for assistance.
Direct Data Entry (Provider Portal)	We support secure online entry of claims through a HIPAA-compliant direct data entry tool on our Provider Portal. The tool is designed specifically for Providers with limited coding experience and recurring billing needs. The tool assists Providers with validation assists for codes (e.g., Current Procedural Terminology (CPT), International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10), cross-field logical checks, and validation of Member and Provider data. We also allow electronic submission of claim attachments, if needed. Providers can submit new claims by starting with prior submissions for a specific Member, creating a template with pre-populated information easily updated for new submissions.
Paper Claims	We receive paper claims on standard CMS-1500 and CMS-1450 (UB-04) and Dental ADA forms. Using Optical Character Recognition technology, we convert paper claims into machine-readable data for subsequent adjudication and payment.

Through our secure Provider Portal, we will offer an online reference tool that allows our Providers to understand our administrative and clinical claim edits at a detailed level. This tool offers claim processing transparency and assists with coding accuracy. Providers will be able to file claims, check claim status, and submit claim reconsiderations, as well as view the status of reconsideration requests through the Provider Portal. Providers can use our Provider Portal to enter and view authorization requests and status. On our public

website, we will offer Providers the ability to determine if prior authorization for service is required.

Claims Pre-Adjudication. Upon claims receipt, our Claims Processing System will translate claims data, perform initial screening, and either reject the claim or assign a unique control number for further processing. This unique control number incorporates the Julian time stamp we affix to all claims upon receipt, allowing us to link all information on a claim and track adherence to timeliness standards. Our timely claims processing is in accordance with Section 16.7.6 of Appendix A, Draft Contract. The X12 EDI compliance edits are established through the Strategic National Implementation Process (SNIP) in our EDI subsystem. We can ensure 99% of the records in the encounter batch submission will pass X12 EDI compliance edits and the Mississippi Medicaid MES/MMIS threshold and repairable compliance edits. We can perform X12 EDI compliance edits established through SNIP level one (1) through four (4). Our system verifies that claims comply with HIPAA syntax and data structure guidelines, validating against ANSI Accredited Standards Committee X12N and DOM Systems Companion Guides in (Item **(2) in Figure 4.2.2.6.A.1.a**). We process paper claims with the same data validation edits as electronically submitted claims in proper HIPAA-compliant formats. We will configure specific requirements in our system. Pre-adjudication edits applied to the claim include confirming Member identifiers, confirming billing and rendering Provider identifiers, and validating other data elements against internal data, such as Member eligibility and Provider data.

Rejected Claims. If a claim does not pass edits (Item **(3)** in **Figure 4.2.2.6.A.1.a)**, it will be rejected via an ANSI 277 Unsolicited (277U) notification to the EDI clearinghouse or submitting Provider, conveying the specific edit that did not pass upfront validation processing. Our Claims Manager has access to our Reporting and Analytics Platform, which allows us to track rejected claims through our Claims Dashboard. The Dashboard allows our Claims Manager to monitor error trends or potential system issues which will be shared with the appropriate business area team for remediation. As our Medicaid affiliate plans have done for all new program implementations, we will closely monitor any claim rejection trends during Contract implementation so that we can rapidly focus on any area for targeted Provider support, training, and assistance. We will also offer technical support for Providers to resolve any claim issues.

Claims Adjudication

Once a claim passes pre-adjudication edits, our Claims Processing System (Item **(4)** in **Figure 4.2.2.6.A.1.a**) performs adjudication edits, including:

- **Field Edits.** Checks for the validity of common data fields, including CPT, ICD-10, age, gender, duplicate, timely filing edits, and date of service logic. Our Claims Processing System will check for data consistency according to business rules outlined by the DOM and NCCI edits and check for ICD-10 code sets in accordance with Section C.2.vii of Appendix A, Draft Contract to improve quality.
- **Member Edits.** Checks for Member eligibility during service date spans, coverage type, and existence of coordination of benefits (COB) or Third-Party Liability (TPL).
- **Provider Data.** The system validates Provider identifiers (Tax ID's (TINs) National Provider ID's (NPIs)) eligibility for both the program and rendering of claim services, network participation status during service date spans, as well as ensuring a Provider submits claims in a timely fashion.
- **Prior Authorization.** When applicable, checks for prior authorization and validates the presence of criteria during the service date spans will be performed.
- **Covered Services.** Our system will check against benefit management rules to determine if the service is covered and eligible for payment, as well as medical necessity including if services are appropriate in amount, duration, and scope. Checks for plan limits and progress towards limits.
- **Pricing.** Applies Provider-specific contractual and financial agreements. Audit trails in the system will retain snapshots of all transactions for historic preservation. This audit function includes date span logic, historical claims tracking, Claims Analyst ID stamping, and accommodates different audit parameters for management controls.

Customized Claim Edits

Our claim code editor allows us to customize edits for Mississippi's specific benefit criteria, coding, and policies.

Payment Integrity. A successfully adjudicated claim will be analyzed to determine clinical claim coding appropriateness and potentially fraudulent or wasteful billing practices (Item **(5)** in **Figure 4.2.2.6.A.1.a).** Our

integrated code editor and other coding analytical tools use nationally recognized coding guidelines that address inaccuracies such as unbundling, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures.

Claims Workflow Management. Our Claims Processing System will manage the workflow of any pending claims that do not automatically adjudicate. If a claim pends, an electronic work item routes immediately to a Claims Analyst with expertise to address the pend issue for resolution (Item **(6)** in **Figure 4.2.2.6.A.1.a**). For example, we can route specific pend codes and issues to our licensed clinical staff for medical review, research, and resolution. In addition, Claims Analysts have immediate access to paper claim images via our Centralized Document Management System (CDMS) to support the routing of information between departments. When the "pend issue" is resolved, we immediately re-adjudicate the claim. Should we receive a claim submission that does not include all necessary documentation or information to process the claim, we deny the claim (in full or partially) back to the Provider within seven days, with a notification regarding the information needed to adjudicate the claim. We monitor these denials by Provider type to assist with tailoring our continued training programs to improve claims payment throughput.

Using Artificial Intelligence (AI) and Machine Learning (ML) in Claims Processing. We will use AI/ML to automatically perform claims operations tasks and improve capabilities as more data is received, without the need for additional programming. For example, AI/ML is used to automate insurance verification, which is a process frequently performed by Claims Analysts to verify Member "other insurance" coverage. AI/ML allows us to perform repeatable claims operations functions in the background, freeing up Claims Analysts to address more complex claims-related work. These innovations improve claims processing timeliness and accuracy for Providers.

Provider Payments. Once a claim successfully passes all claim edits, it is finalized with a status of 'paid' or 'denied' for the next weekly payment cycle (Item **(7)** in **Figure 4.2.2.6.A.1.a)**. We will also offer paper check and paper Explanations of Payment (EOP). The Provider receives an ERA or EOP even for denied claims, clearly stating the reason(s) for claim denial, along with instructions for correction and resubmission, if applicable. In accordance with Section 9.1.6 Off-System Adjustments of Appendix A, Draft Contract, we will not use off-system adjustments without written consent from DOM to correct payment errors.

Outbound Data. Claims data in our Enterprise Data Warehouse (EDW) is used to meet encounter data submission requirements (Item **(8)** in **Figure 4.2.2.6.A.1.a)**. During each week's payment cycle we issue duplicate 835s to the appropriate State agency reflecting claims processing outcomes. Our Claims Processing System sends claims data to our EDW (Item **(9)** in **Figure 4.2.2.6.A.1.a**). This allows us to develop reports in our Reporting and Analytics Platform for submission to DOM, including Claims Activity, Claims Timeliness, and Claims Payment Accuracy.

b. How each component will support major functional areas of the Mississippi Medicaid Coordinated Care program.

Core Processing System Components Supporting Functional Areas

Our Claims Processing System is one of the Core Processing Components of our MIS and will support the major functional areas of the Mississippi Medicaid Coordinated Care Program. The Core Processing Components will work together with other systems in our MIS to ensure all requirements are met.

Member Enrollment System (Member Data). In addition to serving as the source of truth for Member relationships in our MIS, the Member Enrollment System employs a master data management approach to collecting, updating, matching, quality-assuring, storing, and distributing Member enrollment data. We will receive and load data from DOM and other State partners to our MIS components needing that information, such as Clinical Documentation System, Claims Processing System, and Customer Relationship Management System (CRM). The Member Enrollment System will also store Member demographic information, including Member identifiers, address, contact information, confirmed or potential family linkages, special needs, language(s) spoken, current and previous PCP, along with Member preferences (e.g., communication options such as e-mail, phone, or mail), along with a history of changes to that data and it meets the Member Data and Reference Data Maintenance functional requirements. The system automatically maintains historical Member data across

Core Processing Systems

- Member Enrollment
- Provider Lifecycle
- Customer Relationship
- Provider Portal
- Clinical Documentation
- Encounter Data
- Document Management
- Enterprise Data Warehouse
- Reporting & Analytics
- Third Party Liability

enrollment spans for each of our programs, allowing us to accurately validate Member eligibility for dates of service on any claim. We can also use the Member Enrollment System to view an individual's historical participation in our other products.

Provider Lifecycle System (Provider Data). Our Provider Lifecycle System is used to support our core Provider functions, including Provider prospecting, recruiting, enrollment, ongoing engagement, and will align with DOM's Fiscal Agent on Provider Data Maintenance functional requirements. Provider network data will be maintained in our Provider Lifecycle System, a workflow-enabled relational repository used by our Provider Network teams for Provider prospecting, contracting, enrollment, data management, and continuous engagement. Our Provider Network team will enter and update Provider data in the system, ensuring that all data comes from one governing source for complete data integrity. We store and index Provider identifiers including Tax ID, National Provider ID (NPI), Provider's language information, locations, office hours, web URL, ADA accessibility, and other demographic information. ***We also track Provider certifications such as Trauma-Informed Care and Trauma-Focused Cognitive Behavioral Therapy.*** Address verification and standardization software will also be applied to all Provider records. Our Provider Lifecycle System will supply data via our Real-Time Repository (RTR) technology to downstream systems needing that information, including our online Provider Directory. When updates are made to data in our Provider Lifecycle System, the change transaction automatically triggers an update for our online Provider Directory, typically within minutes via a microservice RTR. RTRs are high-performance databases designed for conveying updated information to both external and internal-facing applications.

Customer Relationship Management (CRM). Our CRM system enables us to identify, engage, and serve our Members, Providers, and State partners in a holistic and coordinated fashion across the breadth of their wellness, clinical, administrative, and financial matters. Integrated with our MIS, CRM affords a 360-degree view of our relationship with Members and Providers for our Customer Service Representatives (CSRs). Our CSRs will have immediate access to claims information through our CRM to assist Members and Providers with claims questions and needs when they call. This integration helps eliminate inconsistencies and ensures that staff has access to the information needed to support and assist Members and Providers. For example, CSRs can view a calling Member's information across historical and current eligibility spans, view care gaps, and assist Members with their needs.

Provider Portal. As mentioned above, our secure Provider Portal is a web-based platform supporting Provider administrative self-service capabilities, including eligibility inquiry, authorization submission, and status, claim submission, claim status, claim payment history, peer-to-peer review request, and a growing number of clinical applications. These clinical applications include online care gap notifications and health alerts, Member health records, patient analytics, Provider analytics, care and disease management referral, and clinical practice guidelines. Our Provider Portal will support our medical and behavioral health Providers in their practice of evidence-based medicine.

Clinical Documentation System. The Clinical Documentation System is our Member-centric platform for collaborative care coordination, utilization management, and population health for all Members. Because the Clinical Documentation System is integrated with our EDW, which systematically receives internal and external administrative data, it equips Providers with better information for clinical decision making and utilization management authorization services, therefore, adding to more accurate claims processing. Among other functions, our Clinical Documentation System houses Members' person-centered care plans, which display Member identified health problems, treatment goals and objectives, interventions, outcomes, and milestones and completion dates and will include each Member's profile with Member demographics, care plans, referrals, authorizations, case notes, and Member language and communication preferences. The Clinical Documentation System integration with our EDW and our Reporting and Analytics Platform will allow us to develop reports for submission to DOM, including claims activity, claims timeliness, and claims payment accuracy based on the most accurate, complete, and timeliest transactional data available.

Encounter Data System. We will use our industry-leading encounter workflow system specifically designed for managed Medicaid encounter processing. Fully integrated with our enterprise MIS, our Encounter Data System is configured to meet specific program requirements as defined by the DOM. For every clean claim, our encounter data will display the same line-item detail as received on the claim, regardless of claim type, and

disposition (e.g., paid, adjusted). Our encounter data submissions include diagnosis and Diagnostic Related Group (DRGs) as appropriate and are inclusive of the DOM standards regarding the definition and treatment of certain data elements captured on claims such as counting methods and units. Through our encounter submission process, we will provide all rendered services, Provider's identification numbers, and billed amounts and indicate if the claim is original, adjusted, voided, denied, a replacement, or from capitated services.

Centralized Document Management System (CDMS). CDMS is our automated content management system; expressly designed to efficiently manage inbound and outbound paper and fax document traffic to/from our health plan. CDMS will automate and accelerate the processing of paper and faxed authorization requests, assessments, care plans, survey questionnaires, and other paper-based correspondence. CDMS uses integrated architecture that incorporates a full-featured, secure inbound/outbound fax communications system with enterprise-level document scanning, Optical Character Recognition (OCR), indexing, and routing workflow capabilities to streamline and automate the capture and processing of paper-based documents. CDMS integrates documents and customizable workflows with the appropriate application (e.g., Clinical Documentation System for authorization, assessment, and care plan data, EDW for survey data) and ensures that documents received from Members or Providers maintain logical relationships to key data elements such as identification numbers.

Enterprise Data Warehouse (EDW). Our Reporting and Analytics Platform's foundation is our comprehensive EDW that systematically receives, integrates, and transmits internal and external administrative and clinical data. EDW supplies the data needed for all analytic and reporting applications while orchestrating data interfaces among our core applications. Storing all information in the EDW allows us to generate standard and ad-hoc reports from a single data source.

Reporting and Analytics Platform. Our Reporting and Analytics Platform is a comprehensive family of integrated decision tools and provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with drill down capabilities. This platform powers our Provider practice, Provider clinical quality, and cost reporting information products. Through our Reporting and Analytics Platform, we can report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, Performance Improvement Project informatics, and other critical aspects of operations. We will be able to drill down and stratify on all available demographics including age, geography, race, ethnicity, language, and disability (RELD). The platform includes a suite of industry-leading predictive modeling solutions incorporating evidence-based, care gap/health risk identification applications that identify and report significant health risks at the population, Member, and Provider levels. Online care gap notifications through the Reporting and Analytics Platform allow Members and Providers to access actionable health information via our secure Member and Provider Portals. Additionally, using this platform, we have the capability to create reports enabling us to identify care quality and Provider training opportunities, as well as high performing Providers for primary care assignments.

Third Party Liability (TPL). We have a successful history of maximizing cost avoidance for our Medicaid health plans, as well as recovering payments made for our Members who were subsequently found to have other insurance with TPL. We structure cost avoidance and TPL practices around a "Medicaid as a payer of last resort" principle. We will implement our proven practices for MSCAN and CHIP to meet TPL functional requirements. Inquiring for sources of TPL is an ongoing process and will take place through multiple activities, including HIPAA 834 processing, Member self-reporting, Provider interactions via telephone, Provider Portal, or claims submissions; from Health Care, Care Management system processes; and from clinical management staff. We will bring other insurance information together in our CRM system, which pulls data from our Member Enrollment System, our source of truth for Member relationships and information in our MIS. CRM systematically pulls updated eligibility data, including COB data obtained from the 834, to other applications needing that data, including the eligibility subsystems of all Subcontractors. CRM maintains a Member record, including Member eligibility and is integrated with our Claims Processing System to support the collection and maintenance of COB information at the Member level and, to enable accurate automated cost avoidance through prompt suspension of claims submitted without required Explanation of Benefits (EOBs) or payment information.

2. Describe modifications or updates to the Offeror's claims processing system that will be necessary to meet the requirements of this program and the plan for completion.

Change Management Process

While ***we anticipate no needed modifications to our Claims Processing Systems to support DOM and the MSCAN and CHIP program***, our Claims Processing System is designed to nimbly respond to changing needs for our programs and technology to support accurate claim processing. Our Service Oriented Architecture is comprised of easily configurable system components that can be adapted and adjusted to meet requirements for the MSCAN and CHIP Programs. Although no significant modifications appear to be needed for the MSCAN or CHIP Programs at this time, the ability to adjust for the changing needs of the Medicaid population and related service programs is available without delay. We take a local approach and will provide a resolution team in Mississippi so Providers can talk to local people to solve issues. Changes for Provider types and payment structures, membership category updates, benefit changes, fee schedule updates, and program changes are all examples of easily configurable items within our system. To ease training and administrative burden, we provide a centralized credentialing process, but we will utilize any credentialing process provided by DOM. Our standard change management takes two to three weeks, depending on how many system components the change impacts and if external parties are needed for testing (Providers, agencies, operator, etc.). Described below is how we identify modifications required how they will be tested, implemented, and communicated.

Identifying Needed System Modifications. Our Compliance Department will monitor all correspondence from DOM, other Mississippi agencies, CMS, other Federal agencies, and Subcontractors to identify potential changes to our systems. If a change to our MIS is required, our Compliance Department will coordinate with IT to submit a system change request, which initiates our change management process. We will also identify needed modifications through our Reporting and Analytics Platform dashboards which track real-time claim volume and processing results. Our Claims Manager and staff will continuously monitor claims throughput to quickly identify if claims are delayed due to system issues. In these instances, we quickly perform root cause analysis and remediation to resolve identified issues. Annually, we will review our processes for test and deployment, routine system maintenance, and capacity updates that are planned and introduced before performance issues arise. We weigh three considerations in prioritizing system changes:

- Beneficial impact on service operations;
- Modification size, effort, and complexity; and
- Regulatory and contractual compliance (e.g., a DOM mandate).

Implementing Changes. Our MIS features parameter-based configuration utilities, which mitigate the need for custom software development, and as a result, our system change efforts can focus on precise definitions of business rules, ensuring reliable and efficient system changes. DOM requests will be received by our Compliance Department, which is managed using our Compliance Management System for workflow-enabled tracking of DOM requests. Our Compliance Department notifies other affected departments of the change request for further examination and implementation. Our Compliance Department and centralized Legal and IT Security Departments monitor relevant Federal mandates (e.g., published in the Federal Register) and IT mandates related to security. We will use our Compliance Management System to organize, manage, and document our compliance with Federal and other related mandates.

Testing. We use Scaled Agile Framework (SAFe) change methodology and Information Technology Infrastructure Library-based (ITIL-based) production controls to test upgrades from the software suppliers of our core MIS applications (e.g., claims, eligibility) before release. This approach is used for software development, configuration changes, and functionality testing of individual system components. We perform system integration, regression, and user acceptance/quality assurance testing in test environments to determine how changes in one component impact others. We will also perform stress tests using load simulation software to model the effect of the user, network, and batch process loads on the overall system. Testing is completed by our IT Quality Assurance team, developers, and other stakeholders and is completed with development and configuration changes to ensure that desired functionality works accurately and as expected based on change requirements. The process will include peer review by our software development professionals to ensure consistency with ITIL-based principles of software design and security compliance. Once changes are thoroughly tested and approved, changes are moved into production.

Communicating System Changes. For any routine system change affecting us, our established change advisory team will ensure that we have an appropriate communications plan, both for internal and external stakeholders (including DOM, when applicable), implemented for the change. We coordinate change communications and oversee, as appropriate, written and website notifications, phone, and other communication channels to make sure all impacted parties are notified. We will ensure that our system documentation is current, accurately describes systems operation, IT services, and processes, and is inclusive of the most current system changes. The Chief Operating Officer oversees all Claims Processing System change activity and when required, our Compliance Officer will notify the DOM of any system modifications.
For any system changes affecting DOM, Members, or Providers, we will assemble communications plans that use appropriate combinations of direct mail, fax, outbound automated call campaigns, Interactive Voice Response messaging, call scripting for inbound calls, and public website notices. Our Compliance Officer will communicate all changes, especially changes around defects affecting Provider or Member Portals or services, including a monthly defect report to DOM.

3. Describe the Offeror's claims processing operations including:

As an agile organization, we collaborate, adapt, and change to continually improve our claims operations. ***We view our claims processing operations as one of the most important data gathering aspects of our operations to develop targeted interventions that drive Member outcomes.*** It is an opportunity to provide superior service to our Providers, it will support the DOM's quality and utilization monitoring efforts, Provider education and outreach initiatives, and we will supply the DOM with accurate, complete, and timely encounter information. Our Chief Operating Officer and Network Leadership will oversee claims operations, leveraging Provider Relations (PR) and Claims Liaisons teams. We will have a dedicated team who will be trained on the MSCAN and CHIP benefit plans and DOM-specific processing rules and compliance requirements.

Our claims processing operations are illustrated above in **Figure A.2.2.A.1.a**. Claims Liaisons will serve as the primary coordinators of claims activities between the Health Plan and our Claims Operations Center, providing critical feedback on claim configuration and encounter reporting. Our configuration reimbursement, Provider data management, and enrollment teams will contribute to high auto adjudication and quality outcomes. Provider Relations Specialists, in partnership with Claims Liaisons, help Providers work through any problems with claim submissions and resolution, including initiation of immediate claim adjustments. Providers may also contact Claims Liaisons, and Provider Reimbursement Specialists along with PR staff offer claims training and support for Providers. Our Claims Liaisons will investigate and address claims-related issues identified by our staff or Providers. Our Provider Reimbursement Specialists have specialized focus areas and claims expertise (e.g., health systems, multispecialty groups, PCPs, FQHCs, and rural hospitals). We provide a telephone number that is staffed during billing hours for questions from Providers about refunds, recoupments, audits, cost review actions, cost containment actions, and similar activities pertaining to claims and payment processes.

a. The claims processing systems that will support this program.

Our Claims Processing System is a core component of our MIS and is described in detail above in Section 4.2.2.6.A.1.a. of this RFQ. Our Claims Processing System is currently used to support claims operations nationwide for all of our affiliate Medicaid markets. We have full ownership and control of our system, which affords us the ability to configure and make the necessary changes to support all ongoing needs of the MSCAN and CHIP programs. The Claims Processing System is used to collect, store, and adjudicate claims and accurately pay Providers. The system is integrated with all other core processing functions of our health plan, as outlined in Section 4.2.2.6.A.1.b of this RFQ, including but not limited to our Clinical Documentation System to ensure authorization data is provided for the timely and accurate processing of claims and meets the Claims functional requirements of the contract. Our approach to interoperability ensures data shared between systems is accurate and complete, which is accomplished through technical integration configuration, implementation, and tracking protocols.

b. Standards for speed and accuracy of processing and measures to ensure standards are no less than the Medicaid Fee-For-Service program.

Measures to Ensure Standards. Our priority is to process claims timely and accurately. We will ensure standards for timeliness and accuracy are met or exceeded as noted in Section 9.1.1 Claims Payment Generally of Appendix A, Draft Contract. We will meet all requirements of Medicaid Fee-For-Service timely payment as required under 42 C.F.R. § 447.46 to pay at least 90% of all clean claims (as defined by 42 C.F.R § 447.45) for

covered services, within 30 calendar days of receipt and pay at least 99% of all clean claims within 90 calendar days of receipt, except to the extent an alternative payment schedule has been agreed to in the Contract. The date of receipt of a claim is the date we receive the claim, as indicated by the date stamp on the claim. The date of payment is the date of the check or other form of payment. We exceed MSCAN and CHIP claims processing contract requirements at affiliate health plans. **Table 4.2.2.6.A.3.b** provides an example of one plan's performance.

Table 4.2.2.6.A.3.b Medical Claims Processing Timeliness by Year

Claim Type	2018	2019	2020	2021
% Paid in 15 Days or Less	93.50%	94.60%	96.40%	97.20%
% Paid in 30 Days or Less	99.20%	98.00%	98.90%	99.90%

Reporting and Analytics Platform. Our claims dashboard produced by our Reporting and Analytics Platform will provide day-to-day management and insight into health plan claim transactions. This includes all electronic and paper submitted claims, appeals, Call Center routed inquiries, correspondence, authorization requests, and other forms and faxes received by the health plan. Our claims team will use Dashboard reports to manage the aging of work in accordance with MSCAN and CHIP turnaround times (TAT) and compliance standards. Our claims operations dashboard reporting includes claim receipts, auto adjudication rates, paid and denied claims, first-time claim pended inventory, adjustment inventory, voids, configuration, monthly interest, rejects of claims in front-end services, and encounters. Reports will be updated by the hour, day, week, month, and year; billed amounts; average aging; count; percent; TAT; and Per Member Per Month. For day-to-day claims management, these reports allow timely recognition of any potential challenges or disruptions of routine systems. In addition to early detection of any operational failures requiring immediate action, our established communication protocols will help ensure timely escalation and resolution. Mitigation actions are pre-defined to help ensure service levels are met and standards are no less than Medicaid Fee-For-Service.

c. The Offeror's process for dealing with discovered compliance issues through an expedited process;

Using Data to Monitor and Address Compliance Issues. We will use our Reporting and Analytics Platform and our Grievance and Appeals System data to monitor for compliance issues. Our Compliance Officer will use both tools to ensure compliance with DOM claim processing and reporting requirements. We will build and maintain relationships with those at the DOM to identify and resolve findings before they become compliance issues. Our Reporting and Analytics Platform brings transparency to our claims operations and supports the tracking of mechanisms necessary to satisfy all internal and external audit requirements. Our organization undergoes an annual Statement on Standards for Attestation (SSAE-16/18), in accordance with American Institute of Certified Public Accounts (AICPA) criteria, and Sarbanes-Oxley (SOX) Section 404 testing performed by both internal and external audits and an ISO certification annually. The audits include annual HIPAA risk assessments in accordance with privacy and security rules. Our Grievance and Appeals System data help us identify and implement plan-wide, departmental, or Provider/Subcontractor corrective action, including Provider compliance issues. Using this system, we can also address network gaps, appointment availability, wait times, issues with written materials, additional Provider or staff training needed, FWA, and needed business process improvements. For example, if Grievance data shows an appointment availability trend indicating a potential network gap, the VP of Quality Management will report the information to the VP of Network Development to address the potential network gap. Information will also be reported to Provider Relations staff to determine if any retraining is needed for specific Providers. We will monitor each department's reviews and corrective actions to identify process improvement opportunities.

d. The Offeror's process for and timeframe to correct programming errors and timeline for correcting any claims that were misprocessed as a result; and

Identifying and Correcting Programming Errors. We will require that change requests be completed within 30 days of submission. We identify system issues through our Reporting and Analytics Platform that tracks claim volume and processing results. Our Claims team will continuously monitor claims throughput and can quickly identify if claims are delayed due to system issues. We will perform root cause analysis and remediation to resolve the identified issue. During our audit process, we determine if claim processing errors are due to a configuration or other system issue. Our Claims team immediately creates a change request in our change request workflow system to modify the configuration in a timely manner, which also enables proactive peer review on the most complex change requests. All change requests go through regression testing, validation, and

User Acceptance Testing (UAT) to ensure the achievement of the correct outcome to maintain our commitment to quality. Upon successful completion of these steps, Configuration staff review and approve the change and moves it to production. Our Claims team identifies all impacted claims that are adjudicated incorrectly due to configuration or system issues and initiate adjustments to ensure re-processing for accurate payment and denial, and no further harm is caused.

e. The process of identifying and addressing deficiencies or contract variances from claims processing standards, and an example of how the Offeror has addressed these deficiencies or variances.

Interventions to Address Deficiencies or Variances

Our ability to maintain and exceed claims processing standards is through a continuous improvement process that includes people, processes, and technology. If we identify contract variances or deficiencies, we will address them through the following:

Education and Retraining of Claims Staff. We will offer claims staff training courses spanning the claims/encounter continuum. Comprehensive follow-up training, required quality reviews, claims processor audits, and hands-on support by local staff, such as our analyst mentoring program, identify opportunities for improvement through coaching, education/training, and performance improvement plans, when necessary.

Process Modification. If we identify a potential systemic process deficiency, we will employ best practice methodologies to determine the root cause. Through analysis and cross-functional dialogue with all affected departments, we evaluate, recommend, and implement process improvement plans. If we find that a claims processing error is due to a systems configuration issue, we will create a change request to correct the configuration. We will then test, validate, approve, and implement the change.

Review Claims Data Proactively. We will review our claims data proactively to address any large volume of claims that could be paying incorrectly, and we will compare it to the DOM's administrative code to confirm accuracy. We solicit Provider feedback and work with DOM if the administrative code or fee schedules are not accommodating the Provider community.

Auditing and Quality Review. We will employ a number of claim audit reviews to ensure timely and accurate payment. Our Claims Audit team is responsible for providing an independent and objective evaluation of claims payment accuracy. Claims Audit staff perform statistically valid audits based on a random sample of processed claims (including paid, denied, adjusted) to assess claims for processing, payment, and financial accuracy, as well as compliance with contractual obligations. Quarterly summary of results will be available to the Claims Processing Team and our management team. Within the Claims Department, the Quality Review Team will audit ten claims per Claims Analyst per month to measure adherence to policies and procedures.

4.2.2.6.B Technological Systems

1. Describe how the Offeror will leverage its technology to ensure it produces a consistently effective Care Management System.

We will leverage our Clinical Documentation System to support Members from initial assessment throughout the continuum of care and ensure a consistently effective Care Management System, as described in detail in Section 4.2.2.3.A. We will assess, monitor, and evaluate the effectiveness of the Care Management System by looking at population health, quality of life, cost and utilization reports, and dashboards. Our CM and Utilization Management (UM) Staff will use a variety of tools described below to ensure we identify and reach Members who would benefit from CM. Additionally, these tools will allow us to monitor and assess the efficacy of our approach based on outcomes such as HEDIS, CAHPS, EQRO, and Member and Provider satisfaction surveys. With robust outcome data, we can then make informed decisions, enhancing the efficacy of our CM programs for Mississippians.

Integrated Care Platform

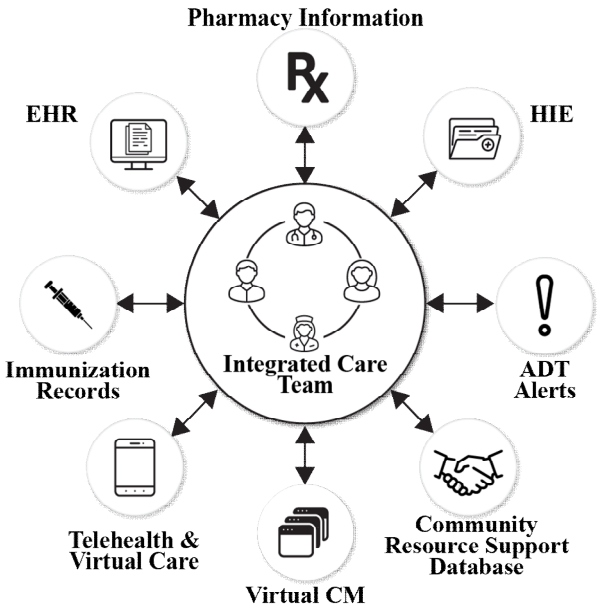
We will use our Member-centric Clinical Documentation System to promote collaborative care that addresses the needs of Members in an integrated manner (i.e., Physical and Behavioral Health). **Screening and stratification features allow us to screen and stratify Members in a consistent manner.** Information obtained from the 834 (enrollment, eligibility, and demographic data), Member's Health Risk Screening, and SDOH Screening is combined with other available Member-level information. We will leverage our Clinical Data and Interoperability Gateway to ingest external data such as Admission, Discharge and Transfers (ADT) and Electronic Health Record (EHR) data such as claims including z-codes, authorizations, and Provider referrals. With a holistic Member view, we then stratify Members into the appropriate CM Risk Level,

interventions, and programs to achieve individual health.

Interoperable Information Systems and Bi-Directional Data Sharing

Our enterprise Management Information System (MIS) supports whole-person care by integrating all of a Member's clinical (physical and behavioral) health information, including health assessment, SDOH, and utilization management data, into a single system to improve risk and care-gap identification, for timely Member engagement. Data from the MIS is fed through the Clinical Documentation System, where we will identify and follow up on Members needing care, including discharge planning, track outcomes, and identify program/quality improvement initiatives to enable effective CM programs. CMs will use the Clinical Documentation System to develop a single, integrated care plan in partnership with Providers, displaying Member health problems, treatment goals, milestone dates, discharge planning, and more. The integrated nature of our systems provides secure care coordination and actionable data that enables role-based support by staff, State agencies, Providers, CBOs to support an effective care management system. See **Figure 4.2.2.6.B.1,** which reflects the integrated Member health information.

Figure 4.2.2.6.B.1



Accessible Tools

Our multi-modal engagement supports a no-wrong door approach to engaging Members and their care teams in CM. We leverage integrated technology platforms and a variety of tools to complement our high-touch approach and ensure Members and care teams can participate in CM in their preferred manner, including by Members referring themselves to Care Management, leading to greater adherence and success in our CM programs.

Member-Facing Tools. We leverage our virtual front door and remote patient monitoring to support Members in connecting with care virtually, accessing appropriate preventive and primary care from anywhere, improving Members' access to care and support. For further details on our digital care management, see Section 4.2.2.3.C.1.a. of this RFQ. In alignment with our focus on health equity, we will assist Members who may not have access to a device, obtain phones through SafeLink or our expanded phone access program to communicate with their Integrated Care Team. In addition to CM supported care, Members will have access to a variety of self-service resources to empower them on their health care journey. The Member Portal will house resources such as online BH resource tools and their care plan to support Members in reaching their health goals. Section 4.2.2.1.D.1 of this RFQ details additional capabilities that will be available on the Member Portal, Mobile Application, and website.

Provider-Facing Tools. As mentioned above, Providers will benefit from a holistic Member view based on our ability to ingest Member data from a variety of partners and to compile and share the data in an actionable manner. Providers will be able to find this information through our Provider Portal where they can refer Members to Care Management and access our Community Resource Support Database, which enables closed-loop referrals to social service organizations.

2. Describe how the Offeror will leverage its technology to measure the success of Quality Management strategies.

Our Quality Management team will leverage technology for a data-driven approach to our Quality Assessment Performance Improvement (QAPI) Program. Our Enterprise Data Warehouse (EDW) compiles information from a variety of sources, internally and externally, detailed above in Section 4.2.2.6.B.1, and we will use this data to identify improvement opportunities in accordance with the Mississippi Comprehensive Quality Strategy and Appendix A, Draft Contract.

Measuring the Success of Quality Management through Technology

Using our reporting and analytics capabilities detailed in the table below, we have demonstrated in similar markets the ability to make data-driven decisions to tackle the right problem, implement the right strategy,

demonstrate outcomes, monitor continuous improvement, and evaluate the impact of interventions. These tools have allowed us to describe what is happening, identify relationships between variables, identify where improvement has occurred, monitor improvement over time, determine the significance of the results, and communicate the results of a project effectively. We will leverage our technology to report on and monitor key performance indicators, such as MSCAN and CHIP Performance Measures, as well as track our progress in meeting initiatives, QAPI Program, and DOM goals. We will use technology to ***monitor and evaluate in near-real time:***

- Performance Improvement Projects
- Adherence to Clinical Practice Guidelines
- Member and Provider satisfaction
- Trends related to the root causes of Grievances and Appeals
- Health care disparities and our efforts to create equity
- Activities related to quality withhold measures

26% Increase in Well-Child Visits

An affiliate market was targeting increasing well-child visits for rural areas. Based on our Reporting and Analytics platform's hot-spotting capabilities, we identified a trend of missing well-child visits in urban areas. In response, we shifted our resources to address the lack of well-child visits in urban areas and as a result saw a 26% increase in well-child visits through our Care Gap Analytics, affirming the intervention.

Technology to Measure Success of Quality Management Strategies

NCQA certified HEDIS engine. Certified software that provides monthly performance measure rates for review and analysis of interventions, outcomes, and evaluates against set benchmarks to determine progress toward goals.

Care Gap Analytics. Analytic tool that updates performance measure rates daily. Member-facing staff can view care gaps and areas of health risk during each Member interaction and arrange for follow-up services and referrals to close care gaps, including preventive services, cancer screenings, and chronic disease management.

Reporting and Analytics Platform. Analytic tool that supports reporting capabilities to inform quality management strategies such as population health by incorporating hot-spotting technology to identify and report risks and disparities at the population, Member, and Provider levels to monitor outcomes of quality management strategies.

Health Equity Dashboard. Identifies disparity reduction opportunities and assists in tracking performance measures towards more equitable outcomes that can be leveraged to monitor quality management strategies.

Provider Analytics. Actionable reporting through the Provider Portal to assess Member outcomes, determine improvement focus areas, drive clinical quality interventions, and evaluate results. These tools are designed to help Providers close care gaps and achieve value-based contracting metrics.

Transparent Evaluation and Reporting Practices

We will utilize data to conduct a comprehensive QAPI Program Evaluation annually to measure the success of our quality management strategies and analyze project outcomes, determine where improvement occurred, identify the relationship between interventions and outcomes, determine if results are statistically significant or sustainable, and provide an overall assessment of the QAPI programs success. Annually we will make Division-approved information about the QAPI Program and our progress in achieving program goals available to Members and Providers online. Additionally, in an effort to promote transparency and excellence, we will work with DOM to identify a format to share raw quality data upon request.

3. Describe how the Offeror will leverage its technology to effectively analyze utilization and create strategies to ensure that utilization is appropriate.

In alignment with Section 8.16 of Appendix A, Draft Contract, we will employ a comprehensive approach to utilization management that leverages technology to guide the development of strategies that ensure Members are able to access the right care at the right time in the right place. For details on our Utilization Management program, please see our response to Section 4.2.2.5 of the RFQ.

Leveraging Technology to Monitor Utilization

We identify patterns of over-, under-, and inappropriate utilization with technology that continuously monitors and analyzes data from clinical activities including claims, immunizations, Prior Authorization, adverse determinations, Care Management, and drug utilization review. This enables us to identify opportunities for improvement, assess internal compliance, and assess Provider compliance with our UM guidelines. Additionally, analyses allow us to monitor program integrity and authorization accuracy. Our staff will review and analyze a variety of utilization data reports at aggregate and detail levels by Member, Provider, specialty,

type of service, diagnosis, place of service, geography, and services authorized versus services received to help us identify and address Mississippi health trends such as disparities, or potential cases of fraud, waste, or abuse. We will equip Providers with analytical tools to help them assess cost and performance, compare patient- and practice-level information to validate they are directing Members to the most appropriate resources, and follow up on care gaps that could lead to poor health results and higher costs.

Technology Strategies to Ensure Appropriate Utilization

The design of our Clinical Documentation System centers on whole-person care versus isolated clinical cases, permitting our care and utilization management staff to easily collaborate and deliver holistic care. Workflow automation and clinical decision support tools enable our utilization managers to work both effectively and efficiently. We have integrated standardized medical necessity criteria into our Clinical Documentation System to assist in making appropriate medical decisions based on nationally accepted, evidence-based standards of care that promote appropriate use of services and improved health outcomes. The Clinical Documentation System also supports the integration of tailored, State-specific clinical criteria to ensure practices are aligned with Mississippi standards.

Providers can access clinical criteria on the public website and complete medical necessity reviews and prior authorization requests within the Provider Portal. Reviews completed on the Portal receive an immediate auto-determination of approval unless a level one review is indicated based on the clinical criteria. We are augmenting this capability with our authorization digital assistant, which uses machine learning technology to leverage years of historical and constantly updated PA review outcomes history. This digital assistant will automatically examine all PA requests submitted via the Portal to identify which PA requests can be approved instantly, considering the Provider, procedure, practice, patients, and other characteristics of a particular PA when compared to our model database of historical PAs.

Bi-Directional Data Sharing. On our secure Provider Portal, Providers can check a Member's recent utilization of services, ADTs, the status of an authorization request, care gaps, as well as Care Plans created by our CM team to support monitoring goals and progress. With near real-time data, Providers can support Members in accessing the care they need without duplicating services.

Member Technology for Appropriate Utilization

We will educate Members on the resources and technology available to them, including virtual care options such as telehealth, beginning at the time of enrollment, and continue to provide educational opportunities at the point of care to encourage preventive services and appropriate utilization. Two innovative technologies include:

- **On Demand Virtual Care.** Members will be able to use a Mobile Application to schedule a telehealth visit with their selected Provider or an on-demand visit with the next available Provider for 24/7 access to PCPs, specialty Providers, and BH Providers. The Mobile Application includes a symptom checking software built on artificial intelligence disciplines, including natural language processing, machine learning, and a probabilistic graphical model, to empower Members to self-manage and direct to the appropriate level of care. Symptoms are assessed through a series of questions, and the member is directed to the correct course of action (e.g. speak to a Clinician, go to the Emergency Department). The Triage functionality will be available 24 hours a day, seven days a week, and is available in English and Spanish.
- **BH Chatbot**. We will conduct a pilot of a BH Chatbot. Developed by clinicians and researchers, the chatbot will be able to respond to Members with depression, anxiety, or other mental health needs by triaging the right level of care, conducting standardized assessments, providing with them self-help content, or even connecting them on-demand to 5,000 standby counselors across the country or scheduling appointments later for support.

4. Describe how the Offeror will leverage its technology to measure the efficacy of Population Health Initiatives and adjust Population Health strategies.

Leveraging Technology to Measure Efficacy of Population Health Initiatives

We will leverage technology to measure the efficacy of Population Health Initiatives and adjust our strategies accordingly. Population health staff will have access to our large-scale Reporting and Analytics Platform to measure all impacts of our Population Health Initiatives. This family of integrated decision tools provides resources and capabilities for standard and ad hoc reporting, data visualization, and online Key Performance Indicator (KPI) dashboards. Reporting to our VP of Finance, our Data and Analytics Manager will lead a team

of highly experienced Data Analysts responsible for supporting the development and execution of all standard and ad hoc reports as part of our contract with DOM. Finance Analysts will provide technical assistance for financial reporting. This dedicated team of Mississippi-based staff will utilize this information to report on all datasets in our platform. The foundation of our Reporting and Analytics Platform is a comprehensive Enterprise Data Warehouse (EDW) that systematically receives, integrates, and transmits internal and external administrative and clinical data. Examples of data gathered in the EDW that we can use to measure the efficacy of Population Health Initiatives include:

- Claims data from Providers, including physical health and BH services and labs
- Member information, such as eligibility history, demographics, service utilization, and Member satisfaction
- Care and utilization management information, such as Health Risk Screenings, Comprehensive Health Assessments, Member care plans, clinical guidelines, referrals, authorizations, and SDOH
- Financial information to support quality and value-based purchasing (VBP) programs
- Clinical information, such as Admission, Discharge, and Transfer (ADT) transactions for real-time notification of inpatient admissions
- Population health information, such as immunization registries and health disparity and equity data, including by race/ethnicity

Member-Tailored Strategies

Our technology allows us to quickly identify Members at risk of ED use, who need a medical home, who need complex Care Management, and can also pick up early on catastrophic disease processes that will need Care Management support. Based on these identifiers, Population Health teams in affiliate markets have implemented ED Diversion Cohorts (outreach campaigns for our Members for better quality care with improved outcomes, while avoiding the ED.)

The integration of EDW within our MIS means that our reports will be based on the most accurate, complete, and timeliest transactional data available for high-speed reporting to DOM across a broad expanse of data. Our EDW is Open Database Connectivity (ODBC) compliant, allowing our Data Analysts to produce ad hoc reports that DOM may request. Our Reporting and Analytics Platform enables us to offer full transparency to DOM.

Gathering Data from Multiple Sources and Systems. We will collect data from internal and external sources and systems using industry-standard application, data, and communication interfaces. The Change Data Capture and Real Time Repository (RTR) capabilities of our MIS integrate and consolidate data we receive. RTRs are high-performance databases designed for conveying updated information to both our internal and external-facing applications. We will invest in gathering timely, valued information about our Members to ensure our programs are effective. We will intentionally gather input from multiple sources to inform our programs and use external data on communication preferences, socio-economic, demographic, and geographic indicators, providing a complete view of each Member. All of this information will be combined to get a full picture of the individual and population-level health needs of our Membership, going beyond traditional means to capture Member and community data, including over 200 external SDOH data elements.

Data Analysis and Ability to Generate Ad Hoc Reports. The Report Builder function of our Reporting and Analytics Platform will allow authorized users to access EDW's data dictionary, organized by subject area (e.g., claims, Provider, Member) for the development of ad hoc reports. Users can query and report on any data element housed in EDW to support ad hoc reports required by DOM. Report Builder offers authorized users an intuitive graphical interface that clearly identifies data without the need to learn coding or query languages. This will enable our staff to fulfill any additional DOM report requests, both ad hoc and recurring. Our staff can also draw upon a library of over 12,000 existing Medicaid Managed Care reports covering administrative, operational, clinical quality, service delivery, compliance, and financial aspects of health plan activities. This library of pre-built ad hoc report templates allows users to create their own reports by subject area in a guided fashion.

SDOH Predictive Analytics and KPI Dashboard. Our SDOH Predictive Analytics Tool is a key technology to help us measure the efficacy of our population health initiatives. It identifies Members and communities with SDOH needs and provides a single indicator, or "score," for a member's risk of adverse health outcomes. Our Predictive Analytics Tool leverages over 200 sources of publicly available data, such as county health rankings, hospital and county community health needs assessments, school performance reports, the USDA's Food Access Research Atlas, the CDC Social Vulnerability Index, and the American Community Survey. The SDOH Predictive Analytics Tool provides insight into the social, economic, and environmental conditions Members

and communities experience in the neighborhoods where they live – hot-spotting SDOH needs to target community initiatives. This insight is augmented by our SDOH KPI Dashboard, which includes detailed Member-level data, such as claims and assessments, with drill-down capabilities allowing users to analyze member patterns and trends in social barriers to care. The Dashboard shows SDOH screenings completed by month by the health plan and Z code claims submitted by providers. It further indicates Members with SDOH needs by category (e.g., food insecurity, housing, education). The Dashboard allows users to assess cost and utilization metrics by SDOH need category. For example, users can view the average cost per member per month or ED visits for Members facing Housing barriers. The Dashboard also allows users to analyze SDOH needs by population segments such as age, race/ethnicity, and gender.

4.2.2.6.C Innovation

1. Describe what innovative technological methods, if any, the Offeror will utilize in the delivery of services to members.

Technological innovation allows us to drive quality results while improving Member outcomes and Provider satisfaction. We continuously make investments in IT resources and solutions that better enable our staff to make data-informed decisions, increase Member access to care, provide resources to Members and Providers in the right setting at the right time, and impact health outcomes for individuals in need. Below, we outline the innovative technological methods we will utilize in the delivery of services to Members, in the development and maintenance of our Provider network, and the rendering of services to the Mississippi Division of Medicaid (DOM).

Innovative Member Technology

We will offer Members a wide range of options to digitally engage through innovative mobile and self-service technologies. Based on national best practices from our affiliate health plans, our technological methods will support Members wherever they are across the population health continuum. All proposed technologies take the Member's experience and feedback into account and are based on Member journey mapping research outlining where Members may benefit from additional support. See **Table 4.2.2.6.C.1** below for an overview of these innovative technological methods utilized in the delivery of services to Members.

Table 4.2.2.6.C.1 Innovative Technological Methods for Members

Technology	Description	Benefit
Benefits Navigation		
Member Portal and Member Mobile App	Our secure Member Portal is fully mobile-optimized, informed by human-centered design, and provides Members online self-service features to navigate their benefits. Self-service functions include the ability to view health alerts, view medication history, view Care Plans, complete health assessments or Notification of Pregnancy, self-refer to Care Management, and download a digital ID card to a mobile wallet. We will offer a Member Mobile App for Members over 18 for benefits navigation and assistance that acts as access to the Member Portal and is downloadable in Google Play, Apple app store, and any other commonly used mobile app platforms.	Self-service, one-stop tool to access health information
Virtual Assistant	We are enhancing communications to meet Members where they are by implementing a Virtual Assistant with natural communication capabilities. Through the Virtual Assistant, we will offer real-time help for Members navigating our public website. For example, the Virtual Assistant will help Members access services, sign up for their secure Member Portal account, and conduct other self-service functions.	Better enables Members to access needed resources and increases health literacy
Health Reminders and Social Determinants of Health (SDOH)		
Voice, E-mail, and Text Outreach	We will use industry-leading health engagement and messaging technologies for facilitating personalized voice and electronic communication (i.e., e-mail, text messages) between our health plan and Members. We view this outreach as a pathway for Members to learn about health coverage benefits, programs, and services, as well as to receive alerts such as medication reminders, care gap alerts, and Member rewards balances. We will comply with all Federal regulations and recognized best practices for e-mail subscriptions and text message opt-ins, and all preferences can be updated at any time. We will be able to pull metrics reports looking at send volume, delivery rate, open rate, clickthrough rate, and unsubscribes. Our affiliate health plans have successfully used this technology to conduct Member outreach campaigns around maternal health, flu prevention, and COVID-19 vaccinations. A COVID-19 vaccination outreach campaign across our affiliate health plans in 2021 delivered 649,000 automated phone calls, 275,000 e-mails, and 4.6 million texts to Members who weren't known to have received a COVID vaccination, informing them of vaccine availability and determining if they had received one.	Reaches Members where they are to deliver targeted messaging to close gaps and improve quality of care
Online Appointment Scheduling Software	We will issue texts or e-mail appointment reminders to Members scheduled through our Online Appointment Scheduling Software. This tool allows Customer Service Representatives and Care Managers to schedule appointments in an online appointment-scheduling portal with participating Providers while on the phone or while meeting with Members. We can securely attach documentation to the appointment to alert Providers of specific care gaps (e.g., EPSDT needs) to ensure a thorough Member office visit. An affiliate health plan successfully utilized this software to close care gaps, meet an over 85% Member appointment completion rate, and improve operational efficiencies for Providers.	Supports care gap closure, increases appointment attendance and improves Provider scheduling experience

SDOH Help Line	We will offer an ***SDOH Help Line to all Mississippians, regardless of payer***. The help line will be a toll-free number available to anyone needing assistance with SDOH, such as housing, utilities, food, or transportation. Calls will be answered by Peer Coaches, hired for their lived experience, who screen callers and refer them to relevant community supports. We will close the loop on all referrals through personal contact and evaluate the quality of the referral services provided. For Members in Care Management, the helpline will immediately alert the Care Manager to a Member's request for appropriate follow-up. An affiliate health plan has delivered more than 13,000 referrals since 2014.	Directly impacts SDOH in the State to ensure Members have access to needed resources
Behavioral Health (BH) Support		
BH Chatbot	We will conduct a pilot of a Behavioral Health (BH) Chatbot. Developed by clinicians and researchers, the chatbot will be able to respond to Members with depression, anxiety, or other mental health needs by triaging the right level of care, conducting standardized assessments, providing with them self-help content, or even connecting them on-demand to 5,000 standby counselors across the country or scheduling appointments later for support.	On-demand BH self-management and clinical support
Digital BH Resource App	We will use a leading Digital BH Resource Application to provide educational resources and support to improve mental health wellness for Members experiencing BH conditions. The app fosters personal responsibility and healthy lifestyles by enabling Members to learn more about their diagnoses, track their symptoms, and receive motivational ideas and information to work toward solutions. Members can engage in personalized e-Learning programs to help overcome depression or anxiety in a safe, confidential environment.	On-demand BH resources for self-management of symptoms
BH Crisis Stabilization Program	We will implement a technology program to expand access to telehealth BH crisis stabilization and intervention services. We will deploy cellular-enabled tablets to allow our critical physical health practitioners, hospitals, Emergency Departments (ED), and first responders (e.g., police, EMTs) to reach qualified BH clinicians on-demand to deliver real-time BH crisis stabilization and therapy services via a virtual visit platform to Members in their greatest moment of need.	Helps prevent avoidable ED visits and inpatient admissions
Remote Monitoring		
Diabetes Remote Patient Monitoring	We will offer remote monitoring for adults with diabetes. This technology automatically monitors all participant results and delivers an appropriate level of intervention (e.g., targeted education or telephonic consultation with a health coach), in the event of potentially dangerous readings or non-compliance and sends notifications to the Member's Provider. Health coaches support Members through personalized education focused on goal setting, treatment adherence, and improving self-management skills. Members at an affiliate health plan experienced a 6% average decrease in glucose levels and a 15% reduction in ED visits compared to those not enrolled in the program.	Enables timely intervention to address dangerous glucose readings
Chronic Care Self-Mgmt. Program with UMMC	Through a partnership with UMMC, we will offer an interdisciplinary program to educate, engage, and empower our Members living with chronic conditions (such as diabetes, hypertension, and/or congestive heart failure) to take charge in monitoring and managing their health. The program will provide continuous monitoring of disease-specific biometrics, Care Management, daily educational sessions, and medication management. Clinical information will be shared electronically with each Member's Primary Care Provider (PCP) to ensure continuity of care.	Empowers Members to self-manage their chronic health conditions
Remote Pregnancy Monitoring	To help expectant Members manage their pregnancy in partnership with their obstetrician, one of our affiliate health plans partnered with a local health system to implement pregnancy-related online monitoring solutions. Through the Maternal Health and Child Program, our affiliate hopes to reduce pregnancy-related complications, premature deliveries, low birth weight deliveries, and infant disease. We will implement a similar program in Mississippi to improve outcomes for infants needing intensive care by connecting rural hospitals to maternal fetal monitoring specialists.	Proactively address pregnancy-related complications to improve outcomes
Digital Care Management		
Digital Care Management Solution	Our Digital Care Management solution is a web and mobile-based platform to extend Care Management resources to drive deeper Member engagement and encourage self-management. The tool enables Care Managers to deploy customized, condition-specific programs and directly communicate with Members through HIPAA-secure messaging. Using the tool's advanced analytics, Care Managers can make evidence-informed decisions to improve program adoption and care plan adherence, as well as identify and address health disparities. Clinical programs offered through Digital Care Management include, but are not limited to, lifestyle management and comorbidities (i.e., stress management, weight loss, smoking cessation), medical care transitions, maternal health, diabetes, chronic heart failure, and BH and wellness. After implementing our Digital Care Management solution, an affiliate health plan saw increases in accreditation rates, as well as increases in HEDIS measures for prenatal and postpartum care.	Increases access to Care Management resources
Virtual Care Management	We will offer our Virtual Front Door initiative to support Care Manager and Member interactions while continuing to navigate the COVID-19 pandemic and protect Members' health. This initiative uses HIPAA-compliant video communications via a version of the familiar Zoom platform to allow Members and Care Managers to securely connect remotely.	Maintains the Care Manager-Member relationship while staying remote to protect Members' health
Resources for Pregnant Members		
Maternal Health Equity Digital Health Solution	We will partner with an organization dedicated to equalizing maternal health outcomes, to pilot their digital health solution for maternal health. The culturally competent tool connects Black expectant mothers with critical resources, including virtual access to peer support, doulas, experts, pregnancy and health tracking, and curated content to drive positive pregnancy outcomes.	Targeted intervention to address pregnancy and health disparities

Virtual Doulas and Lactation Consultation	We will offer a Virtual Doula and Lactation Consultation Mobile App to all pregnant Members upon Notification of Pregnancy. The app delivers unlimited 24/7 audio and video consultations with a diverse network of certified birth doulas and lactation, diet, and nursing experts throughout their pregnancy and postpartum period, addressing barriers to access these services in person.	Addresses access to care barriers
Virtual Group Prenatal Care	We will offer virtual group prenatal care based on Centering Pregnancy principles to expand access to this evidence-based, effective tool to increase maternal outcomes.	Improve maternal health outcomes
Family Planning Mobile App	We will partner with a Mississippi-based nonprofit dedicated to ensuring all people can access high quality family planning, to offer their mobile app to our pregnant Members. The app promotes access to patient-centered contraceptive management education materials.	Reduce the rate of unwanted pregnancies and increase health literacy
Expanding Connectivity		
Expanded Phone Access	We will connect Members to and educate them about the Federal SafeLink program, which offers Members with limited or no phone access a free smartphone. In addition, for those who qualify, we will offer Members expanded benefits of up to 1GB per month beyond their SafeLink allowance. Through this expanded mobile phone access program, we will also provide pre-programmed cell phones with unlimited talk/text to Members or their parents/authorized representatives for those engaged in Care Management who lack reliable phone access.	Increases Member access to care and health resources
Enabling Internet and Broadband Connectivity	Population health experts have suggested that broadband access is a social barrier to good health, as it facilitates access to health care services and the ability for Members to find community resources that address barriers. We will assist qualified Members in applying for AT&T's Access program to enable home-based broadband internet. For Members engaged in Care Management, we will supplement the cost of AT&T Access for those Members who qualify for this expanded benefit. We will also promote and assist Members with applying for the Emergency Broadband Benefit created by the Federal Communication Commission (FCC) to help Members connect digitally. The FCC program provides discounts toward broadband services and devices such as laptops or tablets. We hope to establish a relationship with C Spire in Mississippi to offer Members discounted equipment for home wifi. For Members who need support accessing technology solutions, who do not qualify for these programs, we will offer a grant fund to help cover costs such as purchasing cell phones, expanding data plans, or purchasing MiFi devices for homes.	Increases Member access to care
Member Data Accessibility		
CMS Interoperability Rule and Patient Access Compliance	We currently comply with the CMS Interoperability and Patient Access requirements introduced in the Final Rule, including the Patient Access and Provider Directory Application Programming Interfaces (API), and are actively leading collaborative efforts with other Payers to implement the payer-to-payer data exchange. In compliance with CMS requirements, we will educate Members on maintaining their health information and the benefits of a Personal Health Record booklet. We will post educational materials on our public website and Member Portal to connect Members with information about options for managing their digital medical records. We currently adhere to the CARIN Code of Conduct, a set of industry-leading best practices voluntarily adopted to protect and secure Member health information. We will validate that third-party application developers follow strict privacy standards outline in the CARIN Code of Conduct before authorizing connection to our Patient API. Our Clinical Data and Interoperability Gateway will leverage Real Time Repositories (RTRs) for information exchange and center on a scalable implementation of the open-source, widely available HL7 API FHIR server. Our FHIR server design supports the ONC/CMS mandates for easy access to data for Members in real-time. The payer-to-payer data exchange portion of the Rule allows Members to request that they take their records with them as they move to another health plan. We will enable Members to initiate this request from a previous health plan via our secure Member Portal. Our Payer API will serve as the gateway to authenticate Member requests and automate the exchange of Member data transfers.	Increases portability of Member health records

2. Describe what innovative technological methods, if any, the Offeror will utilize in development and maintenance of its provider network.

Innovative Provider Network Technology

We will leverage years of affiliate health plan experience developing and utilizing innovative technological methods to develop and maintain a Provider network that prioritizes access and the reduction of health disparities for our Members. We value our Provider partners and will invest in innovations that streamline processes, reduce delays to care, and allow Providers to spend less time and resources on administrative functions and more time caring for MSCAN and CHIP Members. These innovations include user-friendly technology and data analytics to inform and improve network qualifications. See **Table 4.2.2.6.C.2** below for an overview of these Provider technological supports, as well as technologies we will utilize in the development and maintenance of our network.

Table 4.2.2.6.C.2 Innovative Technological Methods for Providers

Technology	Description	Benefit
Network Development and Maintenance		
Provider Lifecycle System	All Provider network data will be maintained in our Provider Lifecycle System, a workflow-enabled relational repository used by our Network Management teams for Provider prospecting, contracting, data management, and continuous engagement. The system's user interface facilitates hand-offs between our teams who contract,	Single relational repository for

	configure, and load Providers into our system and provides visibility into our enrollment process. Our Network teams will enter and update Provider data in the system, ensuring that all data comes from one governing source. We store Provider identifiers including taxonomy, Tax ID, National Provider ID (NPI), language, locations, office hours, etc. We also track Provider certifications such as Trauma-Informed Care and Trauma-Focused Cognitive Behavioral Therapy and use address verification and standardization software applied to all our Provider records.	all Provider data
Data Integration and Architecture	Our Provider Lifecycle System will supply data via RTR technology to downstream systems, including our Clinical Documentation System in support of care planning; our Customer Relationship Management (CRM) System enabling call center support for Provider inquiries, outbound campaigns, targeted outreach, and unified communications across phone, fax, e-mail, mobile platforms, or web; and our Online Provider Directory. Updates entered in our Provider Lifecycle System are automatically distributed to our online directory typically within minutes, thanks to our RTR architecture. Our system will also support Provider data exchanges with Subcontractors for claims, encounters, and authorizations, the Council for Affordable Quality Health Care (CAQH), federal Provider databases, and DOM's Fiscal Agent and Credentialing Verification Organization (CVO) for Provider credentialing and re-credentialing purposes.	Efficient and accurate workflow to share data to downstream systems
Provider Engagement Subsystem	We will document every interaction (electronic, physical, and telephonic) with Providers, as well as identified issues and resolution, in the Provider Engagement component of our Provider Lifecycle System. This information can then be used to create reports to identify training needs at the regional or Provider level. For instance, our Provider Relations staff will be able to review key drivers such as complaints, reasons for claim denial, or the frequency of Provider requests to pinpoint the need to retrain Providers in specific processes.	Provider engagement reporting
Geographic Mapping Software	We will use geographic mapping software to proactively monitor network adequacy and access at the State, regional, county, zip code, and Provider-type levels, for both graphical and thematic maps as well as tabular listing reports, using Appendix A, Draft Contract standards to create network reports weekly. The reports will look at the number, type, and location of Providers compared to Member residential locations, highlighting any variance to network access standards. We will conduct trend and root cause analyses to understand network shifts; identify options to improve adequacy/access by contract and individual Provider levels, and develop action plans to address issues.	Determines network adequacy against DOM standards
Provider Data Validation	To ensure our Provider data is of the highest quality and accuracy, we will utilize an industry-leading Provider data validation service. Offerings include ongoing Provider outreach to verify information with automated transmission of updated data weekly into our systems; a secure web portal for Providers to update, verify, and attest to their information; and quarterly database matching to identify needed updates to our Provider data.	Ensures accuracy of our Provider network data
Provider Technological Supports		
Provider Portal	Features of our secure Provider Portal include eligibility inquiry; authorization submission and status; claim submission, color coded visualization of claims status, submission and status of claims reconsideration requests, and payment history; online care gap notifications and health alerts; care plans; Member-specific health records; access to reporting and analytics (detailed below); value-based purchasing (VBP) resources and files; care and disease management referral; ED utilization; an SDOH KPI Dashboard; and clinical practice guidelines.	Administrative burden reduction
Provider Analytics	Accessible via our Provider Portal, this dashboard will bring together a collection of actionable and timely clinical and administrative data to help Providers identify and prioritize Member needs. Data includes cost and utilization trends, quality performance, patient loyalty, disease prevalence, readmissions, and health trends. Providers will have custom selection, drill-down, and export capabilities to help analyze performance and identify factors behind clinical and cost performance to develop targeted actions to improve quality.	Analysis of Provider performance to drive targeted action
Patient Analytics	Accessible via our Provider Portal, this dashboard will enable Providers to access their patient disease registries (PCP or practice level) to view information including evidence-based care gaps, and quality and population health management improvement opportunities. The dashboard offers Providers an integrated view of their patient's physical and BH diagnoses, in addition to medication, lab, and care team data, on a Member level.	Analysis of overall health of the population
Care Gap Analysis Tool	Accessible via our Provider Portal, our Care Gap Analysis Tool delivers prospective, daily care and risk gap analytics to identify and close gaps in care, allowing Providers to easily determine which patients are compliant, due, overdue, failed, or excluded from a particular intervention. Care gap information is available at Member, Provider, and practice levels and is re-computed and updated in near real-time to ensure Providers are working from the most up-to-date information to address gaps.	More timely care gap data to drive quality and HEDIS
Prior Auth (PA) Submission Supports	Our electronic PA submission feature on our Provider Portal will allow Providers to complete Medical Necessity Reviews for selected outpatient procedures with auto-determination rules to approve or send to level one review based on criteria. This feature offers Providers a timely online response to PA requests, reducing overall turnaround time and expediting Member access to needed services. The tool also allows Providers to instantly access all Medical Necessity Criteria online, helping them deliver evidence-based care. We will augment this capability through implementation of our Auth Digital Assistant, which uses machine learning technology to leverage years of constantly updated PA review history. This tool will examine all PA requests submitted via the Portal automatically to identify those which can be approved instantly, based on the Provider, procedure, and other characteristics of the PA when compared to our extensive database of historical PAs. The result will be another marked improvement in PA review speed, again lowering Provider burden.	Timelier PA review, timelier care for Members, and reduced Provider administrative burden
Electronic Health Record (EHR) Integration	We will leverage our Clinical Data and Interoperability Gateway and strategic national partnerships to enhance our data sharing capabilities through bi-directional exchange with Provider EHR platforms. Expanded interoperability capabilities using FHIR, EHR proprietary APIs, HL7, and other standards allow us to automate the extraction of EHR data and deliver insights back into EHRs at the point of care. This bi-directional data exchange with alerts directly within the Provider's existing workflow will greatly improve efficiency and enable them to conduct targeted outreach for quality improvement.	Data delivered directly to Provider's existing workflow
Expanded	We will supply additional data directly to larger hospital and health system Providers who may have their own	Enables

Dataset Sharing	reporting and analytic systems via secure file transfer protocol (SFTP) or other secure e-mail as needed. For instance, we have the ability to send claims data monthly to help Providers audit financial statements and determine cost drivers.	Providers to make more data-informed decisions
Admission, Discharge, and Transfer (ADT) Data	We are dedicated to empowering Providers with more real-time Member information based on ADT data. For instance, we recently enhanced our Provider Portal to display ADT information we receive from an ADT data aggregator or individual Providers. The portal displays if a Member has had an ADT event within the last 12 months, including details such as type of visit, facility name, and discharge disposition. We also integrate this ADT data within our Reporting and Analytics platform for dashboard reporting, allowing us to monitor ADT intake volumes and utilization trends, including facility-level details. Further, we will work with a diverse group of Mississippi stakeholders and Providers to evaluate the right State HIE partners to implement strategic connections with for real-time ADT data feeds and additional use cases. We are committed to supporting and expanding on the existing infrastructure within Mississippi and are in active conversations with partners to explore additional HIE and ADT use cases.	Immediate follow-up and outreach when Members have been admitted, discharged, or transferred
Technology Enablement Fund	We will support Providers with limited technological capabilities and/or Internet connectivity issues by offering a Technology Enablement Grant Fund that helps Providers acquire networking equipment to support electronic functions such as authorization and claims submission, telehealth equipment (i.e., computers, tablets, mobile devices, assistive technologies) to support telehealth adoption, or equipment needed for EHR and HIE adoption.	Providers advance along technological continuum

3. Describe any other innovative technological methods, if any, the Offeror will utilize to render services to the Division.

Other Innovative Technology

We will implement the following additional innovative technological methods in rendering services to DOM for the MSCAN and CHIP programs.

[redacted]

Maternity Analytics Platform	We will supplement our own analytic capabilities by leveraging a maternity analytics platform. The enhanced pregnancy identification and risk stratification will help us detect at-risk pregnancies sooner, prevent preterm births, and reduce racial disparities. The platform uses artificial intelligence-based algorithms to scrub data for more than 3,000 early pregnancy identifiers to detect pregnancies earlier and uncover more data about moms and babies at risk. The platform currently identifies 98% of moms before delivery and 70% in the first trimester, allowing for critical first-trimester prenatal visits, stronger doctor-patient relationships, and higher quality care throughout their pregnancy.	Timelier identification of at-risk pregnancies
Community Resource Support Database	We will make our searchable database of vetted and regularly updated health and wellness resources externally available to Members, Providers, and the public through our public website. The database, available in numerous languages, will help connect Members to local programs and resources that best fit their needs (e.g., housing, transportation, food, BH services). We will provide Members, as well as the Care Managers and community-based organizations (CBOs) that serve them, closed-loop referral tracking and coordination with CBOs. The data will be validated on a regular basis to ensure quality, as well as increase the likelihood that users are satisfied and will continue using the tool to improve their access to resources. Additionally, our staff will have access to easy-to-understand reporting, enabling us to track, trend, and report on membership needs and utilization and gain a deeper understanding of needs at a population and individual level.	Increases Member access to community-based resources
Mississippi Dept. of Child Protection Services (MDCPS) Member Data Access	We will partner with MDCPS to provide access to our secure, role-based web portals for shared access to Member health information for children and youth in foster care. The information contained within the Member record will help Providers, MDCPS caseworkers, and Care Managers improve care coordination, eliminate waste, and reduce errors by providing a Member's medical history and health interactions as they progress through the clinical process. Users can view key Member contacts, allergies, medications, claims history, and more. Role-based access controls will enable us to limit and easily edit what information is shown in the Member's record to specific users based on defined user roles (e.g., Provider, MDCPS caseworker, consenter).	Increases access and portability of foster care Member health records

4.2.2.6.D Continuity of Operations

1. In an appendix no longer than ten (10) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including:
a. Employee training;
b. Essential business functions and responsible key employees;
c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;
d. Communication with staff and suppliers when normal systems are unavailable;
e. Plans to ensure continuity of services to Providers and Members, including the Recovery Time Objective for major components;
f. Security and privacy requirements; and
g. Testing plan, which should be provided to the Division on an annual basis within 30 days of the request.

In alignment with Amendment #5 to RFQ #20211210 issued on February 7, 2022, please see **Attachment 4.2.2.6.D Continuity of Operations,** for a detailed description of our emergency response continuity of operations plan.

APPENDIX 4.2.2.6.D.1 CONTINUITY OF OPERATIONS

Appendix 4.2.2.6.D.1 Continuity of Operations
In an appendix no longer than ten (10) pages, describe the Offeror's proposed emergency response continuity of operations plan. Address the following aspects of pandemic preparedness and natural disaster recovery, including:

Continuity of Operations Overview

We will employ Continuity of Operations and Disaster Recovery (DR) planning best practices to anticipate and respond to disasters and emergency conditions in a timely manner. We engineer our hardware, software, and processes in our Management Information System (MIS) to ensure high availability of our applications, appropriate partitioning and systems monitoring, and prioritization to ensure IT systems, data, and software are available to Members, Providers, and staff after disaster identification. Centralized services in our enterprise-wide data centers will provide resiliency and redundancy to our continuity and disaster recovery planning. We view continuity and DR planning as a high priority to ensure service excellence. Our continuity and recovery solutions, as described in further detail below, will allow for a variety of options depending on the type and severity of the event.

Continuity of Operations in Action

Due to our robust continuity and DR Plans, our affiliate health plans maintained normal operating service levels before and during the COVID-19 pandemic, at no point dropping any calls. All information systems remained online and available, including core systems, websites and secure portals, and data exchange subsystems. Additionally, at the beginning of the pandemic, our affiliate Care Management staff outreached to Members to ensure they had a management plan and proper supports in place. We maintained the ability to receive eligibility data, as well as electronic claims and authorizations. We lost no data during the pandemic and faced no data security incidents. Our full-mesh, multi-vendor Wide Area Network allowed all staff to quickly and seamlessly transition to a work from home environment.

Thoroughly Documented Continuity of Operations and Disaster Recovery Plans. We will have access to a centralized, enterprise-wide business continuity management (BCM) organization which will provide support, coordination, oversight, continuity of operations plan development, and maintenance of our overall business resiliency. Our staff, in partnership with this centralized organization, will maintain and oversee our currently operational continuity of operations and DR plans, as well as supplemental continuity plans. We will conduct regular assessments of our continuity of operations plans in the form of scenario-based exercises. The frequency of these exercises will be determined by the plan's overall criticality. Our DR plans, updated at least annually, will include comprehensive and clearly articulated data backup, DR, and emergency mode of operations policies and procedures; and will be compliant with HIPAA, 45 CFR 164.308, and all relevant Mississippi and Federal regulations.

Supporting Continuity of Operations and DR Plans. We will also maintain a number of supporting plans detailing emergency response, crisis and incident management, and pandemic operations procedures. These supporting plans are based on protocols established by the World Health Organization (WHO) and the Centers for Disease Control (CDC) to respond to and recover from situations impacting our employees and business operations. Our confidential pandemic plan in particular provides strategies to reduce pandemic-related impacts to our staff and operations.

a. Employee training;

Continuity of Operations Employee Training

We will use several methods to train and educate employees on continuity of operations programs. Training programs and presentations for crisis management, DR, emergency response, and other continuity of operations issues will be available through organizational and enterprise-wide channels. Once all our employees are able to safely return to regular in-person engagement in our office spaces, we will periodically conduct emergency preparedness drills to outline and address emergency procedures, such as evacuation routes, weather policies and procedures, tornado shelters, and fire and earthquake procedures. In addition, BCM will partner with members of our local leadership response team to conduct continuity exercises based on plan priority, which serve the dual purpose of highlighting recent plan updates, as well as regular continuity of operations re-training for our key employees. Information about our plans will also be available to our leadership response team at all times.

b. Essential business functions and responsible key employees;

Essential Business Functions and Responsible Key Employees

Essential business functions include claims processing, eligibility and enrollment processing, Member care

management, Provider enrollment and data management, encounter data management, functions such as Member and Provider calls that rely on our telecommunications system, and data interfaces with the State. Responsible key employees include our Chief Operating Officer (COO), members of our Operations team, and a designated Continuity of Operations Champion who is responsible for ensuring the maintenance of our continuity of operations processes and procedures. Our centralized BCM, DR teams, IT Site Reliability Engineers, and Incident Response Operation Center (IROC) will also work collaboratively with our Mississippi staff to coordinate our response to any incidents or disasters and restore services / application access or prevent an outage.

c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

Keeping Key Functions Online

To mitigate disruption of service and avoid loss of data, we own and operate two geographically separated enterprise data centers, connected by a fully redundant wide area network (WAN), where all our core application data will be housed. We will be expanding to three data centers for enhanced levels of continuity and service resiliency for our operations in Mississippi. These facilities employ redundant environmental, power, and networking systems, backup capability, and are hardened to withstand natural disasters. For example, our data centers have a seismic importance factor of 1.5 and can withstand winds up to 165 miles per hour. As data is created in our production environments, it will be immediately replicated in the associated recovery data center. In an event requiring a failover from the primary to the alternate site, we would leverage this back-up replicated data and infrastructure located at the alternate site to continue essential business functions. This architecture will provide our critical applications and infrastructure the necessary resilience and service stability to quickly resume essential business functions within established recovery time objectives (RTOs) or other contractual / regulatory guidelines for service levels, and all remaining operations timely following a disruption. Further, our centralized IROC is made up of systems analysts, engineers, and management staff who will continuously monitor all production systems for performance, service availability, and capacity utilization to anticipate and address situations before problems arise. If we experience a system failure or interruption, IROC will immediately invoke and coordinate response and restoration procedures and activate a temporary virtual command center with a pre-designated incident management team, inclusive of our health plan leadership, to ensure essential business functions are recovered and restored.

Member and Provider Services Call Center Operations. In the event of a disaster, all business functions that rely on our telecommunications system will have top priority – specifically our Member and Provider Services Call Centers. Like our call centers at affiliate health plans nationwide, our Mississippi-based call center will be engineered with several levels of redundancy, allowing for immediate, automated rerouting of inbound calls to our out-of-state Regional Service Center or other affiliates. This will ensure our Members and Providers do not experience a disruption in service or access to care. Staff at our Regional Service Center will have access to the Mississippi Coordinated Access Network (MSCAN) and Mississippi Children's Health Insurance Program (CHIP) knowledge base, including the Mississippi Division of Medicaid's (DOM) approved scripts, guaranteeing the same levels of service and consistently accurate information to callers as our Mississippi Customer Service Representatives.

Claims Operations. Our claims operations will be supported from one of our claims processing centers located across the country dedicated to our claims. The centers are securely networked for voice and data connectivity with all data centers, as well as our offices. Our automated claims workflow system will instantly route our claims workload amongst any of the claims centers, with staff at each trained to handle our claims.

Workplace Closed or Incapacitated. We maintain robust policies and procedures to allow for remote work and remote access informed by HIPAA and the HITECH Act. All applications are run centrally from our data centers, and our virtual standardized desktops connect to centralized data via a WAN. We will review and update our procedures annually to align with industry best practices, risk assessments, and federal and state mandates. Privileged remote access will be provisioned only with approval and role-based or business justification. Affiliate health plans have developed, and we will continue to maintain, an online COVID-19 Resource Center to support our workforce as they rapidly transitioned to a work from home environment in response to the COVID-19 pandemic. Provided resources include help for getting connected remotely, training guides, video tutorials, and more.

d. Communication with staff and suppliers when normal systems are unavailable;

Timely System Availability Communications

Communication with Staff. Impacted staff will be notified via our advanced emergency notification system, which ensures swift notification to staff members in a crisis or emergency, no matter what happens to local or regional communications systems. The system can send voice, SMS text, and email messages to all work contacts in our human resources information system to provide critical information about delayed office openings, building power outages, hazardous weather, evacuations, and system unavailability. Not only will we have staff trained on this notification system locally, but should a disaster inhibit our ability to notify our staff, we can rely on our trained affiliates across the country not impacted by a local disaster to operate the system on our behalf, ensuring 24/7 coverage and redundancy. Additionally, our IROC will maintain structured communications plans to provide ongoing status updates on issue resolution to critical IT and leadership staff following a disaster declaration**.**

Timely Communication with Suppliers and DOM. Further, our continuity of operations plans will have structured communication processes used to update suppliers and DOM in the event of a disaster or emergency impacting system availability. Our Compliance Department will be responsible for providing DOM with a detailed explanation of the disaster and its impact related to critical business functions upon disaster or disruption discovery. For extended disruptions, we will provide DOM with a detailed plan to resume operations.

e. Plans to ensure continuity of services to Providers and Members, including the Recovery Time Objective for major components;

Ensuring Continuity of Services to Providers and Members

System Backup and Recovery. We will perform full and complete system backups nightly on all servers utilizing enterprise-class backup software and online tape backup technology with off-site replication to our designated recovery data center, ensuring robust recovery and resiliency capabilities. Our DR processes will leverage leading technologies and off-site storage to fully recover data and systems from the effects of a disaster and minimize the recovery period. In the case of an outage, the designated recovery data center will restore critical business services including systems, databases, and applications, and can sustain this for three months or longer. From there, all other systems and applications will be restored in accordance with DOM priority, as well as in accordance with the results of our annual comprehensive risk and threat assessments, to ensure DOM satisfaction with our recovery capabilities and mutually agreed upon recovery time and point objectives (RTOs and RPOs). We will align with DOM-defined minimum RTO and RPO timeframes as required.

Communication with Providers and Members. ***We will quickly update our public website to provide emergency-appropriate information for Providers and Members, including tips for preparation, where to access resources, alerts and updates, and service outage notifications.*** All data populating our secure Provider and Member Portals is housed in our data centers, ensuring Member record accessibility for Providers and Members no matter where they are in the event of an emergency. Further, our care management staff will conduct outreach to our Members as appropriate to develop specific strategies to ensure they have access to necessary resources and continuity of care. Depending on the emergency, we will customize the voice scripts in our Interactive Voice Response (IVR) to inform calling Providers and Members of the situation and route their calls accordingly.

Real-Time Emergency Monitoring, Management, and Reporting. To supplement our emergency and disaster preparedness processes and expertise, our health plan and our centralized Crisis Management resources will leverage customized solutions from a leading provider of emergency management and continuity services to track weather-related and other adverse events likely to impact our Mississippi staff, Members, and Providers. Key emergency response staff (i.e., COO, Call Center Managers) will receive detailed reports, dashboards, and email alerts coordinated with the National Weather Service or other governmental agencies which provide office-specific forecasts on inclement weather (winds, storm surge, tornado, hurricane, etc.), enabling us to proactively act on anticipated impacts. For example, we will have access to an Interactive Common Operational Picture, which offers a real-time visualization of all weather-related events likely to impact our offices. From there, we will be able to notify impacted staff, including any employees in the field, to ensure appropriate action is taken. This common operational picture also features a Member data layer used to predict Member impacts at the county-level. We will then be able to proactively conduct outreach to those Members to verify they have the supports they need and reinforce continuity of care. In addition to reporting,

we will have on-demand, 24/7 access to experienced emergency managers and meteorologists who can join our crisis response calls and offer their unique expertise. These meteorologist briefings will provide real-time and location-specific forecasts to offer our leadership additional clarity in making strategic emergency response decisions.

f. Security and privacy requirements; and

A Security Methodology Grounded in Best Practices

Our DR plans will include data security protocols with measures designed to mitigate the additional vulnerabilities presented by business interruptions, disasters, or emergencies. The security components of our plans are part of our continually updated International Standards Organization (ISO 27001) certified security program that safeguards health information data files, records, and Protected Health Information (PHI). This program, a combination of governance, policies and procedures, controls and safeguards, and ongoing training, minimizes data breach risk and ensures data protection. We will use a comprehensive array of information security and privacy best practices, rigorous policies, strong authentication, monitoring tools, and automated business processes to ensure systematic and auditable adherence to HIPAA regulations and standards that apply to normal and contingency operations (including backup and data recovery). In line with ISO 27001 and NIST best practices, we will perform regular risk assessments to evaluate our security posture and identify controls to reduce risk likelihood and impact. In addition, we will continuously monitor our MIS for vulnerabilities and threats, along with notifications from US-Cert and other cyber threat monitoring organizations.

Ensuring Confidentiality of Data. We will ensure the confidentiality of all Member information, including PHI on back up media, by requiring all staff, including personnel engaged in database backup and restoration activities, to sign a confidentiality agreement and by only allowing staff and Providers to request, access, or disclose confidential information as necessary to fulfill assigned duties and responsibilities. All staff will be instructed to immediately notify appropriate DOM staff should they become aware of any confirmed or suspected security breach or unauthorized transmission or loss of data, including those which occur because of an emergency or disaster.

Security Controls and Measures.

Physical Security. We will ensure physical security at our facilities by using electronic access control, alarming, and Network Video Recorder monitoring systems to monitor and control physical access to any areas housing our systems. We will utilize the “least privilege technique” to ensure that only approved employees and third-party contractors are able to access those areas required for their job. We will provide all employees and authorized third-party staff general access at badge issuance. We will require all visitors to check-in/out each time they arrive onsite, and log all visits, collecting the visitor’s name, company, and purpose of visit.

Controls and Safeguards. In addition to the physical system controls above, we will maintain a comprehensive set of HIPAA-compliant administrative, physical, and technical safeguards to ensure the data housed in our systems and backup systems are protected. See **Table 4.2.2.6.D.1.f below** for highlights of these security controls.

Table 4.2.2.6.D.1.f Example Safeguards

Administrative Examples	• Employees/contractors take security training at least annually. • We will perform Security Risk Assessments regularly. • Anti-virus software on PCs and servers.
Physical Examples	• Laptops attached to desks with cable locks or locked in cabinets. • Facility access monitored, recorded, and audited. • Two enterprise data centers, with the expansion to three data centers forthcoming for enhanced levels of continuity of operations.
Technical Examples	• Multi-factor Authentication for employees and contractors. • Desktop PCs are diskless, laptop hard drives encrypted. • Vulnerability management system for automated scanning to monitor and address any vulnerabilities.

Logging Policies and Systems

Our IT Security staff will use software for data loss prevention, which audits the appropriate use by personnel of systems, email, and the internet. Audit trails will be incorporated into the software components in our MIS. We will use security software, along with master data management methodologies and controls with common “cross application” primary and foreign keys, to maintain audit logs and associated transaction reports on user

login activity; records viewed, created, modified, or deleted; as well as the movement of data from source to processed results.

g. Testing plan, which should be provided to the Division on an annual basis within 30 days of the request.

Testing Plan

We will partner with our centralized BCM and DR teams to maintain and test our continuity of operations and DR plans annually as required by applicable federal and State regulations. Such testing will assure we meet RPOs and RTOs, and that our offices can continue to serve Members, their families, and Providers in the event a data center or system is unavailable. All our testing methods will include structured documentation of lessons learned, which will then be utilized to improve response times and address gaps in our plans. We will provide our testing plan and test results within 30 days of the request from DOM. Our continuity and DR testing procedures include:

- **Annual DR Simulation Test.** We will conduct full-scale, comprehensive testing of our MIS recovery capabilities by simulating a disaster to validate that we can deliver systems in an emergency. This simulation will thoroughly test all relevant hardware, software, personnel, communications, procedures, supplies and forms, documentation, transportation, utilities, and alternate site processing. Results of this test, including any failure points or corrective action plans, will be made available as part of an annual report to the State. We will approach interruption testing (actual activation of our DR strategy) with extreme caution and will only conduct it as needed or required to avoid disruption of normal operations.
- **Walkthroughs.** We will perform regular walkthroughs of the specific steps documented in our DR plans to confirm effectiveness and identify potential gaps, bottlenecks, or other weaknesses. These walkthroughs will reflect updated business objectives, allowing us to better respond to changing threats.
- **Parallel Testing.** We will regularly conduct parallel testing by running reports on data in our primary and contingency data centers and comparing results to assess the effectiveness and accuracy of our backup and recovery processes. Output discrepancies would indicate needed process or technology changes.

[END OF RESPONSE]

4.2.2.7: SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION (UNMARKED)

4.2.2.7.A Services to be Subcontracted

1. Describe what services the Offeror will plan to subcontract if chosen as a Contractor.

We intend to Subcontract the following services if chosen as a Contractor:

1. Dental benefit management
2. Vision benefit management
3. Non-emergency transportation
4. Utilization management for orthopedic services
5. Utilization management for specialty services such as cancer, hematology, and medical oncology
6. Utilization management for outpatient diagnostic imaging services and occupational, physical, and speech therapies
7. Print services such as ID cards, new member packets, and replacement identification cards
8. Certain administrative support services including information systems, encounter submission, claims processing, Special Investigations Unit, program integrity, Provider data management, human resources support, BH utilization management, Nurse Advice Line, BH/SUD 24/7 Crisis Line, disease management
9. For a subset of Members enrolled in a specialty diabetes program: diabetes self-management, education, and training, medical nutrition therapy, and point-of-care laboratory testing

2. Describe the Offeror's relationship to any potential subcontractors for each service the Offeror plans to subcontract. In describing this relationship, include the business relationship the Offeror has with each subcontractor and the length of experience the Offeror has with each subcontractor.

Corresponding with the numbering above, we describe our business relationship and the length of that relationship for each potential Subcontractor. In addition to our years of experience, our corporate entity and affiliate health plans have experience with these Subcontractors.

1. Affiliate Subcontractor – 7 years
2. Affiliate Subcontractor – 11 years
3. Unrelated entity – 5 years
4. Unrelated entity – 3 years
5. Unrelated entity – 2 years
6. Affiliate Subcontractor – 11 years
7. Unrelated entity – 6 years
8. Management Services Agreement with Corporate entity – 11 years
9. Unrelated entity – 3 years

4.2.2.7.B Subcontractor Oversight

1. Describe the Offeror's Subcontractor oversight program. Specifically describe how the Offeror will:

a. Provide ongoing oversight of the Offeror's Subcontractors, including a summary of oversight activities, organizational infrastructure that supports Subcontractor oversight, and the types of reports required from each Subcontractor;

Our organization will have a well-developed Subcontractor oversight program to monitor and promote compliance and adherence to all contractual, regulatory, NCQA requirements. This process will be fully compliant with the requirements of Section 13.5 of Appendix A, Draft Contract. We start with carefully selected partners with proven experience to support the delivery of high-quality, person-centered health care services. We are fully committed to maintaining a close partnership with DOM related to Subcontractor oversight and will seek DOM approval of all Subcontractors. We acknowledge that as the Contractor, we maintain sole accountability and responsibility for the performance and oversight of all Subcontractors performing tasks under this contract and have designed our program to fulfill this obligation. Affiliate Subcontractors are subject to the same oversight program with the same high level of oversight as non-affiliate Subcontractors.

Summary of Subcontractor Oversight Activities

In addition to formal audits and reviews, we will monitor Subcontractor performance on an ongoing basis. We will develop and implement written Subcontractor monitoring plans for each vendor. These plans will clearly define the type and frequency of reporting and monitoring for each Subcontractor, establish specific performance metrics, and evaluate performance against identified metrics. These plans will be stored and continually monitored/updated within our comprehensive Compliance Management System, described below. As a standard practice, we will conduct pre- and annual-delegation audits of all Subcontractors. To ensure a

comprehensive audit, we will use a standardized Delegation Review Tool customized for Mississippi to review Subcontractor performance related to specific areas, such as policies and procedures, Member files, reports, marketing material, compliance program, and clinical guidelines, as applicable.

Joint Oversight Committee (JOC) Meetings. We will host quarterly JOC Meetings with each Subcontractor that include a focused review of performance dashboards and reports, complaints and grievances, quality initiatives, and pertinent regulatory updates. Minutes from each meeting will be recorded, approved, and stored for follow-up within our Compliance Management System. Led by Compliance, JOC meetings will include representation from the Subcontractor and other Plan staff related to the Subcontractor's delegated functions, including, but not limited to, leadership and staff from Operations, Care Management (CM), Utilization Management (UM), Quality Management (QM), and/or Network. We have found cross-functional representation at the JOC to be helpful, resulting in faster and more effective solutions to identified issues. More frequent JOC meetings may be held as deemed necessary.

Additional Oversight Activities. Other ongoing Subcontractor monitoring processes, depending on each entity's delegated function(s), include activities such as:

- Analyzing and approving Subcontractor network listings and changes
- Analyzing Call Center, utilization (specific to each delegated function), and claims metrics
- Verification of monthly monitoring for Provider exclusions and reinstatements and (re)credentialing
- Conducting/tracking investigations resulting from grievances, quality of care complaints, or fraud issues
- Compliance review and follow up on feedback from Advisory Committee meetings

Organizational Infrastructure that Supports Subcontractor Oversight

We will take a collaborative approach to Subcontractor oversight. For each Subcontractor, we will designate an individual from our senior leadership team as our internal lead to monitor Subcontractor performance and report issues to Compliance. In tandem, we require each Subcontractor to designate an appropriate senior staff person as their lead. In addition, our Compliance Department, with support from our corporate entity's Compliance Department, will be highly engaged to ensure that all Subcontractors are performing at the highest levels and meeting all applicable State and Federal regulations. Within the Compliance Department, ***we will have staff dedicated solely to vendor oversight.*** As described above, a variety of team members will participate in JOC meetings to provide additional input and promote cross-functional collaboration and insight.

Committee and Operational Meetings. The Compliance Officer or designee will chair and conduct committee and operational meetings to support Subcontractor oversight. This includes, at a minimum, JOC meetings, as well as a quarterly Compliance Committee where vendor performance is reviewed by internal business leads. In addition, our cross-departmental Performance Improvement Team (PIT), chaired by the Chief Medical Director, will meet monthly and monitor all health plan performance metrics, including those related to Subcontractors, identifying opportunities for quality improvement; and monitoring subsequent interventions and results. The PIT reports to the Quality Management Committee (QMC), which is also chaired by the Chief Medical Director, and reviews Subcontractor quality program documentation and/or corrective action plans (CAPs), if applicable.

Technology Infrastructure. We will use a Compliance Management System that supports our contractual and regulatory oversight capabilities, manages our compliance with State contract requirements, and tracks all compliance activities. Our system can accept required and ad hoc reports from Subcontractors via secure file transfer protocols. This system stores contract requirements, documents to demonstrate compliance, and related policies and procedures. Any contract compliance issue identified with a Subcontractor will be tracked within the Compliance Management System along with progress on any identified issues.

Types of Reports Required from each Subcontractor

We contractually require Subcontractors to submit monthly, quarterly, and annual (as well as ad hoc, when necessary) reports. Upon contracting, we will provide each Subcontractor with a robust reporting manual that describes all reporting requirements, including required data/information, reporting frequency, and report submission process. Operations, Network, UM, CM, and QM staff will review and use Subcontractor reports in

the daily administration of Plan responsibilities and the ongoing monitoring of delegated functions. Required reports depend on each Subcontractor's delegated functions and address areas such as:

- Prior authorization turnaround time, approvals, and denials
- Call Center volume and accessibility
- Service utilization
- Claims processing
- Complaints, grievances, and appeals
- Network access reports

b. Ensure receipt and reconciliation of all required data including encounter data;

All data submission requirements will be contained in our written agreements with each Subcontractor, as well as within each Subcontractor's monitoring plan. On an ongoing basis, Compliance will monitor and verify receipt of required data within the specified, required timeframes. Throughout the year, our PIT and QMC will review the data to identify trends related to Subcontractor data submission issues. If issues are identified, we will work with the Subcontractor to develop and implement a plan of action to remediate the issues. Continued non-compliance may result in a CAP, monetary penalties, or contract termination, as indicated.

Encounter Data. Our Vendor Oversight Activities described above will include ensuring our Subcontractors submit all encounter data in an accurate and timely manner, consistent with Section 16.7 Member Encounter Data of Appendix A, Draft Contract. As relevant, each Subcontractor's performance measures include encounter file delivery by specified dates each month. Each Subcontractor is required to submit a Monthly Management Report to us, which includes encounter-related analyses related to the services for which they are subcontracted, including, but not limited to:

- Utilization Statistics and Trends
- Medical Claims Processing Statistics and Trends
- Call Center Statistics and Trends
- Provider Network Statistics
- Prior Authorizations
- Encounter Data Acceptance Rate

As part of our data completeness monitoring program, we will evaluate Subcontractor compliance with encounter reporting requirements and take appropriate corrective action as needed. To support timely and accurate encounter data submission, we will meet with each Subcontractor on a biweekly basis to go over any encounter issues and results. DOM is invited to participate in these calls. In addition, our parent company provides us with encounter submission technology support and error review and resolution services. Subcontractors submit encounters to our centralized Encounter Business Operations (EBO) team to monitor and support each Subcontractor's encounter data submission schedule and delivery date on an ongoing basis.

c. Ensure appropriate utilization of health care services;

Our team will continuously monitor Subcontractors to ensure the appropriate utilization of health care services through a multi-pronged process, including annual delegation audits involving authorization file review, weekly monitoring reports, and quarterly JOC meetings. On an ongoing basis, in direct coordination with CM and UM, Compliance will monitor each Subcontractor's utilization reports and immediately follow up with the Subcontractor regarding concerns or questions, thereby initiating the appropriate monitoring and follow-up activities necessary to address the concern or question. Data and identified issues that require additional insight will be forwarded to the PIT. The PIT analyzes utilization performance measures monthly, addresses any immediate issues, and forwards recommendations to the QMC. The Utilization Management Committee (UMC), consisting of stakeholders from each business area, meets quarterly to review utilization performance measures to identify trends of over/underutilization of services and make recommendations to the QMC accordingly. The QMC will annually review and approve the Subcontractor's UM Program Description, Work Plan and Annual Program Evaluation and, on a quarterly basis, review JOC, PIT, and UMC recommendations and take action, if indicated. Finally, depending on each Subcontractor's delegated functions, other staff may review utilization information and make recommendations. As noted, any issues or concerns will be addressed

with the Subcontractor for appropriate clarification, follow-up, and resolution. Substantive issues will be addressed through the CAP process, with QM and QMC input and oversight. Additionally, we will follow our Fraud and Abuse Compliance Plan, which addresses Subcontractor service patterns monitoring procedures and verification of whether services reimbursed were actually furnished to Members to ensure appropriate health care services utilization.

d. Ensure delivery of administrative and health care services meets all standards required by this RFQ;

Using the processes delineated above, we will ensure adherence to the RFQ and Appendix A, Draft Contract by all Subcontractors. This includes the use of our web-based Compliance Management System, into which Compliance will load the RFQ, Appendix A, Draft Contract, specific Mississippi policies and procedures, applicable State and Federal regulations, and any and all Contract revisions to facilitate systematic and programmatic monitoring of Subcontractor compliance. In addition, our pre-delegation and annual audits use standardized Audit Tools that will be tailored to Mississippi to assess Subcontractor compliance with Offeror, State, Federal, and DOM requirements, as well as NCQA guidelines.

Finally, as described, Subcontractor performance is monitored on an ongoing basis through weekly, monthly, quarterly, and annual reporting. Subcontractors will be required to meet or exceed both our performance standards and DOM requirements for quality assessment, improvement, and reporting, as well as operational/administrative standards, such as Member and Provider Call Center services, network contracting, and management, and utilization review. In addition, where relevant, our organization requires Subcontractors maintain NCQA or URAC accreditation to fulfill all accreditation requirements. We also regularly monitor service performance measures, grievance and appeal trends, as well as Member satisfaction and disenrollment surveys through our oversight program. Examples of specific activities include:

- Compliance and Network staff will review monthly Subcontractor network listings to verify compliance with geographic access standards, such as for our delegated dental and vision networks.
- For Subcontractors with Member and Provider Call Center functions, our Compliance staff review monthly Call Center metrics, including but not limited to the number of calls, abandonment rate (4% or less per month), and speed to answer (30 seconds or less) to verify compliance.
- Our VP of Population Health and Clinical Operations reviews our 24/7 Nurse Advice Line Subcontractor's daily reports of the previous business day's calls to identify the need for follow up of care and tracking trends in after-hours calls.
- For claims processing Subcontractors, Compliance, and Finance staff review monthly reports that address the number and percentage of claims paid within the required timeframe (e.g., 90% of clean claims processed within 30 calendar days of receipt and 99% of clean claims processed within 90 calendar days of receipt), as well as the number of denied claims and reasons for the denial.

To promote health equity and ensure access to services across the membership, our QM staff will further assess Subcontractor performance data related to specific enrolled populations. For instance, we will analyze utilization or quality indicators by eligibility group, socioeconomic level, race/ethnicity, geographic region, or disease category.

e. Ensure adherence to required Grievance policies and procedures; and,

We will educate all Subcontractors regarding our Member and Provider Grievance requirements and standards. All Subcontractors will be contractually required to comply with our Grievance policies and procedures and DOM, State, and Federal requirements, including NCQA standards. We will review each Subcontractor's monthly performance metrics, which include but are not limited to:

- Total number of grievances
- Percentage resolved within the required timeframe
- Percentage of appeals overturned or denied and an explanation of each determination

The monthly performance metrics are reviewed during JOC, PIT, and QMC meetings, and oversight of Grievances is included in the Vendor Oversight Activities described above. As with any Grievance, we will promptly act on any grievances we receive from a Member, Provider, or DOM regarding a Subcontractor's performance. In addition, during audits, and more frequently as they are updated, Compliance reviews the

Subcontractor's grievance and appeal letter templates to ensure inclusion of all required elements, such as Member's rights and responsibilities. We will ensure any changes to templates are approved by DOM prior to implementation of the template.

f. Address deficiencies or contractual variances with the Offeror's Subcontractors, including an example of how the Offeror has addressed a deficiency or contractual variance with a Subcontractor.

The Compliance Officer and other appropriate staff will work with Subcontractors to address any identified deficiency or contractual variance. We have the right to assess monetary penalties and/or terminate the Subcontractor specific delegated functions if the Subcontractor does not meet subcontract, delegation, or monitoring plan requirements. In the case of subcontract termination, we would ensure a smooth transition, performing the delegated activities directly or arranging for them to be completed by another DOM approved Subcontractor to facilitate no lapse in services.

Depending on the severity, when an issue is identified, the Compliance Officer may contact the Subcontractor immediately or call an ad hoc meeting to discuss and resolve issues. We may hold onsite meetings at our office with executive-level Subcontractor staff to address issues in person. In instances of Member risk, we will require immediate corrective action of the deficiency and intervene as needed to ensure Member safety.

If we identify a performance deficiency, Compliance staff will partner with the Subcontractor to develop and implement a written plan of action that includes specific remediation and timelines. In these cases, the Compliance Officer or a designee will closely monitor the action plan results to ensure the deficiency is remedied and steps are taken to prevent the reoccurrence of the deficiency. In addition, if there are CAPs or quality improvement plans (QIPs), the QMC will review and monitor progress. We expect prompt Subcontractor improvement following any identified deficiency, generally within one to two months, and immediately in cases that relate to Member risk. Even after deficiencies have been remediated, we will continue to monitor Subcontractor progress and activity for an additional 6 to 12 months, depending on the nature and level of non-compliance.

Example of how Offeror has Addressed a Subcontractor Deficiency or Contractual Variance

Using the oversight processes discussed herein, our affiliate Medicaid health plans have successfully addressed Subcontractor deficiencies. In one instance, a Subcontractor was consistently missing performance metrics for call answer timeliness, an issue that was discussed at great length during JOC meetings. Following formal notification to the Subcontractor that they were out of compliance with the contract, the Subcontractor determined that they could not meet the metric at their maintained staffing levels and increased staff to successfully fix the issue.

g. Also include acknowledgement of the requirement to perform annual quality review of Subcontractors, which should be included in the Annual Quality Management Program report to the Division.

We hereby acknowledge and embrace the requirement to perform an annual quality review of Subcontractors, as described throughout this response. As a standard practice, these reviews will be completed annually and included in our state-specific Annual Quality Management Reports. Annual quality reviews include a review of relevant HEDIS measures, Subcontractor performance on defined performance metrics, Member and Provider satisfaction surveys, discussion of results, and analysis of potential barriers and solutions. Such a report, including the results of the annual review of Subcontractors will be submitted to DOM.

The Division Annual Quality Management Report will include detailed data demonstrating Subcontractor performance in key indicators. The report will further include an analysis of performance and potential barriers to success, with appropriate plans to address such barriers. As the contract proceeds into subsequent years, the report will also include an analysis of efforts to implement plans to address identified barriers and opportunities for improvement identified in prior years.

h. Describe how the Offeror will ensure the proper classification of all subcontractor expenses between administrative and medical in accordance with the Division's policies.

Expenses related to Subcontractors will be paid on a capitated, per member per month (PMPM) basis. Payments to each Subcontractor are readily identifiable as each Subcontractor is reported to a unique account. All Subcontractors are required to submit paid claims detail monthly to allow us to identify and monitor medical

spend. The difference between the total payment to a Subcontractor and the medical spend per the paid claims data is classified as an administrative expense. This split of medical and administrative expense is validated prior to submission to DOM. Subcontractors are subject to random audits to ensure provided claims data is supported and accurate. We will provide the supporting detail to demonstrate the appropriate separation of administrative and medical costs as requested by DOM.

[END OF RESPONSE]

4.2.2.8: FINANCIAL AND DATA REPORTING (UNMARKED)

4.2.2.8.A. Financial Reporting

1. Describe the Offeror's approach for supplying data as determined by the state to satisfy the requirements for base data needed to develop actuarially sound capitation rates, as described in 42 C.F.R. § 438.5 (c).

In reviewing the actuarial memoranda released with this procurement, we observe that the State's consulting actuary relies on the use of encounter data as the base claim experience used in rate projections for both the MSCAN and CHIP programs. We will facilitate the transfer of the encounter data as required under the terms of the RFQ, incorporating processes and controls to ensure the data meets the operational needs of DOM and the actuary's rate-setting needs.

Our actuaries focus solely on Medicaid and CHIP programs and understand the key components underlying actuarially sound rate setting. This team, working in conjunction with our finance, encounter, and cost reporting functions, will work collaboratively with DOM and its actuarial contractor to ensure that rate data is accurate and appropriate for use in capitation rate development. Our actuarial team will:

- Help reconcile variances between reported financial information and accepted encounter data, and provide details of variances that should be considered in rate setting
- Provide supplemental data to assist in developing cost estimates for new benefits and program changes
- Provide perspective on rate setting impacts pertaining to the regulatory environment, Actuarial Standards of Practice and CMS rate-setting requirements, and our insight into the delivery system and Medicaid program

Included in our encounter submission to DOM will be encounters from our Subcontractors to ensure we can provide a comprehensive understanding of medical expenses. All our contracts with Subcontractors will require compliance with DOM's standards for timely, accurate, and complete encounter submissions; failure to do so may result in penalties as specified in the Subcontractor agreement. In addition, we recognize that sub-capitation agreements can often be a source of variance when comparing reported encounters in sub-capitated arrangements to the sub-capitation medical expense in cost reports. This variance is due to the sub-capitation payment being an agreed-upon cost paid by the plan to the vendor, but the actual vendor encounter experience will likely differ. We will provide background and support to assist the actuary and DOM in reconciling any such variances.

For the development of non-benefit costs, we understand that DOM's actuarial contractor utilizes reported cost information submitted as part of a plan's financial cost templates. This is a standard practice seen in capitation rate development and we will provide this information as part of the reporting process. We will address any questions about submitted financial reports and administrative costs, including General Ledger details and reconciliation. Further, we will support the development of accurate cost report data for non-benefit costs by booking administrative expenses at a program level in the General Ledger, sourcing administrative costs from the General Ledger, and categorizing at requested levels (e.g., direct vs. indirect, corporate overhead), and reconciling the final reported amounts to the statutory financial statements to ensure accuracy.

2. Describe the Offeror's approach for the timely completion and reporting of the Medical Loss Ratio (MLR) reporting requirements, as described in the Contract (in accordance with 42 C.F.R. § 438.8 and 438.74), to include the Offeror's computation of medical claims cost and non-claims cost (administrative expenses) to include the costs associated with any subcontractors utilized.

Our quarterly and annual MLR reporting to the DOM will comply with all requirements of Appendix A, Draft Contract, including submitting necessary documentation with the Annual MLR report. We will calculate current year-to-date MLR Capitation Revenue by multiplying the contracted PMPM rates by our membership provided by DOM and including the accrued 1% withhold, plus the Mississippi Hospital Access Payments (MHAP) and Medicaid Access to Physician Services (MAPS) revenue paid to our plan by DOM, less applicable premium taxes of 3%. Our MLR Reporting will also include our computations of Total Adjusted MLR expenses, which will include all medical expenses incurred for services provided to our Members obtained from our financial records. We will adjust medical expenses for health care quality improvement expenses along with other additions, deductions and/or exclusions as required by the MLR reporting requirements. Non-claims costs (i.e., administrative expenses) will be obtained from our plan's financial records.

To ensure that we meet the deadlines of contractually required reporting, we will create a Regulatory Deliverable Tracking Profile for each State Deliverable in our Compliance Management System. We will embed a tracking identification number in each Regulatory Deliverable Tracking Profile that is used to monitor

the status of each required submission. Our system will present monitoring dashboards to our Compliance and Reporting Manager to track the status of each State Deliverable, and an Excel spreadsheet will serve as a backup to the system. The system will alert the Responsible Party, Approver, and Submitter of each report's status. This process will inform those responsible of all upcoming and/or past due reports and gives deadlines for the completion of the tasks. We will apply these procedures to ensure timely completion and uploading of the report so that we may obtain appropriate level approval and submission to the requestor. The system also allows the Compliance and Reporting Manager to maintain the status of the report requestor's approval.

4.2.2.8.B. Data Reporting

1. Encounter Data

a. Describe the Offeror's approach for collecting, validating, and submitting complete and accurate encounter data in a timely manner to the Division consistent with required formats. Include how the Offeror proposes to monitor data completeness and manage non-submission of encounter data by a Provider or a Subcontractor. Provide the key components of the Offeror's encounter completeness plan.

We have a developed, rigorous process to ensure the encounter data we collect from Providers and Subcontractors and submit to DOM will be complete, accurate, and timely following State, Federal, and DOM requirements. Our local team will be led by our Chief Financial Officer who will oversee our encounter completeness monitoring program, in conjunction with our finance, compliance, data analytics, Provider relations, claims, and encounter staff to ensure successful encounter submission and performance. This team will have an in-depth understanding of State-specific claims processing rules and will work closely with our local Provider Relations team to support Provider communication and education. We will be supported by a centralized Encounter Business Operations team (EBO) which was strategically built to include resources with expertise in all aspects of the claims and encounters life cycle (including Provider data, eligibility, claims processing, and configuration), and capitalizes on that knowledge to ensure compliance with all contractual measures. The EBO is an agile team that learns and shares expertise based on variations in State requirements across our affiliate health plan operations. The EBO uses a coordinated team approach with local claims staff, enterprise support teams, and Subcontractors. Under our direction, the EBO will document and implement encounter business requirements, ensure billing edits are in place in alignment with DOM requirements, monitor file processing and delivery, and analyze encounter holds and rejects. This proven approach will ensure encounter processes and performance requirements are consistently met. We have reviewed all DOM requirements regarding encounter data and DOM's Encounter Companion Guides for Professional, Institutional, Dental, and Pharmacy encounter claims and will adhere to all data specifications.

Encounter Data Volume

Across our affiliate health plans, the EBO supports the submission of more than 300 million encounters per year.

From Claim to Encounter: Our End-to-End Approach

We attribute our success in encounter data production to our end-to-end view of encounter preparation. From Provider claim submission to encounter data preparation, we recognize that to support complete, accurate, and timely encounter submission in compliance with 42 CFR 438.242 and 42 CFR 438.818, we need to support and enhance accurate claims submission to minimize downstream errors and collect service information from Providers in standardized formats. Our front-end controls will help ensure complete, accurate, and timely encounter submission to support back-end encounter data preparation. Our data monitoring and validation processes and procedures have resulted in ***an encounter accuracy rate of 99%*** at affiliated health plan in CY 2021 serving a similar population. Our claims and encounters processes and controls are aligned with all requirements in Section 16.7 Member Encounter Data of Appendix A, Draft Contract. We will comply with industry-accepted clean claim standards, including capitated claims, by requiring the submission of complete and accurate data to support proper adjudication of claims. Upon claim receipt, our compliance software will validate data against ASC X12 HIPAA Version 5010 syntax, for data structure, and test for conditional rules requiring secondary fields. This will help ensure data complies with the DOM Encounter Companion Guides as we process the claim, and that downstream encounter data we produce is compliant with DOM standards. We will process claims through our middleware to map, translate, and validate the data to ensure that common edits are consistently applied, and all critical claim data elements are present in sufficient detail to support comprehensive financial reporting and utilization analysis. If any claim transaction is rejected, we will notify the Electronic Data Interchange (EDI) trading partner, submitting Provider, or Subcontractor and convey the reason it did not pass validation processing. Prompt notification to Providers and Subcontractors will enable

correction and resubmission of the claim so we can process and submit the encounter to DOM or its Agent in a timely fashion.

Encounter Data System (EDS). We will use an industry-leading EDS for encounter reporting. EDS is a comprehensive encounter workflow system specifically designed for managed care encounter processing. Our EDS will edit and validate claims data, create encounter submissions files, load inbound response files, and track and report encounter data status. EDS' table-driven configuration function will allow us to implement encounter rules and edits to ensure encounters are HIPAA-compliant 837 transactions and conform to all DOM-specific business rules, formats, and transmission specifications in the DOM Encounter Companion Guides, Section 16.7.1 of Appendix A, Draft Contract, or other State and Federal submission standards. EDS will indicate claims payment status and claim type (i.e., original, void, or replacement). Further functionality provided by EDS will include:

- Support of DOM-specific business rules to "scrub" data prior to submission resulting in more accurate and compliant submissions; scrubs are also monitored to identify process improvement opportunities
- Automation of defined correction actions, in concurrence with DOM guidelines, to correct encounter rejections
- Linkage to base claim database, outbound encounters, and inbound acceptance reports to facilitate comprehensive encounter reconciliation efforts
- Assistance in the prioritization of encounter correction activities
- Support for extensive operational and executive reporting needs to identify encounter trends, monitor acceptance rates, and proactively correct issues through integration with our Enterprise Data Warehouse (EDW)
- Automated extract and delivery mechanisms to minimize bottlenecks and need for manual intervention

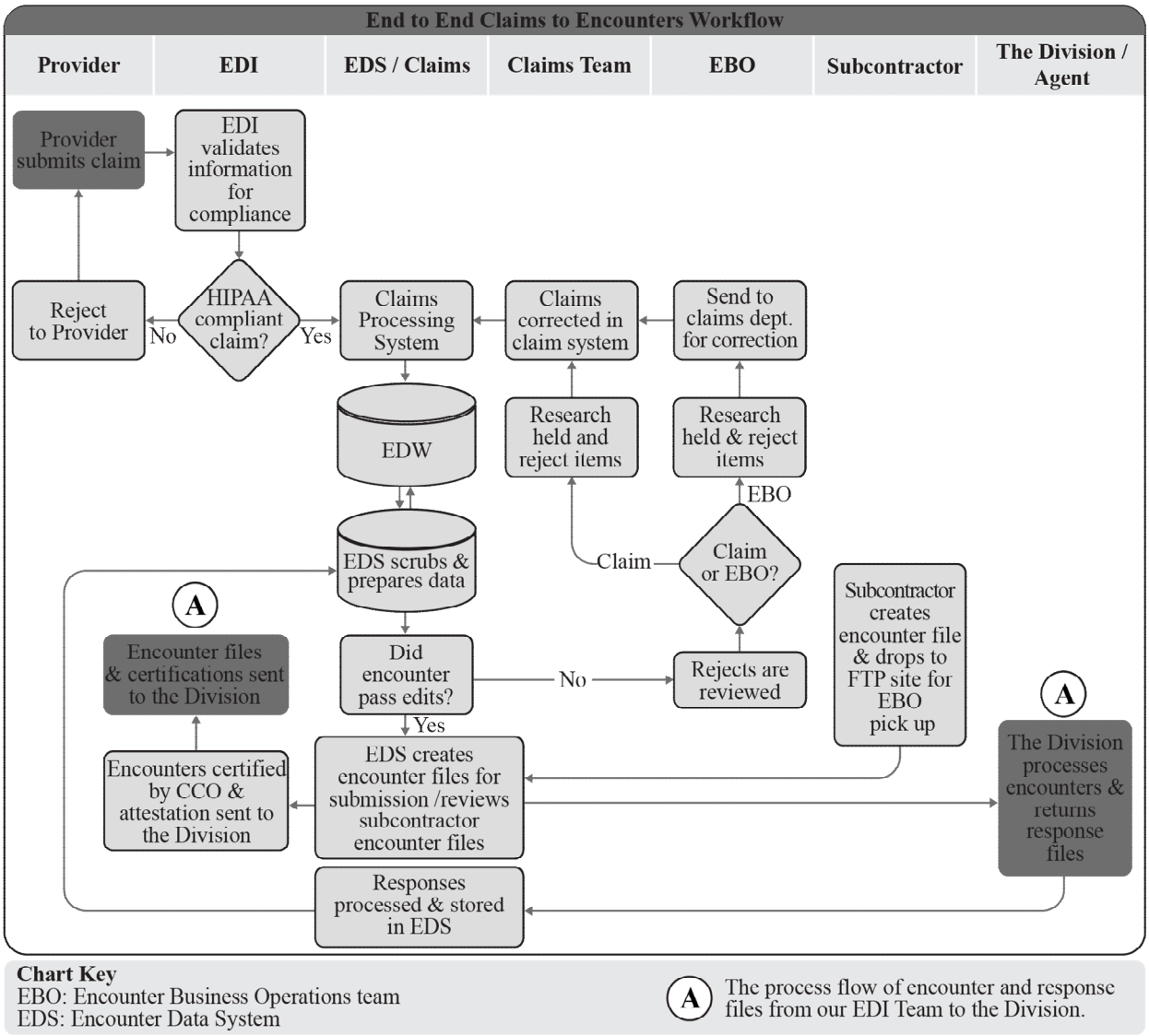
Equipped to Capture Encounter Claim Detail. Our best-in-class Management Information System (MIS) will be configurable to meet all program requirements as defined by DOM. We will configure our systems and processes to accommodate any changes made by DOM. For every clean claim, our encounter data will display the same line-item detail as received on the claim, regardless of claim type, and disposition (either paid or denied). We include fee-for-service (FFS) equivalent detail including, procedures, diagnoses, Diagnosis Related Group (DRG) as appropriate, National Drug Code (NDC), interest paid or recovered, "zero paid" claim lines, cost settlements, sub-capitated services, third party liability denials, and claim line adjustments. Encounter detail will include all services, the rendering Provider's identification numbers, billed amounts, and paid amount information. An indication of whether the claim is original, adjusted, voided, denied, a replacement, or from a capitated service will also be included. Encounter data does not include claims rejected for HIPAA or EDI errors. During our EDI and pre-adjudication validation, the claims data received will be reviewed for completeness and appropriateness. This includes checks for data formatting, as well as comparing items such as Member number to Member's name and date of birth.

Aggregating Encounter Data within our Enterprise Data Warehouse (EDW). Our Claims Processing System will retain snapshots of all transactions (e.g., paid, denied, suspended, appealed, changes, adjustments, voids), and include date span logic, historical claims tracking, operator ID stamping, and other audit parameters for operational monitoring and retrospective reviews. We will retain all data elements billed by the Provider as well as our claims detail history necessary for creating encounters in compliance with DOM. The EDW supports access to all data necessary to manage the entire encounter process including any need for extended encounter data reporting, such as capabilities to identify encounter trends, monitor acceptance rates, and produce operational analytics.

Encounter Data Workflow

Please see **Figure 4.2.2.8.B.A** below for an illustration of our entire end-to-end claims to encounter process, including Subcontractor submissions.

Figure 4.2.2.8.B.A Claim to Encounter Workflow



Encounter Accuracy, Completeness, and Timeliness

Encounter Accuracy. We will employ multiple stages of systematic encounter editing and processing to ensure that submitted encounters are accurate, based on X12 EDI compliance edit requirements set in the Strategic National Implementation Process (SNIP) levels 1 through 4 and DOM's Encounter Companion Guide. EDS allows us to drill down to the detailed claim service line level to rapidly examine and act on any encounter-related issues, as appropriate. When we do have errors, we will systematically review them to identify and resolve issues through system controls, Provider education, or other methods. Through our systems, processes, and partnership approach, we are confident that we will meet and exceed DOM's accuracy standard.

Encounter Completeness. We will review, monitor, and audit encounter data for completeness in alignment with DOM requirements. We recognize that it is important to submit complete encounter data, including all paid and adjusted claims submitted by participating and non-participating Providers, our Subcontractors, and Providers with whom we have capitated arrangements. To ensure completeness of encounter data submitted to DOM or its Agent, we will compare monthly financial data (from finalized claims) with corresponding accepted encounter submissions to ensure encounter data is not just being accepted, but also that what is being accepted is a complete representation of the services provided. Using this process, we can account for every paid claim, verifying finalized claims processed as encounters, inclusive of all payment adjustments. Where discrepancies arise, we will reconcile and resolve these issues to ensure all encounters are submitted to DOM or its Agent in an accurate, complete, and timely manner. We will also assist DOM in the reconciliation of the Cash

Disbursement Journal to Contractor Paid Amount totals for submitted claims. Our Subcontractors will also be required to balance and reconcile paid claims with processed encounters, enabling us to proactively monitor the Subcontractor's encounter inventory and identify potential issues putting encounter data completeness at risk. Should control totals not match between the paid claims report and encounter files, we will perform root cause analysis with the Subcontractor and implement a solution or corrective action plan, if necessary, before submission to DOM.

Data Completeness Monitoring. Under the oversight of our Chief Financial Officer, our local staff and EBO will administer an encounter data completeness monitoring program to ensure all encounter data standards are met. This program will:

- Demonstrate that all claims and encounters submitted to us will be submitted accurately and timely as encounters to DOM's Agent, and demonstrate that denied encounters are resolved and/or resubmitted;
- Evaluate Provider and Subcontractor compliance with contractual reporting requirements; and
- Demonstrate that we have processes in place to act on the information from the monitoring program and take appropriate action to ensure full compliance with encounter data reporting to DOM.

We will submit, by way of our Compliance Officer, an annual Member Encounter Data Completeness Plan, inclusive of the three elements listed above. Our Compliance officer will be responsible for reporting the results of associated internal completeness audits to DOM on at least an annual basis, or by request. This will include collaborating with our VP of Quality on the Member Encounter Data component of the Quality Management (QM) Program, as well as supporting DOM and/or external review organizations by making available medical records and claims data available, as requested for data validation.

Encounter Timeliness. We will create and submit encounter data files for each claims payable run following DOM's stated submission timeframe schedule. We will monitor and ensure all standards and formats are met as defined by DOM, including those in the DOM Encounter Companion Guide. An important aspect of timeliness is having an appropriate mechanism for ensuring delivery and receipt of encounter submissions. Our transaction manager software will handle our automated, scheduled file exchanges with DOM or its Agent to ensure timely delivery and receipt of encounter submissions. To confirm successful transmission, we will monitor EDI acknowledgments issued by DOM upon each submission for encounter data. We will submit encounter files for paid and denied institutional, professional, and behavioral health claims, as well as corrected encounter files, following DOM's weekly submission schedule. We will submit finalized encounter submission files via secure File Transfer Protocol (SFTP) to DOM or its Agent. These encounter submission controls will allow us to ensure we submit complete and timely Member Encounter Data no later than the 30th calendar day after the date of adjudication and that includes all data as specified in DOM's data provision, submissions, and processing requirements. Our Chief Financial Officer, or an authorized designee, will affix their written certification and signature to any Encounter Data, report, or related information submitted to DOM.

Encounter Data Timeliness

Our encounter submission controls have supported an affiliate health plan in submitting 99.98% of encounters within 30 calendar days.

Encounter Correction and Resubmission

Our EDS will process encounter response files, update the encounter status, and identify encounters for reprocessing for timely error resolution. The system's ability to receive and process encounter response file reports from DOM or its Agent will facilitate encounter reconciliation workflows and prioritization of encounter correction activities. Encounter errors received in the response file, as well as those encounters that failed scrub edits, are sent to the appropriate team (i.e., Claims, Provider Relations, EBO, etc.) for root cause analysis and resolution. If an encounter file with an error needs reprocessing, we will make corrections at the source in our Claims Processing System and resubmit through EDS. If an identified systematic error requires a system configuration change, we will submit a configuration change request to correct program logic issues at the source. Once corrected, we will resubmit encounter batches to DOM or its Agent in the next encounter cycle. These change management best practices will ensure prompt implementation of any new edits or changes DOM intends to implement regarding Member Encounter Data, given the minimum 60 calendar days notification. If DOM rejects a file of encounter claims, we will resubmit the rejected files with all the required data elements in the correct format within 30 calendar days from the date we received the rejected file. If DOM or its Agent

discovers errors or conflicts with a previously adjudicated encounter claim, we will adjust the claim and resubmit the encounter as either a replacement or voided encounter within 30 calendar days of notification by DOM.

Continuous Improvement. Furthermore, we will leverage operational feedback to inform, adjust, and continuously improve each step in the encounter process. Our integrated Reporting and Analytics Platform offers encounters quality and monitoring dashboards which allow us to view the encounter process at the aggregate level, trended over time, to spot performance anomalies for operational improvement. For example, these dashboards will allow us to continually monitor DOM encounter edits and rules (known as "scrubs") that we have configured in EDS and identify trends. We will regularly examine the highest encounter "scrub" reasons as reported in EDS. Wherever possible, we will use that information to move encounter edits that occur frequently on the "back end" (in EDS) – to the "front end" (EDI, Claims Processing System). This will enforce those edits at the point of claim submission and reject or deny inaccurate claims submissions as early as possible. Our goal is to have Providers submit the claim correctly, thereby ensuring timelier Provider payment.

Subcontractor Monitoring

Our validation and oversight processes will ensure quality Subcontractor encounter submissions to reduce errors, improve accuracy, and ensure timeliness. All Subcontractors who receive claim submissions from Providers on behalf of the Coordinated Care Program will be contractually obligated to submit their encounter data to us to be validated against DOM-specific processing rules to determine the overall accuracy and ensure data can be submitted in HIPAA-compliant formats. We will monitor Subcontractor performance metrics, including timely delivery of encounter files, appropriate coding and inclusion of data elements, and adherence to formats set forth by DOM. Along with detailed, biweekly attestation reports from the Subcontractors highlighting encounter submissions from the prior weeks, the EBO will track and load encounter response file summaries into EDS to validate the figures produced by each Subcontractor. If a Subcontractor falls outside monthly performance guidelines, they are subject to liquidated damages and/or a Corrective Action Plan, as appropriate. Our Compliance Department will monitor Subcontractor encounter submissions via quarterly Joint Oversight Committee (JOC) reviews with each Subcontractor. We understand the importance of visibility and ownership of Subcontractor encounter data and its performance, which is why we continue to refine existing logic to enhance EDS capabilities to capture and reconcile all encounter submissions.

Management of Non-submission of Encounter Data

We will encourage Providers to submit claims as soon as possible after dates of service. We will use a four-pronged strategy to monitor accurate, timely, and complete encounter claim submissions from Providers:

1. **Contractual Obligation.** All Provider agreements will include language mandating Providers to submit all encounters accurately, timely, and completely per Mississippi regulations, ensuring Providers submit claims within 180 calendar days from the date of service and resubmit denied claims within 90 calendar days from the date of denial. Further, our contracts will stipulate that we reserve the right to deny payment if Providers fail to submit encounter data following DOM policies and standards outlined in Appendix A, Draft Contract.
2. **Trend Monitoring / Data Analysis.** We will closely monitor our Providers' claims volume and submission trends to establish baselines. We will continuously review these trends to watch for deviations, which could indicate non-submission of required encounter data, prompting outreach and education to Providers.
3. **Attestation.** We will receive attestation from Providers that all encounters were submitted for each reporting period.
4. **Incentives.** Through our value-based purchasing (VBP) programs, we will tie financial incentives to quality measures that require all encounter data to be submitted.

As noted above, Providers will be contractually obligated to submit zero-pay encounters for service delivery to our Members. To address Providers submitting encounters without paid claims, we will monitor and reconcile zero-pay encounter submissions to the capitation payments for each capitated Provider, ensuring appropriate and expected service utilization for the Providers' assigned panel. We will process zero-pay claims the same as any other claim, with systematic key field data validation, edits, and logic that check for the same level of

billing detail to ensure accurate and complete encounters. Once we adjudicate zero-pay claims, we will prepare encounters for DOM in the same manner as encounters produced from any other claim and apply the same compliance and business rule edits. All encounters from capitated Providers will be captured and transmitted to DOM or its Agent following HIPAA requirements.

Proactive Approach for Subcontractor Non-submission. The approach we will take with our Subcontractors will involve early communication of a deficiency related to reporting requirements, performance, or other contract or service issues. We will require monthly and quarterly reports from our Subcontractors demonstrating compliance with required performance metrics. Our pre-delegation and annual re-assessment process for Subcontractors will consistently review and enforce the policies and procedures specific to the delegated activities, including encounter submissions. Our Subcontractor agreements will outline our ability to enforce performance requirements. Per contractual agreements with our Subcontractors, a QI Plan or Corrective Action Plan (CAP) and financial sanctions may be applied if service level agreements related to encounter submissions to us are not met.

Claims Support and Provider Training

Our approach to supporting Providers in claims submission will meet Providers where they are, offering a multitude of options to submit encounter claims data to us, as well as targeted educational opportunities to address non-submission of encounter data. In our experience across affiliate health plans, we receive electronic claims closer to the date of service, and with significantly fewer submission errors, than paper claims. Because of the extra level of automated, front-end edits applied, electronic claims are cleaner submissions validated in near real-time. The ultimate result is more accurate, timely, and complete encounter data. Because of these advantages, we will promote, educate, and support electronic submissions from all Providers. However, we recognize that Providers are at different points along the technological continuum and will also support and accept paper claims submissions from Providers. Our Providers will have many options to submit encounter claims data via whatever avenue that works best for them:

- **Claims Clearinghouses.** We will support HIPAA 837 EDI submission via over 80 clearinghouses.
- **EDI Batch File.** Providers will be able to securely submit HIPAA EDI 837 files through our Provider Portal, which features our online interactive claims file testing and the ability to track submitted claims status.
- **Direct Data Entry (DDE).** We will enable HIPAA-compliant online claim entry on our Provider Portal, with assistance for the Provider for code validation, cross-field logical checks, validation of Member and Provider data, and online help.
- **Multi-Payer Portal.** Providers will also be able to submit claims through the multi-payer portals, allowing them to use a single portal to interact securely with multiple payers for checking Member eligibility, benefits, and claims submission.
- **Paper Claims.** We will receive paper claims on standard CMS-1500 and UB-04 forms. Using Optical Character Recognition (OCR) technology, we will convert paper claims into machine-readable data for subsequent adjudication and payment.

We will also use a coordinated mix of targeted communications, training, and support strategies to help ensure that our Providers file accurate, timely, and complete encounter claim submissions, and understand the importance of key field combinations, population of data fields, and coding consistency. In addition to systematic edits and validation controls, we will offer Providers:

- **Face-to-face and Virtual Training.** Our Provider Network Specialists will deliver group and one-on-one training sessions at Provider sites. We will offer the latter for new Providers joining our network, and upon request from all Providers.
- **Claims 101 Webinars.** We will offer bi-monthly Provider claims training webinars, developed in collaboration by our Provider Relations and Claims teams, based on trends and grievance root cause analyses. While we educate individual Providers at the time of a grievance or appeal, extending this education to all Providers will develop a wide knowledge base and facilitate quality encounter claim data.
- **EDI Service Center.** Available via phone to all submitters, our centralized EDI Solution Center will be available to address any issues or questions EDI claim submitters might have.

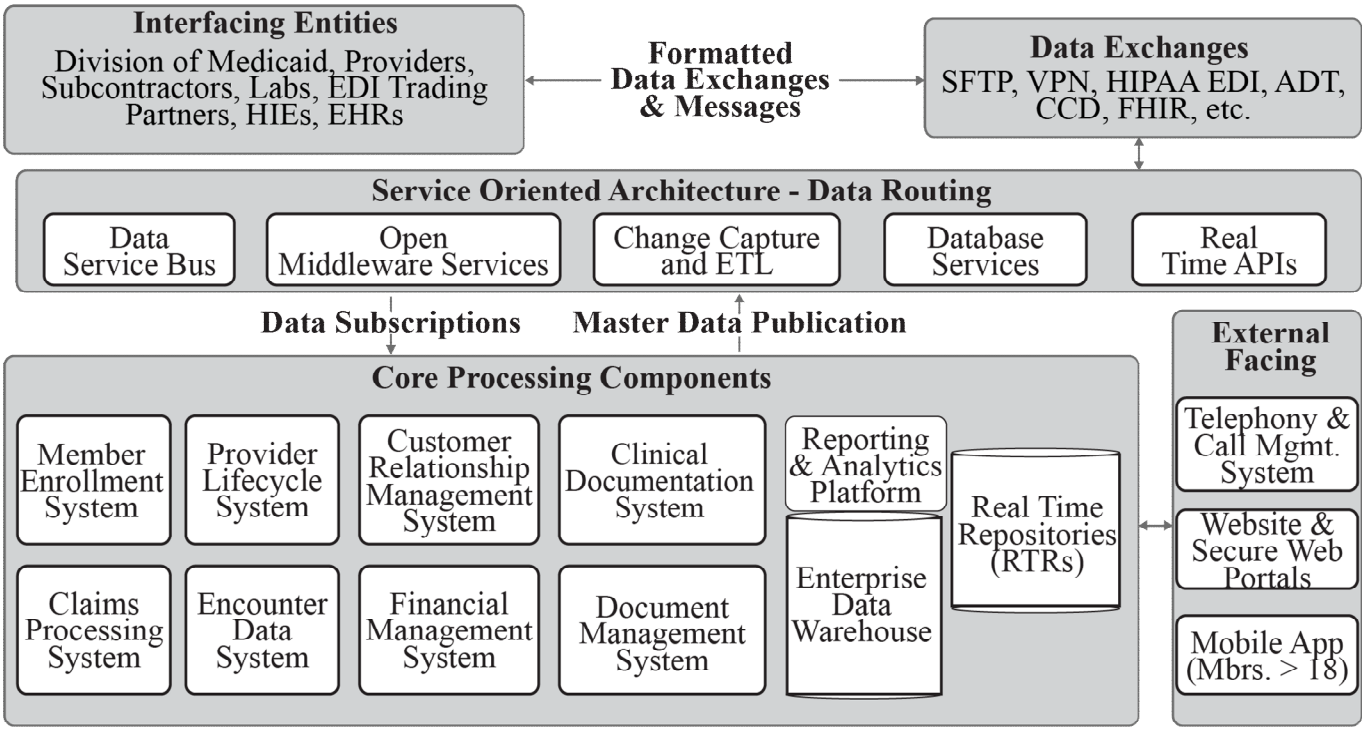
- **Online Assistance.** We will have several resources available on our public website and secure Provider Portal, including information on submitting claims (paper or electronic); billing and payment guides covering coding related to specific specialty services for particular Provider types; and how to enroll in our free EFT service.
- **Provider Claims Scorecard.** The scorecard will put evidence-based, actionable metrics in the hands of our Providers, which they can use to improve their claim and encounter submissions, ultimately leading to higher quality outbound encounter data. The report displays information on a 12-month, rolling basis on claims and encounters submitted, accepted, paid, denied, and rejected, and displays top reject and denial reasons.

2. Health Information System Data
a. Describe the Contractor's approach to maintaining a health information system that collects, analyzes, integrates, validates, and reports data including but not limited to the following areas:
i. Utilization
ii. Claims, Grievances and Appeals
iii. Disenrollment (for other than loss of Medicaid eligibility)
iv. Member Characteristics
v. Provider Characteristics
vi. Care Management Utilization
vii. Clinical Data
viii. Population Health

Comprehensive Health Information System

Our comprehensive Health Information System (HIS), also referred to as our Management Information System (MIS), will collect, analyze, integrate, validate, and report all information and data necessary to seamlessly support all business functions. We will bring both the systems and experience to support DOM, as well as all major operations functions involved in the MSCAN and CHIP programs. Our HIS complies with the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), the 21st Century CURES Act, Section 6504(a) of the Affordable Care Act, and applicable State and Federal laws and regulations. Our HIS design is informed by the Centers for Medicare and Medicaid Services' (CMS) Medicaid Information Technology Architecture (MITA) with integrated components and industry-standard application, data, and communication interfaces, meeting CMS interoperability standards. Please see **Figure 4.2.2.8.B.B** below for a high-level diagram of our HIS structure that will be used to support Mississippi. We have reviewed Appendix A, Draft Contract, and are confident our HIS will meet or exceed all HIS and reporting requirements outlined in Section 16 of Appendix A, Draft Contract.

Figure 4.2.2.8.B.B HIS Diagram



Collecting Data from Multiple Sources and Systems

We will collect data from internal and external sources and systems using industry-standard application, data, and communication interfaces. The Change Data Capture and Real-Time Repository (RTR) capabilities of our HIS integrate and consolidate data we receive. RTRs are high-performance databases designed for conveying updated information to both our internal and external-facing applications. We will use data management best practices and tools such as reference data management and metadata management, which ensure data is represented and stored accurately, completely, and uniquely (e.g., eliminates data discrepancies or duplicates). Our approach to data management and governance will ensure our Mississippi-based staff will have access to timely data that is understandable, clean, consistent, and reliable for reporting purposes.

Data will be loaded in our EDW using standard extract, transform, and load (ETL) processes. Our EDW will systematically receive, integrate, and transmit internal and external administrative and clinical data, including utilization, claims, grievances and appeals, enrollment/disenrollment, Member and Provider characteristics, care management utilization, clinical, and population health data, as well as lab test results and health assessment information. EDW will supply the data needed for our Reporting and Analytics Platform while orchestrating data interfaces among our core applications including our Clinical Documentation System, Customer Relationship Management System (CRM), and our Claims Processing System. Housing all information in the EDW will allow staff to generate standard and ad hoc reports from a single data repository. Examples of data collected in the EDW include the following:

- Claims data from Providers including physical health and BH services and labs will flow to EDW through our premier health plan administrative Claims Processing System after processing and payment.
- Member and Provider Grievances and Appeals will be entered and tracked in the Grievance and Appeal System before being integrated into EDW.
- Member information, such as the eligibility history, enrollment/disenrollment, demographics, contact information, service utilization, Member satisfaction, will be captured in our Member Enrollment System, which serves as the source of truth for all Member data. The system will employ a master data management approach to collecting, matching, quality-assuring, storing, and distributing Member enrollment data we receive from DOM to the EDW and other HIS components needing that information.
- Provider information such as participation status, specialty, and demographics will be maintained in our Provider Lifecycle System, a workflow-enabled, relational repository used for Provider contracting, data management, and engagement. The system will supply this data to EDW and other HIS components such as our Clinical Documentation System to support care planning, CRM to enable call center support for Provider inquiries, and our online Provider Directory for needed updates typically within minutes thanks to our RTR architecture. This system will also support Provider data exchanges with DOM and its Credentialing Verification Organization (CVO) for Provider credentialing and recredentialing purposes.
- Care and utilization management information, such as the Health Risk Screening, Comprehensive Health Assessment, Member care plans, clinical guidelines, referrals, authorizations, and social determinants of health (SDOH) will be maintained in our Clinical Documentation System.
- Financial information to support quality and VBP programs will be maintained in our Financial Management System, which records and reports all financial administrative data.
- Clinical information, such as Admission, Discharge, and Transfer (ADT) transactions for real-time notification of inpatient admissions, as well as all required information specific to the Medicaid beneficiary outlined in Section 16.5.1 of Appendix A, Draft Contract such as diagnoses, immunizations, allergies, plan of care data, etc., will be housed in our Clinical Documentation System and distributed to the EDW and other HIS components needing that information such as our externally-facing secure Member and Provider Portals.
- Population health information, such as immunization registries and health disparity data including by race/ethnicity will be captured from Member and public data sources and pulled into our EDW for data analysis and predictive modeling in our Reporting and Analytics Platform.

Clinical Data and Interoperability Gateway. To deliver information closer to the point of care, Providers, hospitals, Health Information Exchanges (HIEs), and even DOM will be able to interface with our Clinical Data

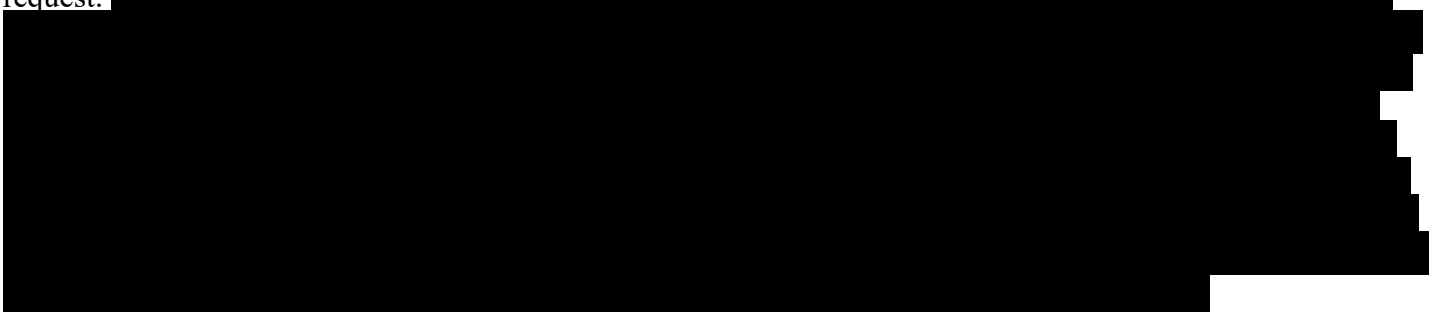
and Interoperability Gateway for HHS Office of National Coordinator (ONC) standards-based data interchanges, including Health Level Seven (HL7) Fast Health Care Interoperability Resources (FHIR), Admission, Discharge, and Transfer (ADT) data, Continuity of Care Document (CCD)/Consolidated-Clinical Document (C-CDA) exchange, and other standardized health information transactions.

An Integrated Reporting and Analytics Platform

Management teams and staff who will be located in Mississippi will have access to our large-scale reporting, analytics, and data warehousing platform. This Reporting and Analytics Platform will provide resources and capabilities for standard and ad hoc reporting, data visualization, and online Key Performance Indicator (KPI) dashboards. We will utilize this information to support the key aspects of our administrative and compliance operations, Provider analytics, population health management, and to help guide our approach to continuous quality improvement. All data stored in our Reporting and Analytics platform will be updated frequently (in many cases in near real-time), enabling the best possible reporting accuracy. The integration of our EDW within our HIS means that our reports will be based on the most accurate, complete, and timeliest transactional data available for high-speed reporting across a broad expanse of data. Our systems are capable of reporting multiple data sets (i.e., clinical, care management plans, SDOH, encounters) to DOM in both structured and unstructured formats. The platform can generate recurring and ad hoc reporting and dashboards needed to support our operations. Our EDW is Open Database Connectivity (ODBC) compliant, allowing our Data Analysts to produce ad hoc reports that DOM may request. This platform also includes a suite of predictive modeling solutions incorporating evidence-based, proprietary care gap/health risk identification applications that will identify and report significant health risks at the population, Member, and Provider levels.

Making Data Available

We will send collected data and records in formats adhering to standards required by the State and Federal government to DOM, CMS, the Mississippi Insurance Department, and any other oversight agency of DOM upon request. Our adherence to interoperability standards will allow us to send data in formats including HL7 FHIR, Application Programming Interfaces (APIs), and United States Core Data for Interoperability (USCDI) regularly, and we will work with the Systems Work Group to define a mutual statement of work and schedule to implement software and hardware solutions required for the successfully delivery of all available data. We will also integrate with any future DOM Government-to-Constituent CIAM with Federation initiatives. Our data records (including those related to clinical, encounter, and care management) will be housed in our enterprise datacenters as an integrated part of our HIS, allowing for rapid data access for data and records retrieval upon request.



Systematic Data Validation

Within our EDW, we will perform many validation processes to ensure the completeness and timeliness of data. If errors occur during these validation processes, alerts will be sent to our EDW support teams who immediately triage the data issues for prompt resolution. For example, our EDW performs quality checks horizontally, vertically, referentially, and temporally (trending) to ensure data quality. Additionally, our data quality controls include multiple levels of accountability, from data lineage tracking to active data cataloging, helping to ensure that valid, reliable, and accurate data are obtained. Our EDW will provide the master cross reference of our data names and formats, systematically map each data element name, and contextual use information with equivalent metadata, for each production application. Through the EDW's centralized repository of code lists, we will enforce all industry-standard code sets and formats, including HIPAA-mandated sets. For data formats not governed by industry standards, we will enforce formats used in the system of record of that data element.

[END OF RESPONSE]

4.2.2.9 PROGRAM INTEGRITY

4.2.2.9.A. Fraud, Waste, and Abuse

1. Describe the Fraud, Waste, and Abuse program that the Offeror will implement, including:

We are committed to the integrity of DOM's Coordinated Care Program. Our Fraud, Waste, and Abuse (FWA) program will support DOM's goals of clarity, oversight, and public transparency of CCO performance. We will comply with all Federal and State requirements as well as all written direction by the Office of Program Integrity regarding FWA investigations, overpayments, and any other program integrity related activities and reporting. We will routinely engage with the CMS Office of Inspector General (OIG) and actively participate in national task forces on federally funded health care FWA control. Our philosophy is that all staff, Providers, Subcontractors, and Members have the responsibility for program integrity, including the identification and reporting of potential FWA. Our Special Investigations Unit (SIU) will maintain an FWA Hotline and the number will be published in the Member Handbook, Provider Manual, Newsletters, and on our public website. We will investigate all referrals and keep the information confidential. Our FWA approach includes effective internal and external controls to safeguard Medicaid funds against unnecessary or inappropriate use of services and payments.

$16.7 Million Net Savings

In a similar market, from January through October 2021, our prepay code edits, payment and clinical policies, and post payment recovery programs resulted in over $16.7 million in net savings.

Compliance Program

To prevent FWA, we will implement and maintain a Compliance Program, as described in 42 CFR. 438.608 and DOM's policies and procedures, that includes, at a minimum all elements cited in Section 10.1.1 of Appendix A, Draft Contract. Our Compliance Program will include policies, procedures, and standards of conduct for staff, Board members, Providers, and Subcontractors to ensure compliance with all applicable Federal and State requirements. Key contributors to the implementation of our Compliance Plan include:

- Mississippi-based **Compliance Officer** who will lead the Compliance Committee
- **Compliance Committee** that will meet quarterly and consist of members of our Executive Team and report directly to the Board of Directors
- **FWA Work Group** who will meet monthly and consist of Mississippi-based staff from Compliance, Quality, Network, and Population Health and report to the Compliance Committee
- **SIU** will consist of a local Investigator, Compliance, Operations, Finance, Population Health, and Quality staff, as well as additional centralized investigators, and provide training, investigative support, and clinical review support

Staff Training

Central to our Compliance Plan is a comprehensive FWA training program for employees at all levels of our organization. FWA training is required for all employees within 30 days of hire for new employees, annually for all staff, and on an ad hoc basis when circumstances warrant. The Employee Handbook, provided to every employee, serves as a resource and a tool to reinforce FWA training material. Our FWA training program will include modules on:

- Code of Conduct
- HIPAA Privacy and Security
- FWA Identification and Reporting
- False Claims Act and Employee Whistleblower Protections
- Provisions of 42 CFR 438.610 Regarding Prohibited Affiliations

Providers and Subcontractors

Providers are our partners in proactive FWA detection and prevention. We will include information about FWA in the Provider Manual, Provider Newsletters, and on our public website. We will offer FWA training during New Provider Orientation sessions, as well as supplemental on-site or web-based training regarding claims submission and FWA as needed. We will educate Subcontractors during their initial orientation and mandatory annual trainings. Our Subcontractor agreements will require Subcontractors to comply with State mandates,

policies, and all relevant laws and regulations. We will contractually obligate Subcontractors to report concerns about FWA and remind them of this obligation in every quarterly Joint Operating Committee meeting.

a. Proactive and reactive fraud, waste and abuse detection methods that will be used, including dollar amount thresholds used for initiating a review, if applicable;

As described below, we will use proactive/prospective (prepayment) and reactive/retrospective (post-payment) controls to monitor and detect potential FWA. We do not set dollar thresholds for initiating reviews.

Proactive/Prospective FWA Detection

Edit	Description
Primary Claim Editing Software	Following claim adjudication, we will use claim editing software integrated with our Claims Processing System to analyze all claims in real-time to determine clinical coding appropriateness and fraudulent billing practices. The software reviews claims against common coding standards established by the American Medical Association (AMA), CMS, and medical specialty societies, and identifies potential FWA triggers such as unbundling, mutually exclusive codes, procedure frequency-by-day, and age/gender discrepancies.
Secondary Claim Editing Software	We will use secondary claim code editing software to further compare submitted claims to correct coding rules / guidelines. The software compares services to the Member's history to determine if the service is medically likely. Edits are based on CMS, AMA/Current Procedural Terminology, and Specialty Societies.
Third Party Liability (TPL) / Cost Avoidance	We will update the Member "other insurance" fields in our Claims Processing System, allowing us to apply appropriate rules during adjudication for TPL cost avoidance to prevent waste. If our system pends or denies the claim based on information within the Member's TPL record, we will notify the Provider of the reason for denial, along with the primary carrier's name and Member eligibility dates.
Duplicate Claims Edits	Through machine learning models, we will prevent waste by scanning for potential duplicate claim submissions ("double bills") by identifying claims with the same information, which include service dates, procedure codes, modifiers, diagnosis codes, Provider identification numbers (such as NPI and Tax ID), charged amounts, Member information, and potential bundling/unbundling of services.
Clinical Reviews	We will review policies for clinical appropriateness, publish them, and follow these policies during the claims payment process. Clinical review will provide an additional screening of clinical billing discrepancies on a prepayment basis.
Utilization Monitoring	Utilization Management activities to prevent FWA include: • Verifying Member eligibility • Reviewing medical necessity of the service • Determining appropriateness of the service being authorized • Verifying that the service is covered • Referring Members to appropriate Providers We will monitor metrics such as hospital admissions for ambulatory sensitive conditions that result in unnecessary costs to Medicaid. We will monitor and analyze data at the aggregate and detail levels by Member, individual Provider, Provider specialty, type of service, diagnosis, place of service, and region, and compare the authorized services to the services that have been delivered.
High-Dollar Inpatient Reviews	We will conduct prepayment reviews of inpatient itemized bills for unbundled charges, billing errors, non-covered medications, etc. to make sure we are paying only for appropriate charges.

Reactive/Retrospective FWA Detection

Tool	Description
Retrospective FWA Software Suite	We will utilize a suite of industry-leading retrospective fraud detection tools to help detect FWA, electronically house SIU investigative files and documentation, and link SIU cases to internal and external reference sources (including medical records). The suite's case and financial tracking and reporting capabilities align with National Health Care Anti-Fraud Association financial reporting standards, and State and Federal reporting requirements. The suite includes the following: • A tool that contains powerful fraud rules and algorithms developed by industry experts who understand the essentials of fraud detection and prevention. These post-payment algorithms will produce smarter results and fewer false positives with unique external data sources incorporated into its analytics. Our SIU investigators and analysts will use this tool to perform proactive data mining for potential leads, and vet and investigate whether there is a high confidence level that fraud exists. • An ad-hoc querying tool enables users to run real-time queries and complex pattern reports from data loaded into the software suite. The tool completes template reports (that may be reused and accessed by users), aggregated summary reports, trending analysis reports, cross-claim querying capability, fraud alert impact analysis, and customized reports to meet the specific State, Federal, and DOM reporting needs. • A tool to empower users with functionalities to monitor pharmacy expenditures. By conducting cross-claim analysis between pharmacy and medical claims, the tool will identify prescription drugs improperly billed, detect prescribers providing medications inappropriate for diagnoses or outside the standard of care, and demonstrate abusive Member patterns of prescription use.
Data Mining	After payments have been processed, we will identify any overpayments made by using data mining processes. We will use in-house solutions as well as multiple vendors to review paid claims data to ensure proper payments were made.
AI Models	We will utilize Artificial Intelligence (AI)-powered data models which employ neural network learning to identify procedures that appear inconsistent with a Member's demographics, reason for visiting the Provider, or final diagnosis received. These models will assist in identifying Providers who are billing codes more often than expected compared to

	peers of the same specialty. The models will be trained specifically on cases that have been successful in the past with analytically derived prioritization algorithms that select the FWA leads most likely to succeed for prepayment and retrospective review. These machine-learning algorithms look for unusual and potentially suspicious behavior on the part of Providers. Our Data Governance policies and procedures require a rigorous and ongoing review process to ensure the AI model results are useful, accurate, fair, and avoid reproducing disparities and biases. Within the SIU, investigators and analysts will evaluate cases where the lead is determined to represent potential fraud.
Rule-Based Scenarios	Our SIU will also utilize analytic tools that use rule-based scenarios to identify Providers whose billing violates clinical policy, such as those around pediatric overutilization, home health, allergy testing and therapy, etc.
Medical Record Audits	We will conduct medical record audits on targeted inpatient paid claims to ensure the Diagnosis Related Group (DRG) and level of care coding on the claim billed can be supported by the records.
FWA Referrals	We will encourage Providers, Members, and employees to report any potential FWA cases. We will prominently post our toll-free FWA hotline number that will be operated by an independent third party in a stand-alone frame on the front page of our website, along with links to the Office of the Inspector General – Health and Human Services (HHS) and our Fraud Reporting Form and web page. In addition, we anticipate receiving notifications of potential FWA during CCO State meetings.
FWA Activity Website	We have access to an information-sharing website that includes regular postings of information about potential Provider FWA activities by more than 100 insurance companies nationwide. Our SIU investigators will use this as part of the due diligence they perform in their investigations.
Online Investigation Directory	Our SIU investigators will use powerful online investigation software throughout different phases of an investigation. The software is powered by thousands of data sets and leverages cutting-edge public records technology to bring key public and proprietary records together in a customizable dashboard and enable SIU investigators to uncover hard-to-find data. The software may be used to quickly analyze a large quantity of consistently updated records from diverse sources.
EOB Reviews	Using a statistical software package from the CMS OIG, we will send EOB mailings to Members to verify services. Our team will ask Members who receive an EOB, but have not received the service, to contact us to report the discrepancy.

b. Process for acting upon suspected cases of fraud, waste and abuse;

Following notification of a potential case, we will conduct a risk assessment to determine whether further investigation is warranted, then our SIU will perform the preliminary investigation. In the preliminary investigation, we will assess risk based on the Provider's financial exposure, Member vulnerability, risk of reoccurrence, and possible regulatory violations. This approach will help determine whether a full investigation is warranted, if Provider education is required, or if closure of the case is recommended. At this stage, the SIU may request medical records from the Provider to determine if potential FWA extends beyond what was initially identified by the referral or prepayment software. At the conclusion of the initial review, the SIU staff will prepare a preliminary report which may include a recommendation to review additional medical records, conduct an onsite investigation, interview Members or Providers, educate and/or recover identified overpayments. If no irregularity is detected, the case would be closed and documented.

If the SIU identifies a situation with credible FWA, our Compliance Officer will be notified immediately, and the SIU will initiate the process described in **Table 4.2.2.9.A.1.b** below. If the initial evidence suggests a billing irregularity, the Manager of Compliance will report the case to DOM. Once we have received Division approval to proceed, the SIU will select a sample of claims for medical record review. Upon approval, the SIU will send a certified letter or electronic correspondence with read-receipt confirmation to the Provider requesting the medical records. Our team will also conduct onsite FWA audits of some Providers, and DOM will be invited to participate in these reviews. Once the investigation is complete, the SIU will review the findings and discuss the results with the Chief Medical Director, Compliance Officer, and the FWA Work Group. Our Compliance Officer will ensure that DOM receives all relevant evidence in a timely manner. If it is determined that there is a billing error rather than fraud, the SIU will prepare and send an education letter to the Provider and a Provider Network Specialist will reach out to offer technical assistance. Upon request, we will coordinate a meeting with the Provider to review the results of the investigation, facilitate education/training of staff on correct billing guidelines, and work out the details for repayment of any funds owed. After these activities have occurred, we will conduct a review to ensure that the Provider has self-corrected and/or determine if additional follow up is needed.

Table 4.2.2.9.A.1.b SIU Process

Role	Description
Intake and Triage Analysts	The SIU Intake and Triage Analyst will enter tips into the case tracking system and complete a cursory review of the allegation to determine if there is a misunderstanding or a potential of FWA. If it is a misunderstanding, they will resolve the issue, but if there is a potential for FWA, the analyst will forward the information to an investigator.

Proactive and Prepay Analysts	The Proactive and Prepay Analysts will review claims data to identify aberrant billing practices proactively. They will make a recommendation as to whether the Provider or scheme should be pursued via prepay or retrospective review. If the case moves to prepay, these analysts will monitor and track the prepay review findings.
Investigator	The Investigator will pursue reactive and proactive investigations to either corroborate the allegations or determine them to be unfounded. The Investigator will review the documentation provided by the SIU Analyst and request clinical records. They will also perform additional data analysis on Provider billing codes and payment records; conduct a search on the FWA Activity Website; review any disciplinary actions; and review Provider and vendor contracts. Based upon the findings in the investigation, the Investigator may also conduct an on-site audit.
Clinical Investigator Medical Records Review	The SIU will include a Clinical Review team comprised of coding auditors, registered nurses, behavioral health professionals, and licensed therapists. The Clinical Investigator will conduct a detailed review of the clinical records and compare them with policies, regulations, and industry guidelines to identify aberrant billing practices and make sure Members are receiving the services for which the Provider billed.

c. Process for complying with federal regulations related to disclosures and exclusion of debarred or suspended Providers;

We are not owned by, nor will we knowingly 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 our contractual obligation with DOM, in accordance with 42 CFR 438.610.

Our organization has established internal controls and written policies and procedures that articulate our commitment to comply with all state and federal requirements related to disclosures and exclusion of debarred or suspended Providers. Our Credentialing Team will query the US Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities Database, DOM's Excluded Provider Listings, and other local or national resources upon receiving a Provider's application, and monthly thereafter. If applicants are found to be debarred or suspended, they would be denied network participation. If an existing contracted Provider is found, the Credentialing Team will notify Compliance, UM, and Claims. The Compliance Officer will notify DOM, and the Provider would be immediately suspended from the network. We would then recoup any claims paid to the Provider during the exclusion period and re-direct any open authorizations in coordination with the Member and Provider.

d. Process for interacting with the Division, including the Office of Program Integrity; and

We will use the most current version of the Program Integrity Fraud and Abuse Standard Operating Procedure for referrals and reporting to the Office of Program Integrity. Timely communication with DOM is vital to our FWA prevention and response activities. We will expedite referrals to DOM if a delay in reporting could result in harm to a Member; the loss, destruction, or alteration of evidence; an unrecoverable monetary loss; and/or hindrance of an investigation or criminal prosecution of the alleged offense. Our plan and our Subcontractors will cooperate fully with State and Federal agencies in any investigations and subsequent legal actions. Once we report a case of suspected FWA to the State, we will suspend all efforts to take further action pending approval from DOM to ensure that we do not interfere with any ongoing State investigation or enforcement. We will not disclose the existence of any investigation conducted by State or Federal law enforcement officials. If the State gives us approval to complete our own investigation, our Manager of Compliance will immediately notify the SIU to proceed with the investigation. On an ongoing basis, we will report Providers to DOM if we suspect they are submitting claims that are wrongly coded or not supported by documentation, we receive a credible report of FWA, or we have requested recoupment that is not received. In these cases, our Manager of Compliance, or designee, will forward all relevant information to DOM and appropriate State agencies. In addition, we will send to DOM weekly FWA Case Reports and quarterly FWA Status Reports, including a list of recoupments from Providers. We propose to meet with DOM staff on a quarterly basis to discuss these reports and identified issues of FWA.

e. Other components of the Offeror's fraud, waste, and abuse program.

Preventing Prescription Drug FWA

Our SIU will monitor potential FWA tied to prescribing patterns using utilization data from the Pharmacy Benefit Administrator (PBA), the Pharmacy drug database, and other sources of pharmacy claims data. The SIU will monitor appropriate prescribing practices and Providers operating outside peer norms through interface with the PBA. We will also aim to reduce potential FWA related to specific types of prescription drugs, such as

opioid-related drugs, benzodiazepines, and high-cost human growth hormones. This program will provide our team with a limited point-of-care analysis of two years of our claims data using, supported by substance use disorder subject matter experts to identify potential diversion or FWA. The analysis can identify prescribers, patients, dispensers, and medications associated with suspected diversion and possibly collusive relationships. This data and analysis will assist our team in determining whether this sample warrants an expanded and longer-term engagement.

4.2.2.9.B Claims Denials

1. Describe the Offeror's proposed Denials Review and Reporting program, including:

Efficient Claims Denial Review and Reporting

Our Denial Review and Reporting program will not only pay claims timely and accurately but also focus on denial reduction by finding areas of opportunity for Provider education, staff education, policy changes, and system enhancements to facilitate faster payment through efficient and accurate claims auto adjudication for MSCAN and CHIP. We will maintain written policies and procedures, approved by the DOM, providing mechanisms for Providers to appeal the denial of claims. To improve the Provider experience and reduce administrative burden, we have an online reconsiderations process for claims payment denials, which improves functionality and decreases manual processing. We will provide support for denied claims to ensure all rules and timelines are followed, including reviewing denied claims weekly to evaluate possible outliers or trends. We will review claims reports for the overall volume of claims compared to claims paid, top denial reasons, and review highest denial volumes by servicing Provider. When an outlier is discovered, claims are analyzed further for any possible system concerns or Provider billing issues. If a system issue is found, a configuration change request will be submitted to correct the system and the issue will be flagged for review during the next 4 to 24 check runs depending on the configuration change. If a billing issue is identified, the Provider Relations team will be notified to reach out to the Provider.

a. A description of the Offeror's Denials Management program;

Denial Management Program. Our Denials Management program will include criteria and protocol for denial; the process for identifying claims and/or claims lines for denial; online capabilities for claims payment reconsiderations; opportunities to notify and educate Providers on how to lessen claim denials; and denial reports to DOM. Our Denials Management program will be based on all DOM requirements related to claims processing and will be informed by our experience across affiliate health plans. We have experience in affiliate health plans responding to Provider inquiries in a timely fashion, and resolving all Provider incorrectly paid or denied claims within 30 calendar days. The program will consist of extensive initial and ongoing Provider education and training regarding procedures and supporting tools; identification of denial issues and implementation of needed adjustments; and prospective, concurrent, and retrospective claims reviews to ensure accuracy. Our denials will follow DOM-approved written policies and procedures including criteria for authorization or denial of payment for services rendered by in-network and out-of-network Providers. We will utilize dashboard reporting to track and monitor all paid and denied claims daily, providing ongoing oversight to support the accuracy of the claims process. Our reporting capabilities, discussed further below, will enable us to submit to DOM a list of denials processed and meet all Claims Denial Report requirements in Section 16.2.4 of Appendix A, Draft Contract.

b. A summary/listing of the Offeror's denials criteria/protocol;

We will require all claim submissions, whether in electronic or paper format, to pass system and plan-specific edits prior to acceptance, for example, each claim must be readable and include all required data elements. Claims that do not pass these initial edits will be rejected and or denied and must be corrected and resubmitted. Claims containing all minimum edits will be accepted into our system for processing. During the adjudication process, claims will be reviewed and denied based on criteria in the following categories in **Table 4.2.2.9.B.1.b** but are not limited to these categories.

Table 4.2.2.8.B.1.b Denial Categories

Prior Authorization	Claim submitted is for a covered service that requires, but did not obtain, authorization prior to providing the service.
Claims Completion Errors	Claim submitted includes errors, such as incorrect claim form, invalid or missing diagnosis code(s), missing explanation of benefits, or invalid/non-matching Member or Provider information.
Duplicate Claims	Claims for the same service is duplicated for the same Member from the same Provider.
Services Not Covered	Services are not covered for that Member as denoted per fee schedules.

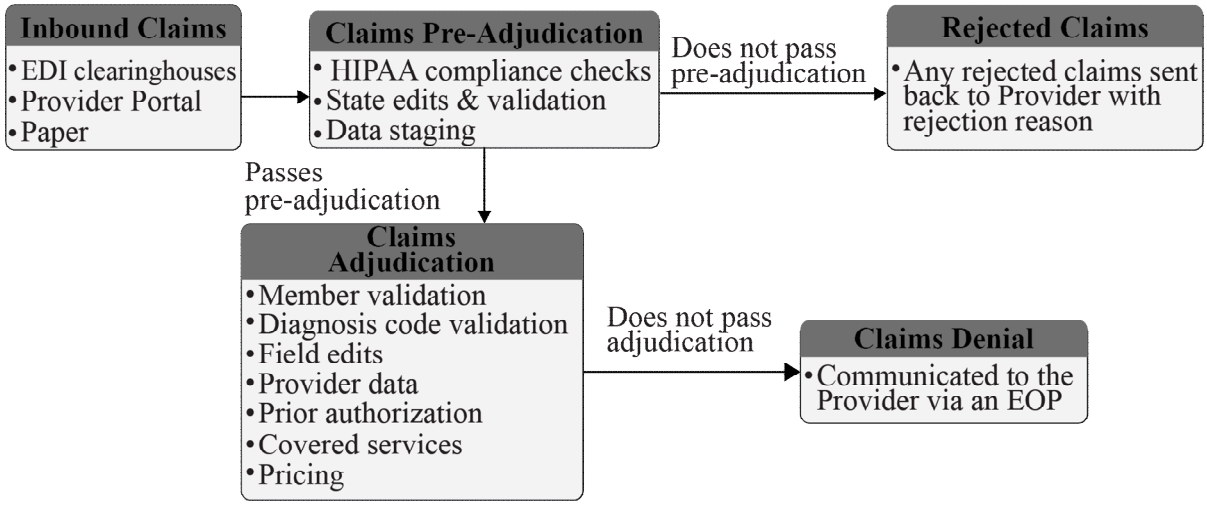
Member Not Eligible	Services not covered due to the Member not being eligible on date of service.
Timely Filing	In accordance with Section 16.7.2 of Appendix A, Draft Contract, we will encourage Providers to submit claims as soon as possible after the date of service but no more than 180 calendar days following the date of service.
Coordination of Benefits	When a Member is covered by more than one insurance carrier, it must be determined which carrier is responsible for payment.
Other	Claim submitted by a Provider who has been sanctioned by the DOM or CMS, or is actively under payment integrity review, or claim submitted exceeds allowable units per day.

We will have criteria for authorization or denial of payment to out-of-network Providers approved by DOM within 60 calendar days prior to use. Denials in our Claims Denial Report will be listed by category and include at a minimum the denial categories listed above. We will include in the report a detailed explanation for any percentage of denial in excess of 2% by individual denial category. We will also provide a detailed explanation if the monthly aggregate denial rate exceeds 6%.

c. The Offeror's process for identifying claims and/or claims lines that meet the Offeror's denial criteria;

We will receive claims via Electronic Data Interchange (EDI), paper submissions, and our Provider Portal. We will have support tools in place at every avenue to ensure Providers submit all required documentation to keep denials to a minimum and ensure timely and accurate processing through our integrated systems. The data architecture and integration of our core systems including our Reporting and Analytics Platform, Claims Processing System, and Enterprise Data Warehouse will enable us to meet all claims reporting requirements. We will track error rates in claims and encounter data received from Providers on the front end of claim processing, as well as prior to submission to DOM as processed encounter data. Our claims process and payment system will be configured to meet eligible benefits criteria contained in our contract to serve MSCAN and CHIP for both in-network and out-of-network Providers. Our Claims Denial Process is outlined in **Figure 4.2.2.9.B.1.c**.

Figure 4.2.2.9.B.1.c Claims Denial Process



If a claim fails pre-adjudication edits and compliance checks, we will reject the claim and notify the Provider with the rejected reason and additional information needed to adjudicate the claim. Once a claim passes pre-adjudication edits, it will be loaded into our Claims Processing System, which will assign each claim a unique control number as part of our ongoing tracking of processing timeliness and retain an audit trail of historic activity. From there, the claim will move to adjudication, which each claim must pass to reach a paid, denied, or pended status. If a claim does not pass claims adjudication edits, we will deny the claim and notify the Provider with an Explanation of Payment (EOP). Our claims team will review the edits to determine if a Provider is consistently billing with unbundled, incidental, or retired codes. If identified, we will contact and educate the Provider's staff. We perform this same process as part of our Fraud, Waste, and Abuse (FWA) program. If, upon successful completion of the adjudication process, a claim is denied, the Provider receives notification of the reason(s) for the denial included in the weekly EOP, along with instructions for correction and resubmission if applicable, as well as the process for an appeal. For denied appeals, we notify the Provider. We include a statement that the Provider may appeal the determination to DOM with the procedure and forms required to

make the appeal. If a claim pends in our Claims Processing System, an electronic work item will be immediately routed to staff with the expertise, such as a licensed clinician, for medical review to address the pend issue for resolution and re-adjudication. Post-adjudication claims will be analyzed to determine clinical claim coding appropriateness using nationally recognized coding guidelines to address inaccuracies through our code editing software.

d. The Offeror's reconsideration process as it relates to claims denials; and

To reduce Provider administrative burden, when a Provider disagrees with a claim payment decision, we will offer Providers the option to submit reconsiderations online through our secure Provider Portal. Using the Provider Portal, we will give Providers the ability to submit and track reconsiderations online. When we receive a reconsideration request, Providers will receive electronic acknowledgement. When necessary, more information may be requested from the Provider. Through our Portal, Providers can attach supporting documentation and track reconsideration status. We will also provide email notifications of a reconsideration's status whether paid, pending, denied, or still being processed. Providers can also view and download acknowledgement letters and other supporting documentation, decreasing manual processing and improving the Provider experience.

e. The Offeror's process for notifying and educating Providers of claims denials.

Providers will be notified in writing for each denied claim on an EOP, explicitly detailing every reason that the claim is or may be denied so Providers may address all issues at one time, as well as the process for an appeal. If a denial is issued due to missing required information or documentation, this notification will specifically identify the missing information. For denied appeals, we will notify the Provider, including a statement that the Provider may appeal the determination to DOM, include information on the appeal process and any forms required. Our Provider education will include written guidelines for the claim submission process and subsequent claims denial criteria in our Provider Manual, available in print and on our health plan website. We will also distribute approval and denial criteria to all out-of-network Providers to whom Members are referred. We are committed to working with Providers to ensure they understand where they can obtain information, and our Provider Relations staff will provide ongoing support. We will notify and educate our Providers of the denial process through multiple outlets such as:

- Face-to-face training through the initial Provider orientation and ongoing training workshops, including monthly meetings with our top 10 Provider groups
- DOM workshops with in-person Provider Relations staff and/or Claims Liaisons to assist with specific Provider issues
- Print and web-based communications including our Provider Manual and quarterly Provider Newsletters
- Telephonic and e-mail support, such as through our EDI Help Desk
- Prior authorization detail on our public website
- Online, secure Provider Portal support including medical necessity information; Prior Authorization submission tool; claims adjudication logic; and EDI testing and certification

We will conduct outreach related to upcoming billing or coverage changes so that these can be taken into consideration as quickly and seamlessly as possible, and work with Providers to ensure coverage for our Members.

4.2.2.9.C National Correct Coding Initiative

1. Describe the Offeror's process to comply with Medicaid National Correct Coding Initiative (NCCI) for MississippiCAN, to include Offeror's timeline for pulling Medicaid NCCI files, testing, and implementation.

National Correct Coding Initiative Readiness and Compliance

We will comply with all Medicaid National Correct Coding Initiative (NCCI) policies and edits as defined in the most recent Medicaid NCCI Policy Manual, as well as other nationally recognized standards (NCQA, American Medical Association (AMA) Coding, UB-04 editor), and testing and implementation requirements. NCCI edits prevent improper payments if incorrect code combinations are used and define the maximum units of service for HCPCS/CPT codes billed for the same Member on the same date of service, therefore improving claims processing accuracy and timeliness, which results in providing better service to our Members and Providers. We will collaborate with DOM to ensure our policies are approved by the DOM and address

manually priced claims, items, and services. From Provider claim submission to adjudication, to the resulting encounter data submission to the DOM, we will leverage operational feedback to monitor, adjust, and continuously improve each step in the data production and reporting process. We will employ technical and administrative controls throughout the claims submission to encounter preparation process to ensure submitted encounters are accurate based on NCCI edits and national and state-specific requirements. We will ensure all submitted claims follow the DOM requirements through a series of Electronic Data Interchange (EDI) and adjudication edits within our Claims Processing System, as well as detailed claims data monitoring via reporting dashboards to assess every step in the claim to encounter process.

Code Editing

Our Management Information System (MIS) is securely integrated with our Claims Processing System claim editing software to provide additional claim edit processing and to detect clinical coding errors, inaccuracies, and potentially fraudulent billing practices without disrupting turnaround time. We will use claim editing software to apply clinical edits and fraud, waste, and abuse detection, informed by the software's nationwide database of Provider billing practices and patterns. Our automated Claims Processing System will review claims pre-payment using code-editing software to ensure alignment with NCCI edits from CMS. We will configure custom NCCI edits needed to comply with DOM payment rules that differ from national edits. These tools will review all claims in real-time against coding standards set by the DOM, NCCI, AMA, and medical specialty organizations. Our code editing software has thousands of edits to assess claims coding accuracy. As part of our pre-payment claims process, the software will detect and document coding efforts on claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes against rules established by the NCCI. Claims billed that do not adhere to NCCI standard coding will be denied. Our code editing software contains a comprehensive set of rules addressing NCCI procedure-to-procedure edits, medically unlikely edits, and coding inaccuracies such as unbundling, fragmentation, up coding, duplication, invalid codes, and mutually exclusive procedures. The software flexibility allows us to accommodate state-specific edits.

Testing and Implementation

Our claim editing software vendors will test and configure NCCI updates in their system and apply correct coding guidelines and NCCI editing. After CMS posts complete updated NCCI edit files quarterly, vendors are contractually obligated to update their software by the 60th day after the file release date. After the files are released, vendors will test and configure the NCCI updates in their system. After testing and configuration are complete, our claim editing software vendor will notify us via email and deliver the updates via a secure portal where we will oversee the installation of the updated file. Our claim editing software vendor will host the software externally, and we will hold them responsible for incorporating, testing, and putting NCCI edits and changes into production. Once edits are in production, our claim editing software vendor will notify us that the updates have been deployed. Vendors will continuously monitor updates after implementation and provide us with weekly or monthly status reports.

[END OF RESPONSE]

4.2.2.10 SUBROGATION AND THIRD-PARTY LIABILITY

4.2.2.10.A Approach

1. Describe the Offeror's proposed approach to conducting subrogation and Third-Party Liability activities, including:

We are committed to partnering with the Division of Medicaid (DOM) to ensure the Mississippi Division of Medicaid Coordinated Care Organization Program pays Providers according to the payer priority rules in both federal and state law and regulations, including the Social Security Act, 42 C.F.R. § 433 Subpart D, the State Plan, CHIP State Health Plan, and applicable Federal and State laws. Under the oversight of our Chief Operating Officer (COO), our Third-Party Liability (TPL) and subrogation program will contain health care costs while ensuring Member care is not interrupted during coordination of benefit (COB) activities. Our TPL program will adhere to DOM's standards and is based on Medicaid as a payer of last resort principle using a combination of technology, policies, and engagement with stakeholders. Our TPL program is supported through claims automation, edit controls in internal systems, Provider education, and activities conducted by leading TPL vendors and our internal Health Savings Unit (HSU) who specialize in Third-Party Resource (TPR) identification, COB, post-payment recovery, and subrogation in the public sector. Through our innovative ***COB Center of Excellence***, we continually improve our TPL program's effectiveness through collaborative and innovative approaches. We will make every reasonable effort to determine the liability of third parties to pay for services provided to Members, including identification of other payers such as health insurers, Medicare, liability insurance, and workers' compensation insurance. Through our Compliance Management System, we will maintain comprehensive policies and procedures for identifying existing TPL resources, undertaking cost avoidance, and recovering liability from the third party.

a. Process for capturing Third Party Resource and payment information from the Offeror's claims system for use in reporting cost-avoided dollars and Provider-reported savings to the Division;

We will take a proactive, comprehensive approach to identifying and capturing TPR for reporting cost-avoided dollars and Provider-reported savings to DOM. Our Medicaid affiliate experience has shown that the best approach to TPL/TPR is to minimize the need to recover costs in the first place through cost avoidance. We will employ several methods to support our comprehensive approach to capturing TPR including processing TPR information from the State's daily TPL file, claims processing activities, TPL vendor practices, Provider interactions, and point-of-service investigation including Member self-reporting.

DOM TPR File Processing

After receipt of the TPL daily file, which identifies assigned Members with TPR information, other identified coverage will be brought into our Member Enrollment System. This system centrally houses current and historical Member information and will systematically feed updated eligibility data, including TPR data obtained from the TPL daily file (and other sources) to applications requiring that data, including the eligibility subsystems of all delegated vendors (e.g., vision, dental, non-emergency transportation). If the TPL/TPR data from DOM differs from the information we have received from any other source, we will report TPL discrepancies back to DOM in the required format daily. We will include all TPL resources identified for Members from all available sources as part of our submission to DOM, including TPL identified by all delegated vendors.

Claims Processing Activities

Our Member Enrollment System is integrated with our Claims Processing System to support the collection, maintenance, and application of TPR for TPL processing. Using information from the State's TPL daily file and other sources, our Claims Processing System will enforce TPL cost avoidance when a third party pays a benefit through prompt suspension of claims submitted without required Explanation of Benefits (EOBs) or payment information from a primary payer. Our claims-paying Subcontractors will follow similar processes for TPL cost avoidance. We will not cost avoid claims for EPSDT and Title IV-D child support services. Using a "pay and chase" policy and in accordance with DOM's billing manual, we will pay for these services and then seek reimbursement to pursue recovery from liable third parties. Please see our response to Section 4.2.2.10.A.1.c of the RFQ below for more details on our process for adjudicating claims involving third party coverage.

TPL Vendor Partner Practices

Through our partnership with leading vendors, we will work to ascertain the legal liability of third parties to pay

for care and services available under MSCAN and CHIP, and actively pursue payment recovery from the responsible carrier. We will securely send eligibility data, including TPR data obtained from the State TPL file (and other sources), to our industry leading TPL and health cost containment vendors who take this information and match it to their database of national insurance eligibility information. This information will be updated regularly to identify other available insurance coverage. Our TPL vendor uses a comprehensive data platform, which is one of the largest commercial datasets in the country for identifying other insurance coverage for Medicaid Members and houses more than 1.5 billion insurance carrier-eligibility records. Their review includes comparing coverage information it receives from over 1,250 different sources, mainly other insurance carriers. When a match is found, they will verify coverage directly with the carrier through a combination of online tools and telephone contact and send the resulting data back to us. We will load this "Member level" TPR and updated carrier information into the Member Enrollment System to feed our Claims Processing System for cost avoidance. We will share TPR identified from our TPL vendor partners in a daily file exchange with DOM.

Subrogation Recovery Vendor. We partner with a recognized leader in health care subrogation services to provide post-payment recovery for subrogation, malpractice claims, and product liability. We have found success across the country in using this vendor to provide superior services for our subrogation recoveries. We will closely partner with our subrogation vendor to analyze all MSCAN and CHIP paid claims for potential accidents, allowing us to identify possible subrogation. Using various data resources, the subrogation vendor will obtain information about the accident or injury. If our subrogation vendor is not able to identify the responsible third party, they will send a questionnaire to the Member to determine if there is TPL for the expense incurred. Our subrogation vendor may also communicate with the Member's attorney to obtain information about the accident or injury to determine the liable third party responsible for payment. All initial letters sent to attorneys or insurance companies will be approved by DOM, and we will submit copies of all form letter templates and document templates as part of Readiness Review.

Vendor Oversight and Monitoring. Through our Vendor Oversight Program, we will adhere to DOM's requirements in Section 13 of Appendix A, Draft Contract, as well as applicable Federal and Mississippi laws and regulations. Our Payment Integrity team will work with leaders in our Compliance and Finance departments to monitor and provide oversight of our TPL and cost recovery vendors through annual validation and pre-contracting audit activities. If issues are identified, we will work with our TPL vendors to remediate through corrective action plans. Our Vendor Oversight Program includes ongoing monitoring activities, including monthly and weekly meetings with our TPL vendors focused on TPL operations and data. During monthly meetings, we discuss topics and prioritize Provider-facing issues that impact our TPL program such as cost avoidance, direct carrier billing, disallowance activity, and outstanding invoices. We develop and monitor action plans and next steps to resolve any operational issues that impact Providers and the overall performance of our TPL program. Our Information Technology department's Payment Integrity team will also meet with our TPL vendors weekly to monitor data exchanges and ensure files are loaded correctly. This process will generate a Missed Savings Report that allows us to monitor claims that were paid primary for Members our TPL vendor identified as having other insurance coverage on record, providing insight into potential issues such as delays in loading TPL records. If file loading issues are identified, we will coordinate with our TPL vendor and internal IT support teams to validate and resolve the issues to ensure correct and timely file loading. We will maintain documentation of TPL vendor oversight and monitoring activities in our Compliance Management System, which will include audit reports, tracking of vendor reporting, evidence of adherence to performance standards, details from key meetings, and requests to improve performance issues.

Provider Interactions

We will educate Providers on the importance of and processes for identifying TPL/TPR information when Members receive services. Education will be provided at Provider orientations, ongoing training, through the Provider Manual, and the Provider Portal. Key topics will include the process for submitting denial notices from third parties, accident details, and medical records corroborating no other liable parties, or EOB or payment information from a third party where Member liability exists in the TPL and other payer segments of their HIPAA 837 EDI claim submissions, or their paper claim submissions. Our Provider Relations (PR) team will offer network-wide Provider education for identified trends and targeted education for individual Providers

experiencing high levels of claim denials due to TPL. For example, a PR team at a Medicaid affiliate of similar size assisted a Provider with identifying other insurance carriers by demonstrating to the Provider how to use a feature on our secure Provider Portal that allows Providers to view a Member's other insurance carrier information via the Member Health Record.

Provider Portal TPL Features. Our secure Provider Portal allows authorized Provider users to see TPL information we have on record for a Member, affording them a means to check for TPL as part of their routine Member eligibility verification process before claim creation and submittal. The Provider Portal allows Providers to submit TPL documentation by uploading images, PDFs, Microsoft Word documents, or other digitally formatted TPL related documents. In addition, a Provider may enter a claim directly via our HIPAA compliant direct online claim entry tool with logical field checks. For example, if a Provider indicates that the Member has other insurance, but no entry is made concerning third party payments, the application alerts the user to the missing information while they are entering the claim.

Point-of-Service Investigation

Our health plan staff may also discover TPL information through routine processes such as when conducting Health Risk Screenings, when reviewing prior authorization documentation from Providers, or when conducting concurrent reviews with inpatient facility staff. In addition to our dedicated claims processing and recovery teams, we will train our entire health plan staff to use every Member and Provider interaction as an opportunity to identify TPL/TPR. For example, our Care Managers can create and send a claims note in our Clinical Documentation System which will be reviewed by our Payment Integrity team and trigger subsequent transmission of updated TPL information through our integrated Management Information System (MIS). Additionally, our Customer Relationship Management Platform (CRM) allows Customer Service Representatives to collect and capture any TPR information from a Member, such as during a New Member Welcome Call or other call center interaction.

b. Process for retrospective post payment recoveries of health-related insurance;

While we will utilize a proactive cost avoidance approach to TPL/TPR, we recognize there will be instances when we are not aware of other payers and must engage in retrospective post-payment recovery. Our internal HSU will work closely with our TPL vendors to identify and pursue all potential TPL payments. Weekly, we will provide our recovery vendor with a claims detail report of claims processed the previous week. If the vendor determines that a claim is related to TPL for a Member with other insurance, the vendor will initiate steps to recover the overpaid TPL dollars from the insurance carrier on our behalf. For subrogation claims, the vendor negotiates a settlement with the third party. We prioritize direct carrier billing with other insurers and primary payers for recovery efforts to ease the administrative burden on our Providers. ***At a Medicaid affiliate of similar size, over 82% of COB recoveries involve direct carrier billing or recovery from other insurance companies where the Provider is not affected.***

To reduce administrative burden caused by recovery activities requiring the Provider to bill other insurance carriers, we verify and approve claims identified for post-payment recovery before issuing overpayment notification letters. We promptly send notification letters to alert Providers of identified overpayments and our intention to recover funds. Providers then agree to settle the overpaid amount or refute the findings by responding with an appeal within a designated timeframe. If the Provider provides sufficient support for their appeal, the overpayment will be overturned and will not be recouped. For Providers who do not refute the findings and agree to settle the overpaid amount, our credit balance vendors will work with Providers to confirm payments, sign off on the refund, and send the refund back to us. We will coordinate with our vendors to cease recovery activities after 180 days from the date of payment of a claim subject to recovery. For TPL overpayment audits, we will submit to DOM a schedule of the Provider TPL desk or onsite audits prior to conducting the actual audit. Findings and recoveries associated with the Provider TPL overpayment audits will be included in our monthly report to DOM in the required format.

c. Process for adjudicating claims involving third party coverage;

As mentioned above, other identified third-party coverage is brought into our Member Enrollment System, which will systematically feed TPR data to our claims system. During claims adjudication, we accurately determine the amount of money we are responsible for per DOM's rules and fee schedule. We use the following

processes, tools, and methods to adjudicate claims involving third party coverage:

- **System Edits.** During the claims adjudication process, our Claims Processing System checks for other coverage and pends the claim based on the information contained within the record. For pended claims, a dedicated team of resources within our claims operations team processes TPL/TPR claims to determine any additional liability as to the secondary payer. To enable accurate automated cost avoidance, claims for Members with other coverage that are submitted without required EOBs or payment information from a primary payer are denied.

$8.9 Million

From 2020-2021, our automated system edits helped us achieve $8.9 million in COB cost avoidance savings for a Medicaid affiliate of similar size.

- **Decision Support Tools.** If the claim received with TPL information included on the EOB meets certain requirements and doesn't match the TPL information we have in our system, the claim will be routed to a TPL Analyst to verify enrollment with the third party and/or the Member. The TPL Analyst then updates the Member record to ensure we are coordinating benefits appropriately. We monitor trends in claim pends and denials due to TPL through our claims dashboard. This dashboard allows our Claims Analysts to analyze daily, weekly, and monthly trends for claims pended with 'EXTP' codes, which indicate claims that were routed to TPL Analysts to verify other insurance. We also monitor trends in 'L6' codes, which indicate claim denials for Members with other insurance on file without the EOB from the primary carrier. In coordination with our PR team, we use this information to resolve TPL issues or educate Providers, if needed, to ensure appropriate billing for Members with TPR. For example, the PR team at a Medicaid affiliate of similar size worked with a women's health clinic experiencing claim denials due to incorrect primary insurer information on file. The PR team reached out to TPL Analysts to have the primary insurer removed from our system. After the system updates were made, the incorrectly denied claims were reprocessed.
- **Artificial Intelligence and Machine Learning (AI/ML).** Our AI/ML capabilities allow our MIS to automatically learn from user interactions and improve capabilities as more data is received without the need for additional programming. We use AI/ML to enhance our processing of TPL and complex claims for routing to appropriate Claims Analysts for rapid handling. As part of our validation process for insurance verification, we will use AI/ML to efficiently assist Claims Analysts to verify Member other insurance coverage and update our Claims Processing System appropriately which will ensure accurate payment.

d. Process for identifying, recouping, and releasing claims;

We maintain a detailed process to identify, recoup, and release claims through systematic claims processing edits, partnerships with TPL vendors and our internal HSU, internal policies and procedures, and other external sources. Our TPL vendors and internal HSU will directly bill other insurance carriers or recoup funds from Providers within 30 calendar days of identification. Our subrogation vendor alerts us whenever an accident is identified through data mining. These claims are then rechecked for other coverage. For these subrogation cases involving an accident or injury, our subrogation vendor will file a lien against the claim filed with the liability carrier for the expense we paid. The liable carrier then reimburses us upon settlement for the amount of reimbursement available on the liability policy. We will only prepare a standard subrogation release of a claim related to the claims we have. For services we do not cover, we will provide notice that DOM may have a separate lien for these services and will provide DOM's designated contact information. We understand that DOM's subrogation claim takes priority over our subrogation claim. In cases where DOM has a claim related to the accident, we will first coordinate with and notify DOM before negotiating the claim. We will compile TPR claims (claims from our carrier insurance billing program and recoveries from other insurance carriers) into a monthly TPL Report we will send to DOM, accurately displaying the amount we are actively pursuing. Once our TPL vendors or HSU recoups the correct amount of funds, the claim will be reprocessed with the appropriate payment amount, and an adjusted encounter will be sent to DOM's fiscal agent.

$3.3 Million

From 2020-2021, our TPL program at a Medicaid affiliate of similar size recovered over $3.3 million through subrogation activities.

e. Process for conducting education for the Offeror's attorneys and insurers about MississippiCAN and CHIP;

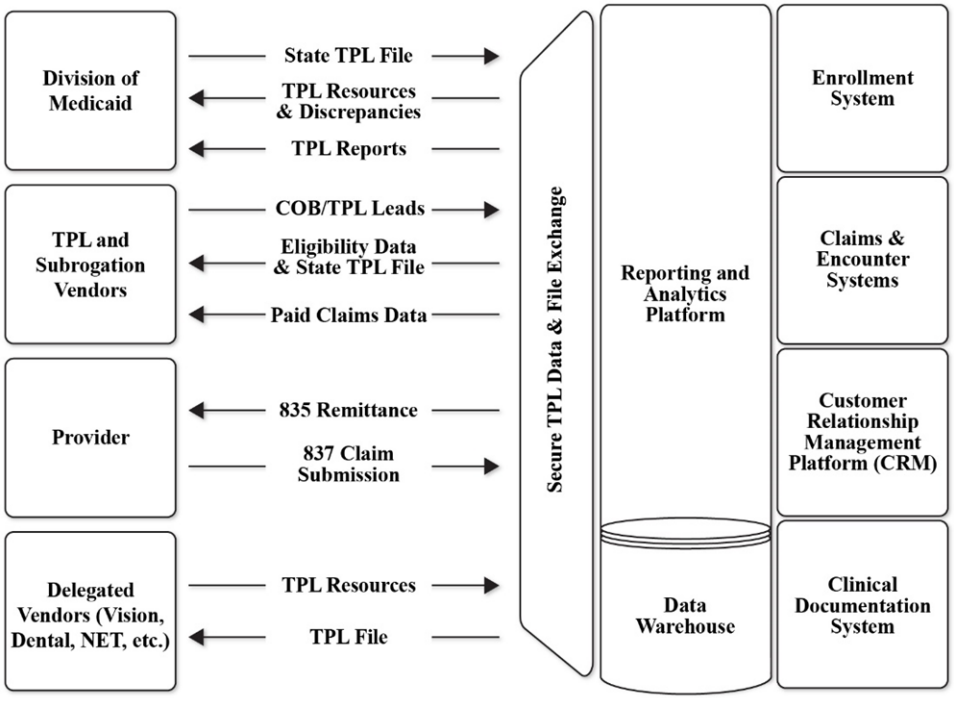
We will educate all stakeholders on their role in helping to ensure the transparency and integrity of the Coordinated Care Program. All employees will receive training on contractual requirements, including specific

education about TPL, COB, and subrogation. TPL-related policies will be accessible to all staff at any time through our Compliance Management System. All information about our TPL program will be tailored specifically to MSCAN and CHIP requirements. We have dedicated attorneys and insurance professionals, including those from our leading TPL vendors, who specialize in TPR identification and post-payment recovery in the public sector. Our TPL vendors' legal team has lawyers that will be assigned specifically to support our health plan operations and will support our Compliance department in researching and continuously monitoring Mississippi law. We will partner with this legal support team and other operational support teams to train and educate attorneys and insurers about MSCAN and CHIP programs. For example, our leading subrogation vendor maintains State-specific chapters of a national subrogation law manual, which is the industry standard legal treatise on subrogation and recovery law that has been published annually for over 20 years. Through relationships that our attorneys and TPL vendors' attorneys will develop in the pursuit of recoveries, we will properly inform and educate other insurers and law firms on their duties under Mississippi law so they can effectively assist us with TPL and recovery activities on behalf of the MSCAN and CHIP programs. Our education will include DOM-approved letters that will be issued to other insurers and third parties, which will contain DOM-provided language to ensure we do not imply we are an Agent of the State, DOM, representing Medicaid, or settling on behalf of the State or DOM while in the pursuit of recovery from liable third parties.

f. Data analytics and informatics used to support the process; and,

Our MIS stores and processes all data necessary to support our TPL processes. The TPL data we collect is housed in our Enterprise Data Warehouse (EDW) and is available for reporting and analysis through our Reporting and Analytics Platform. The EDW receives, integrates, and stores TPL information from our core systems including our Member Enrollment System, claims and encounter systems, CRM, and Clinical Documentation System. Our analytic and reporting capabilities combined with data we exchange with our vendors will allow us to support all TPL and subrogation processes necessary to meet all DOM's TPL requirements outlined in Section 12 of Appendix A, Draft Contract. Please see **Figure 4.2.2.10.A.1.f** for a summary of how TPL data will flow to and from key stakeholders and our core systems that will support our TPL and subrogation processes.

Figure 4.2.2.10.A.1.f TPL Data Flow



g. Process for providing supplemental third-party data and files to the Division.

We will submit all required supplemental data, files, and reports to DOM in the frequency and format required in Sections 12 and 16.2.7 of Appendix A, Draft Contract. Every month, our Compliance Officer will securely send the Third Party Casualty, Third Party Leads and Cost Avoidance, Third Party Subrogation, and TPL

Recoveries files to DOM. These reports will include TPR lead information with identified TPR not represented on DOM's TPR file, data showing the total amount of all claims that were denied (cost avoided) due to the existence of having a TPL on file, total amount of all monies recovered from other insurance companies, and total amount of monies recovered from Providers due to audits, reviews, and disallowances after we paid the claims as primary.

Remote Access and Data Query

We will provide DOM with reasonable and appropriate access to required operational data through our Cloud Reporting Suite, an extension of our Reporting and Analytics Platform, in a format agreed upon with DOM. Our Cloud Reporting Suite will enable authorized DOM users to securely access table-level data sets in our EDW, including but not limited to claims, encounters, and Subcontractor data. Users will be able to view, filter, sort, drill down and extract to Microsoft Excel the information needed to serve DOM's monitoring and decision support needs. Additional features include the ability to query up-to-date information, generate reports, and view configurable dashboards to quickly display data in a manner that is useful for the end-user.

h. Process for reconciling third-party liability payments received on an annual basis for submission to the Division's actuaries for rate setting purposes.

We understand the capitation rates set by DOM's actuaries rely on the accuracy, transparency, and integrity of our TPL operations, including our process for reconciling and reporting encounter records reflecting TPL payments received/recovery amounts. We will comply with DOM's requirements using our industry-leading Encounter Data System. We will configure our Encounter Data System to identify previously paid claims that have been adjusted or voided due to TPL, which will automatically trigger the creation of an encounter adjustment or void record. Because our Encounter Data System is an integrated component of our MIS, the system works with the most current adjudication status of processed claims, regardless of TPL payment collection/recovery status. This enables us to adjust and resubmit the encounter as either a replacement or a voided encounter. We capture Claim Adjustment Reason Codes (CARCs) and specific EX codes reflecting recoveries. Through integration with our EDW, we will provide DOM with an annual report of these encounter adjustments or void records reflecting claims that were reconciled due to TPL overpayments.

2. Does the Offeror have an internal process in place to benchmark their TPL collections against "best practices" to ensure that they are optimizing the TPL recoveries on behalf of the Division?

Yes, we have a process to benchmark our TPL collections against best practices developed by an industry-leading health care cost containment company specializing in recoveries. Due to the scale of our health plan operations nationally, we also benchmark State-specific TPL collections against recoveries of other affiliate Medicaid health plans.

a. If yes, describe the Offeror's process.

To ensure we are meeting financial performance targets and optimizing TPL recoveries, we benchmark our recoveries against a best practice developed by a national industry leader in cost containment. The best practice is based on a Per Member Per Year (PMPY) TPL recovery savings benchmark. For Medicaid programs like MSCAN and CHIP, the industry best practice is to achieve $5 PMPY in recovery savings after a TPL program has been implemented for over 3 years. ***Based on the results of our Medicaid affiliates nationally, our TPL program is currently achieving recovery savings of $8.54 PMPY, well above the $5 PMPY industry best practice.*** We also benchmark our TPL recoveries against recoveries of our affiliate Medicaid health plans, including those with a similar size and population. This will allow us to rank our MSCAN and CHIP recoveries compared to affiliates across the nation. Through our Reporting and Analytics Platform, we will monitor our TPL recoveries on an ongoing, monthly, and annual basis by analyzing reports and trends. Our monitoring process includes a review of historical performance data and analyzes for significant variances to identify opportunities for continuous improvement. The recovery measures we analyze include collections tied to direct carrier billing methods or subrogation cases for Members involved in an accident or injury where a settlement was reached. We also monitor Provider recoupment measures in cases where Providers bill the other insurance carriers directly. These metrics will allow us to monitor recoveries from our TPL recovery vendors as well as our internal HSU. Please see **Table 4.2.2.10.A.2.a.**

$9.6 Million

From 2020-2021, our TPL program recovered $9.6 million at a Medicaid affiliate of similar size, including $6.3 million in COB recoveries and $3.3 million in subrogation.

Table 4.2.2.10.A.2.a TPL Collection and Recovery Measures

TPL Collection and Recovery Measures	Measure Description
Commercial Insurance (CI) Billing*	Direct carrier billing for claims we have paid, but when another carrier is responsible. Payments are recovered directly from the carrier and the Provider is not affected.
CI Billing ($)	Sum of dollars recovered through direct carrier billing activities
CI Billing (PMPM)	Dollars recovered through direct carrier billing activities relative to membership as measured on a Per Member Per Month (PMPM) basis
COB – Commercial Disallowance**	Recoveries for claims paid for Members with other primary insurance. Recoveries are made from the Provider, who then can bill other insurance. Mostly Provider recoupments.
COB – Commercial Disallowance ($)	Sum of dollars recovered from Providers when Providers bill other insurance
COB – Commercial Disallowance (PMPM)	Dollars recovered from Providers when Providers bill other insurance relative to membership as measured on a PMPM basis
COB - Medicare Disallowance	Recoveries for claims paid for Medicaid Members who have Medicare as primary. Recoveries are made from the Provider, who then can bill Medicare. Mostly Provider recoupments.
COB – Medicare Disallowance ($)	Sum of dollars recovered from Providers when Providers bill Medicare
COB – Medicare Disallowance (PMPM)	Dollars recovered from Providers when Providers bill Medicare relative to membership as measured on a PMPM basis
Health Savings Unit (HSU) - Internal COB	Recoveries for claims paid for Members with other primary insurance. Recoveries are made from the Provider, who then can bill other insurance. Mostly Provider recoupments.
HSU – Internal COB ($)	Sum of dollars our HSU recovers from Providers when Providers bill other insurance
HSU – Internal COB (PMPM)	Dollars our HSU recovers relative to membership as measured on a PMPM basis
Subrogation	Recoveries are from other insurance companies for reimbursement on claims we paid for Members involved in an accident or incident where a settlement was reached to pay for expenses incurred for the Member. Also includes workers compensation.
Subrogation ($)	Sum of dollars recovered through subrogation activities
Subrogation (PMPM)	Dollars recovered through subrogation activities relative to membership as measured on a PMPM basis

*Collection is made directly from insurance companies whenever commercial insurance is discovered
**Collection is made from the Provider, who provided the other insurance information allowing them to bill the other carrier

4.2.2.10.B Effectiveness

1. Describe any innovative approaches the Offeror will take to ensure that its Third-Party Liability program is effective.

COB Center of Excellence

Our local health plan leadership will collaborate with our parent company's COB Center of Excellence to develop and implement innovative TPL approaches that help contain health care costs and reduce Provider administrative burden. The COB Center of Excellence focuses on receiving and validating other insurance, updating COB business rules, process optimizations, COB analytics, and post-pay recovery. This team of experts is comprised of Medicaid cost avoidance and payment integrity specialists from across our affiliated health plans. These subject matter experts identify and implement procedural and systemic enhancements for our TPL and cost avoidance processes that each health plan will customize in their state in collaboration with Providers and regulators. In addition, as part of our philosophy of continuous improvement, they develop innovative solutions to proactively identify TPL and increase cost avoidance results. ***The investments made by the COB Center of Excellence in TPL innovation and continuous improvement have yielded millions of dollars in efficiencies and savings that have helped each of our affiliate health plans operate effective TPL programs.***

TPL Module. For MSCAN and CHIP, we will partner with the COB Center of Excellence to implement an innovative TPL Module to streamline pre-payment cost avoidance activities. The TPL Module will optimize claims and TPL processing, including capabilities that ensure effective integration and reconciliation of TPL data to maximize cost avoidance savings and reduce the need for post-pay recovery. Our TPL Module will provide the following capabilities and benefits:

- **Single Source of Truth.** Single repository for all TPL data from multiple sources, providing the most comprehensive, up-to-date Member other insurance information. Will allow additional sources of TPL

information to be ingested in our systems to provide the timeliest data needed for effective cost avoidance and accurate other insurance identification. Will include advanced data cleansing capabilities for all TPL records.

- **Transparent Workflow Management and Vendor Oversight.** A seamless system user interface for TPL staff to quickly view and update TPL information from a single source of truth, while offering enhanced data and workflow tracking for staff that perform TPL activities. Will include flexible TPL vendor quality tracking and compliance reporting to support decision-making for TPL operations and TPL vendor oversight. Dynamic workflow tracking and management capabilities will provide us with maximum insight and transparency into our TPL program**.**

2. Describe any additional measurements the Offeror will use to measure the efficacy of its Third-Party Liability program.

In addition to the TPL collection and recovery metrics included above, we review ongoing, monthly, and annual reports and trends using various TPL metrics to measure the efficacy of our TPL program. Please see **Table 4.2.2.10.B.2.**

Table 4.2.2.10.B.2 Additional TPL Measures

Additional TPL Measures	Measure Description
COB savings	The amount we save when paying secondary on a claim
COB savings ($)	Sum of dollars saved when we pay as secondary on a claim
COB savings (%)	Dollars saved when we pay as secondary on a claim as a percentage of the total paid claims dollar amount
COB savings (PMPM)	Dollars saved when we pay as secondary on a claim relative to membership as measured on a PMPM basis
COB cost avoidance	The amount we save when denying a claim received without an EOB when there is other insurance coverage for the date of service billed
COB cost avoidance ($)	Sum of dollars saved when we deny claims received without an EOB when there is other insurance coverage
COB cost avoidance (%)	Dollars saved when we deny claims received without an EOB when there is other insurance coverage as a percentage of the total paid claims dollar amount
COB cost avoidance (PMPM)	Dollars saved when we deny claims received without an EOB when there is other insurance coverage relative to membership as measured on a PMPM basis
Total COB savings	The total amount we save through COB cost avoidance + COB savings activities
Total COB savings (%)	The total amount we save for COB cost avoidance (paying secondary on a claim) + COB savings (denying claims received without an EOB when there is other insurance coverage) as a percentage of the total paid claims dollar amount

[END OF RESPONSE]

4.2.2.11 ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

4.2.2.11.A File Management

1. Describe how the Offeror will use the Division's eligibility and enrollment files to manage membership. Include the process for resolving discrepancies between these files and the Offeror's internal membership records, such as differences in Member addresses.

Managing Membership through Eligibility and Enrollment Files

We will load daily 834 Enrollment files / monthly Member Listing Reports (Member files) for eligibility and enrollment into our Management Information System (MIS) through standardized add, term, and modify protocols. We will process Member files through our HIPAA-compliant Member Enrollment System, which receives, validates, integrates, manages, and distributes Member information to downstream system components needing that information, easing the administrative burden on Providers and Members.

Monitoring Enrollment. Our Eligibility and Data Analytics Teams will monitor enrollment and disenrollment trends through our:

- **Daily Oversight Dashboard**, which tracks Member processing in terms of adds, reinstates, changes, terms, voids, continues, and errors.
- **Eligibility Processing Dashboard**, integrates with all system components that require eligibility data. The Eligibility Processing Dashboard electronically receives detailed information on each eligibility record from receipt through each downstream interface. We can track the status of eligibility updates via drill-down capabilities allowing us to identify potential issues immediately. The Eligibility Processing Dashboard has full reporting capabilities to trend eligibility updates and reconciliation operations, spot trends, and inform continuous quality improvements.

Our comprehensive monitoring ensures we will process all files within the designated timeframe. If we notice a significant number of Members who should be eligible, that are not, or vice versa, our Finance and Data Analytics Teams will assist in confirming the magnitude of the records impacted. If there is a discrepancy, we will work with the DOM to resolve eligibility.

Leveraging Reporting. Our ability to receive and reconcile Member data from daily enrollment files with existing membership records will allow us to produce various reports, including error reports, capitation reports, dual Members reports, and detailed records of change on each Member record. These reports allow us to monitor discrepancies such as if a Member had been retroactively assigned Medicare coverage or missing information on the Member's enrollment file and resolve them promptly to support our seamless process for managing membership as detailed below.

Resolving Discrepancies. Any Member records that include discrepancies will default to our Queued Error Report. Our staff will alert all parties within 24 hours if a file is missing and then work to locate and process the file and ensure we are not delayed in updating Member information. If we identify individuals on the Member files who are in eligibility categories not eligible for enrollment in Mississippi MSCAN or CHIP, we will notify DOM immediately so files can be updated. In addition to these systematic validation and verification processes, our Eiligibility Specialists will work with Finance to reconcile our Member eligibility and enrollment information against the DOM's 820 premium capitation payment. Through this process, we will also be able to identify any discrepancies between our MIS's Member information from the 834 file and Member demographic information we may have collected via Member outreach or from Providers, including differences in Member address. Eligibility staff can add information in real time in our Member Enrollment System so that it is visible through our interoperable systems within 24 to 48 hours, enabling staff, Providers, and Members to see the most current information. If our system is not able to automatically correct discrepancies identified in the Exception Report, staff will make manual corrections. Our affiliate Medicaid Eligibility teams have created several reports for our vendors, as well as internal teams, including:

- Vendor Void Report - delivered to each vendor to notify them of voids processed
- Disenrollment Report - delivered to all internal departments
- Pregnancy Report and Foster Care Report - alerting Care Management of new Members

When Member eligibility retroactively terminates, we will also work to recoup claims. We will flag these changes through the 820 reconciliation process or an updated record on the 834/Member Listing report. If a Member's coverage end date is backdated, the Data Analytics Team will conduct a claims analysis on the retroactively termed span to determine whether coverage recoupment is needed and if so, whether another payer

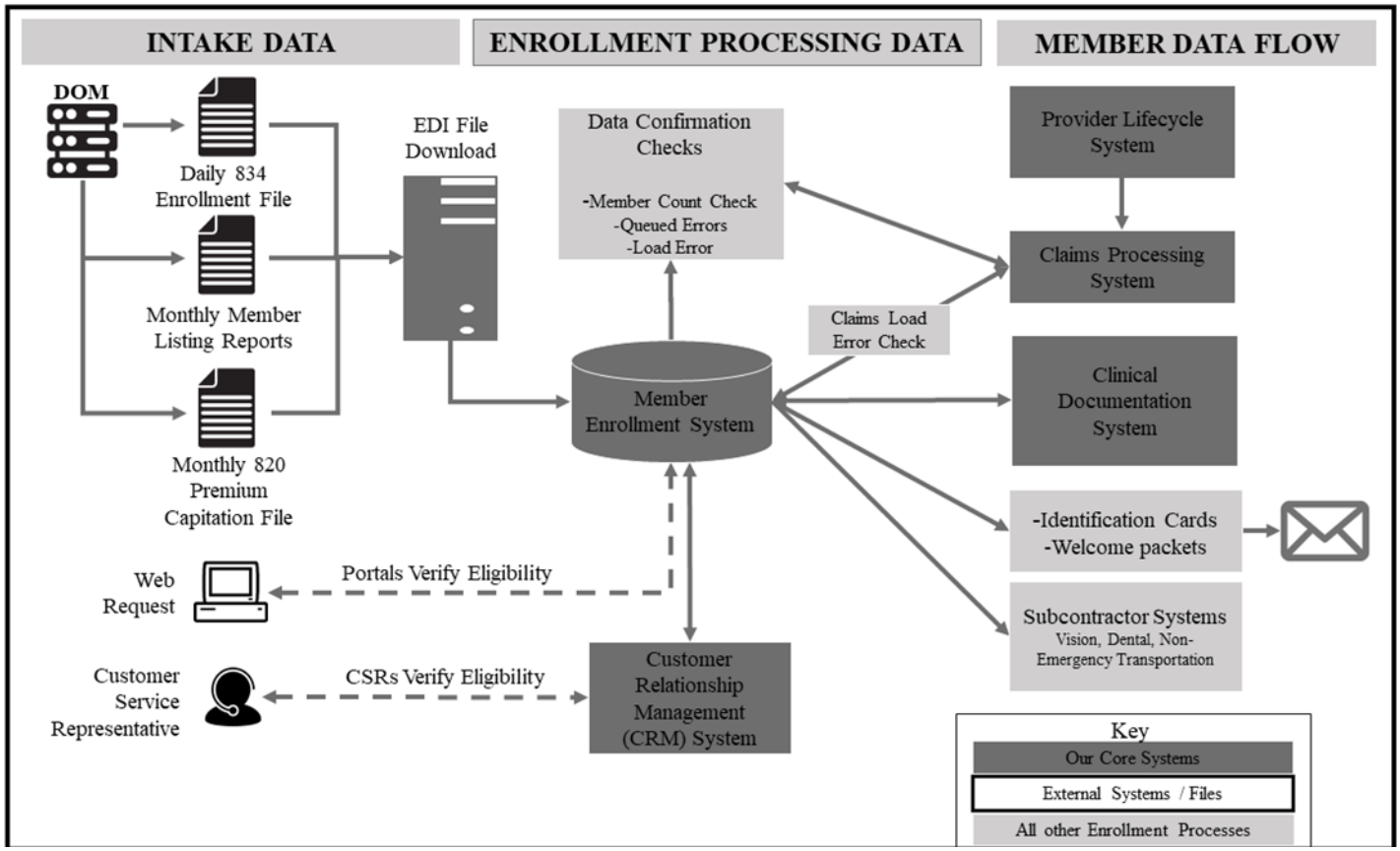
may be identifiable for the Provider to resubmit claims. To ensure proper staffing for maintaining processing timeframes, we will have backup staff trained to complete the enrollment and disenrollment process.

Third Party Liability (TPL). After receiving the State TPL daily file, which identifies assigned Members with Third Party Resource (TPR) information, other identified coverage is brought into our Member enrollment system. This system systematically feeds updated TPR data obtained from the TPL daily file (and other sources) to applications requiring that data. If the TPL/TPR data we receive from the DOM differs from the information we have received from any other source, we will report TPL discrepancies back to the DOM in the required format daily along with information of any other TPL resources we identify.

Timely Data to Support the Continuum of Care

Timely, accurate Member eligibility and enrollment information is critical for staff and Providers to effectively manage Members and ensure they have access to benefits and services that will help them achieve or maintain better health. As noted above, our Member Enrollment System acts as the single "source of truth" for all informational aspects of a Members' relationship with our plan, including Member demographics and contact information. Once Member eligibility and enrollment information from the Member files has been loaded into the Member Enrollment System, it is integrated into our support systems. See the process flow graphic below for details.

4.2.2.11.A.1 Eligibility and Enrollment Process Flow



Supporting Functional Operations. Staff from our functional operations teams will access new Member eligibility and enrollment information within 24 to 48 hours of when we receive the Member files from DOM. Our vendors will also have access to the eligibility and enrollment information within the same time.

- **Customer Service.** Our Customer Relationship Management (CRM) Platform allows us to capture and store new or additional demographic details such as phone numbers, addresses, and other contact information we gather during contact with Members without overriding what was sent on the Member files. We will proactively reach out to Members and generate a list of new Members for our staff to use for New Member Welcome Calls, where Members learn about their enrollment, the benefits and services available, and help them choose a PCP if they don't have one. Additionally, Customer Service Representatives (CSRs) will see if a Member has chosen a PCP in the CRM platform and verify their selection on each call. For

Members who have not made a PCP selection, CSRs will be able to match Members to PCPs who meet their geographic, cultural, and linguistic needs to help them find a strong PCP Member match based on Member needs and PCP capabilities (a process more fully described in our response to Section 4.2.2.11 of the RFQ).

- **Care and Utilization Management.** We populate Member eligibility and enrollment information from the Member files into our Clinical Documentation System that supports Care Management and coordination. Using a sophisticated set of data, including Member information, claims, and input from Providers and Members, we will match Members identified for Care Management with the Care Management Team that reflects their primary health needs. For example, we use eligibility category data to help identify if a Member has lapsed in their preventive care so we can coordinate care and services as quickly as possible. Eligibility and enrollment information in our CRM Platform and our Clinical Documentation System enables staff to pre-arrange accommodations for Members with differing abilities or arrange for language interpretation services prior to an appointment. Additionally, clinical staff will be able to review Member records to see medical/claims histories for Care Management or utilization management. Similarly, via our secure Provider Portal, Providers will be able to verify Member eligibility, access information about Members assigned to them and their care gaps, see a Special Needs Registry with health status information on Members with special health care needs, and review their patients' Member Health Record. Members will also be able to review and update their information online through the secure Member Web Portal, see their care gaps, and change their PCP or access health education materials.
- **Quality Improvement.** Through our Reporting and Analytics Platform, claims, and Quality Work Plans, we will monitor and evaluate health plan performance and the quality and appropriateness of care and services for all our Members. We will leverage Member data to conduct surveys with Members who request disenrollment to identify and address issues that impact Members, as discussed below in our response to Section 4.2.2.11.A.2.a of the RFQ.

2. Describe the Offeror's process for engaging Members who request to disenroll stay enrolled, including:

In our process for engaging with Members who request to disenroll, we will ensure compliance with Appendix A, Draft Contract and all DOM disenrollment requirements. We will work to dispel any misunderstandings the Member may have and support them in continuing with our plan or acknowledging their decision to choose another. Below, we describe our proposed process for outreach and engagement of Members, conducting Disenrollment surveys, and topics that we will cover in the survey.

a. Process for outreach and engagement of Members;

Outreach Process

We will identify Members through a weekly disenrollment report or through inbound calls. For Members who may request to disenroll, either within 90 days or within the annual disenrollment opportunity, our CSRs are trained to reach out to Members via phone to understand why they wish to disenroll and confirm that the Member would like to disenroll. We understand requests for disenrollment will come to us through various means, and we will reach out to Members who choose to disenroll based on how we receive their disenrollment requests and the nature of those requests, as described below.

Disenrollment Requests to the Customer Service Call Center. When a Member directly requests to be disenrolled, our Customer Service Representatives (CSRs) will use a DOM approved guide regarding the advantages of being enrolled in a Coordinated Care Organization (CCO), including building a relationship with a PCP/PCMH that can be their medical home. We will educate Members on the non-transferrable nature of any Member rewards that may have accrued with us, information regarding the FFS Medicaid program, and the possibility of co-payments for certain services. If there are specific issues or problems a Member has experienced that are influencing their decision to disenroll, a CSR will listen and document those concerns and help the Member resolve them during that contact, or as quickly as possible for matters that require further research. Our experience in affiliate markets like Mississippi has helped us learn the kinds of concerns that Members typically voice as reasons for choosing to disenroll and develop tools to help them solve problems and answer questions thoroughly and quickly, which often results in their choosing to stay enrolled. We will teach Members how to use the public website and Member Portal, which offer tools and access to information whenever it is convenient for them. If a Member still wishes to disenroll, CSRs will document the information in the CRM Platform. As detailed in Appendix A, Draft Contract, we will send DOM a summary report from the Disenrollment Survey we conduct of reasons why Members choose to disenroll.

Disenrollment Requests to Care Management (CM) Staff. In the event a Member expresses to someone on their Care Management team their desire to disenroll, we will listen to the Member's concerns and try to identify specific issues or problems they can then work with the Member to resolve. For example, Members may not feel their PCP is the right fit or may express dissatisfaction about difficulties finding a specialist they want or need. As much as possible, Care Management staff will assist Members with solving their concerns right away. They also may engage additional staff, such as our Contracting and Network Development team, to help with more complex issues such as engaging new specialists or additional PCPs in a particular geographic area. First and foremost, they ensure the Member's needs are met, even if that ultimately means the Member still chooses to disenroll.

b. Conducting Disenrollment surveys with Members to determine the reason for Disenrollment. Include how the Offeror will use results from the survey to improve the program; and

Disenrollment Survey Process

Upon receipt of a disenrollment, an Eligibility Specialist will generate a report listing the Members who are pending disenrollment. This report is used to outreach to each Member who requested to disenroll with a survey to elicit reasons why they choose to disenroll and move to another health plan or FFS Medicaid. We will work with DOM to approve a survey and train team members on the survey instrument to ensure there is no undue influence in trying to persuade a Member to remain with our health plan. Additionally, to increase our response rate, we will utilize mail and e-mail (where available) to provide Members another avenue in responding to the disenrollment survey, other than over the phone.

Data Informed Quality Improvement. We will leverage the disenrollment survey data to help us understand why Members may choose to leave our health plan. We have the ability to analyze disenrollment data to understand trends that may be occurring during a specific time, in a particular geography, or for a specific population. As we have established in affiliate markets, we will hold quarterly Quality Management Committee (QMC) meetings and allot time to discuss and review disenrollment surveys. If we identify an issue, our QIC will use this information to help prioritize outreach and quality improvement initiatives that will have the greatest impact or for which there is a demonstrated need. In addition to conducting the disenrollment surveys, we will also solicit input from other sources, such as our Member and Community Advisory Committees (MAC and CAC) to help us identify Member issues or concerns that may be driving disenrollments. Our Performance Improvement Teams (PIT) review performance issues related to Member disenrollments and creates action plans with measurable goals to make improvements, as needed, which may involve leaders and teams supporting a variety of plan functions and include staff training, staffing level or schedule adjustments, gathering staff feedback, and finding ways to improve coordination among functional areas that impact Members and Member supports.

Supporting Program Improvements. We are practiced in collaborating with State entities to share data, including for disenrollment. Disenrollment data can be leveraged to better understand Member pain-points and implement holistic program improvements. In Mississippi we will deploy an enhanced welcome experience, leveraging video tutorials to meet Members where they are, and expand targeted Provider recruiting efforts to encourage Member to remain with our health plan.

c. The Offeror's draft disenrollment survey.

Our disenrollment survey will cover a variety of topics to understand the key drivers leading a Member to request disenrollment. In an open-ended manner, our survey will seek to:

- Confirm that the person being contacted participated or currently participates in our health plan
- Learn the length of time the Member had been enrolled with our health plan
- Uncover the main reasons behind switching to another health plan (network, transportation, incentives, customer service, etc.)
- Understand the types of supports the Member may have received from our health plan (in person services, transportation, etc.)
- Understand the resources the Member may have received from our health plan (welcome packet, informational flyers, etc.)

Please see **Attachment A.4.2.2.11.A.2.c Draft Disenrollment Survey** for additional details. We will create quarterly reports and work plans from disenrollment survey responses and share these findings with the DOM.

4.2.2.11.B Assignment of Members to a Primary Care Physician

1. Describe the Offeror's proposed process to assign Members to a Primary Care Provider (PCP) within sixty (60) calendar days of Enrollment. Include a discussion of the Offeror's approach to:

As described in our response to Section 4.2.2.11.A of the RFQ above, we will pursue operational proficiency because of the important downstream actions set in motion by the timely and accurate processing of eligibility and enrollment files. Promptly delivered and validated eligibility and enrollment files will ensure that all Members will be assigned Primary Care Providers (PCPs) within 60 days of enrollment, thus enabling them to begin accessing benefits and services without delay. It will also allow us to preserve PCP assignments so Members receive uninterrupted care. Members who are stratified as Medium or High risk will be assigned to a Patient Centered Medical Home (PCMH). Below we describe our methodology for assisting Members with PCP selection as well as selecting PCPs for Members who have not chosen one.

a. Assist Members when selecting a PCP and selection of a PCP for Members who do not make a selection;

Members have preferences driving their decisions when selecting PCPs and often have questions regarding the process. To assist Members with PCP selection, we will show them how to identify PCPs aligned with their health and cultural needs and personal preferences as well as show them how to self-select using our online Provider Directory. In this manner, we will encourage and provide Members with resources to make important, informed decisions about their health. In the following sections, we will describe our proposed Member outreach campaign, including the methods, materials, and other resources that support the establishment of a strong Member-PCP relationship.

Assisting Members With PCP Selection

Through our affiliate health plans, we have learned that engaging Members within the first 30 days of enrollment may lead to greater initial and ongoing engagement in their health. Accordingly, we will develop a new Member outreach campaign aimed at informing Members about PCP selection using the following methods:

New Member Welcome Packet. We will send all new Members a Welcome Packet within 14 days of receiving the Member Listing Report. We will provide these materials at the required 3rd-grade reading level as certified by the Flesch-Kincaid Tool and will include the following:

- ***Introduction Letter*** and ***Identification (ID) Card***. These materials will inform Members how to access our online Provider Directory. For Mississippi Coordinated Access Network (MSCAN) Members and Mississippi Children's Health Insurance Program (CHIP) Members who have not yet selected a PCP by the time they receive a Welcome Packet, the ID Cards will not have a PCP listed. Upon PCP selection, we will provide written notification of the assignment and new ID Cards with the PCP's name.
- ***Information Flyer***. The flyer will inform Members how to obtain a hard copy of the Provider Directory pursuant to 42 CFR 438.10(f)(6)(h).
- ***Member Handbook***. Our separate Member Handbooks for MSCAN and CHIP will include a section dedicated to informing Members about the role of PCPs, how to access the online Provider Directory for unassisted PCP selection, to contact our Call Center for assistance with PCP selection, and education and a reward through our Member Incentive Program to visit their PCPs within 90 days of enrollment. We will also provide a QR code within the Member Handbook to direct Members to the Member Portal and Mobile Application, where they can access and view their digital ID card.
- ***Member Booklet***. Since Members are likely to open the Welcome Packet to locate their ID Cards, we will take advantage of this touchpoint and include an informational booklet that includes important information about the role of PCPs.

New Member Welcome Calls. Within 30 days of a new Member enrollment, we will conduct New Member Welcome Calls, making a minimum of three attempts at different dates and times. During the call, we will assist Members with PCP selection or verify the existing assignment and will educate them about the role of PCPs. We will also offer to make their first appointment during the call using our online appointment scheduling tool. In addition to assisting with the Health Risk Screening, we will conduct a mini-Social Determinants of Health (SDOH) screening and refer to Care Managers or Social Services Specialists, if needed, to remove SDOH barriers to care. Using this additional information, we will help educate Members on making PCP selections within the broader context of their health and social needs to ensure Member-PCP alignment.

In addition, we will ask Members with assigned PCPs if they are satisfied. Because the Member-PCP relationship is such a strong determinant in whether Members engage in their care, we will reassign PCPs, if requested. In reassigning, we will use criteria such as the Members language needs, location, previous PCP relationships, family enrollment, and other criteria to identify PCPs Members will engage with. Based on standards for both urban and rural access, we will offer Members a choice of at least two PCPs in our network. This will include all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). We will also offer all American Indian/Alaska Native Members the option to choose an Indian Health Services (IHS) or other tribal Provider, if and where available.

New Member Welcome Visit. We will go above and beyond Contract requirements and conduct an in-home visit within the first 90 days of enrollment for all new Members. This practice will help us build a strong rapport with our Members at the very beginning to encourage engagement and honest information sharing. An in-home visit also enables us to identify and address social determinants of health before they become barriers to care, help the Member select a Primary Care Provider that meets their needs and preferences, and demonstrate how to access the Member Portal, Member Mobile Application, and telehealth resources.

Selecting PCPs for Members Who Have Not Selected

We will submit our policies and procedures (P&Ps) governing PCP auto-assignment to the DOM for review and approval within ninety (90) days of contract award as well as submitting any updates for approval.

If after multiple attempts we are unable to reach Members who have not selected a PCP within 30 days of enrollment, we will assign a PCP within 60 days of enrollment using a DOM-approved auto-assignment algorithm that will incorporate multiple factors such as:

- Previous Member relationship with a PCP
- Family member relationships with a PCP
- Member language, gender, and/or cultural preferences
- PCP is located within 15 miles for Members in urban areas and within 30 miles for Members in rural areas
- The PCP is accepting new patients
- Prioritization based upon quality-of-care criteria

In addition, our P&Ps will include a documented process for ensuring PCPs are willing to accept the assignment of Members prior to assigning the Members as well as assigning medium to high-risk Members to Patient-Centered Medical Homes (PCMHs).

Assigning Members Previously Enrolled with Our Coordinated Care Organization (CCO)

As described in Section 4.2.2.11.A of this response, our Member Enrollment System will support all eligibility and enrollment functions across all our functional areas, which will enable us to see if a Member was previously enrolled with our CCO, and if so, their most recent PCP relationship.

Assigning Newborns a PCP. We will strive to minimize any delay between delivery and newborns appearing on the Member Listing Report. For example, when we learn that a Member is pregnant, our Care Managers will outreach to Members to inform them of programs and services available through our CCO, such as our Maternal and Child Health Program. We will offer women who meet the criteria the option of receiving services through DOM's Perinatal High-Risk Management/Infant Services System. Care Managers will work with expectant mothers to select a PCP for their baby within 60 calendar days prior to the expected delivery date.

For Members who still have not chosen a PCP for their baby, the Care Manager will contact new mothers within 30 days of receiving notification of delivery to assist them with PCP selection. We will contractually require our Providers to file DOM's Request for Newborn Health Benefits ID Number Form. This will trigger the process to generate newborn information in DOM's system, including a Member ID number, and notify us of the delivery. Care Management (CM) staff will remind hospital staff engaged with the Member to file the request form. Once we receive the newborn enrollment on the Member Listing Report, we will follow the same process for new Members described above if the mother has not chosen a PCP.

Helping Members with Special Needs Find the Right PCPs. If we identify Members with special needs, we will educate the Member/guardian on how to access CM services and the role of PCPs in supporting ongoing care needs. For example, we help Members with developmental delays find PCPs experienced serving these

Members. We will also allow Members with disabilities and/or chronic conditions and children with special health care needs to select specialists as PCPs, a process described below.

b. Track data to confirm that every Member is assigned;

Our Eligibility Specialists will track data and review Member files stored in our Member Enrollment System to confirm all Members have an assigned PCP. The Member Enrollment System will include a PCP assignment column on the Member Listing Report to enable staff to easily identify Members without PCPs, which will trigger the PCP assignment process as described above. Although this is primarily an automated process, we will take the additional step of manually verifying every Member has an assigned PCP. We will promptly contact Members without PCPs to assist with PCP selection or assign PCPs if we are not able to reach Members. ***By taking this additional step, we will ensure we account for all Members requiring PCPs.***

c. Inform PCPs/PCMHs of new Members within the required time frames; and

Our process of informing PCPs/PCMHs of new Members will include loading the Member Listing Report into our Management Information System (MIS), which distributes information to downstream operational systems within 24-48 hours. Then, we will generate a New Member Roster for each Provider. The Roster includes new Member demographics, contact information, effective assignment date, and special needs indicators. We will notify Providers via e-mail regarding the new assignments or changes to their Member assignments. For Providers who prefer self-service, we will provide instructions on securely logging into our Provider Portal to access their new Member roster or see changes to the Roster. This information will be available no more than the required five business days of receipt of the Member Listing Report. In addition, Customer Service Representatives (CSRs) will be able to access the Patient List to view up-to-date Member eligibility and enrollment information for Providers or Members who contact us.

d. Confirm that PCPs/PCMHs received the list of assigned Members.

We will include a statement of acknowledgment on the Patient Roster in the secure Provider Portal to confirm that PCPs/PCMHs received the list of assigned Members. The acknowledgment will state, "By accessing the Member panel via this secure Provider Portal, the PCP acknowledges that they have received notice of and accept the assigned Members listed therein." This statement will be included in all Provider contracts, ensuring Providers receive formal notice of the availability of their Patient Roster on the Provider Portal, which will be updated within 24-48 hours. In addition to the list of assigned Members, the Patient Roster will include Member care gaps, disease management alerts, and an emergency department (ED) high utilizer flag, alerting Providers if a Member has been to the ED more than three times in the last 90 days.

2. Provide a sample of the report the Offeror will use to notify PCPs of their assigned Members.

Figure 4.2.2.11.B.2 below provides a sample report we will use to notify PCPs of their assigned Members. Providers can access their Patient List in the Provider Portal and can print or export the Patient List to Microsoft Excel. Provider Relations Specialists (PRSs) will offer training for PCPs on reading and using the Patient Roster and can assist Providers who call the Provider Services Call Center with questions about the report or about any new Members assigned to them. Providers can review the explanation guide online or request a hard copy at any time.

Figure 4.2.2.11.B.2: Patient List *(columns A-K)*

[DATE]

[HEALTH PLAN]

By accessing their Member panel via this secure web portal the Primary Care Practitioner acknowledges that they have received notice of and accept the assigned Members listed therein.
This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this Member.

Member Last Name	Member First Name	Preferred Language	Member ID	Effective Date	Term Date	Product Name	Gender	Date of Birth	Phone Number	Address 1
LAST1	FIRST1	LANGUAGE	ID1	2/1/2022	12/31/9999	TANF	F	1/1/2022	6011234567	1 Miss Dr
LAST2	FIRST2	LANGUAGE	ID2	2/2/2022	12/31/9999	TANF	M	1/2/2022	6011234567	2 Miss Dr

LAST3	FIRST3	LANGUAGE	ID3	2/3/2022	12/31/9999	TANF	F	1/3/2022	6011234567	3 Miss Dr
LAST4	FIRST4	LANGUAGE	ID4	2/4/2022	12/31/9999	TANF	M	1/4/2022	6011234567	4 Miss Dr
LAST5	FIRST5	LANGUAGE	ID5	2/5/2022	12/31/9999	TANF	F	1/5/2022	6011234567	5 Miss Dr
LAST6	FIRST6	LANGUAGE	ID6	2/6/2022	12/31/9999	TANF	M	1/6/2022	6011234567	6 Miss Dr
LAST7	FIRST7	LANGUAGE	ID7	2/7/2022	12/31/9999	TANF	F	1/7/2022	6011234567	7 Miss Dr
LAST8	FIRST8	LANGUAGE	ID8	2/8/2022	12/31/9999	TANF	F	1/8/2022	6011234567	8 Miss Dr

(columns L-Y)

Address 2	**City**	**State**	**Zip**	**Provider First Name**	**Provider Last Name**	**NPI**	**Care Gaps**	**Special Needs**	**DM**	**New Member**	**No HRA**	**ED**	**CM**
Apt 1	CITY	MS	ZIP	PFIRST1	PLAST1	1234567890	CARE GAP	SN	DM	N	N		
	CITY	MS	ZIP	PFIRST1	PLAST1	1234567890	CARE GAP	SN	DM	N	N		
Apt 2	CITY	MS	ZIP	PFIRST1	PLAST1	1234567890	CARE GAP	SN	DM	N	N		
	CITY	MS	ZIP	PFIRST1	PLAST1	1234567890	CARE GAP	SN	DM	N	N		
	CITY	MS	ZIP	PFIRST1	PLAST1	1234567890	CARE GAP	SN	DM	N	N		
	CITY	MS	ZIP	PFIRST1	PLAST1	1234567890	CARE GAP	SN	DM	N	N		
	CITY	MS	ZIP	PFIRST1	PLAST1	1234567890	CARE GAP	SN	DM	N	N		
	CITY	MS	ZIP	PFIRST1	PLAST1	1234567890	CARE GAP	SN	DM	N	N		

3. Describe the Offeror's proposed process to ensure that any new Member has an appointment scheduled with the selected PCP within at least ninety (90) calendar days of Enrollment.

Ensuring New Members Have A Scheduled Appointment

For Members who have selected or been assigned a PCP, we will guide them towards scheduling their first office visit to establish the relationship with the PCP. We will include an outreach campaign, innovations, and other strategies described below to establish the Member-PCP relationship within 90 days of enrollment.

Real Time Appointment Scheduling. We will utilize our online appointment scheduling tool to ensure new Members have an appointment scheduled with a PCP/PCMH within 90 calendar days of enrollment. Through the online appointment scheduling tool, CSRs and other Member-facing staff will be able to use the tool to schedule Member appointments while engaged with Members who have agreed to make their first PCP visit.

New Member Outreach

As mentioned above, we will launch a new Member outreach campaign to engage Members via our new Member materials, phone calls, text, e-mails, and in-person visits as we describe below:

- **New Member Welcome Packet.** We will mail the Welcome Packet within the required 14 days of receiving the Member Listing Report. Both the Member Handbook and the Member Booklet will inform Members about our Member Incentive program that will provide rewards for seeing their PCP. These materials will be provided at the required 3rd grade reading level.
- **New Member Welcome Calls.** These calls will focus on assigning PCPs to Members needing one, verifying existing assignments and Member satisfaction regarding the assignments, and changing PCPs upon request. We will inform Members about our Member Incentive Program and will use the online scheduling tool described above to schedule Members for PCP visits. We will offer Members the opportunity to participate in a three-way call with Provider offices for appointment scheduling to enable Members, if they choose, to ask questions of their Providers that are important to them.
- **New Member Welcome Visit.** We will go above and beyond Contract requirements and conduct an in-home visit within the first 90 days of enrollment for all new Members. This practice will help us build strong rapport with our Members at the very beginning to encourage engagement and honest information sharing. An in-home visit also enables us to identify and address social determinants of health before they

become barriers to care, help the Member select a Primary Care Provider that meets their needs and preferences, and demonstrate how to access the Member Portal, Member Mobil Application, and telehealth resources.

- **Digital Engagement: New Member Online Welcome Toolkit.** To keep pace with Members who prefer digital information, we will offer a Welcome Toolkit on our public website with links to information such as PCP selection and access to educational webinars on our video library informing Members about appropriate utilization. In addition, we will include hyperlinks to YouTube videos and Podcasts featuring community leaders who will welcome new Members to our CCO and encourage them to schedule their first PCP visit. Our affiliate health plans have seen that offering digital content increases Members' engagement with their health, especially younger Members and families.

Members in Care Management

For Members identified for or enrolled in Care Management (CM), Care Managers will provide additional outreach and support to schedule PCP appointments, including a reminder call prior to scheduled appointments and a follow-up call to ensure the Member's needs were met and they were satisfied with the PCP and the services received.

Provider Engagement

Providers logging into the secure Provider Portal will be able to see Member care gaps, such as annual visits due, and thus outreach to Members to schedule appointments. We are developing a deep network of Mississippi Providers participating in value-based purchasing (VBP) programs which will drive an increase in PCP appointments within the first 90 days of a Member's enrollment as we have seen in other states.

4. Describe the Offeror's proposed policies and procedures for designating a Specialist as a PCP/PCMH for Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs.

We will have P&Ps that will provide for Members with chronic conditions, or children with special health care needs to designate specialists as their PCPs/PCMHs. Our P&Ps will comply with the requirements of Section 3.2.4 of Appendix A, Draft Contract. Should a new Member request a specialist as a PCP/PCMH, we will support those Members and their specialist Providers with preserving the relationship and ensuring continuity of care subject to our P&Ps, described below. We will inform Members how to request a specialist as their PCP/PCMH in our Member Handbook, our public website, and through CSRs and other Member-facing staff. We look forward to working with DOM to review these P&Ps and ensure they support Member choice for Providers who are qualified to care for Members with complex conditions.

Our P&Ps will also provide for the following specialty Providers to perform as PCPs:

- Pediatricians
- Family and General Practitioners
- Internists
- Preventive Medicine specialists
- Obstetricians/Gynecologists
- Physician Assistants
- Nurse Practitioners (subject to the stipulations in 3.2.4.1.f)
- Specialists who perform primary care functions upon request
- Other Providers approved by DOM

Similar to how the PCP assignment process described above in our response to Section 4.2.2.11.B.1 of RFQ factors Member needs with PCP qualifications to ensure a good match, we will also assess the needs of Members with complex conditions to ensure specialists can provide the quality of care these Members need. Our P&Ps will stipulate, for example, that for specialists to serve as PCPs, they must meet all credentialing criteria as well as contractually agree to meet all the criteria of a PCP, including:

- Their PCP duties are within the scope of their training and clinical expertise
- They will actively manage all Member care needs
- They will provide preventive care and support access to behavioral health care and community services
- They must be able to submit encounter data
- They must have admitting privileges at a contracted hospital
- They will be accessible to Members 24 hours a day, seven days a week

Our process provides for Members and specialists to establish the relationship without undue burdens. For example, both the Member and the specialist can initiate the process by providing the following information:

- Member name and demographic information
- Medical information such as diagnosis, history, medications, and equipment
- Treating physician history whether the Member has seen a PCP, which physicians are treating the Member, and when they were last seen
- Treatment plan whether the specialist has demonstrated how they will support the Member
- Additional information such as disclosing any known issues or circumstances that might impede the specialist's ability to serve as the Member's PCP

Our P&Ps provide for our Chief Medical Director to review the Member or Provider request within five days or 24 hours for expedited requests. If the specialist meets the qualifications described above, we will contact the Member, the specialist, and the previous PCP (if applicable) and mail a new ID Card reflecting the updated assignment.

5. Describe the Offeror's proposed process for communicating with Members about their PCP/PCMH assignment and encouraging Members to use their assigned PCP/PCMH and keep scheduled appointments.

Communicating With Members About PCP/PCMH Assignments

As we have described throughout our response to this section, we will implement policies and procedures, such as manually verifying PCP/PCMH assignments as needed, to ensure new Members have assigned PCPs/PCMHs together with an outreach campaign to guide Members in visiting their PCPs within 90 days of enrollment. Our Member outreach will continue beyond the initial 90 days of enrollment and will consist of various communication methods to meet Members where they are and engage them with their PCP/PCMH. We provide examples of the outreach methods in **Table 4.2.2.11.B.6.**

Table 4.2.2.11.B.6: Communicating With Members About PCP/PCMH Assignments

Modality	Communication Examples
Mailed Member Materials	• New Member materials mailed within 14 days of enrollment will include instructions on how to select a PCP, the PCP's role in advancing the Member's health, and the rewards for making an office appointment within 90 days of enrollment • Mailed appointment reminders tying in with Member birthdays and annual wellness/preventive care visits that are due • Educational mailings such as Urgent Care brochures for Members with frequent, avoidable, ED visits to educate on engaging with PCP/PCMH to access care more appropriately
Telephonic Outreach	**Outbound Calls** • New Member Welcome calls within 30 days of enrollment assigning/verifying PCPs/PCMHs, scheduling their first visit, documenting language/accessibility needs as well as SDOH barriers to accessing PCPs/PCMHs, e.g., transportation • Care Management Staff calls to middle/high-risk Members verifying if assigned PCMH is meeting Members' needs and offering reassignment to a different PCMH or a specialist • Appointment reminders conducted 30 to 45 days before recommended screenings and services are due **Inbound Calls** • Call Center CSRs verify Members' satisfaction with PCPs/PCMHs, reassign/educate Members on PCP self-selection via the online Provider Directory using search filters to personalize search aligned with Member needs/preferences, educate on role of PCP/PCMH and schedule appointments, warm transfer to Care Management Team for Members with complex needs for appointment assistance or follow-up care
In-Person	• New Member Welcome Visit within the first 90 days of enrollment. • Home Visits by Community Health Workers/Care Management staff engage new or existing medium to high-risk Members to verify PCMH assignments and ensure access to care including educating on participating in telehealth visits • Community Events with Community Relations team participating in Back to School and other events and providing approved Member materials with information about PCP/PCMH selection, immunization calendars including COVID-19 vaccine information, and referring Members to Member Services and/or the Care Management team as needed for personalized assistance
Digital	• Public website, Member Portal, and Mobile App provide online functionality enabling Members to search for and change PCPs, order hard copy ID Cards and access a Digital ID Card to be downloaded to a mobile wallet, self-refer to Care Management, and view resources to remove SDOH barriers to care • New Member Welcome texts (subject to DOM approval) to our Members' mobile devices will include hyperlinks to a New Member Welcome page featuring YouTube videos spotlighting community leaders who will welcome new Members to our CCO and encourage them to schedule their first PCP visit. The Welcome page will link to the online Provider Directory, provide instructions on self-selecting PCPs and on opening a Member Incentive Program account and other resources

Encouraging Members to Utilize Their Assigned PCP/PCMH

PCPs have a vital role ensuring our Members make and keep appointments within the first 90 days of their

enrollment. To support our PCPs with Member engagement, we will educate them on the tools and resources we will offer, such as the online Member health record accessible via our secure Provider Portal. The record will contain detailed care gaps and other clinical information, including reports to track Members who are overdue for recommended PCP visits or other services.

For ongoing education, we will inform PCPs of appointment scheduling requirements during Provider orientation and educate them about best practices for meeting their responsibilities through quarterly site visits as well as written and online materials. We will contractually require PCPs to conduct well-care visits within 30 days of a Member's request, and they must outreach to Members who are noncompliant with required EPSDT/Well-Child screenings to assist and schedule visits if Members request help. In addition, we will develop a robust network of PCPs participating in value-based purchasing agreements (VBP). VBPs will incentivize PCPs to engage Members and close care gaps.

6. Describe the Offeror's proposed process for communicating with Members about PCP/PCMH assignments and assigned PCP/PCMH utilization. Include how the Offeror will monitor, identify, and resolve Member barriers to using assigned PCP/PCMH and keeping appointments.

Please see our response to Section 4.2.2.11.B.6 above for our proposed process for communicating with Members about assignments and encouraging utilization of the assigned PCP/PCMH.

Monitoring, Identifying, and Removing Barriers To Keeping Appointments

Increasing Members' Health Literacy. According to the Agency for Health Care Research and Quality, there is evidence that all Members may experience difficulty comprehending health care information. For these Members, lower rates of health literacy may be the primary barrier to keeping appointments and a primary driver of health disparities. Using Member feedback from satisfaction surveys, Grievances, and other capture methods, we will identify if lack of understanding with their PCPs is impeding Members' ability to engage in their care and leading to missed appointments. We will monitor overutilization of the ED, another possible sign of a Member needing the education to understand how to access care appropriately. We will help increase Members' health literacy using the following strategies:

- ***Increasing health literacy at the systems level*** by strengthening Members' understanding of how to navigate managed care, including learning to engage their PCPs to learn about their health through the innovative Ask Me 3® Technique. This technique will prompt Members to ask three specific questions during Provider visits: 1) "What is my main problem?" 2) "What do I need to do?" and 3) "Why is it important to me?" ***This innovation will help increase Members' understanding of their health and enable Providers to become active participants in increasing Members' health literacy***.
- ***Promoting PCP Utilization*** through a Multi-Cultural Toolkit to engage Black and Hispanic Members whose understanding of how to access care, such as ED visits for low acuity needs, may be influenced by faith and community-related health beliefs. Our culturally aware approach will honor Members' beliefs while educating them on more appropriate settings for care, such as urgent care centers or PCP office visits.
- ***Using Members' Technology Literacy*** to engage them with digital content on our public website, secure Member Portal, or Mobile App. With DOM approval, for example, we will send new Member welcome texts with hyperlinks to YouTube videos featuring community leaders encouraging Members to make their first PCP visit. Our welcome page will also include a video library containing educational webinars about the role of PCPs and PCP selection. Digital information enables Members to acquire health care knowledge via a multi-media experience, which, for many Members, is their preferred method, especially younger Members and families.

In addition, we will also use these methods to monitor, identify, and remove barriers to care:

- ***SDOH Mini Screens***. CSRs and other Member-facing staff will conduct mini-SDOH screenings to identify barriers to care and refer Members with SDOH needs to our Social Services Specialist to remove these barriers, such as scheduling transportation for MSCAN Members. CSRs will also warm transfer Members to our Care Management team who can assess more comprehensively for barriers and educate the Member on the use of telehealth. For example, low mobility, chronic conditions, or COVID-19 restrictions may impede face-to-face Provider office visits.
- ***Care Management Team***. Our CM team will work with Members to track care gaps and over/under-

utilization of services that may indicate issues with accessing appropriate care. CM staff will look for barriers during follow-up calls to Members who have been discharged from the hospital or psychiatric facility. When they identify barriers, they will immediately engage with Members to eliminate issues, for example, by working with an interpreter, finding a PCP/PCMH with specialized disability access and experience, or scheduling an appointment during evening or weekend hours.

4.2.2.11.C Member information

1. Describe the Offeror's proposed process for providing Members with information packets, including identification cards, by fourteen days after the Contractor has received notice of the Member's enrollment. Include the following:

We will ensure we provide Members with information packets, including ID Cards, within 14 days of receiving the Member Listing Report by continuously auditing our processes to ensure compliance with the timeliness requirement. Our approach will consist of the Call Center Quality Department team comparing the number of new and re-enrolling Members with the number of information packets sent, including the mailing dates to audit for compliance with the 14-day timeliness requirement. Because our process will consist of sequentially numbering the information packets, we will identify if packets are sent out of sequence. We will pause the process until we locate the missing information packet if this occurs. Our Compliance Department will provide DOM with the date and number of Welcome Packets/ID Cards distributed to Members each month.

Additionally, our Quality Management (QM) team will review Member complaints monthly, identify issues related to Member materials, and implement changes as needed to prevent reoccurring issues. Our QM team will monitor materials distribution timeliness through a quarterly review of Subcontractor and internal performance reports, Member Grievances, and Provider complaints. The QM team will develop and monitor corrective action plans, as needed to ensure compliance. In addition to mailing hard copies of the Provider Directory to Members who request them, we will also provide hard copies to State Medicaid Regional Offices, WIC offices, and other locations as directed by DOM. We will have hard copies of Provider Directories at our future Mississippi-based offices. For Members re-enrolling with our CCO within 60 days of a previous disenrollment with us, we will send a new Member ID Card and, upon request, the full Welcome Packet and/or a Provider Directory.

We will collaborate with DOM to identify best practices for providing the Welcome Packet electronically, such as by e-mail, or sending text messages to new Members with hyperlinks navigating them to an online Welcome Packet. Our affiliate health plans have seen that providing information, such as Welcome Packets, via digital channels helps drive Member engagement, especially among younger Members and families.

a. Language alternatives that will be available;

In addition to producing materials in English, we will publish and have readily available Member materials in prevalent non-English languages meeting the 5% threshold in compliance with DOM’s Limited English Proficiency Plan and State and Federal law. In addition, we will provide interpreters trained in over 200 languages, including American Sign Language (ASL), through our ISO-certified, language interpretation services partner to support all aspects of Members’ care, including collecting medical history and providing health education. We will be deliberate in seeking to hire bilingual staff to support Members speaking non-English languages. All Member materials, including our website, will inform Members how to request translations for materials and interpreters for live conversations.

b. How the Offeror will comply with information requirements listed in Section 3.2.6, Member Information Packet of Appendix A, Draft Contract;

We will publish the Welcome Packet and all Member information at a 3rd grade reading level, as measured by the Flesch-Kincaid Grade Level Test, and will comply with all the information requirements in Section 3.2.6 in Appendix A, Draft Contract, such as:

- Mailing the Welcome Packets no later than 14 calendar days after receiving notice of Members' enrollment
- Using standard mail, in envelopes marked with the phrase "Return Services Requested" for mailing the Member ID Cards
- Ensuring the Welcome Packets will contain introduction letters, MSCAN and CHIP ID Cards indicating the Member's first effective date of Enrollment, instructions on obtaining a Provider Directory as set forth by 42 CFR 438.10(f)(6)(h), and Member Handbooks
- Providing DOM with a copy of the materials for annual review and approval or when changes are made to

the materials
- For Members re-enrolling with our CCO within 60 days of a previous disenrollment with us, we will send a new Member ID card and, upon request, the full Welcome Packet and/or a Provider Directory

c. The Offeror's proposed methods and creative approaches for obtaining correct Member addresses; and

Proposed Methods And Creative Approaches For Obtaining Correct Member Addresses

We will propose the following methods and creative approaches for obtaining correct Member addresses. Our methods will include successfully reconciling DOM's eligibility and enrollment files with the Member addresses populated into our Customer Relationship Management (CRM) tool via the validated Member List Report. In addition to the addresses from the Member List Report, the CRM will provide a record of the addresses Members have provided in the past or that we have obtained from other sources and whether mailings to these addresses have been successful and not returned. We will direct all Member-facing staff to obtain updated addresses whenever they have contact with Members and to update the information in the CRM. Staff will ask Members to provide their updated addresses to DOM or the Social Security Administration as well as other agencies and community organizations providing services to them.

We will implement creative strategies such as:

Successfully Locating High-Risk Members

CHWs from affiliate health plans have successfully tracked down over 46% of our hard-to-reach, high-risk Members and provided them with support and updated their mailing addresses.

- Developing innovative bidirectional data exchange contracts with the Homeless Management Information Systems operated by the Mississippi Continuums of Care, such as Balance of State.
- Using the four, local Mississippi area codes when we call Members instead of toll-free 800 numbers that Members tend to ignore when displayed on their phones.
- Working with Providers, including community pharmacies, to identify hard-to-reach Members when they present for services so our Provider Services Representatives can update the CRM.
- Collaborating with community organizations who may be providing services to our hard-to-reach Members. For example, some organizations serving unhoused populations will allow their clients to list the organization's mailing address as their own to receive mail at these locations.
- Placing DOM's Change of Address forms on resource tables at community events for Members to update their addresses, and we will provide these forms to community partners as well as to Providers.
- Secure messaging via the Member Portal and SMS texting well as through social media posts on our Facebook page instructing Members how to contact us when their address changes.
- Conducting a New Member Welcome Visit and additional in-person visits by Community Health Workers. These are opportunities to verify home addresses.

d. Process for following up with Members whose information packets or identification cards are returned.

Our process for following up with Members when materials are returned will comply with the requirements in Section 3.2.6. in Appendix A, Draft Contract, and will include a systematic response to reconciling Member addresses. As noted above, we will mail Welcome Packets marked with "Return Services Requested" on the mailing envelopes. Prior to mailing the Welcome Packets, we will compare the Member addresses on file, which have been validated with DOM's enrollment files as described earlier, with the US Postal Services (USPS) database to determine if mail can be delivered to the addresses in our system. In this manner, we will not mail Welcome Packets to undeliverable addresses. For returned Welcome packets, we will follow this process:

- Update Member addresses if USPS provides a new mailing address on the returned mailing envelopes
- View the CRM system to identify changes in addresses since the original mailing and mail new Welcome Packets or ID Cards to the new addresses
- If Members' addresses have not changed, we place alerts in our CRM noting that the returned materials were marked as "Undeliverable" and for Member-facing staff to obtain updated addresses when speaking with Members
- If staff obtain the updated addresses in the CRM, the system will trigger new mailings and all subsequent mailings will go to these addresses

We will validate Member addresses monthly with DOM's enrollment files, and we will direct all mail to the

new addresses from these files.

e. Offeror may choose to include sample Member materials in excess of the page limit.

Please see **Attachment 4.2.2.11.C.1.e Sample Member Materials** for our sample materials.

ATTACHMENT 4.2.2.11.A.2.c DRAFT DISENROLLMENT SURVEY

One (1) appendix response to A.2.c, limited to five (5) pages. The Offeror's draft disenrollment survey.

Health Plan Member Disenrollment Survey

DATE: ____ ____ / ____ ____ INTERVIEWER:_____
Interaction ID: _____ PHONE: (_____) _____-_____

Good afternoon. This is _____ calling on behalf of Health Plan. We are conducting a brief survey about **Health Plan**. (A LINE A CARE)

- ASK FOR MEMBER NAME ON THE LIST. IF UNDER 18 YEARS OF AGE, ASK TO SPEAK WITH HEALTH CARE DECISION MAKER FOR THAT CHILD.
- REINTRODUCE AS NECESSARY.

Let me reassure you I am not selling anything. This is strictly a professional research survey, and I am hoping you can share a few minutes with me. The survey should take less than 5 minutes. Thank you.

Q1.) Do you or anyone in your household participate in Health Plan?

1 Yes → IF SPEAKING TO PERSON ON LIST, SKIP TO Q3
2 No → GO TO Q2
3 Don't Know → GO TO Q2

Q2.) Have you or anyone in your household <u>ever</u> participated in Health Plan?

1 Yes → GO TO Q3
2 No → THANK AND TERM

Q3.) For how long have you been with your primary care doctor?

1 Years (1) _____ OR Months (2) _____ Don't have one (3) ____

Q4.) And how long have you been with Health Plan?

1 Years (1) _____ OR Months (2) _____ Don't have one (3) ____

Q5.) How satisfied are you OVERALL with Health Plan?
Would you say you are: (READ LIST)

1 Very Dissatisfied
2 Dissatisfied
3 Somewhat Dissatisfied
4 Neutral
5 Somewhat Satisfied
6 Satisfied
7 Very Satisfied
9 Don't know

Q5a.) Is there any specific reason you are [INSERT ANSWER FROM Q5]? PROBE & CLARIFY

_____

_____

Q6a.) Read each question separately and record the answer:

	Statement	Yes	No	DK/RF
a.	**Has anyone eached out to you or contacted you directly to ask you about your health history in order to provide you with the services you need? This may have been referred to as a Health Risk Assessment.**	**1**	**2**	**9**
b.	**Has anyone from Health Plan visited you in your home/ the person in your home covered by Medicaid?**	**1**	**2**	**9**
c.	**Have you ever called Health Plan to request transportation? (yes/no probe on complaints)**	**1**	**2**	**9**
d.	**Have you ever called Health Plan to request to call member services? (yes/no probe on complaints)**	**1**	**2**	**9**
e.	**Have you ever called Health Plan to request help for any other reason? (yes/no probe on complaints)**	**1**	**2**	**9**

Q6b.) Read each question separately and record the answer:

	Statement	Yes	No	DK/RF
a.	**Have you ever received information in the mail from Health Plan?**	**1**	**2**	**9**
b.	**Have you ever received a Welcome packet?**	**1**	**2**	**9**
c.	**Have you ever received information about Member Incentives?**	**1**	**2**	**9**
d.	**Have you ever received any other benefits information by mail?**	**1**	**2**	**9**

Q7.) According to our records, it indicates that you/PERSON IN THE HOUSEHOLD WHO WAS COVERED UNDER are switching from Health Plan to another plan on _____ 1st of this year. When the decision was made to switch to another health plan, were you the decision maker, another person in your household, or did the State automatically switch you? (IF SOMEONE ELSE, ASK WHO)

1 Yes, someone else in my household did → GO TO Q**7a** _____
2 Yes, I did → GO TO Q**7b**
3 Yes, the State switched us → GO TO Q**7c**
4 No → THANK AND READ INSERT AT

IF "OTHER" PERSON, TRY TO DETERMINE HOW RELATED OR WHO THEY REPRESENTED:

_____

(IF RESPONDENT SOUNDS ALARMED, DISTRESSED, SHOCKED, OR UNKNOWING, DIRECT THEM TO CALL [NAME] AT HEALTH PLAN, TOLL FREE AT [NUMBER] OR HEALTH PLAN WILL CALL YOU IF YOU PREFER) IF ANYONE FALLS INTO THIS CATEGORY, NEED TO KNOW BEFORE LAST DAY OF MONTH.

Q7a.) Is there a way I can talk with _____ or are you comfortable answering the rest of my questions? It will just take a few more minutes!

Q7b.) What was the main reason you decided to switch away from ? Any other reasons? What do you mean by that? How could it have been improved?)

Q7c.) IF SWITCHED BY THE STATE OR UNAWARE THEY WERE SWITCHED: When you discovered you had been switched, what did you do next? Did you call anyone?

7b/c.) INTERVIEWER INSTRUCTIONS: PROBE AND CLARIFY

_____

_____

_____

Q8.) Next, I am going to read you a list of services provided by . Please rate each one on a scale of 1 to 7 in which a 1 is you were "not at all satisfied" up to a "7" which means you were "totally satisfied" with the service. You may use any number between 1 and 7. (READ ONLY IF NECESSARY - If you do not have an opinion or not sure, simply say so.)

INTERVIEWER INSTRUCTIONS: Probe thoroughly for valid answers. If they respond "Don't Know," ask if anyone else in the family ALSO UNDER may have had an experience with a particular service. The grid below is pre-coded for these opened responses.

SATISFACTION WITH PLAN ATTRIBUTES While you were with Health Plan, please tell me how satisfied you were with the following services.	1 = NOT AT ALL SAT ----- 7 = TOTALLY SAT							
	Not at all	Not very	Some what	Neutral	Satisfied	Very Satisfied	Extremely	DK/ RF
a. Selection of doctor is in the network	1	2	3	4	5	6	7	9
b. Selection of hospital is in the network	1	2	3	4	5	6	7	9
c. Ability to get the prescriptions and medications you need	1	2	3	4	5	6	7	9
d. Transportation to your doctor, provided by	1	2	3	4	5	6	7	9
e. Health Plans's Care Coordination Team	1	2	3	4	5	6	7	9
f. Home visit by CHW (staff from our Health Plan)	1	2	3	4	5	6	7	9
g. Member Services at Health Plan	1	2	3	4	5	6	7	9
h. Welcome Packet (information about benefits and selection of doctors and so forth)	1	2	3	4	5	6	7	9
i. Ongoing communications from the Health Plan	1	2	3	4	5	6	7	9
j. Hospital coverage	1	2	3	4	5	6	7	9
k. Member Incentive Program	1	2	3	4	5	6	7	9
l. Customer Service	1	2	3	4	5	6	7	9

INTERVIEWER INSTRUCTIONS: Probe and clarify any plan attributes that received a 1, 2, 3 or 4 rating.

_____

_____

Q9.) While you were with Health Plan, please tell me how much the following features influenced your decision to switch from to a different managed health plan.
Use the 1 to 7 scale in which a 1 means it did not influence your decision at all and a 7 means it was extremely influential. You may use any number between 1 and 7.

EVALUATION OF INFLUENTIAL FACTORS	1 = NOT AT ALL INFLUENTIAL 7 = EXTREMELY INFLUENTIAL 9 = DK/RF							
				Probe and clarify				
	Not at all	Not very	Some what	Neutral	Influential	Very Influential	Extremely	DK/RF
a. Selection of doctors in the network	1	2	3	4	5	6	7	9
b. Selection of hospitals in the network	1	2	3	4	5	6	7	9
c. My doctor encouraged me to switch to another plan	1	2	3	4	5	6	7	9
d. Hospital encouraged me to switch to another plan	1	2	3	4	5	6	7	9
e. I wanted other or different benefits (Such as – List:	1	2	3	4	5	6	7	9
f. I was recommended to another health plan by a friend or family member (word of mouth)	1	2	3	4	5	6	7	9
g. I learned about another plan from advertising / marketing campaign	1	2	3	4	5	6	7	9
h. I was more familiar with the plan I'm switching to (name recognition)	1	2	3	4	5	6	7	9
i. Needed prior authorization	1	2	3	4	5	6	7	9
j. Getting preauthorization for medications/prescription denied at the pharmacy	1	2	3	4	5	6	7	9
k. Unable to get brand name prescriptions	1	2	3	4	5	6	7	9
l. Unspecified problems with prescriptions or medications	1	2	3	4	5	6	7	9
m. Customer Service Experience	1	2	3	4	5	6	7	9
m. The plan switching to has more benefits and easier to access care	1	2	3	4	5	6	7	9

For any scores between 4 and 7, probe why._____

_____

_____

Q10.) How important are the following additional benefits to you when considering switching to another health plan?

	Extremely Important	Very Important	Somewhat Important	Not Very Important	Not At All Important

a. Dental	**1**	**2**	**3**	**4**	**5**
b. Vision	**1**	**2**	**3**	**4**	**5**
c. No co-pay	**1**	**2**	**3**	**4**	**5**
d. More prescriptions per month	**1**	**2**	**3**	**4**	**5**
e. Hospital coverage	**1**	**2**	**3**	**4**	**5**
f. No prior authorization for services	**1**	**2**	**3**	**4**	**5**
g. Reward program	**1**	**2**	**3**	**4**	**5**
h. Over-the-counter pharmacy program	**1**	**2**	**3**	**4**	**5**
i. Other benefits (Such as – list:	**1**	**2**	**3**	**4**	**5**

Q11.) If given a choice, how likely would you be to return to the Health Plan?

1 Very unlikely
2 Somewhat unlikely
3 Somewhat likely
4 Very likely
5 Extremely likely
9 Don't know

Q12.) What would have to happen to encourage you to stay with or return to Health Plan?

_____

_____

_____

This concludes our survey. Thank you for your time. Have a nice day/evening!

ATTACHMENT 4.2.2.11.C.1.e SAMPLE MEMBER MATERIALS

One (1) appendix response to C.1.e, limited to five (5) pages. The Offeror may include sample member materials.

Welcome to Health Plan

Use this packet to help you better understand your insurance plan and the benefits available to you. It includes important forms and a quick reference benefits booklet. Use these resources to find information about your Health Plan benefits, services and programs.

Questions?

- Call 1-**XXX-XXX-XXXX** (Relay XXX)
- Visit **XxxxxxxxXxxxxxXxx.com**

If you need this information in another format, please contact member services.

YOUR NEXT STEPS TOWARD A HEALTHIER LIFE

Below is your ID card. Please check to make sure all **information is correct**.

Always carry your Health Plan ID card with you.

Create your own Health Plan account at **xxxxxxxxxxxxxxxxx.com.**

Complete the forms online or fill them out in this packet and drop them in the mail.

Looking for a provider? find a healthcare provider by visiting xxxxxxxxx.com Click on Find a Provider for the most up-to-date listing for our providers. If you want to change your PCP, you can do this through your online account or by returning the included form.

Your ID Cards

Bienvenido(a) a

Health Plan

Use este paquete para ayudar a entender mejor su plan de seguro y los beneficios a su disposición. Incluye su manual para miembros, formularios importantes y un folleto de beneficios para referencia rápida. Use estos recursos para encontrar información sobre sus beneficios, servicios y programas de Health Plan.

¿Tiene preguntas?

- Llame al **1-XXX-XXX-XXX** (Relay 711)
- Visite **XxxxxxxxxXxxxxXxx.com**

Si necesita esta información en otro formato, comuníquese con Servicios para los miembros.

Sus tarjetas de identificación

SUS PASOS SIGUIENTES HACIA UNA VIDA MÁS SANA

Abajo está su tarjeta de identificación. Revísela para asegurarse de que toda la **información esté correcta.**

Lleve siempre consigo su tarjeta de identificación de Health Plan.

Cree su propia cuenta de Health Plan en xxxxxxxxxxxxxx.com.

Llene los formularios en línea o llene los que están en este paquete y envíelos por correo.

¿Está buscando un proveedor? Encuentre un proveedor de atención médica visitando **xxxxxxxxxxxxxxxxxx.com.** Haga clic en Encontrar un proveedor para ver la lista más actualizada de nuestros proveedores. Si quiere cambiar de PCP, puede hacerlo a través de su cuenta en línea o enviando de regreso el formulario incluido.

[END OF RESPONSE]

4.2.3 INNOVATION AND COMMITMENT

Central to the Division's strategy for the next contract cycle are a number of new and/or improved initiatives it plans to implement. In this section, the Offeror is asked to make short proposals, giving high-level details about how the Offeror would approach design and delivery of the named program elements. The Division expects the Offeror's proposals to be innovative, drawing on the Offeror's knowledge of advancements in the Medicaid industry that prioritize improved health outcomes, equity, and care; the needs of the MississippiCAN and CHIP populations; and the Offeror's creativity. The Division also expects the Offeror to demonstrate its expected commitment to its proposals by including estimated workforce needs and financial investment where prompted (and of its own volition if the Offeror's wishes to include such details in its plans). The Offeror should also be attentive to standards and expectations described in Appendix A, Draft Contract, in designing its proposals.
After award, winning plans will have to collaborate with the Division, and in some cases, with each other, to have a final plan for each of the following aspects of the Contract.
As noted above, the total number of points available for responses to this subsection is 110 points. Points available per element of this subsection are included in the element's title.

4.2.3.1 VALUE-BASED PURCHASING

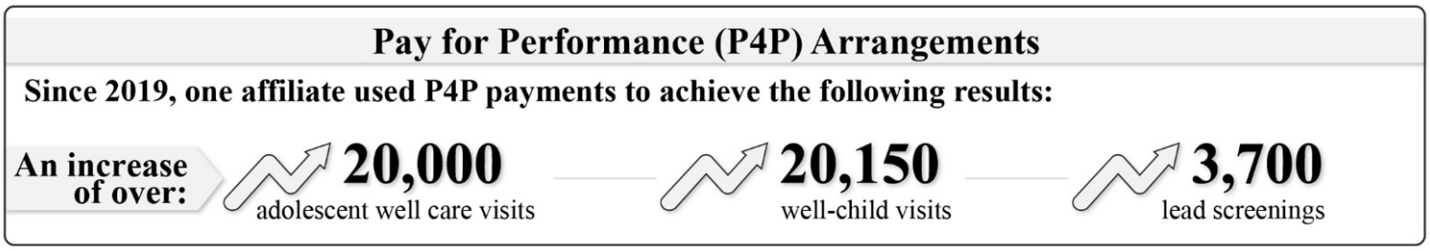
The Division intends to develop a Value-Based Purchasing program to improve health outcomes during the next contract cycle. This program will be developed collaboratively, with input from winning offerors, Division subject matter experts, providers, members, and other stakeholders. The result will be the Mississippi Division of Medicaid Value-Based Purchasing Work Plan, which will be updated as needed to reflect the needs of the Division. More information about this initiative is in Section 8, Quality Management, of Appendix A, Draft Contract. The Offeror must produce a Value-Based Purchasing proposal for the Division, taking into account the Offeror's knowledge of the needs of the Division, its Members, providers, the state, and the requirements included in Appendix A, Draft Contract. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.

Our Overall Value-Based Purchasing Approach

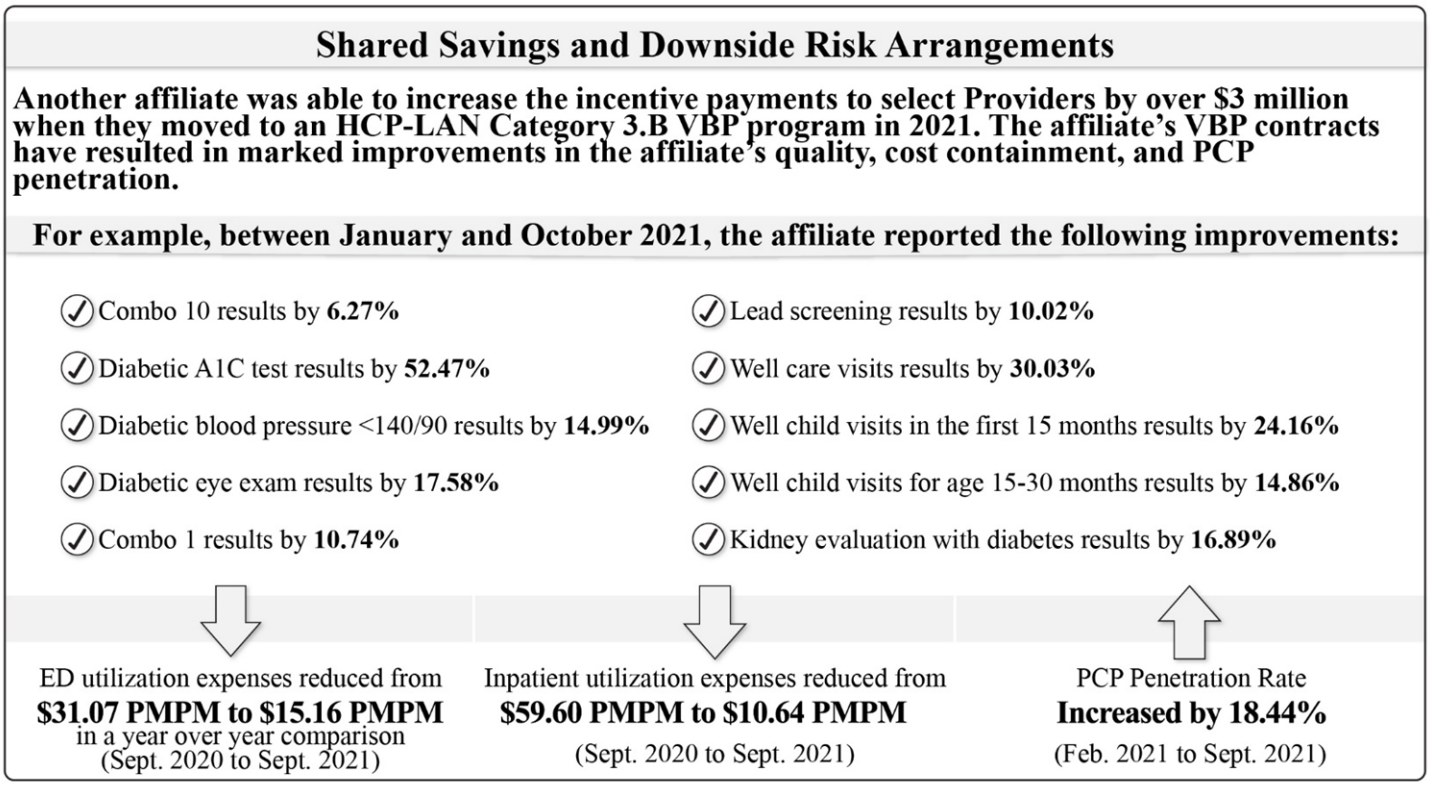
Using value-based purchasing (VBP), we are able to align the success of our Providers with the well-being of our Members and achieve meaningful improvement in health outcomes while lowering the overall cost of care. Our Medicaid VBP program links payment to value for improved quality, reduced costs, and better Member satisfaction. We are committed to assisting DOM with its efforts to develop its Medicaid VBP Work Plan. We will develop our Integrated Primary Care Value Based Purchasing (IPC-VBP) proposal in the first 90 days of the contract, using an inclusive stakeholder process. The process will engage stakeholders such as:

- DOM and other relevant agencies, such as the Mississippi Department of Mental Health (MDMH)
- Federally Qualified Health Centers (FQHCs)
- Community Mental Health Centers (CMHCs)
- Accountable Care Organizations, such as Aledade's PCP and FQHC networks
- Community Health Center Association of Mississippi (CHCAMS)
- Mississippi Association of Community Mental Health Centers
- Mississippi State Medical Association
- Mississippi Rural Health Association
- Mississippi Public Health Institute
- University of Mississippi Medical Center (UMMC)
- Evers-Williams Institute for the Elimination of Health Disparities at UMMC
- UMMC Preventive Health Program
- Children's Hospital of Mississippi

We will meet with key informants and conduct a landscape analysis to include all relevant stakeholders. We will use our extensive knowledge, coupled with the insight we gain from our stakeholders, to develop our IPC-VBP Proposal (Proposal). The Proposal will take into account the needs of DOM, the needs of MSCAN and CHIP Members, Mississippi Providers, and the overall goals and objectives of the State to improve the health and well-being of its residents. Our Proposal will also incorporate the health needs that Mississippi has identified in its assessment and planning efforts, including through the State Health Improvement Plan and State Health Assessment and DOM's contractual requirements for CCOs. Our IPC-VBP Proposal will dovetail with our Patient Centered Medical Home (PCMH) proposal. The stakeholder process that we describe in both the PCMH response in Section 4.2.3.2 and this VBP response will be conducted concurrently in a single planning process to maximize the time of the involved stakeholders. We are able to meet specific performance targets, as outlined in the Performance Measures Manual and will meet all performance targets that are established in DOM's Medicaid VBP Work Plan.

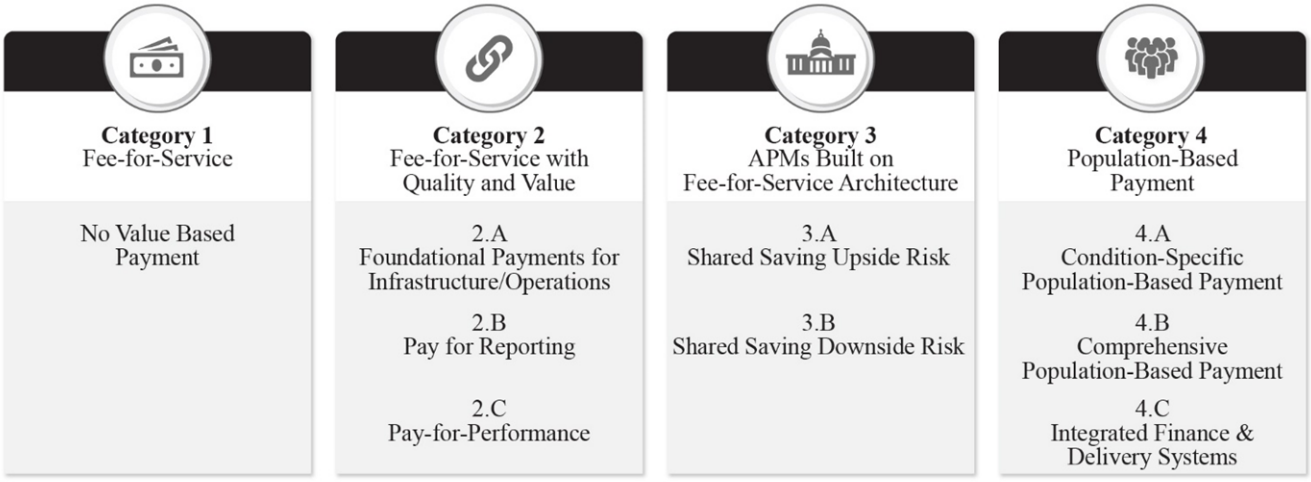


We have significant experience in VBP across our Medicaid markets and have been a pioneer in VBP, working closely with our state partners across the country since they began using alternative payment methodologies (APMs). Our goal in every state has been to increase the use of VBP strategies and assist Providers to move from volume-based to value-based payment methods. As it will be with the development of our IPC-VBP proposal for DOM, our focus in other states has largely been on primary care and the role that VBP plays in supporting advanced primary care practice. We have also established VBP in certain specialties, such as endocrinology and hematology. We collaborate with Providers to design goals, metrics, payments, and supports for our VBP programs that specifically meet the unique needs of Medicaid Providers and Members and help Providers advance to risk models that hold Providers accountable for the services they can control while also offering them enhanced revenue opportunity. Our success depends on strong partnerships with PCMH Providers and ACOs, investments in actionable data, and high touch technical expertise that supports Provider success. We realize that all PCPs participating in MSCAN and CHIP have not all advanced at the same pace in terms of PCMH practice transformation. By providing the right incentives to the right practices at the right time, we can leverage proven methods to successfully advance Provider practices across a continuum of payment and care transformation.



To achieve this goal, we offer VBP across the entire spectrum of the Health Care Payment Learning & Action Network (HCP-LAN) APM Framework, represented in **Figure 4.2.3.1.A** below.

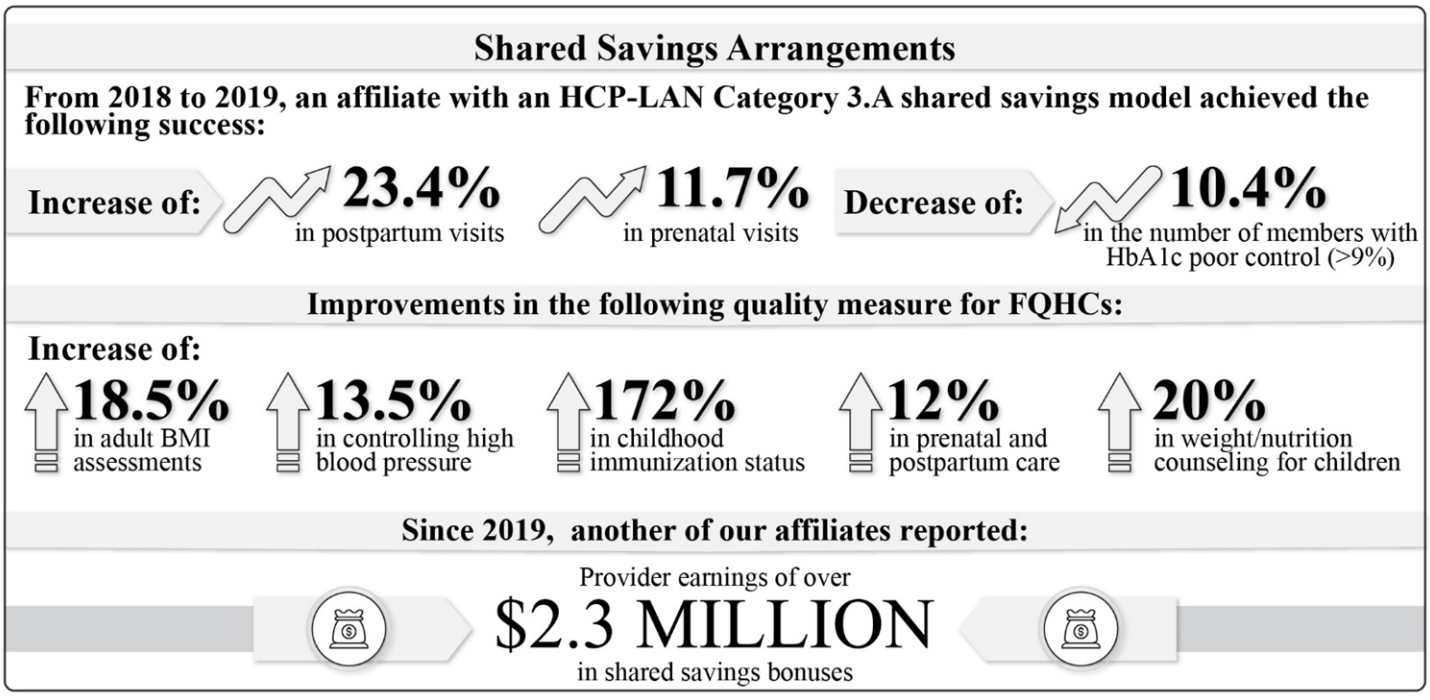
Figure 4.2.3.1.A HCP-LAN APM Framework



Our VBP Experience and Success

Across our Medicaid health plans nationwide, we currently have over 16,527 Provider contracts for 10 million Members aligned with HCP-LAN APM Category 2C or higher. ***Currently, 76% of our Medicaid enrollees are linked to quality and risk models***. We have experienced substantial performance improvement in aggregate through VBPs. Medicaid performance-based payments have resulted in:

- 20% lower ED use and 10-15% lower inpatient admissions
- 25% higher quality scores among participating Providers
- 30% additional payouts to Providers



Proposed VBP Payment Strategies

Based on our extensive knowledge of the health care needs in Mississippi and our understanding of DOM's priorities, we propose a number VBP strategies that have demonstrated success across our Medicaid programs nationwide. These strategies will be reviewed and further informed with input from local stakeholders, using the

planning process that we have described above. We reiterate our commitment to work with DOM and all stakeholders in establishing locally responsive strategies to achieve the State's goals and objectives as DOM develops its VBP Work Plan. In the section below, we frame our proposed VBP strategies in terms of health care needs and concerns that have been identified by Mississippi State agencies (e.g., DOM, MDMH, Mississippi Department of Health), including those resulting from the burden imposed on MSCAN and CHIP Providers as they care for Members in the midst of the COVID-19 pandemic.

Expansion and Use of PCMHs in Improving Outcomes and Reducing Cost. Our support of the PCMH model is discussed at length in our response to Question 4.2.3.2. Our IPC-VBP approach will support PCMHs and help them move along the VBP continuum. Where PCPs are involved in shared savings models and ACOs, but have not yet achieved PCMH recognition, our IPC-VBP Proposal will provide financial incentives for them to gain and maintain PCMH recognition. We will provide a payment to all Providers to attain and maintain PCMH recognition. The payment will be provided to PCP practices that have been accepted into our PCMH program as fully recognized or working toward recognition. The table below illustrates a VBP model that we have used successfully in other states to meet this objective.

Model (HCP-LAN Category)	Model Description
PCMH Recognition (2.A, 2.B, 2.C)	Entry level model that supports PCPs of any size to gain/maintain PCMH recognition by providing a PCMH payment (PMPM) to recognized PCMHs or PCPs working toward recognition. FFS + incentive payments for reporting certain HEDIS/health outcome measures and improvement over time.

Our IPC-VBP approach will not only support the expansion and use of PCMHs in Mississippi, it will also include VBP models that offer an enhanced reimbursement structure to Providers ready to accept downside risk, in addition to upside quality payments.

[redacted]

Behavioral Health. We have decades of experience managing behavioral health services for both children and adults covered by Medicaid programs across the country. We understand that behavioral health conditions drive the total cost of care for many high-risk Members. A recent study of over 21 million Medicaid recipients confirms that the most expensive Medicaid Members (10%) account for over 70% of the total annual Medicaid costs, and that 57% of those Members are affected by behavioral health conditions or mental illness. Treatment of behaviorally led conditions for high-risk Medicaid Members accounted for 44% of the costs of the entire Medicaid health care spend for those 21 million Medicaid Members[1]. This study, and many similar research findings, underscores the urgency for effective treatment in financial models that support evidence-based, collaborative care.

We have a national team of experts with deep experience that are dedicated to advancing the approaches to behavioral health care in use by our Medicaid affiliates across the country. We will bring sophisticated analytic

[1] Davenport, Stoddard, et al. *Milliman High Cost Patient Study 2020*. Milliman, 13 Aug. 2020, https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx.

systems and performance-based strategies to our VBP approach in Mississippi. We partner with several behavioral health analytics and service management companies that have demonstrated success in managing risk, improving care, and reducing costs in the delivery of behavioral health care to the Members we serve. The programs we have supported have demonstrated improvement in health outcomes for some of our most complex Members. We will enable our MSCAN and CHIP BH providers to drive outcomes and integrate care through the following:

BH P4P Program. Our BH P4P Program will promote Mississippi BH Provider engagement of moderate to high-risk Members in appropriate care settings. Working in collaboration with CMHCs, we will financially incentivize participating BH Providers to engage Members, administer baseline and follow-up assessments, initiate treatment, and deliver timely follow-up care that results in demonstrated improvements in select BH HEDIS measures and Member outcomes. The program is backed by our analytics partner, which aggregates heath and assessment data from multiple sources to support program reporting and reduce Provider administrative burden. To support Providers in success under VBP, we will use predictive modeling and other analytic tools to develop and share reports that provide data such as non-medical risks, claims, care gaps, ADT alerts for ED visits and inpatient admissions. In sharing these reports, our dedicated Provider Relations staff offer BH Providers data transparency and identify opportunities to improve workflows and optimize Provider success.

Mindoula. We will deliver innovative BH services and care coordination in a downside risk value-based arrangement with Mindoula. Each intervention will increase access to care, improve health outcomes for Members, and improve cost outcomes to the State through team-based, 24/7 care extension, psychosocial education and skills training, addressing social determinants of health, and optimizing and enhancing our BH provider network. Our Members will benefit from Mindoula programs such as, Interpersonal Violence Reduction, Suicide Prevention, OUD & SUD Exposed Pregnancy, Substance Exposed Living. Mindoula's care coordinators give PCPs resources to provide integrated behavioral health care to Members who might otherwise need an external referral. Mindoula currently works with over a dozen national health plans serving Medicaid populations, as well as with regional and statewide health systems across the country.

We will design our VBP behavioral health model to meet MSCAN and CHIP Providers where they are today and help them take on more complex models of payment as they progress in the capacity to manage risk and be accountable for care, cost, and outcomes. We realize that many Providers that are not part of ACO programs for their most complex behavioral health Members will need to begin with FFS-based P4P contracts that allow them to earn bonuses for the use of evidence-based clinical measures. As Providers progress along the value-based continuum, bundled payments and upside risk programs will allow them more flexibility in the use of funds to invest in innovative care solutions that improve the health and well-being of their Members, including team-based integrated care, case management, and the coordination of services aimed at addressing critical social determinants of health (SDOH).

Integration of Physical and Behavioral Health Care. Our IPC-VBP proposal will provide incentives for PCMHs to integrate behavioral health care into their primary care settings, such as incentive payments for achieving behavioral health integration according to SAMHSA/HRSA Standard Framework for Levels of Integrated Health Care. Our payment models are designed to support meaningful bi-directional PH and BH

[redacted] to assist Providers with the complex tasks of managing care, managing risk, and accounting for service in VBP contracts. We have partnered with organizations like Aledade in numerous states, and we will contract with Aledade in Mississippi, where both rural private PCPs and FQHCs have formed ACOs that contract with MSCAN and CHIP.

We recognize that access to care is a challenge for ***Mississippians living in rural northeast Mississippi*** due to an inadequate supply of physicians, compounded with an older average age of PCPs. To reduce SDOH barriers and increase member engagement and access to primary care for members living in 15 counties in northwestern Mississippi, we will implement a value-based targeted Virtual PCP program. Virtual PCP is an innovative value-based program designed to increase access, improve quality, decrease costs, and advance health equity. The program will supplement efforts by the Member's local PCP to increase engagement, not replace the PCP. Over a 9-month pilot period, a Medicaid affiliate serving a similar population achieved a 3% decrease in non-emergent ED visits, 97% Member satisfaction with the Virtual PCP, and HEDIS improvements i

- Chlamydia Screening (13.6 percentage point increase)
- Lead Screening in Women (10.5 percentage point increase)
- Postpartum Visits (23 percentage point increase)
- Child and Adolescent Well Care Visits (2.1 percentage point increase)

Health Disparities in SDOH. VBP can be a strong tool to design equity-focused payment and contracting models (payment approaches). The Milbank Memorial Fund reports that the movement toward value-based care provides a significant opportunity to address SDOH while improving value and quality of care. These equity-focused payment approaches can support and incentivize care delivery transformation to reduce disparities in health and health care. Equity goals can address disparities within specific populations, geographic areas and health conditions, and can be measured through access to care, process of care, and clinical or non-clinical outcomes. As we develop our IPC-VBP proposal we will use the planning process we have described above to involve all stakeholders in identifying disparities and SDOH that we will use in VBP to mitigate disparities. There are examples we collectively learn from, such as:

- Michigan's ***Index of Disparity***, which estimates the population disparity by combining the disparity experienced by all subgroups into one metric.
- Colorado's Primary Care APM measures improvement relative to a provider organization's own benchmark which can facilitate ***fairer comparisons*** across Providers and accounts for contextual factors (e.g., COVID-

19 pandemic) that may influence outcomes.

- The Center for Medicare and Medicaid Innovation's ***Accountable Health Communities screening tool*** is an entry-point tool used by organizations participating in the Accountable Health Communities model.
- The ***PRAPARE assessment tool***, maintained by the National Association of Community Health Centers, works in conjunction with core questions from the Accountable Health Communities tool but assesses a more expansive set of SDOH measures.
- Washington State Medicaid developed the ***Predictive Risk Intelligence System (PRISM)*** decision-support tool, which identifies the medically and socially complex patients by integrating payment, administrative, and assessment data across the medical, social service, behavioral health, and long-term care sectors. This is data that the Mississippi State agencies may be able to provide but is not likely to be accessible to CCOs.

We will design our VBP model through a health equity lens. We will work with experts, like the Evers-Williams Institute at UMMC, which focuses on health care, food insecurity, education, and research to address the determinants of disparity and advocate for policies to eliminate them. We will draw from our experience integrating SDOH into our VBP strategy in other states. The table below illustrates VBP models that we have used successfully in other states to address SDOH and health equity. We propose to build this model into our IPC-VBP proposal.

[redacted]

Chronic Conditions. We will align with DOM in making improving health and cost outcomes related to chronic conditions a major priority for our health plan. Vigilant Health, a Mississippi company with industry leading clinical results, has a national scope and growing national recognition. We will partner with Vigilant to offer a value-based comprehensive health management program in all 82 Mississippi counties for Members with one or more of the following twelve chronic conditions:

- Diabetes
- Hypertension
- Dyslipidemia
- Mental Health
- Chronic Kidney Disease
- Stroke
- Peripheral Vascular Disease
- Ischemic Heart Disease
- Congestive Heart Failure
- Chronic Lung Disease
- Cancer
- Pregnancy

The Vigilant model is designed to integrate the highest standards of medical science, good medical practice, deep insights into human behavior, and population science into a unified whole that is simple in its application for clinicians and powerful in its results for patients and payers. The model will have the following components:

- Community physician participation, leadership, and collaboration
- Clinics for Members in every Mississippi county staffed with dedicated care managers and patient engagement specialists
- Intensive medical management including customized plans of care for the population as a whole and for each individual Member developed and care navigation and management guided by data analytics and the plans of care
- A technology platform built to measure clinical and economic results, drive performance improvement, guide quality management activities, and manage utilization
- Live patient encounters through remote communications media and technology, including telemedicine.
- Reduction of barriers to access through the elimination of waits for appointments
- Health education and wellness programs

Vigilant has a 22 year track record of clinical and economic results in Mississippi, including disadvantaged individuals in underserved rural and urban communities. The Vigilant program eliminates health disparities in

the individuals enrolled in its programs related to socioeconomic status, education, neighborhood and physical environment, employment, and social support. Their specialized diabetes program has demonstrated a decrease in medical paid claims of $2,742 per participant and improvements in HbA1c, blood pressure, and cholesterol control. Severely out of control diabetes (A1c > 9.0) decreased by 73%, hospitalization rates decreased by 50%, and ED utilization rate decreased by 23% among program uses.

Sickle Cell Disease. We will build a VBP strategy for providing incentives to PCPs/PCMHs to better care for children and adult Members diagnosed with Sickle Cell Disease (SCD), which disproportionately affects Mississippians of African American descent. In addition to the training tools we plan for our PCMH program, we will establish benchmarks for PCP treatment of the disease and require tracking and reporting of care. We will build incentives into our IPC-VBP model to achieve better results with the standard of care and better access to care for MSCAN and CHIP Members. To address SCD coupled with behavioral health condition(s), we will contract with Mindoula for its innovative Sickle Cell Disease Management program.

Perinatal Health. Mississippi continues to have one of the highest rates of adverse perinatal outcomes (e.g., low birth weight, pre-term birth, infant mortality) in the country, with racial, socioeconomic, and geographic disparities in those outcomes. We have had success addressing perinatal outcomes in other Medicaid markets. In our meetings with stakeholders during the IPC-VBP proposal planning process, we will explore which VBP strategies would be most effective at supporting continued improvement in perinatal health outcomes in Mississippi. The table below illustrates a VBP model that we have used successfully in other states to improve perinatal outcomes. We propose to build this model into our IPC-VBP proposal.

[redacted]

Children with Complex Needs. We have a number of VBP programs aimed at children with complex medical needs, children experiencing serious emotional disturbances, and children with medical conditions complicated by trauma or other behavioral conditions. We will work with UMMC and pediatric behavioral health Providers to offer VBP options that will support them in providing care for children with complex needs. Flexible payment arrangements using VBP have been shown to improve health outcomes and lower costs for children with complex needs. The table below illustrates VBP models that we have used successfully in other states to improve care for children with complex needs. We propose to build these models into our IPC-VBP proposal.

[redacted]

Implementation

Appendix A, Draft Contract asks how the IPC-VBP proposal will handle certain implementation issues. We discuss these issues below.

Provider Recruitment and Retention. Our VBP strategy in MSCAN and CHIP will honor our commitment to work in close collaboration with Providers to continuously refine program measures and performance targets to reflect and advance population health and care transformation that addresses the needs of our Medicaid Members. We will execute a Provider recruitment strategy immediately upon contract award, leveraging our Provider Relations infrastructure. Our Provider network activities, including recruitment are addressed in our response to Section 4.2.2.2.A of the RFQ. Our VBP options will be an asset in our ability to develop a comprehensive and complete network for MSCAN and CHIP. We will form a Joint Investment Task Force to partner with ACOs to advance care initiatives that will meet the aim of improving health and lowering costs.

VBP has been cited by experts in health policy at CMS, the Milbank Memorial Fund, Center for Health Care Strategies, Patient Care Primary Care Collaborative, and Robert Wood Johnson Foundation as a key strategy to offer flexibility in service delivery payment that can support community-based efforts in prevention, care coordination, peer support, Member engagement, and PCMH models. We understand the impact that such activities have on improving health and reducing costs for Medicaid Members. We have the demonstrated commitment to build inclusive VBP models that support these services.

Tools and Capabilities for Executing VBP and Assuring Its Success. We will leverage our full capabilities in managing VBP contracts and accounting for results. We will apply data science and analytic techniques to assess a Member's risk for developing disease or adverse health outcomes and other predicted health behaviors. Predictive analytic tools enable us to develop targeted VBP strategies and communicate rising risk to Providers so they can meet VBP performance measures.

We have a wide range of technology tools that can assist our Providers in succeeding in VBP contracts. Our Reporting and Analytics Platform provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards. Through our Reporting and Analytics Platform, we have the ability to report on all datasets, including HEDIS, EPSDT services, claims timeliness, Performance Improvement Projects, and other critical aspects of operations. Our Provider Portal offers data on cost and utilization trending, quality measure performance, disease prevalence, readmissions, and health trends. The platform features custom selection, drill-down, and export capabilities to identify trends and factors behind clinical and cost performance and develop targeted actions to improve quality. It includes the following functional tools to manage VBP contract performance:

- Patient Analytics Dashboard, which enables nurse Care Mangers and other authorized members of the Provider health care team to access chronic conditions registries, gaps in care, opportunities to improve outcomes, physical health and behavioral health diagnosis, medication, lab, and care team data. The Dashboard can be used to aggregate data for Members across a health population segment.
- Provider Analytics Dashboard, which gives Providers the ability to assess cost and utilization trending, performance on quality measures, and health trends. Data can be analyzed by individual Provider panel, an entire practice, a practice network, or a health population.

Payment Methodology. We will increase the use of VBP to establish a goal that 80% of our payments to MSCAN and CHIP PCPs/PCMHs will be in an HCP-LAN APM Category 2 or higher. We will use our tools and staff expertise to form true partnerships with our VBP Providers to help them steadily move up the APM continuum as they gain experience with the principles of accountability and management of risk. Our utilization and cost analysis can help Providers understand their role in impacting the total cost of care for their population, and also understand what type of risk sharing arrangement works for them. The overall goal of our VBP will be to improve the lives of the people of Mississippi through better health care for better overall health. We will work with all stakeholders in fulfillment of that common vision.

Enrollment. During our planning process, we will discuss enrollment issues with DOM to determine what considerations should be made in auto-enrollment as it relates to VBP, consistent with Section 3.2.3 of Appendix A, Draft Contract. In addition to CCO enrollment considerations, we will ensure that Provider attribution methods reflect the performance of VBP Providers, the needs of the Member, geographic access to care, and the ability of Providers to work toward closing health gaps for the populations they serve.

Innovation

We propose to use VBP strategies to bring innovative care approaches to address anew some of the health issues discussed above. For example, we will offer the following programs through HCP-LAN 3.B shared savings with downside risk contracts with Mindoula in Mississippi:

Interpersonal Violence Reduction. A program that analyzes claims and other population health data to identify Members who may have suffered injury due to self-harm, abuse, assault, or poisoning. Three years of data and results in one state has shown a 265% return on investment ($3,929 PMPY) for Members with a Level I Interpersonal Violence score, resulting in 48% fewer hospital admissions, 13% fewer ED visits, and 25%

lower pharmacy costs than the control cohort.

Suicide Prevention. Mindoula provides child and adolescent telepsychiatry and virtual Dialectical Behavioral Therapy on a FFS basis as an in-network Provider for CCOs across the country. Mindoula couples this with 24/7 Care Management for Members and their caregivers delivered through a smart phone app that includes telephonic access, location-based tracking for crisis management, sleep monitoring, health care navigation to available local resources and a connection to in-network behavioral health Providers.

High Risk Care Coordination. Midoula works with CCO data to risk stratify Members who are diagnosed with a SMI. The program then uses 24/7 tech enabled care coordination to support the Member in obtaining the needed clinical and social services that will support their daily living and help manage crisis. The program works closely with CMHCs, FQHCs, and other Providers who are on the front lines of care with these Members. Mindoula has demonstrated a total cost reduction of 10%, with higher results for certain segments of the population, including Members with sickle cell anemia ($18,000 PMPY savings), chronic pain ($6,500 PMPY savings), and Members living in rural areas ($7,160 PMPY savings).

Improving Outcomes in Substance Exposed Pregnant Women. Mindoula's StrongWell program is designed to help women who are using opioids or other illicit drugs, working closely with the local Provider community and supporting Members with 24/7 Care Management, including support from certified Peer Recovery Specialists and Nurse Educators, to reduce costs and improve outcomes. We will also explore developing incentive programs, using the Centers of Excellence Model, to work with local FQHCS and prenatal Providers to co-locate medication assisted treatment in prenatal care centers.

In addition to the above programs offered through Mindoula, to combat the opioid overdose epidemic, we will develop incentives as part of our IPC-VBP proposal for the co-location of Medication Assisted Treatment (MAT) in primary care practices, particularly PCMHs. See our response to Section 4.2.3.2 of the RFQ for more information on the training aspects for this MAT initiative in the PCMH program.

4.2.3.2 PATIENT-CENTERED MEDICAL HOME (PCMH)

The DOM has placed an emphasis on Patient-Centered Medical Homes for its next contracting cycle. PCMHs should be made available to all medium- and high-risk Members. The system is discussed more in Section 6.2.5, Patient-Centered Medical Homes, of Appendix A, Draft Contract. The Offeror must produce a PCMH proposal for the DOM, including how it will have PCMHs interact with other elements of its programs to Members' benefit, with an emphasis on the mechanisms through with PCMHs will be able to coordinate with Care Management, any incentive programs used to recruit and retain PCMHs, and methods for measuring success of PCMHs both individually and as a system. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.

Our Overall Patient Centered Medical Home Approach and Experience

We have long recognized the value of Patient-Centered Medical Homes (PCMHs). Since 2007, when the Joint Principles of the PCMH were first published by primary care-oriented medical societies and payers and Providers were brought together by the Patient-Centered Primary Care Collaborative, we have been engaging PCMHs in innovative care coordination, quality improvement programs, and value-based purchasing (VBP) arrangements that have bent the curve on cost and improved health outcomes for the Members we serve. ***Our experience in many Medicaid-sponsored payer/Provider initiatives allows us to bring sophisticated tools, innovative payment strategies, knowledge, and expertise to bear in strengthening the PCMH initiative in Mississippi.*** Our approach to PCMH model implementation benefits from the lessons we have learned and the experience we have gained in our affiliate health plans. Our models are often developed in response to State agency requirements, including alternative payment methodologies (APMs) targeted to PCMHs. We have the demonstrated capacity to develop a robust PCMH program for MSCAN and CHIP Members. Our PCMH initiatives have proven successful in integrating care, providing care management that is based in the community, and reducing unnecessary utilization of high-cost services. **Table 4.2.3.2.A** below summarizes some of the recent lessons learned and successes in our Medicaid-based PCMH programs nationwide.

Table 4.2.3.2.A PCMH Lessons Learned and Successes from Affiliate Medicaid Plans

Lessons Learned	Demonstrated Success
PCMH support results in improved outcomes	Our affiliate health plans recognize that ongoing PCMH support, engagement, and data sharing contribute to improved outcomes. During the first year of assigning 1,300 children with special health care needs to a pediatric PCMH, one of our affiliates reduced hospital admissions by 63%, emergency department (ED) visits by 39%, and achieved cost savings of nearly $5.2 million. Another affiliate achieved a 56% decrease in NICU rates for Members assigned to a Federally Qualified Health Center (FQHC) serving high-risk pregnant Members by implementing community-based integrated care coordination. **Our PCMH program in Mississippi will include strategies to achieve these types of results.**
Supporting PCMH transformation allows PCP practices to deliver integrated, coordinated care	Our affiliates have significantly increased the number of PCMH practices in their states using grants that helped Providers to achieve PCMH recognition. We partnered with the State agencies and Primary Care Associations (PCAs) to fund the grants, which have been administered through PCAs and medical societies. Our affiliates have developed and executed comprehensive PCMH training programs that led to increased PCMH recognition as well as continued innovation among the established network PCMHs. **We plan to partner with the Community Health Center Association of Mississippi (CHCAMS) to supplement and leverage their training resources to support the PCMH transformation of the remaining FQHCs in Mississippi (35%) who have yet to achieve NCQA (or equivalent) PCMH recognition. We will work with other academic and medical associations to facilitate PCMH recognition among private PCPs in our MSCAN and CHIP networks**.
Dedicated PCMH specialists maximize NCQA PCMH recognition	We provide dedicated PCMH specialists in most of our affiliates. One of our affiliates recently supported 30 PCP practices in attaining NCQA PCMH recognition. **Our PCMH program will include a dedicated PCMH Program Director to work directly with our PCMH Providers and those aspiring to PCMH recognition**.

We believe that a robust PCMH model includes team-based practice organization with the following nationally recognized functional elements:

- Standards for data collection, medication reconciliation, and evidence-based clinical decision making, particularly for complex patients with chronic disease
- Patient-Centered access to care and continuity
- Care management support for patients and clinicians
- Care coordination for patients with chronic illness and complex conditions
- Continuous improvement processes using performance measurements

Drawing from our national expertise and capabilities, we can assure DOM that we have the capability to support PCMHs in developing, maintaining, and strengthening these basic elements. Using our advanced data analytics, care management, Member engagement, and value-based purchasing, we can support our PCMHs and leverage their strength to provide meaningful improvement in health outcomes and total cost of care for our MSCAN and CHIP Members. The coordination of our CCO capabilities coupled with the advanced practices of our PCMHs will assure that every Member receives the care they need, when and where they need it, in a manner that is socially, culturally, and linguistically appropriate to their individual circumstances.

We will create a comprehensive PCMH strategy and submit it to DOM within 90 days of the contract award. We will work with DOM to revise our approach as it works toward developing uniform approaches across CCOs and PCMHs. We are also committed to fulfilling DOM's contract requirement to develop an NCQA-recognized PCMH program for each medium and high-risk Member identified in the Health Risk Screening and Comprehensive Health Assessment. To develop our PCMH strategy in the first 90 days, we plan to use an inclusive stakeholder process, engaging State officials from the DOM and other relevant agencies (e.g., Mississippi Department of Mental Health), FQHCs, CHCAMS, the Mississippi State Medical Association, the Mississippi Rural Health Association, the Mississippi Public Health Institute, the Mississippi Association of Community Mental Health Centers, University of Mississippi Medical Center, and Members in MSCAN and CHIP. This stakeholder list is not exhaustive. As part of our planning process, we will meet with key informants and conduct a landscape analysis to include all relevant stakeholders in our planning process.

We will leverage our expertise and experience on innovative PCMH program development. Experts within Mississippi and available through our national departments will design and implement a program that strengthens Mississippi's current PCMHs and expands the model to more PCPs. We will use an integrated team approach to support PCPs in both small and large practices in their continued transformative PCMH journey. We can provide tools, share best practices, establish guidelines, and work collaboratively with Members, Providers, and stakeholders across Mississippi in meeting DOM's goals to maximize the use and benefits of the PCMH model.

We will place a PCMH Director who will work with all prospective and existing PCMH practices on strengthening their model development. The PCMH Director will oversee our training activities and will collaborate with associations, such as CHCAMS, involved in PCMH transformation training. We also plan to support the ongoing efforts of PCMH-recognized practices by sponsoring training conferences where PCMHs can share best practices and develop innovative programs, for example, behavioral health integration programs to address social determinants of health (SDOH), use of telehealth, and expansion of medication-assisted treatment (MAT) in their primary care practices. These training opportunities will be a critical retention strategy with PCMHs. Our process to partner with PCMHs is illustrated in **Figure 4.2.3.2.A**. The PCMH Program Goals 1-6 below provide details on our approach for the PCMH program in Mississippi.

Figure 4.2.3.2.A Process to Partner with PCMHs to Improve Primary Care Services

PCMH Program Goals

In this broad overview of our PCMH program, we highlight six goals for our proposed PCMH strategy. We discuss specific processes that DOM specified in Section 6.2.5 of Appendix A, Draft Contract as they relate to these goals.

Goal 1: Increase the number of MSCAN and CHIP PCP practices with PCMH recognition

We will partner with all Mississippi Providers who are committed to advancing Mississippi's PCMH model through value-based approaches and quality outcomes. Our experience working closely with FQHCs will allow us to provide the MSCAN and CHIP programs with effective care in Mississippi's rural regions and hardest to reach populations. Currently, 65% of Mississippi's FQHCs are recognized by the Health Resources and Services Administration (HRSA) as having PCMH recognition (either NCQA, Joint Commission, or Accreditation Association for Ambulatory Health Care [AAAHC]). All of Mississippi's FQHCs participate in the CHCAMS Primary Care Collaborative (CHCAMS-PCC) and participate in an accountable care organization (ACO) with Aledade, a national company that has provided ACO services and value-based contract management to Providers across the United States. Since 35% of the FQHCs are not PCMH-recognized, we will work closely with CHCAMS to support continued PCMH training. ***Our goal is to see 100% of CHCAMS's FQHCs attain PCMH recognition from NCQA (or any other DOM-approved external accrediting organization (i.e., Joint Commission, AAAHC)).***

It appears that there are no private PCP practices or groups with PCMH recognition in Mississippi. In certain areas, such as the Mississippi Delta, where none of the PCPs are PCMH recognized (e.g., Delta Family Medical Services, a private practice, and Delta Health Center, the nation's first FQHC), we are encouraged by the fact that these practices are in Aledade value-based ACOs. This indicates that those practices are using data to manage care toward better health outcomes and cost-efficiency. Our PCMH program staff will work with them and all PCPs, to help them attain NCQA PCMH recognition.

We are committed to working with DOM, academic medical partners, hospital systems, medical associations, and Provider networks to support private PCPs in obtaining PCMH training and attaining PCMH recognition. We believe this is particularly important for PCPs currently participating in MSCAN and CHIP VBP contracts. ***Our goal is to increase PCMH recognition for private PCPs in the first 18 months of contract execution.*** We will focus on recruiting PCPs who serve a significant number of MSCAN and CHIP Members. We will analyze claims data to determine which PCPs are serving the highest number of Members in our network. We will consider what their status is in our VBP contracting arrangements and then our Network Development team, along with our PCMH Director, will arrange a meeting to discuss the PCMH program and its advantages to them and their Members.

We plan several strategies to recruit and retain PCMH practices. Our PCMH Director will reach out to non-PCMH PCPs (focusing first on high volume and safety-net Providers) to discuss their interest in and readiness for PCMH recognition. We will review incentives that we will offer PCMHs, such as a Pay for Performance. If the PCP is then interested in obtaining PCMH recognition, we will work with them to determine their readiness and help them locate the training resources that they will need to enter the PCMH program. Providers that enter our PCMH program will need to pass the NCQA readiness test, have the necessary information technology in place, hire PCMH program staff, and enter a PCMH training program.

CHCAMS and other medical associations have contracted with PCMH coaching consultants and trainers. Since there are training resources available, we do not foresee providing PCMH training directly. Rather, our PCMH program will assist in paying for training through PCMH incentive payments detailed in our response to Section 4.2.3.1 of the RFQ. We would be eager to work with DOM and stakeholders in establishing a statewide training initiative. Many states have their own transformation collaborative training centers that are open to FQHCs and

private practices alike. There are HRSA-funded resources available directly to FQHCs and through CHCAMS-PCC. If a statewide training collaboration is not developed, we will assist individual Provider organizations that are ready to take on PCMH transformation in locating training resources, such as:

- **Agency for Health Care Research and Quality.** The PCMH Resource Center, provides a PCMH practice facilitation curriculum and links to information and resources for all aspects of the PCMH model, including information technology capabilities, care coordination, staffing, quality, and accessibility.
- **HRSA.** Provides information on PCMH resources available to federally funded organizations.
- **Primary Care Collaborative (PCC).** Provides a wealth of PCMH information, tutorials, and links to training resources.
- **TransforMED.** A PCC subsidiary provides a full suite of transformation services, including onsite coaching.
- **Professional Medical Associations.** The American Academy of Family Physicians and the American Academy of Pediatrics both have information, training resources, and links to training for their Members.
- **Primary Care Development Corporation.** Provides onsite coaching for PCMH transformation as well as training models.
- **Qualis Health.** Works with organizations and states in providing a full curriculum of PCMH practice transformation, including onsite coaching.

Goal 2: Improve accountability for outcomes using PCMH tools and processes to ensure the success of PCMH practices and the system as a whole

Our PCMH program will leverage our capabilities to help PCMHs improve their health outcomes. We have reporting tools that allow our Providers to drill down through their clinical data to effectively manage patients with chronic conditions within a Provider panel and individually. Our secure Provider Portal will give our PCMHs real-time ability to drill through sets of clinical, health outcome performance, utilization, and cost data for their Members. PCMH teams can sort the data in a variety of ways to view practice-level and practitioner-level dashboards and reports by any health population group and use our tools to improve care by focusing on problem areas and creating strategies to improve their overall performance in managing Members' chronic illnesses. We will produce health outcome reports that are compliant with MSCAN and CHIP reporting requirements and share those with PCMHs. We will regularly report chronic conditions outcome data to our PCMH partners at the practice and ACO network level, giving them clear, aggregated results for specified time periods that allow them to track their continued performance and take timely steps toward improvement. Our PCMH Director, Provider Relations Specialists, and members of our Population Health team will assist PCMH practices in learning how to use these tools. We will meet regularly with PCMH practices as well as ACO networks to review clinical outcomes and cost data.

We know that PCMHs need constant monitoring and support to maintain their models year after year. Staff turnover in PCMHs can alter the commitment of clinical leadership to the PCMH model or change the functioning of care management teams. PCMH care managers are a critical component, and recruitment/retention of PCMH care managers has been an ongoing challenge for many PCMHs nationwide. We have found that the best way to ensure the continued success of PCMHs is for us to build processes that regularly engage each PCMH. We will inventory PCMH model function on an annual basis, require them to maintain external PCMH recognition by NCQA, and measure key aspects of their performance. The tools we will provide to our PCMH Providers and the processes we will use to evaluate their performance include:

- **Provider Dashboards.** Using our Provider Portal, the dashboards will include quality measure targets and highlight gaps in care, SDOH scores, health assessment data, and other issues that PCMH practices need to address to achieve quality and cost targets. These dashboards can be tailored to the needs of the practice.
- **Utilization Reports.** These reports will include Member attribution lists, new patient lists, and population-specific utilization data such as ED visits, hospital admissions, length of stay, readmissions, specialty care utilization, and pharmacy utilization.

- **Hospital Event Data to Manage Care Transitions.** This will include Admission, Discharge, and Transfer (ADT) data to track hospital admissions, discharges, and transfers so that the PCMH care managers can quickly connect with patients to help manage their transitions.
- **Member Assignment Processes.** As DOM requires, we will build a process to assign Members to a PCP within 60 days of enrollment. Our Member enrollment process will include a protocol to educate Members about the value of a PCMH when selecting a PCP. Our Provider Directory will clearly indicate which PCPs have PCMH recognition. Our Member Handbook will also provide information about the PCMH model, its value to Members, and the process for selecting a PCMH as the Member's PCP. We will assign medium and high-risk Members to a PCMH in their area. We will communicate directly with our PCMH Providers on their assigned Members using the Provider Portal, new Member reports, utilization reports and Member attribution reports.
- **Quarterly Performance Review at each PCMH.** Our PCMH Director, along with members of our Provider Relations and Quality Management teams, will meet quarterly with ***every*** PCMH. This review will require the attendance of PCMH's clinical team(s) and senior staff. The following will be reviewed at each meeting:
  - Health Outcome Measures Reports from the most recent reporting period
  - ED Utilization Reports for the most recent prior quarter and rolling average for the year
  - High-Risk Utilization Reports by population, including a list of patients with high utilization
  - Hospital Utilization Reports that include population and risk scores, with cost and length of stay
  - VBP Reports, including benchmarks, earned savings, and incentives
  - Specialty and Pharmacy Utilization Reports
  - Member Attribution Reports, used to identify any problems with assignment, notification, and Member engagement according to the standards set in the Provider contract and PCMH program
  - A PCMH Progress Report, completed by each practice to discuss ongoing transformation activities, identify problem areas and/or corrective actions, and track PCMH team staffing, indicating any vacancies
  - A PCMH Scorecard, based on the NCQA review tool and completed during the performance review meeting that will give the scores on key areas of PCMH functionality (staffing, technology, reporting, access, care management, health outcomes, cost outcomes, and innovation). The scorecard will use a color code (green, yellow, red) to score functional domains. Red scores will require the PCMH to develop corrective action plans.

In addition to measuring their performance and engaging their PCMH teams, we will have a strategy to assist under-performing PCMHs. An underperforming PCMH (that has one or more Red Scores that remain unresolved for two quarters) will be given 90 days to resolve the performance issues. After those 90 days, an under-performing PCMH may be suspended from the PCMH program until issues are resolved. This may affect their participation in VBP contracts that require PCMH recognition. A suspended Provider may apply for reentry in the PCMH program (with reinstatement of VBP savings and bonuses) when it has demonstrated that it has resolved the areas of insufficiency and can successfully function as a PCMH. Any Provider that loses PCMH recognition from NCQA will be placed on probation for 90 days to resolve the accreditation issue, after which they will be suspended from the PCMH program until their PCMH recognition is restored. Network participation in MSCAN and CHIP is not predicated on PCMH recognition, and therefore a PCP's network participation will remain unchanged even if they drop out of the PCMH program.

We will meet quarterly with ACO networks that are PCMH-based, such as Aledade's FQHC network. We will review collective performance reports, including health outcome measures, quality measures, and cost data. We will raise the individual PCMH performance status of any ACO member on probation during these ACO meetings.

Our senior leadership team will evaluate our PCMH program on a semi-annual basis. Our PCMH Director will prepare reports for our senior leadership to review the following metrics:

- Health outcome measures
- Cost performance (total cost of care, cost by funds, risk-adjusted cost Per Member)
- Population-based utilization
- Population-based access to care
- Member satisfaction
- PCMH engagement (recruitment, retention, performance)
- Program activity (narrative report of program activities, collaborations, innovation projects)

We are also committed to engaging with DOM and other stakeholders in State and regional meetings where PCMH program performance is discussed.

Goal 3: Improve outcomes in chronic diseases; and

Goal 4: Reduce inappropriate ED utilization and hospital readmissions

We support DOM's decision to leverage PCMHs as a key to improving health outcomes for Members with chronic conditions and to reduce inappropriate ED utilization and hospital readmissions using PCMH intervention. Studies have shown that the PCMH team approach to coordinated care is highly effective at improving health outcomes for Members managing chronic diseases. PCMHs have also demonstrated their effectiveness at reducing ED utilization and hospital readmissions through their transformational practice activities (such as extending primary care office hours, coordinating after-hours care, coordinating in discharge planning, and ongoing patient education about where and when to seek hospital-based care). We commit to DOM's requirement of offering a PCMH to all medium and high-risk Members. As stated in Goal 1, we aim to increase the number of PCPs that have PCMH recognition for supporting this Member assignment. Our Care Managers will engage each medium and high-risk Member in their selection of a PCP, educating them as to the value of the PCMH model and assigning them to a PCMH.

We will support PCMHs as the central point of coordination for the Member's care. Our PCMH contracts will include requirements that PCMHs use their full capacity in the medical home model to communicate with other treating Providers as well as with our Care Management staff about Members' needs, services, and care plans. PCMHs will be active participants in the Integrated Care Team and following up on action items, such as referrals to specialists or behavioral health clinicians. We will use the following tools in coordinating care for Members with chronic and complex conditions with our PCMHs:

Clinical Practice Guidelines. Our national clinical experts review clinical practice guidelines for chronic conditions and provide training and guidance to our affiliates. We will use nationally recognized practice guidelines in our PCMH program, educating PCMHs about clinical practice guidelines and preventive health guidelines using online tools and within our PCMH engagement meetings. We will align our standards with those in use by the PCMH recognized practices (i.e., the FQHCs), which are currently following national protocols developed and approved by HRSA. We will conform our guidelines to any clinical practice guidelines adopted by DOM.

Timely Care Coordination. We have tools that allow our Providers to receive timely, actionable information from other health care settings, including ED, hospitals, and other inpatient settings. We will make ADT data we receive through strategic partnerships available to our PCMHs through the Provider Portal. We will offer bi-directional data exchange to our PCMHs that can produce standards-based clinical data. These timely exchanges of clinical information will allow PCMH care management teams to engage patients at transitions in care and help avoid readmissions. ED reports will allow PCMHs to connect the same day with patients to reinforce appropriate use and plan follow-up care.

Collaborative Care Management. Our PCMH program will include processes that link the care coordination provided by the PCMH with our care management responsibilities as a CCO. This will include documentation within the Clinical Documentation System to inform our Care Managers to the PCMH assignment and the PCMH care manager responsible for the individual Member and allows them to identify when a Member that

needs care management is assigned to a PCMH. Then our Care Managers will coordinate with the PCMH care manager, sharing insights and data from our systems, to maximize Member engagement and follow-up care. ***Actions and results of our care management will be visible to the PCMH through the Provider Portal and bidirectionally exchanged with their EHR when connections exist to ensure all parties have a complete picture of the Member.*** Our Care Managers will be available for consultation with PCMH teams, specialty Providers, hospital staff, and Members. We will continue to work collaboratively with individual PCMHs and PCMH-based ACOs on technology-led and people-led enhancements in care management.

Member Engagement. We will educate Members, their families, and their caregivers about the importance of follow-up care through our Member and Provider Handbooks, Member Services Call Center, and care management process, including our Transitions of Care program. We will further support our Members with tools and resources such as a Personal Health Record booklet that will help Members track information such as medications and needed post-discharge care. Our Care Management staff will proactively outreach to Providers and provide timely information to support effective care delivery and follow-up. For example, our Care Management staff will:

- Communicate with Members to assure baseline and regular medical evaluations
- Incorporate treatment plans into our care plan to support treatment plan goals
- Obtain any needed physician orders, provide authorizations, and contact Provider offices at the Member's request to assist with scheduling appointments and ensure continuity of care
- Coordinate with contracted and non-contracted Providers, as needed, to ensure continuity of care

Goal 5: Lower total cost of care using VBP to PCMHs

The ways in which our VBP strategy will be used to support PCMHs are discussed in detail in our response to Question 4.2.3.1 above, including options for PCMHs to participate across the entire Health Care Payment Learning & Action Network. VBP will make PCMHs accountable for access to care, quality of care, health outcomes, and cost of care. Aledade's CHCAMS ACO participants include all the FQHCs, 65% of which have PCMH recognition. Aledade reports that it's FQHC ACO achieved a shared savings bonus of $8,355,542 in its first full year (2020). This is an example of how VBP can be used to support PCMHs and account for their performance in cost and quality outcomes.

Goal 6: Improve health care to Members through PCMH practice innovation, with a focus on the following initiatives in alignment with DOM goals: Integrated Physical Health and Behavioral Health, Expanded Access to Care, Telehealth, Opioid Use Reduction, Improved Perinatal Outcomes, and Sickle Cell Disease Management

Our PCMH sponsored training is designed not only to encourage PCPs to undergo PCMH practice transformation but also to assist experienced PCMH practices in advancing their model using team-based practices that have been demonstrated to improve health outcomes, improve health care delivery, and lower the cost of health care. We will leverage our experience from working with advanced PCMH practices across the country and collaborate with our Mississippi stakeholders and training partners to design and implement PCMH Advanced Practice Innovation Programs as part of our PCMH strategy. These programs will focus on the following practice innovations:

Integrated Physical Health and Behavioral Health. Integration of medical care and behavioral health care has improved access to care and reduced health disparities. Many individuals who live with complex medical conditions also have (often unmet) behavioral health needs. Chronic disease can lead to depression or anxiety. SDOHs not only affect access to behavioral health care, but they are also often contributing factors to physical and mental illness. We have seen a significant increase in behavioral health issues among children during the COVID-19 pandemic, coupled with unprecedented demand for behavioral health treatment nationwide. Integrated care allows MSCAN and CHIP PCMHs to better diagnose and address the behavioral health issues of children and adults. Co-location and integration of care, particularly substance use disorder treatment (including MAT for opioid addiction) can reduce the stigma often associated with mental illness and addiction. Co-location improves access to treatment for individuals who can often be difficult to engage. Studies have shown that trusted relationships that children and parents often build with their pediatrician, for example, greatly

facilitate the behavioral health treatment of children.

We have experience assisting PCMHs in building integrated behavioral health capacity within their practices. We have participated in Substance Abuse and Mental Health Services Administration (SAMSHA)-sponsored Integrated Health Homes projects in other states, and we have assisted states that have undertaken integrated behavioral health projects. Mississippi has made some inroads with integrated care. The Mississippi Department of Mental Health partnered with Mississippi Department of Health and Mississippi Public Health Institute to issue the *Roadmap for Integrated Care in Mississippi* in March of 2017, which describes efforts in behavioral health integration that have been made by community-based organizations and health care Providers. Since that report, most FQHCs now offer both physical health and behavioral health services. Many of them, particularly PCMH-recognized FQHCs, have integrated those behavioral health services and included behavioral health staff on their PCMH teams. We will continue to support those integration efforts.

Our PCMH program design will incorporate best practices from the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS), using the Standard Framework for Levels of Integrated Health Care. CIHS has a wealth of training resources and technical assistance programs to help practices move along the integration continuum from coordinated referrals to co-location and ultimately to full integration. SAMSHA offers training through its Primary and Behavioral Health Care Integration Program, its Minority AIDS Initiative Continuum of Care program, and its Behavioral Health Equity Program. We will work with DOM and the Mississippi Department of Mental Health to identify these and other resources to support PCMHs as they work towards integration. We will use the tools that CIHS makes available, including the Integration Practice Assessment Tool (IPAT), to help implement training programs for PCMHs statewide. Our PCMH Director will be responsible for collaborating with stakeholders on the development of integrated physical health and behavioral health transformation. For PCMHs already on the behavioral health integration continuum, we will develop initiatives that support their integration. Incentive payments, VBP strategies, and training will be available to all PCMHs that integrate behavioral health care.

Expanded Access to Care. We realize the burden that inaccessible care places on the most vulnerable MSCAN and CHIP Members. We will work with our PCMHs to provide incentives for implementing strategies that expand access, such as expanded hours (evenings and weekends), open-access scheduling, telehealth, mobile health applications, pop-up testing and vaccination programs, and walk-in urgent care. We will continue to support school-based health centers across the State, many of which are run by PCMH-recognized FQHCs.

Telehealth. Telehealth is an important way to reach Members who face barriers to care due to location, working hours, stigma, and transportation. We will support the expanded use of telehealth for both medical and behavioral health care. We will contract for a robust network of telehealth services and assist our PCMHs in integrating clinical data from telehealth services into their records and on the PCMH dashboards. Our aim is to ensure that our Members have access to care when and where it is needed most. PCMH partners are a great resource in helping to achieve this aim.

Opioid Use Reduction. To combat opioid overdoses, we propose leveraging PCMHs to expand access to MAT. Programs like Project ECHO provide online training to PCPs nationwide, using team-based practice principles and allowing Providers to become experts in MAT. These types of programs provide PCMHs with education, ongoing consultation, processes, and protocols. We will work with our PCMHs to engage and support the right training program that will assist them in establishing MAT in their primary care settings. Our goal is to establish MAT in at least 50% of MSCAN's PCMHs within the first 18 months of the contract award.

Improved Prenatal and Perinatal Outcomes. Mississippi has persistently had one of the highest infant mortality rates in the United States. The Mississippi Department of Health reports a 2018 infant mortality rate of 8.43 deaths per 1,000 live births. Mississippi continues to see significant racial disparities in infant mortality, with the Black infant mortality rate at 11.6 deaths per 1,000 live births compared to the white rate of 5.9. Similarly, in 2018, the pre-term birth rate was 12.1% for white infants, compared to 17.3% for Black infants and 9.4% for babies born of other races. Pre-term births accounted for two-thirds of all infant deaths. In its 2018 report, the Mississippi Department of Health notes that efforts to reduce Mississippi's overall infant mortality rate must address critical SDOH, including poverty, education, and the effects of historical, structural, and

interpersonal racism and bias on maternal and infant health.

PCMHs play an important role in providing vital health care and preventive interventions that impact perinatal health and reduce infant mortality and poor birth outcomes. Many of Mississippi's FQHCs are providing prenatal care to MSCAN Members; recent data shows that over 50% of all prenatal care to MSCAN Members is provided by an FQHC. These Providers have strong ties to community-based organizations and partner with them regularly to address SDOH that play such a large role in perinatal health outcomes. Our PCMH team will work to support programs such as prenatal and parenting education, nutrition counseling, access to nutritious food, and outreach from Community Health Workers. We have extensive national experience in the states we serve, building incentives into our PCMH contracts to focus on perinatal health and the reduction of poor birth outcomes. We will work with PCMHs to incorporate evidence-based standards of care, quality metrics, and incentive payments, such as:

- Preconception health and pregnancy planning
- Effective contraception use (the percentage of women 18-50 with continued use of a "most effective" or "moderately effective" contraceptive method)
- Timely entry (first trimester) into prenatal care
- Postpartum follow-up care on or between 21 and 56 days after delivery

Sickle Cell Disease (SCD) Management. Nearly half of Mississippi's residents are of African American descent and they make up a disproportionate share of MSCAN and CHIP Members. The National Institute for Children's Health Quality (NICHQ) reports that one out of every 365 Black children is born with SCD each year, making it one of the most common serious genetic disorders in the United States. As medical advancements improved, most people living with SCD survived to become adults. However, both adults and children with SCD face a lifelong battle with pain, infection, and complicating health issues. The NICHQ Sickle Cell Disease Treatment Demonstration Program funded improvement projects from 2014-2017 in four Regional Coordinating Centers across the nation.

The lessons learned from these projects are now being adopted by PCPs and PCMHs nationwide. Telehealth initiatives have increased Provider knowledge and 100 Project ECHO clinics have expanded opportunities for Provider education in treating SCD. Project ECHO has also teamed with the SCD Association of America to provide SCD Community Health Worker Training, which can be accessed by our PCMHs. Our PCMH program will provide training and education to Providers to improve treatment of SCD, using the Compendium of Tools and Resources compiled by the SCD Treatment Regional Collaboratives. We will establish data and benchmarks for PCP/PCMH treatment to track measures such as:

- Pediatric and adult use of hydroxyurea
- Pediatric and adult use of other disease-modifying therapies
- Rates of pneumococcal immunization
- Pediatric transcranial doppler screening
- Transitional care planning

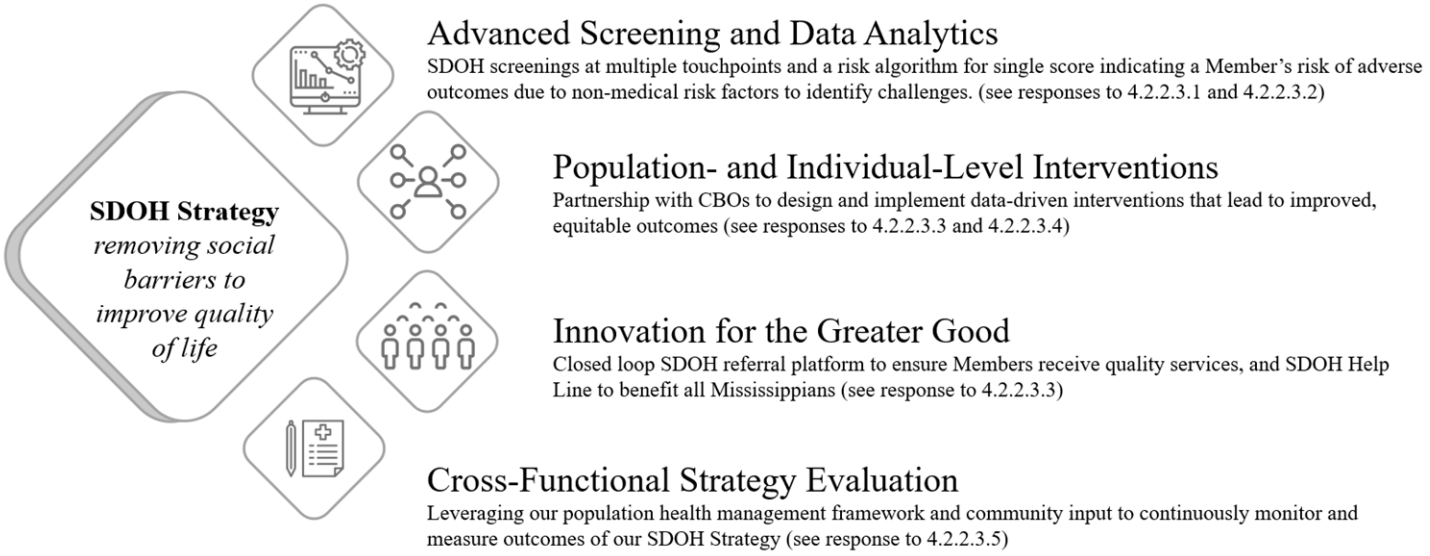
In summary, we reiterate our commitment to supporting and expanding the PCMHs in Mississippi. We look forward to engaging stakeholders in a planning process to produce a PCMH strategy for DOM in the first 90 days of the contract, we are fully prepared to integrate VBP strategies into the funding of PCMH activities to reinforce our strategy, and we have the demonstrated expertise to support continued innovation within the PCMH framework to advance care to our Members.

4.2.3.3 SOCIAL DETERMINANTS OF HEALTH (SDOH)

The Division requires Contractors to devote at least 0.5% of its Capitation Payment to efforts to improve Social Determinants of Health during the next contract cycle. The Offeror must produce a proposed SDOH Strategy that addresses the following questions:

We share DOM's commitment and focus on addressing social determinants of health (SDOH) to attain the highest level of health for all people, no matter who they are or where they live, while lowering unnecessary health care costs. We prioritize assessing and addressing our Member's support network, housing stability, safety in all environments, access to affordable quality food, gainful employment, and available transportation to create sustainable change that removes barriers to good health. We have decades of experience collecting and analyzing data and developing SDOH screening tools**.** Our person-centered Care Management (CM) and Community Health Worker (CHW) models can be used to identify and address the SDOH needs of all Members. We will use our knowledge and experience to improve SDOH and achieve health equity, ultimately improving health, wellness, and delivery of care to effectively support the needs of the Mississippi Coordinated Access Network (MSCAN) and CHIP populations. As discussed throughout our response below, our SDOH Strategy focuses on cross-sector collaborations with community-based organizations (CBOs), Providers, and State agencies to identify and address SDOH needs in the communities we serve. **Figure 4.2.3.3.1.i** below illustrates our SDOH strategy.

Figure 4.2.3.3.1.i SDOH Strategy



Organizational Commitment and Resourcing

While our SDOH efforts and initiatives are woven into our health equity strategy and across our organization, we will build a team of committed professionals who will oversee, drive, and enhance our efforts to ensure the social needs of MSCAN and CHIP Members are met. We will hire a local Director of Health Equity to oversee the strategic design, implementation, and evaluation of initiatives that address social and community health, including reducing disparities and increasing cultural sensitivity. The Director will oversee three Community Engagement Specialists (CES) dedicated to facilitating strategic community partnerships in each region (central, north, and south). This team will work collaboratively to ensure the SDOH needs of our Members are continually identified through every Member contact, addressed through data-driven partnerships designed to support Members and improve the community as a whole, and incorporated into our CM model. The Director of Health Equity will lead a cross-functional internal Health Equity Governance Committee and serve on our national SDOH network of more than 100 experts who collaborate to share innovations, best practices, and lessons learned across the country. Each CES will lead a ***Community Impact Council*** (CIC) in their region. CICs will provide feedback about SDOH and health disparities activities. They will also continuously assess, enhance, and improve the appropriateness and quality of our services to achieve health equity.

1. Describe the Offeror's approach to and experience with collecting data on non-medical risk factors for targeted Medicaid populations, the types of domains and metrics collected, standardized screening tools that are utilized, and methods used to analyze and act on the data.

Data Collection

We have deep experience synthesizing physical health, behavioral health, pharmacy, dental, vision, Member demographics, utilization, and Member assessments, including SDOH data into our single Reporting and Analytics Platform. **Table 4.2.3.3.1** details elements we use to collect data on non-medical risk factors.

Table 4.2.3.3.1 SDOH Data

SDOH Data Element	SDOH Data Collection Sources
Transactional Data (e.g., Claims, Utilization, Eiligibilty Files)	We analyze physical health, behavioral health, pharmacy utilization, vendor data (i.e., dental and vision), referrals/prior authorizations, and historical claims data to identify care gaps that may reveal barriers related to SDOH. We also capture, monitor, and analyze Z code utilization to view local trends and drill down to communities and SDOH categories. The information will be available to Providers via our secure Provider Portal to support data transparency and closed-loop referrals.
Provider and CBO Data Submissions	We will implement a Provider and CBO incentive program that promotes data sharing for non-medical risk factors and referrals to CM from our Provider and community partners. This incentive is an extra push to collaborate to solve community and Member-centric determinants of health. We will also educate and incentivize Providers to submit Z codes and ICD-10 billing codes related to social needs.
Clinical Data and Interoperability Gateway	Our Clinical Data and Interoperability Gateway will offer enhanced data sharing capabilities through bi-directional data exchange with Providers through connection with large scale EHRs. Expanded interoperability capabilities using FHIR, EHR proprietary APIs, HL7, and other standards allow us to automate data extraction from Providers' EHRs and deliver insights right back into their systems. The Clinical Data and Interoperability Gateway enhances our ability to address care gaps at the point of care, conduct efficient quality monitoring, and gather additional health information, including about Member's social determinants of health.
Population Health Assessments and Public Data	To understand SDOH needs at a national, state, county, and community level, we review and aggregate publicly available data from sources such as the 2021-2026 Mississippi State Department of Health State Health Assessment, the 2021 Mississippi Primary Care Needs Assessment, overall health rankings from the Robert Wood Health Foundation, the 2021 Adult Hospitals Community Health Needs Assessment conducted by the University of Mississippi Medical Center, 2019-2020 Children's of Mississippi Community Health Needs Assessment, and hospital and county Community Health Needs Assessments. Data is aggregated and used to inform our SDOH strategy by prioritizing regions, areas of opportunity (housing, food, and transportation), and Member demographics.

SDOH Domains and Metrics Collected. We collect and organize domains using categories from Healthy People 2030 and CMS Accountable Health Communities. The core domains include social and community context, employment, education, housing, access to nutritious food, transportation, and stress. Our analytics currently break data down into 80+ metrics within each domain (e.g., childcare, utility supports, internet access) to drive highly targeted referrals and interventions. Data that feeds our metrics and domains are collected using the methods discussed above and the following SDOH standardized screenings tools. Within our Reporting and Analytics Platform, our SDOH KPI Dashboard, discussed in detail below, provides an enterprise-wide view of metrics related to non-medical risk factors.

SDOH Standardized Screening Tools

- **Health Risk Screening Tool (HRS).** Using the National Committee for Quality Assurance standards, our HRS tool is clear and easy for Members to understand. The HRS includes an evaluation for non-medical risk factors and will be submitted to the DOM within 90 days of contract award for approval. We administer the HRS to Members in person and via telephone, mail, or through a secure Member Portal at least once every calendar year, within 90 calendar days for all Members upon contract implementation and within 30 calendar days from the effective date of enrollment for new Members or from the date of a self- or Provider referral. Members with an assigned CM are screened more frequently and as needed (e.g., change in health status).
- **Comprehensive Health Assessment (CHA).** The CHA also identifies barriers such as a lack of support system, financial barriers, safety issues, cultural or linguistic challenges, and physical, mental, or cognitive disabilities, as well as evaluating the need for social supports and community resources that may improve health and living circumstances.
- **SDOH Mini Screen.** We will use a brief validated SDOH screening tool (adapted from CMS) for ongoing point in time Member SDOH data. Our staff can facilitate this Mini Screen at any Member touchpoint to identify changes in non-medical risk factors. The SDOH Mini Screen consists of seven questions to quickly

identify non-medical risk factors and social support needs to develop interventions to address barriers. The tool is available through the secure Member Portal and Member Services Call Center. All Member-facing staff will have access to the tool, which is currently used by our Medicaid affiliates.

Non-Medical Risk Factor Data Analysis and Strategy Development

We will incorporate this data into our risk stratification model and CM delivery system to support Member interventions and activities. For example, CM staff use our SDOH Predictive Analytics Tool and SDOH KPI dashboard to create individual profiles that offer a view of Member needs based on their demographics and where they live. We will monitor gaps in social services throughout Mississippi to inform our health equity work. We will refresh baseline population assessments quarterly to identify prevention opportunities within our CICs and conduct longitudinal analyses for trends in utilization, health disparities, and quality outcomes.

In coordination with internal committees and CICs, our QMC will review reports, monitor outcomes, and develop health improvement and disparity reduction activities across the enterprise. Our Quality and Provider services teams will use KPI Dashboards to monitor and track performance on measures including HEDIS and EPSDT services. This data will be used to focus improvement efforts, including Provider education, quality initiatives, outreach, and inform Member and Provider program changes. Promoting access to timely and meaningful data across the system, we structure special reports for Providers, CBOs, and staff to analyze and act on data.

The data we collect will guide our strategic local partnerships and solutions. Our three regionally-based CESs will pursue partnerships and initiatives with CBOs to address non-medical risk factors and develop sustainable community supports to improve Member health status. We work within communities and share information to create common agendas, build shared measurement systems, implement mutually reinforcing activities, create consistent communication channels, and promote system sustainability. We will focus our efforts on Mississippians by zip codes and among specific Members or communities with identified disparities. Our technology platform will generate actionable information on non-medical risks within a community by census tract to identify high-need areas or "hotspots" and intervene accordingly. These analytics, combined with direct Member and local stakeholder input, community information, and referral tracking data from our platform, will help us identify significant gaps in a communities social service network.

2. In the Offeror’s view, what are the greatest SDOH challenges facing the MississippiCAN and CHIP populations?

SDOH Challenges for MSCAN and CHIP Populations Overview

Poverty, food insecurity, transportation, and housing are the most significant SDOH challenges for MSCAN and CHIP Members based on our deep understanding of Mississippi's health assessments and other data sources. These findings align with the findings from the 2020 Mississippi State Department of Health State Health Assessment, in which participants most frequently cited these as the top challenges in the State. Using our SDOH Predictive Analytics Tool, we found that the average risk score for ***urban census tracts in the State is nearly 23 percentage points higher*** than rural census tracts, indicating a greater concentration of needs in

multiple SDOH domains across urban areas- with the most significant discrepancy in food access. We also see four percentage points higher ratings on the Poor Housing and Lack of Transportation Index in urban census tracts. Rural areas, however, have an increased need for transportation. Some SDOH indicators have different geographic patterns. For example, the ***Delta Region has a high percentage of Black individuals with average risk scores over 60***. There are ***also high concentrations of SDOH needs in the Western half of the State and parts of the south*** along the Gulf Coast to counties along the Alabama border.

Poverty (Below 100% of FPL). Mississippi had the highest percentage of people living in poverty nationally (2017)[2] and ranked the second hungriest State[3]. Approximately 20.75% of individuals live in households with income below the FPL in Mississippi.[4] Nearly 65.5% of Members live in census tracts with a poverty rate greater than 20%, and 86.2% of Members live in tracts with a median family income less than the state average of $45,081. High poverty rates are concentrated in the western, central, and eastern regions of the State, with the highest density in the western parts of the State. Jefferson County has the highest average poverty rate of 45.8%. Counties with low average median income are spread throughout the State with dense areas in the northern, western, and southern regions. Poverty is a critical indicator because it creates barriers to health services, healthy food, and other necessities that contribute to poor health status.

Food Insecurity. On average, 40.7% of the urban population lives in low food access tracts (defined as living more than a mile from the nearest supermarket, supercenter, or grocery store) compared to 12.2% in rural populations. Approximately 40% of urban tracts are classified as ***food deserts*** compared to 22% of rural tracts (1 in 3 Members live in a census tract considered a food desert). Rural areas with less population density also have high SDOH needs. Mississippi has the highest projected food insecurity rate in the country in 2020,[5] with nearly 1 in 5 people and 1 in 4 children facing hunger.[6] ***Food access*** appears to be a significant risk factor, with 4 of 5 Members living in low-food census tracts and 1 in 3 in a census tract designated as food deserts. The Delta Region (DeSoto County, Tallahatchie County, Bolivar County) and Benton County have the highest rates of low food access, and one-third of the region is considered a food desert. Jackson County is predominately urban with outlying high rates of low food access. More than half are estimated to be below the SNAP threshold of 130% poverty level among the food insecure. All tracts in Benton, Issaquena, Tunica, Montgomery, Amite and Wilkinson counties are food deserts. There is a concentration of food deserts in western Mississippi, where low population density likely leads to fewer grocery stores. Furthermore, the Robert Wood Johnson Foundation's project - the State of Childhood Obesity - shows Mississippi continues to have a high obesity rate, which may be in part to poor eating habits and disparities in accessing healthy food.[7]

Transportation. The greatest transportation gaps are found in the western and southern regions of the State. Participants of the 2021 Mississippi State Department of Health State Health Assessment session most cited housing as a challenge in their communities, especially for low socio-economic status communities - compromising their accessibility and safety. Forty-one percent of Members live in census tracts with high (over 60) Poor Housing and Lack of Transportation Index (PHLTI) percentiles. Approximately 43.2% of Members live in census tracts where the rate of individuals without vehicle access in the household is above the U.S. average of 8.6%, with Issaquena and Sharkey's counties ranking the lowest. Eight counties have average PHLTI percentiles of 80 or greater (Bolivar, Holmes, Claiborne, Greene, Wilkinson, Sharkey, Tunica, and Issaquena. Seven counties have 14% or more households with no vehicle access (Humphreys, Bolivar, Washington, Sharkey, Noxubee, Leflore, and Issaquena).

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[2] Nave, R.L., and Mississippi Today September 14 R.L. Nave. Mississippi Still Has Worst Poverty, Household Income. Mississippi Today, 10 May 2021, https://mississippitoday.org/2017/09/14/mississippi-still-worst-poverty-household-income-u-s/.

[3] Top 10 Hungriest States in the U.S. Friends Committee On National Legislation, 10 Nov. 2021, https://www.fcnl.org/updates/2021-11/top-10-hungriest-states-us.

[4] Lynch, Victoria, et al. "Improving the Validity of the Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits." Census.gov, Urban Institute, Health Policy Center, 27 Sept. 2011, https://www.census.gov/content/dam/Census/library/working-papers/2011/demo/improving-the-validity-of-the-medicaid-chip-estimates-on-the-acs.pdf.

[5] Norwood, Ashley. Child Hunger Is on the Rise in Mississippi. MPB - Mississippi Public Broadcasting, 21 Nov. 2020, https://www.mpbonline.org/blogs/news/child-hunger-is-on-the-rise-in-mississippi/.

[6] "What Hunger Looks Like in Mississippi." Hunger in America, Feeding America, https://www.feedingamerica.org/hunger-in-america/mississippi.

[7] Prioritizing Children's Health during the Pandemic. Robert Wood Johnson Foundation, Oct. 2020, https://media.stateofobesity.org.

Housing. Household Vulnerability, the degree to which a family is at risk of becoming unhoused due to additional financial stressors, is a significant issue in many counties – mostly in the western and eastern parts of the State where nearly three in four Members live. The Mississippi 2020 HUD Point-in-Time Count and Housing Inventory Count accounted for 1,107 homeless persons across the state and were unsheltered (48%), in emergency housing (30%), or transitional housing (22%). Half identified as Black or African-American, and 46% identified as white (by comparison, 38% of the state population is Black, 59% of the population is white).[8] Mississippi has the highest rate of renters in the country (27%).[9] An estimated 61.5 % of parents with incomes at or below 138% of the FPL reported delaying or forgoing health care in the past 12 months because of the cost, difficulties taking time off work, difficulties balancing family or childcare obligations, and transportation challenges.[10] According to the National Low Income Housing Coalition, there is a shortage of rental homes affordable and available to extremely low-income households already severely cost-burdened (spend more 50% of their income on housing) and are more likely than other renters to sacrifice necessities like healthy food and health care to pay rent. One quarter (27%) of Members are cost-burdened, with housing costs exceeding 30% their total household income. Although lower than the national average, most households have a single source of income.[11] Housing costs can cause increased stress levels in adults leading to potential health issues.

3. What approaches will the Offeror take to address these challenges?

Our SDOH Model

Within our CM model is an SDOH Framework, depicted in **Figure 4.2.3.3.3**, designed to connect Members with resources such as housing, utilities, transportation, food assistance, affordable childcare, employment, and more. It is an organizing framework that systematically identifies, addresses, and measures SDOH needs through a "no wrong door" approach centered on equity and using evidence-based interventions and partnerships. We track interventions targeting SDOH across our affiliates to inform population health and community engagement strategies. We align proven programs with Member and community needs and deliver local investments and resources. We connect Members to CM supports, medical care, SDOH programs, and resources through strategic, value-based community partnerships with CBOs, grassroots connections, and social service providers. We keep innovating to meet the changing needs of our Members by using data-informed, outcome-based contracting with community partners to drive shared outcomes and collective Member impact. The goal is for Members to thrive across the entire continuum of need.

Member Engagement. Due to the complex individual needs of Members, we employ a high-touch, no-wrong door approach that includes locating Members and engaging them in services and supports, peer-to-peer coaching, care gap closure initiatives, and community outreach events. CHW's native to our Member

[8] "Mississippi Homelessness Statistics." Homelessness Statistics, United States Interagency Council on Homelessness, https://www.usich.gov/homelessness-statistics/ms/.
[9] "The State of the Nations Housing 2021." Joint Center for Housing Studies of Harvard University, President and Fellows of Harvard College, 2021, https://www.jchs.harvard.edu/sites/default/files/reports/files/Harvard_JCHS_The_State_of_the_Nations_Housing_2020_Report_Revised_120720.pdf
[10] Haley, Jennifer, et al. Parents with Low Incomes Faced Greater Health Challenges and Problems Accessing and Affording Needed Health Care in Spring 2021. Urban Institute, Jan. 2022, https://www.urban.org/sites/default/files/publication/105304/lowinc1_0.pdf.
[11] "Mississippi." Housing Needs by State, National Low Income Housing Coalition, https://nlihc.org/housing-needs-by-state/mississippi.

communities will be located throughout the State and available to meet Members in their homes, at work, or in the community. Other methods of Member engagement from our staff will include phone calls, texting, emails, and letters. As individual SDOH needs are identified, Members are engaged at the appropriate level to meet their needs. CHWs and Care Managers engage Members, collaborate with the Member and available supports, and develop a care plan to address the Members unique social, behavioral, and physical health needs.

Closed-Loop Facilitation of Referrals and Coordination. We will facilitate access to services and closed-loop referrals through our ***Community Resource Support Database***, a searchable online database of vetted and current health and wellness resources that will be accessible by our CM staff, Members, caregivers, and Providers. The database will be available in numerous languages to connect Members to local programs and resources that best fit their needs, including housing and transportation. We provide closed-loop referral tracking and coordination using validated data to ensure quality and users reliability. Additionally, staff have access to easy-to-read and easy-to-understand reporting, enabling us to track, trend, and report on Member needs and utilization. Care Managers can also use these features to gain a deeper understanding of population and individual Member needs.

Engaging Community and Leveraging Partnerships. Identifying, partnering, and engaging with organizations outside the traditional health plan benefit structures, such as nonprofits and grassroots organization, is necessary to address SDOH needs effectively. As such, we will develop protocols for population health management services in alternative and community-based settings, including providing assistance in homeless shelters, group homes, residential placements, and other public or nonprofit facilities. Also, while we have powerful data analysis tools to pinpoint disparate health outcomes in communities within those neighborhoods, local partnerships help us identify and address root causes to inform our program development and investments. Equally important is the engagement of community members. We will use regional ***Community Impact Councils*** comprised of innovators in their respective SDOH areas of expertise and Members from the community to confirm identified local and regional needs, facilitate communication with stakeholders, and create a forum to develop solutions to eliminate barriers to care. Other affiliates have used this model to develop innovative community-based programs and pilots, develop solutions to emerging issues, direct community investments, and provide feedback on current services.

Strategic SDOH Program Investments. We will invest a minimum of 0.5% of Capitation Payments toward innovative SDOH projects through tailored and strategic partnerships with CBOs. The proposed SDOH investments described below will be submitted to DOM for approval. By incentivizing and investing in CBOs and other community partners to provide resources for Members with SDOH needs, we will create new avenues to improve health outcomes, reduce avoidable costs, and remove social barriers. Each regional CES will propose regional investments to support community priorities with input and guidance from the CICs. Our Health Equity Governance Committee will work across functional areas to produce insights and risk data for the CICs. Projects will be data-driven and demonstrate measurable outcomes. Based on our data analysis and a holistic approach to health, we focus our relationships statewide to expand food access, reduce disparities, and close care gaps. Our strategies will be tailored to reflect needs and resources by region based on local feedback in conjunction with regional analyses and priorities, local strengths and infrastructure, and existing efforts. We also seek to test new strategies and replicate or enhance promising strategies via pilot programs and partnerships likely to produce measurable, scalable, replicable, and cost-effective outcomes. Our investments will support local CBO capacity building such as data interoperability and infrastructure to work collaboratively and effectively, demonstrate measurable impact, and support future VBP contracting opportunities. We propose investing the required capitation payments in the following domains as identified in Section 4.2.3.3.3 of this response:

- **Poverty**: Our Member Employment and Education Program will address poverty by offering Members resources and opportunities for education and employment in partnership with State agencies and educational institutions. Through partnerships with CBOs, our Member Incentive Program, and Care Grants, we will support individuals' basic needs, such as childcare, telecommunications, utilities, and rent. This includes partnering with Community Action Agencies across the state to invest in and leverage their

workforce development initiatives.

- **Food Insecurity**: We will work with Extra Table to support additional pantries and programs in areas informed by our SDOH Predictive Analytics Tool and SDOH KPI dashboard. Extra Table uses 100% of its funds for food procurement and distribution. We will work with Extra Table and FQHCs to develop and deploy medically tailored meal programs for Members with chronic conditions such as HIV and diabetes.
- **Transportation**: We will offer transportation to address non-medical risk factors through our non-emergency transportation vendor.
- **Housing**: We will identify Members in need of housing and connect them with resources by establishing close relationships with CBOs that serve this population. Additionally, we will exchange data with the local Homeless Management Information System (HMIS) to receive timely updates of Member housing support needs.

In addition to these specific strategies, we will partner with Community Action Agencies (CAAs) to provide wraparound services addressing Member SDOH needs in their communities. CAAs offer a network of 17 affiliates that help low-income Mississippians rebuild their lives, nurture their families, revitalize their communities, and become self-sufficient. We propose working with the CAAs to determine community needs and implement programs to address food insecurity (nutrition support in 45+ locations), health literacy, medical transportation, and education (e.g., to support children 0-5, perinatal education to reduce infant mortality). SDOH strategies may include initiatives that will leverage existing programs. Our approach will start by analyzing our SDOH data to determine the areas of greatest need and scale over time. Our focus is to support people of color, adults, and children with food insecurity, pregnant women, the elderly, people with disabilities, young children, people with transportation needs, and people with low levels of health literacy. Other services offered by CAAs include workforce development, housing, and utility assistance.

SDOH Help Line. Mississippians have access to our toll-free SDOH helpline Monday through Friday from 9:00 a.m. to 6:00 p.m. to anyone needing assistance with non-medical risk factors (i.e., housing, utilities, childcare, and food). A national team of diverse Peer Coaches identifies the caller's needs, conducts the SDOH mini screen, assists with goal setting, and connects Members to local resources. We close the loop on all referrals through personal contact and evaluate the quality of referral services. All calls will be documented in our Community Resource Support Database. The helpline staff follow-up with every caller to ensure they received the needed assistance to close the loop. For Members in CM, the assigned Care Manager is alerted and will provide appropriate follow-up incorporating all needs and services in the Member's care plan.

4. How will the Offeror address Health Equity through its SDOH programs?

Commitment to Address SDOH and Advance Health Equity

Health equity is ingrained throughout our organization and integral to our mission, demonstrated through our commitment to addressing SDOH needs and ensuring health equity is incorporated into our policies, practices, and operations. The interplay of individual and systemic factors contributing to SDOH and health disparities across Mississippi is complex. To support this work, we will employ best practices from affiliates across the country and hire CHWs from the communities we serve who understand our Members' unique ethnic, cultural, and language needs. In addition to promoting our Member services and resources, CHWs participate in regional events and targeted outreach campaigns to address specific community gaps or identified disparities.

[redacted]

Community Impact Council (CICs). We will establish at least three CICs (north, central, and south) to engage a diverse group of local civic leaders, community stakeholders, and local advocates to develop collaborative

initiatives that improve community health and wellbeing due to identified services gaps. The local CES will lead each CIC. CICs will confirm local and regional needs identified through our data, facilitate stakeholder communication, and develop local, community-driven solutions to address health inequities. CICs will also support efforts towards sustainable change, expand innovative community-based programs, create solutions to emerging issues, and evaluate our services.

SDOH and Health Equity Training. We will deliver health equity education and leadership programs to all staff to create a health equity lens from which we view all operations. Sharpening staff's ability to spot social barriers and become better leaders, we will develop a comprehensive training program to help staff gain a deeper understanding of our Members and how to interact with them in a culturally responsive manner. All staff will be required to participate in the training and use lessons learned to inform discussions and address health equity in all our programming. Training will be offered in person through teleconferences and online webinars. **Table 4.2.3.3.4** below describes examples of training modules.

Table 4.2.3.3.4 SDOH and Health Equity Training

Training Topic	Content Overview
Poverty Competency	Fosters a deep understanding of the types of poverty, its history and causes; awareness of personal attitudes and beliefs about impoverished people; and understanding oral culture and relational styles of communication.
Cultural Competency	Cultural competency is a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups, and the sensitivity to know how these differences influence relations with patients. Our training promotes a set of complementary behaviors, attitudes, and policies that help professionals work effectively with diversity of cultures.
Disability Sensitivity	Reviews the data around the business case for allyship for people with disabilities and caregivers, explores how to become an authentic ally for people with disabilities and caregivers and identifies tools, resources, and next steps.
Motivational/ Interviewing	Trains staff to take a partnership approach with Members, using open-ended questions, affirmations, various types of reflections, and summarizing to assess Member attitudes about change and appropriate next steps.
Trauma-Informed Care	Identifying and understanding the effects of trauma on development and particularly on behavior in both children and adults is crucial in assessing Member needs and in understanding the context of behavior. This training is not only a component of CM training but includes an expansive curriculum for Providers and CBOs, including a discussion about Adverse Childhood Experiences. Using this model, one of our affiliates has provided training on trauma-informed care to over 60,000 people since 2008.
Person-Centered Thinking	Person-Centered Thinking training uses copyrighted training material developed by The Learning Community for Person-Centered Practices, started in 1989 by Michael Smull and Susan Burke-Harrison at the University of Maryland. The training provides instruction on how to discover what is important to and important for the Member, and how to support the Member to find balance. The discovery is used to identify the strengths, capacities, preferences, needs, and desired outcomes of the Member. It encouraged empowerment of the Member to make their own informed decisions, develop personally defined outcomes and goals, and identify both community and paid supports to achieve the life/outcomes they choose.
Racial Equity	Topics include Authentic Allyship, Cultivating Equity and Inclusion, and Courageous Conversations.
Unconscious Bias	This training is offered through our Diversity, Equity, and Inclusion team and includes Introduction to Unconscious Bias, Unconscious Bias Fundamentals, Gender Identity and Transition.
LGBTQ+	Allyship from Awareness to Action – Out and Proud, offers training and education on approaching LGBTQ+ issues in the workplace.

Provider Education. Initial education and training for Providers will be conducted no later than 30 days before implementing Appendix A, Draft Contract, and we will complete initial education and training for newly contracted Providers at least 30 calendar days before their start date. Trainings will include education on topics such as health equity, poverty and disability sensitivity, and cultural competency to create an understanding of cultural humility with specific attention to the role of implicit and explicit bias in interpersonal interactions. This required training will be included in our Participating Provider Agreements.

5. How will the Offeror integrate SDOH evaluation into other programs (i.e., Care Management, Quality Management)?

Our approach to integrating SDOH evaluation will include leveraging our population health management framework and community input to continuously monitor and measure outcomes of our SDOH work. We will use our ***SDOH KPI Dashboard*** data that captures SDOH core domain category information. Outcomes include, but are not limited to, performance quality HEDIS measures; engagement rate in community referrals; cost of care; enrollees' self-reported SDOH needs and quality of life; process; and health outcome measures targeted for

the disease/condition. We will monitor and trend results over time and share results with our Providers, CIC's, and community partners for feedback on additional program improvement opportunities. We will establish goals and evaluation measures related to other programs based on findings from:

- **Member and Quality Outcomes**: such as improved health literacy or reduction in BMI
- **Community Wellbeing Outcomes**: such as improved employment rates, reduced rates of food insecurity
- **Program Outcomes**: such as improved HEDIS outcomes in disease management or CM

Member and Provider Call Centers. Our full-time Quality Specialists evaluate Member and Provider Call Center interactions using our customer service evaluation software integrated with our telephony system. We will monitor and ensure Members who call for SDOH support and referrals receive a warm transfer to CM for assistance. Our Member and Provider Services audit report cards address courtesy, accuracy, quality measures, and cultural competency. Supervisors will receive audit results weekly and provide immediate coaching as necessary. We will develop a toolkit for Call Center staff to offer guidance on how to help Members seeking SDOH supports based on our years of experience and feedback. Call center staff will have access to our Community Resource Support Database, which will be evaluated regularly to ensure the resources listed are accurate and match the SDOH needs and services identified from our analysis. Call center staff will receive training on implicit bias, SDOH, and cultural competency.

Care Management. Our CM program is centered on meeting Members where they are through various outreach channels to improve health literacy and remove SDOH barriers to achieve health equity. Critical to this effort is addressing SDOH and equipping Members and caregivers with timely information while promoting healthy behaviors through Member incentives, aligned Provider incentives, and value-based care. For example, we supply homeless or high-risk Members with smartphones to access telehealth services and Providers, Care Managers, our 24/7 Nurse Advice Line, and Behavioral Health/SUD Line for access to clinical personnel acting within the scope of their licensure to practice a BH/SUD-related profession. Additionally, supporting Members with special needs to maintain maximum functioning and wellness often requires additional assistance with community resources. CM staff identify Member needs for community resources during our initial assessment and care planning processes; during follow-up interactions, including administration of our SDOH Mini Screen; through Member Services requests; and from family input, informal supports, and Providers. Identified needs are documented in the Member's Care Plan for regular monitoring and follow-up. Members who are not in CM will receive support based on the need to identify and coordinate with community resources through outreach to Providers and closed-loop referrals. Members and caregivers will also have access to our Community Resource Support Database, where they can self-refer to community resources and receive appropriate follow-up to ensure their needs are met. As appropriate, CM staff ask agencies that provide local SDOH resources to participate in case conferences and build SDOH capacity, as described in our response to Section 4.2.3.3 of the RFQ.

Quality Management. SDOH factors will be incorporated into our Quality Management Program through evaluation of Member and Provider satisfaction and grievance and appeals data and our Member, Community, and Provider Advisory Committees, and Quality Management Committee and subcommittees. We will use data analytics to connect usage of peer resources with improvements in access to SDOH and quality outcomes by comparing enrollees engaged with peers with control groups and assessing utilization before and after engagement. Our framework to evaluate the effectiveness of health equity initiatives will include assessing for and incorporating SDOH factors by measuring racial, geographic, gender, disability, or other disparities pre-and post-intervention through our Health Equity Dashboard that displays performance across priority HEDIS measures.

Additionally, use the Social Determinants of Health: Staffing table in Appendix E, Innovation and Commitment Tables, to provide staffing information for the Offeror's proposed SDOH approaches. The Social Determinants of Health: Staffing table does not count against the Offeror's response limit to this question.

Please see **Attachment 4.2.3.3 Appendix E SDOH Staffing Tables**.

4.2.3.3: Social Determinants of Health (SDOH) (Unmarked): 20 points available

If additional and/or dedicated staff will be required to execute the Offeror's SDOH proposal, use the chart on the following page to provide that information.

If no additional/dedicated staff will be required to execute the Offeror's SDOH proposal, indicate that by marking the below and submitting this page at the end of the Offeror's SDOH proposal. **This page will not count against the Offeror's SDOH proposal page limit.**

[ ] The Offeror does not expect to require additional and/or dedicated staff to execute its SDOH proposal.

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Social Determinants of Health: Staffing	
Title of Position: Director of Health Equity	
SDOH Component to which Position will be Linked: The Director of Health Equity will lead a cross-functional internal Health Equity Governance Committee and serve on our national SDOH network of more than 100 experts who collaborate to share innovations, best practices, and lessons learned across the country.	
Description of Position: The Director of Health Equity will provide leadership and management to define, implement, and evaluate strategies to achieve equitable access and reduce disparities in clinical care and quality outcomes. The director will also oversee strategic design, implementation, and evaluation of initiatives to address social and community health, including improving health equity, reducing disparities, and increasing cultural sensitivity. This strategy includes tracking, assessing, and improving disparities in care, and supporting the diverse cultural, language, economic, education, and health status needs of those served by Managed Health Services. The director will partner with other senior leaders to develop and drive forward the key strategies of the organization to incorporate an equity lens into all improvement strategies, including quality, patient safety, and population health, to improve health outcomes and the member experience. • Responsible for implementing Health Equity Program to reduce disparities through determining the root cause of inequities, developing targeted initiatives, implementing Culturally and Linguistically Appropriate Services (CLAS) programs, and Collecting, measuring, and analyzing data to track progress in disparity reduction efforts • Provides collaboration with state, county, and local agencies to promote services that improve health outcomes, decrease health disparities and reduce the cost of care. • Works to embed health equity across the organization so that health equity becomes part of the practice, process, action, innovation, and organizational performance and outcomes • Lead a cross-functional internal SDOH/Health Equity Committee and serve on our national SDOH Champions Network	
Number of Staff Expected to Fill this Position/Staffing Need: [redacted]	
Employee(s) filling this position would be: [ ] Hourly **[X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time** [ ] Part-Time
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[X] Mississippi** [ ] Out-of-State
Title of Position: Community Engagement Specialists	
SDOH Component to which Position will be Linked: Each CES will lead a Community Impact Council (CIC) in their region. CICs will provide feedback about SDOH and health disparities activities. They will also continuously assess, enhance, and improve the appropriateness and quality of our services to achieve health equity.	
Description of Position: Develop, implement, and provide oversight for Health Equity programs and SDOH initiatives by facilitating strategic community partnerships in one of three regions (central, north, and south) as	

determined by The Director of Health Equity. This team of specialists will work collaboratively to ensure the SDOH needs of our Members are incorporated into our CM model, continually identified through every Member contact, and addressed through data-driven partnerships designed to both support the Member and improve the community as a whole. They will ensure the successful integration of cultural competency into operational programs and oversee cultural competency requirements to external stakeholders and government agencies, including government relations, network providers and delegated entities.

- Develop, manage, and oversee health equity programs in region
- Lead a Community Impact Council in the assigned region and provide oversight and direction of all our activities associated with SDOH and health disparities and to assess the appropriateness of care and service delivered and to continuously enhance and improve the quality of services provided to members to enhance health equity
- Lead and coordinate workforce staff development in cultural competency
- Collaborate with multiple functional areas on the implementation of Compliance Program goals, including member and provider materials
- Serve as the subject matter expert to key stakeholder and team on health equity and cultural competency, including developing, planning, and coordinating training. Responsible for oversight and implementation of key regulations and polices related to health equity, cultural competency, language services and health literacy including readiness assessments, monitoring and corrective actions
- Monitor network adherence to the provision of cultural competent care
- Lead the development and coordination of targeted health equity promotion programs including place-based and health plan level initiatives
- Research and make recommendations to executive management team on population specific initiatives
- Responsible for Quality Management Performance Improvement (QMPI) Committee reporting including analyzing results to determine progress against plan elements and evaluating the Plan(s) Health Equity program, including compliance with CLAS standards and state and federal regulations
- Represent the Plan(s) in Community/ Stakeholder Workgroups and Forums related to Cultural Competency and health equity
- Responsible for any regulatory deliverables related to health equity and CLAS

Number of Staff Expected to Fill this Position/Staffing Need: [redacted]

Employee(s) filling this position would be: [ ] Hourly **[X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time** [ ] Part-Time
Expected Wage of Position (Hourly rate or salary): [redacted]	**Expected Location of Employee:** **[X] Mississippi** [ ] Out-of-State

4.2.3.4: VALUE ADDED BENEFITS (VALUE-ADDS)

The Division will assess any proposed Value-Adds as part of the Innovation and Commitment score. A list of Division-curated Value-Adds are included in Appendix E. The Offeror may choose from the Division's list of value-adds, describe some of their own, both, or elect not to include value-adds in its proposal.
If no Value-Adds are included, the Offeror will receive a score of zero for this section.
If offering any Value-Add in its response, the Offeror should make summary proposals of any and all Value- utilizing the following charts provided in Appendix E:
• Value-Added Benefit: Summary Chart
• Value-Added Benefit: Staffing (if applicable)
If the Offeror is not including Value-Adds with its proposal, the Offeror should use the form provided in Appendix E as its answer to this request.

See **Attachment 4.2.3.4 Appendix E Value Added Benefits**.

Division-Curated Value-Adds for CCO Contract

The Division has compiled a list of desired Value-Adds for this procurement. If an Offeror chooses to include value-added services in its qualification, the Offeror may choose from this list, propose their own original value-added services, or include a combination of both. To the extent that some or all of the desired value-added services may be covered through the offeror's Care Management strategy, that should be made evident in the Offeror's Care Management answers in its qualification.

Perinatal

1. Full sponsorship, including any materials, fees, transportation, and childcare for Members, and support for providers, of the Centering Pregnancy Model and/or prenatal classes for pregnant members.
2. CPR and Parenting classes for parents/caregivers
3. Dental preventative care during pregnancy and postpartum
4. Wound care management or home health nursing in postpartum for cesarean sections and slow-healing vaginal lacerations

Expanded Services

1. Hearing aids for members over 21
2. Vision benefits for members over 21
3. In-home respite services
4. Home modifications and/or environmental adaptations
5. Over-the-counter (OTC) monthly allowance for non-prescription/commonly used OTC and hygiene items
6. Enhanced dental services

Social Determinants of Health

1. Nutrition Assistance, including but not limited to additional nutrition resources for Members (even those who receive SNAP and/or WIC benefits) and education and training for Members regarding nutritious foods and food preparation
2. Utility payment assistance
3. Pest Control/Bed Bug home treatment
4. Education and employment supports, including but not limited to paying for GED classes, supporting pregnant minors in pursuit of high school diploma, paying for skills training, and supplying Members with a computer and internet in the home

Children

1. A monthly supply of diapers and baby wipes for children until they are potty trained
2. Car seats and booster seats for children, including ensuring that parents/caregivers receive proper installation training
3. Childcare of a Member's sibling(s) during a Well Child or EPSDT visit

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Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Vision Benefit for Members over 21	
Target Beneficiary Population(s): Ages 21+	
Benefit description, including any limitations and prior authorization requirements: Maintaining healthy vision is key to preventing certain long-term health conditions. Our Vision Value-Added Benefit will offer eligible Members one eye exam per year and one pair of eyeglasses every calendar year for every Member 21 and over. Limited to one eye visit per year and one pair of eyeglasses annually. No prior authorization required.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Boys and Girls Club Memberships	
Target Beneficiary Population(s): Youth ages 6-18	
Benefit description, including any limitations and prior authorization requirements: We will cover membership fees to the local Boys and Girls Club for Members ages 6-18. Programs in academics, character building and leadership, and health and wellness will allow Members to grow their knowledge and implement what they learn to lead healthier lives. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** $[redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: YMCA Membership	
Target Beneficiary Population(s): Ages 19+	
Benefit description, including any limitations and prior authorization requirements: Our plan will cover membership fees to a local YMCA for Members age 19 and over. Memberships offer families a variety of fitness programs and activities designed to help Members learn, grow and thrive in their community. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Weight Watchers	
Target Beneficiary Population(s): Adult Members with a BMI equal to or greater than 25	
Benefit description, including any limitations and prior authorization requirements: Utilizing the criteria of a BMI of equal to or greater than 25, we will offer a free six-month membership, including access to e-tools, for qualified Members identified through Care Management. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Community Baby Showers	
Target Beneficiary Population(s): Pregnant Members	
Benefit description, including any limitations and prior authorization requirements: As part of our Maternal and Child Health Program, we will host baby shower events across the State. Baby Showers will be conducted in a health fair environment led by our Care Management team and assisted by our dedicated member staff. Topics will include prenatal care, nutrition, the risk of smoking and benefits of smoking cessation, understanding baby care items (e.g., car seats, cribs, diapers, etc.), the progress of a fetus throughout pregnancy, the importance of regular follow-up with medical Providers, common health issues that occur during pregnancy, and a review of our benefits and programs. Baby Showers will be held in the communities where our Members reside. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Care Kits	
Target Beneficiary Population(s): Foster Care Members, Members with Sickle Cell, Members with infants in the NICU, and Members discharging from the hospital	
Benefit description, including any limitations and prior authorization requirements: Care Kits for Foster Care Members will provide basic care items that can travel with children transitioning into Foster Care. The kits will be age-appropriate and culturally sensitive. The items are supplied in a sturdy duffle bag or backpack and will include items such as a blanket, hot/cold tumbler, dental kit, earbuds, and a journal and pen. Infants and young children receive more age-appropriate items. The Care Kits will provide the Foster Member comfort and give them something of their own to alleviate some of the loss and stress that occurs when a child enters care. Sample contents in our NICU Kit include newborn clothing and essentials (e.g., baby onesie, socks, bibs, diapers and baby wipes, suction pump, pacifier, and thermometer), and delivery/postpartum educational materials such as safe sleep practices. Contents in the Sickle Cell Kit include Member materials on understanding Sickle Cell Disease; digital thermometer, hot/cold pack, water bottle, color-coded arm bands, and bracelets that help adults and children communicate their pain levels (i.e., blue is mild, yellow is medium, and red is severe pain). Care Kits for Members discharging from an inpatient stay will receive a kit that includes a medication planner, stress ball, important phone numbers sheet, member tip sheet, and transportation brochure for our Members who are being discharged and transitioned from a PRTF or inpatient psychiatric or rehabilitation facility. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Car Seat Installation	
Target Beneficiary Population(s): Caregivers with Members who require car seats.	
Benefit description, including any limitations and prior authorization requirements: Our plan staff will be certified to train caregivers in the proper car seat installation. Members without car seats can utilize Care Grants through another Value-added benefit provided by our plan. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Care Grants	
Target Beneficiary Population(s): Members in Care Management	
Benefit description, including any limitations and prior authorization requirements: Our Care Managers will be empowered to meet identified Member needs in real-time using Care Grants. Funds may be used for things such as emergency utility assistance, pest control, car seats, and diapers. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add?No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Member Employment and Education Program	
Target Beneficiary Population(s): Ages 19+	
Benefit description, including any limitations and prior authorization requirements: We will offer education and employment supports to provide Members with tools to further their education and achieve and retain employment. The benefit includes GED training and testing, English as Second Language classes, interview coaching, and financial literacy classes. Our Member's training and ongoing support in this Program will increase employment opportunities and retention. In addition, we will be partnering with Historically Black Colleges and Universities and other higher education facilities to provide this Program across the State. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Expanded Phone Access Program	
Target Beneficiary Population(s): Members in Care Management who have been identified as high risk and not eligible for SafeLink and do not otherwise have reliable phone access.	
Benefit description, including any limitations and prior authorization requirements: We will offer a smartphone distribution program through our expanded cell phone program, which provides pre-programmed cell phones for certain high-risk Members or their parents/ guardians enrolled in Care Management who lack reliable phone access. This will allow Members to make and receive calls from their Providers, Care Managers, pharmacies, important family contacts, our 24/7 Nurse Advice Line and 24/7 Behavioral Health/SUD Crisis Line as well as 911. Additionally, Members can activate the phone alarm feature to remind them to take medications, a functionality beyond that which is available through a standard mobile phone. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Postpartum Home Health Nursing for Wound Care	
Target Beneficiary Population(s): Postpartum Members with a c-sections or slow healing vaginal wound	
Benefit description, including any limitations and prior authorization requirements: This Value-Added Benefit will promote healthy home care for Postpartum Members with up to 90 days of home health nursing. This covers wound care for c-sections and slow-healing vaginal wounds, lowering ED visits and unnecessary Provider visits while improving the Members recovery in the comfort of their home. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Over-the-Counter (OTC) Allowance	
Target Beneficiary Population(s): Heads of Households	
Benefit description, including any limitations and prior authorization requirements: Every head of household enrolled will be eligible to receive $10 worth of OTC items each month. The OTC benefit will cover typical OTC medications (e.g., pain relievers, vitamins) as well as eyeglass kits, reading glasses, and assistive aid devices such as pill containers and magnifying glasses. Providing these necessities will allow Members to live a life with less pain, read their prescription labels with vision aids, and improve their daily lives. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Virtual Group Prenatal Classes	
Target Beneficiary Population(s): Members identified with high-risk pregnancies	
Benefit description, including any limitations and prior authorization requirements: Our Pregnant Members identified as high-risk will be eligible to receive virtual group prenatal classes based on the Centering Pregnancy Model, reducing the complications of high-risk pregnancies. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Expanded Transportation Benefit	
Target Beneficiary Population(s): Heads of Household	
Benefit description, including any limitations and prior authorization requirements: Our Expanded Transportation Benefit will provide additional transportation services to grocery stores and food pantries with a limit of 3 round trips per month, reducing food insecurity for our Members in Mississippi by lowering barriers to accessing healthy foods. Limitation of 3 round trips per month. Prior Authorization required.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? No [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Asthma Program	
Target Beneficiary Population(s): Members enrolled in our Asthma disease management/health coaching and a combination of two or more asthma-related ED visits or hospitalizations within the prior six months.	
Benefit description, including any limitations and prior authorization requirements: Our Asthma Program will reduce in-home exposures to asthma attacks, improve quality of life, and decrease the need for ED and other physical and/or behavioral health visits. Eligible Members will receive the following household items and services: • $100 allowance for hypoallergenic bedding • Medical masks • Carpet cleaning services • HEPA filter vacuum cleaner No prior authorization or limitations requirements.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: CHIP Non-Emergent Transportation (NET)	
Target Beneficiary Population(s): CHIP Members	
Benefit description, including any limitations and prior authorization requirements: We will provide CHIP Members with NET to and from medical appointments, including the scheduling of rides. No prior authorization requirements or limitations.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Preventive Dental Care During Pregnancy and Postpartum	
Target Beneficiary Population(s): Pregnant Moms, up to six months postpartum. .	
Benefit description, including any limitations and prior authorization requirements: We will provide all dental services except cosmetic visits/procedures to include six month cleanings, fillings, extractions, and restorative services. No prior authorization. Limited to six months postpartum.	
Projected utilization in year one (total units): [redacted]	**Price per unit:** [redacted]
Gross value: [redacted]	**Offsetting costs (provide amount and basis for estimate):** [redacted]
Net Value (gross value minus offsetting costs): [redacted]	**Will a staffing investment be made for this Value-Add? [X] Yes [ ]** **If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.**

4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked): 10 points available

The Division has provided on the following page a curated set of Value-Added Benefits in which it is interested for the Offeror to review. The Offeror may choose to use any of these Value-Adds as part of its proposal or choose to use none.

Use the Proposed Value-Added Benefit: Summary Chart for each Value-Add the Offeror is including in its response to this section.

If additional and/or dedicated staff will be required to execute a Value-Add, use the Value-Added Benefit: Staffing Chart to provide that information.

If no additional/dedicated staff will be required to execute any of the Offeror's Value-Adds, indicate that by marking the below and submitting this page at the end of the Offeror's Value-Adds proposal.

[X] The Offeror does not expect to require additional and/or dedicated staff to execute any of its proposed Value-Adds.

If the Offeror has chosen not to offer any Value-Adds in its qualification, indicate that below, and submit this page as the Offeror's response to this request.

[ ] The Offeror is not including Value-Adds as part of its qualification response.

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4.2.3.5: PERFORMANCE IMPROVEMENT PROJECTS

The Division is seeking to standardize Performance Improvement Projects in its next contracting cycle, both for the purposes of scalability and measurement. This is discussed more in Section 8, Quality Management, of Appendix A, Draft Contract. After selection, Contractors will submit their PIPs to the Division for standardization, and Contractors will be required to cross-collaborate on at least one PIP. The Offeror should include with its proposal summaries of its first year of proposed Performance Improvement Projects for MississippiCAN and CHIP.
To respond to this requirement, the Offeror should make summary proposals of four (4) potential PIPs utilizing the following charts provided in Appendix E:
• Performance Improvement Project: Summary Chart
• Performance Improvement Project: Staffing (if applicable)

See **Attachment 4.2.3.5 Appendix E PIPs**.

Performance Improvement Project (PIP): Summary Chart

PIP Title: CHIP Well-Child Visits

Target Beneficiary Population(s): CHIP Members ages 0-30 months

Overview of PIP Strategy and Goals: The proposed CHIP Well-Child Visits PIP goals are:

1. Increase the rate of Well Child Visits for children who turned 15 months during the measurement year who received six (6) or more Well Child Visits to 80% (CQS benchmark).
2. Increase the rate of Well Child Visits for children 15-30 months during the measurement year who received four (4) or more Well Child Visits to 80% (CQS benchmark).

Strategy:

- Initiate a root cause analysis of the barriers to timely Well-Child Visits for CHIP Members, including assessing population demographics and historical utilization, community needs assessment data, and our Health Equity dashboard. For example, the Health Equity Dashboard will stratify data by race, ethnicity, language, disability, and geography to assess for social determinants of health (SDOH) and other disparities that are barriers to health equity.
- Define outcomes, including frequency of reporting and analysis. Minimum data sources will include demographic data, notification of pregnancy data, claims data, care management information such as care plans, and clinical practice guidelines including the ACIP Recommended Immunization Schedule and AAP Bright Futures. Outcomes will be presented at least quarterly at Performance Improvement Team (PIT) and Quality Management Committee (QMC) meetings. HEDIS W30 measure will be used to measure impact.
- Based on final analysis of population needs and barriers, develop evidence-based interventions to meet the PIP goals. This will include a combination of Member and Provider education and outreach campaigns, including OBGYN Providers; culturally responsive education materials; Member incentives; Provider incentives via value-based purchasing (VBP) arrangements; scheduling assistance and appointment reminders; and addressing SDOH through community partnerships and value-added benefits. For example, we will deliver materials, resources, and messaging around the importance of and schedule for Well-Child Visits, such as magnets or stickers, during car seat installations by our certified staff.
- Routinely report PIP findings in health plan PIT and Health Equity Governance Committee meetings to gain multidisciplinary insight and recommendations and include PIP progress reports at QMC and annual outcomes in the QM Program Description.
- Draw conclusions based on outcome data, perform an evaluation of the project using quantitative and qualitative analysis, and test the outcome using a t-test to identify significance with a p-value less than 0.05.

Reason for choosing this PIP: Any PIP focus areas selected are evidence-based, relevant to the population, and can demonstrate a long-term sustainable impact. The Well-Child Visit PIP closely aligns with the CQS and Appendix A, Draft Contract. Access and engagement in regular and preventive care is critical to promoting lifelong health. Well-Child Visits include a wide variety of screenings that, if not performed, may result in the risk of increased potential morbidity and even mortality from various childhood diseases and conditions. Regular screenings help to ensure that conditions that may exist are diagnosed and treated quickly, and children are protected with age-appropriate immunizations and vaccinations.

Tools for measuring impact: We will utilize proven QM tools to measure and evaluate PIPs. Tools include but are not limited to barrier analysis (Root Cause Analysis, Fishbone Diagram, 5 Whys), Histogram, Pareto Chart, Run Chart, Control Chart, Scattergram, and t-test. The HEDIS W30 measure will be used as the data source for measurement of impact on quality outcomes.

Will staffing investment be made for this PIP? { X }Yes or { }No
If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.

Performance Improvement Project (PIP): Summary Chart

PIP Title: Appropriate Medication Management in Children with Asthma

Target Beneficiary Population(s): CHIP members ages 5 to 18 identified as having persistent asthma

Overview of PIP Strategy and Goals: PIP goals include:

1. Increase the rate of Asthma Medication Ratio (a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year) in CHIP members ages 5-11 with persistent asthma to 75% (MS CQS Benchmark) during the measurement year.
2. Increase the rate of Asthma Medication Ratio in CHIP members ages 12-18 with persistent asthma to 79.22% (NCQA 75th percentile National Benchmark) during the measurement year.

Strategy:

- Conduct an initial root cause analysis of the barriers to appropriate medication management for children with asthma, including an assessment of population demographics, historical utilization, community needs assessment data, and our Health Equity dashboard. For example, we can pinpoint geographies with high rates of asthma due to air quality and other environmental issues and design interventions and targeted campaigns in those areas. By identifying issues and needs, we can develop a more personal, high-touch approach, leveraging local resources and employing field-based staff to support the needs.
- Data sources will include demographic, disease prevalence, pharmacy, and claims data, as well as CM information such as care plans and clinical practice guidelines from the National Asthma Education and Prevention Program, U.S. Department of Health and Human Services, and Global Initiative for Asthma's Global Strategy. Minimum frequency of reporting and analysis is monthly reporting with results presented at least quarterly at Performance Improvement Team (PIT) and Quality Management Committee (QMC) meetings.
- Based on root cause analysis and needs assessment, develop evidence-based interventions to increase rate of asthma controlling medications compared to asthma acute medications. This will include targeted Member and Provider education and outreach campaigns tailored for the local community; pharmacy reporting; Asthma Management Plans; Medication Therapy Management; culturally responsive, age-appropriate Member education materials; Member incentives; Provider incentives; scheduling assistance and appointment reminders; and addressing SDOH through community partnerships and value-added benefits. For example, we will conduct onsite Environmental Home Assessments to evaluate specific triggers and provide items and services to help reduce asthma risk (e.g., hypoallergenic bedding, medical masks, carpet/filter cleaning) as part of our asthma DM program.
- Routinely report PIP findings in PIT and Health Equity Governance Committee meetings and include PIP progress reports at QMC and annual outcomes in the QM Program Description.
- Perform an evaluation of the project using quantitative and qualitative analysis and test the outcome using a t-test to identify significance with a p value less than 0.05.

Reason for choosing this PIP: Asthma is a relatively controllable disease but significant disparities exist based on race and ethnicity. Appropriate asthma medication management can improve a child's health outcome by reducing asthma exacerbations, the need for rescue medications, and health disparities. Proper asthma medication management can also reduce costs of ED and hospital visits.

Tools for measuring impact: We will utilize proven tools to measure and evaluate PIPs including barrier analysis (Root Cause Analysis, Fishbone Diagram, 5 Whys), Histogram, Pareto Chart, Run Chart, Control Chart, Scattergram, and t-test. The HEDIS AMR measure will be used as the data source for measurement of impact on quality outcomes, including a breakdown to assess for health equity.

Will staffing investment be made for this PIP? { X}Yes or { }No (see PIP Staffing Chart)
If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.

Performance Improvement Project (PIP): Summary Chart
PIP Title: Management of Diabetes Risks in the Seriously Mentally Ill (SMI) Population
Target Beneficiary Population(s): MSCAN Members ages 18 to 64 with a diagnosis of diabetes and schizophrenia or schizoaffective disorder
Overview of PIP Strategy and Goals: PIP goals include: 1. Increase the percentage of Members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year to 72.12% (NCQA 75th percentile National Benchmark) during the measurement year. **Strategy:** • Initiate a root cause analysis of the barriers to care, including assessing population demographics and historical utilization, community needs assessment data, and our Health Equity dashboard. On an ongoing basis, we will use claims, pharmacy data, disease registries, and predictive analytics to identify Members with increased risks. • Minimum data sources will include demographic, diagnosis, lab, and claims data, as well as CM care plans, and clinical practice guidelines including the American Diabetes Association (ADA) Standards of Medical Care in Diabetes and ADA Position Statement for the Psychosocial Care of People with Diabetes. Minimum frequency of reporting and analysis is monthly reporting with results presented at least quarterly at Performance Improvement Team (PIT) and Quality Management Committee (QMC) meetings. • Based on the root cause analysis and needs assessment, develop evidence-based interventions to increase glucose and cholesterol testing in the eligible population. This will include tailored Member and Provider education and outreach campaigns; use of disease registries and predictive modeling for individual identification and outreach; referrals to integrated PCMHs and enrollment in CM; culturally responsive education materials; Member incentives; Provider incentives; scheduling assistance and appointment reminders; and addressing SDOH through community partnerships and value-added benefits. For example, we will ensure all Members with SMI have access to a smartphone to improve communication, engagement, and appropriate utilization of health care services. • Routinely report PIP findings in health plan PIT and Health Equity Governance Committee meetings and include PIP progress reports at QMC and annual outcomes in the QM Program Description. • Draw conclusions and sustainability based on outcome data, perform an evaluation of the project using quantitative and qualitative analysis and test the outcome using a t-test to identify significance with a p value less than 0.05.
Reason for choosing this PIP: SMI is associated with increased morbidity and mortality and people with SMI are reported to be less likely to receive recommended diabetes care. Individuals with SMI have a life expectancy much lower than the general population, with a shorter life span related to medical conditions. Disparities in health care compound the problem of increased morbidity and mortality for people with SMI.
Tools for measuring impact: We will utilize proven Quality Management tools to measure and evaluate PIPs. Tools include but are not limited to barrier analysis (Root Cause Analysis, Fishbone Diagram, 5 Whys), Histogram, Pareto Chart, Run Chart, Control Chart, Scattergram, and t-test. The HEDIS SMD measure will be used as the data source for measurement of impact on quality outcomes. The Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) HEDIS measure will be used as the data source for measurement of impact.
Will staffing investment be made for this PIP? { X}Yes or { }No **If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.**

Performance Improvement Project (PIP): Summary Chart

PIP Title: Prevention of Childhood Obesity and Obesity-Related Conditions

Target Beneficiary Population(s): MSCAN children ages 10-13

Overview of PIP Strategy and Goals: PIP goals include:

1. Decrease the incidence of obesity and obesity-related conditions (diabetes, hypertension, and hyperlipidemia) in children ages 10-13 by 5% one year post-implementation.

Strategy:

- Conduct an assessment of the contributors to obesity in children in Mississippi, broken down by community. This will include a review of community needs assessments and other publicly available data on children's health, and a population analysis using our Health Equity Dashboard to stratify data by race, ethnicity, language, disability, and geography.
- Define outcomes, including frequency of reporting and analysis. Minimum data sources will include demographic, diagnosis, and claims data, as well as CM care plans and clinical practice guidelines such as the American Academy of Pediatrics Clinical Report: Preventing Obesity and Eating Disorders in Adolescents and Final Recommendation Statement on Obesity in Children and Adolescents from the U.S. Preventive Services Task Force.
- Based on the root cause analysis and needs assessment, develop evidence-based interventions with a Pediatrician with board certification in childhood obesity, including targeted Member and Provider education and outreach campaigns tailored for the local community and leveraging school nurses and school communications and events. We will also conduct webinars with dietitians or nutritionists; use disease registries and predictive modeling for individual identification and outreach; engage Members in DM; provide culturally responsive education materials for youth, parents, and caregivers, such as inexpensive recipes for food obtained with SNAP program; and addressing SDOH through community partnerships and value-added benefits. For example, we will cover membership fees to local Boys and Girls Clubs and can provide athletic shoes or other items to support physical activity through care grants.
- Routinely report PIP findings in health plan PIT and Health Equity Governance Committee meetings to gain multidisciplinary insight and recommendations and include PIP progress reports at QMC and annual outcomes in the QM Program Description.
- Perform an evaluation of the project using quantitative and qualitative analysis and test the outcome using a t-test to identify significance with a p value less than 0.05.

Reason for choosing this PIP: Childhood obesity is a complex health issue affecting children nationwide. Children as young as 10 already have a diagnosis of obesity and many have the precursors of diabetes and heart disease. If weight is not managed by age 13, they are more likely to have hypertension, diabetes, and hyperlipidemia. Childhood obesity also leads to adult obesity and increases morbidity rates. Helping to reduce the percentage of children diagnosed with obesity and obesity-related conditions in children will have long-term effects on their health.

Tools for measuring impact: We will utilize proven Quality Management tools to measure and evaluate PIPs. Tools include but are not limited to barrier analysis (Root Cause Analysis, Fishbone Diagram, 5 Whys), Histogram, Pareto Chart, Run Chart, Control Chart, Scattergram, and t-test. Disease prevalence and incidence of obesity and obesity-related conditions will be used as the data source for measurement of impact.

Will staffing investment be made for this PIP? { X}Yes or { }No

If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.

Performance Improvement Project: Staffing	
Title of Position: Quality Improvement Specialist	
PIP to which Position will be Linked: Well-Child Visits, Appropriate Medication Management in Children with Asthma, Management of Diabetes Risks in the Seriously Mentally Ill Population, and Prevention of Childhood Obesity and Obesity related Illnesses	
Description of Position: Clinical position that performs duties and functions to comply with quality improvement programs according to state and federal requirements, supports continuous quality improvement	
Number of Staff Expected to Fill this Position/Staffing Need: 1 FTE	
Employee(s) filling this position would be: [X] Hourly [ ] Salaried	**Employee(s) filling this position would be: [X] Full-Time [ ] Part-Time**
Expected Wage of Position (Hourly rate or salary): 40,000.00 - 68,200.00 USD Annual	**Expected Location of Employee: [X] Mississippi [ ] Out-of-State**

4.2.3.6: HEALTH LITERACY CAMPAIGNS

The Division is implementing a new Health Literacy Campaign strategy for the next contracting cycle. The Division plans to coordinate a common strategy among Contractors in order to best amplify important health education to Members. More details can be found in Section 8.10.8, Health Literacy Campaigns, of Appendix A, Draft Contract.
To respond to this requirement, the Offeror should make summary proposals of four (4) potential campaigns utilizing the following charts provided in Appendix E:
• Health Literacy Campaign: Summary Chart
• Health Literacy Campaign: Staffing (if applicable)

See **Attachment 4.2.3.6 Appendix E Health Literacy Campaigns**.

Health Literacy Campaign: Summary Chart
Campaign Title: Ask Me 3
Target Beneficiary Population(s): All Members
Overview of Campaign Strategy and Goals: This campaign aims to empower Members to be responsible for their health and advocate for themselves when meeting with clinicians. ***Ask Me 3®*** approach helps Members frame Provider interactions around three specific questions to ask during visits: (1) What is my main problem?; (2) What do I need to do?; and (3) Why is it important to me? Ask Me 3 will be implemented in accordance with our Health Education and Literacy Plan that will guide our approach to communicating with our Members and families/caregivers, including development and input from the Health Equity Governance Committee, Health Equity Director, and Health Literacy Advocate. All Member-facing staff will be trained on Ask Me 3 and how to speak with Members about engaging in their health care and better understanding their health care needs, conditions, and treatments. We will make program materials available to Members and Providers through our public website, training and onboarding, and as part of our Member and Provider Newsletters and other promotional materials.
Reason for choosing this Campaign: Health care can be complicated and intimidating. Ask Me 3 helps Members focus on what they need to know during conversations with clinicians so that they can better manage their health following the visit with the doctor. Ask Me 3 was designed by health literacy experts in collaboration with the Institute for Healthcare Improvement (IHI) and is intended to help patients become more active Members of their health care team and to improve communication between patients, families, and clinicians.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): Written materials developed by IHI licensed for use will be made available through our website and distributed to Providers during onboarding and other office visits and to Members through our Welcome Packet and during community events. We will promote Ask Me 3 through our social media channels, such as Facebook. To further support our individual Members, we will include prompts for Ask Me 3 in text appointment reminders and personally support Members with Ask Me 3 when providing appointment scheduling services.
Tools for measuring engagement: To measure the level of engagement, we use both quantitative and qualitative data. Our Care Management (CM) staff and Providers will have the most direct line of sight to our Members and how they are engaging with the health care system. As part of Ask Me 3 we will include specific questions in our Provider Surveys to measure Member engagement and participation in their care. Our CM staff will integrate Ask Me 3 into a Member's care plan, following up to ensure Members received the information they needed to understand and address their care needs. In addition to this direct feedback, we will use Provider Analytics, which is designed to help our staff and Providers identify and prioritize efforts based on clinical needs and opportunities and understand the next best action to improve population health. Provider Analytics can also help our Providers and staff track engagement and Provider loyalty. Engagement measures the Provider's efficacy with engaging their assigned members to be seen for annual primary care visits and appropriate follow up, while loyalty measures the Provider's ongoing effort to maintain exclusivity as the PCP for their assigned panel of members, which can be an indicator of Member engagement. We will include KPIs on Member engagement within our dashboards for ongoing oversight.
Tools for measuring impact: Evidence-based practice shows that improving health literacy and engagement results in better care, lower cost, the closure of care gaps, and better overall health. We will measure the impact of improved health literacy and engagement through HEDIS rates for preventive and chronic care and care gap closures.
Will a staffing investment be made for this Campaign? [ ] Yes [X] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

Health Literacy Campaign: Summary Chart
Campaign Title: Teen Health
Target Beneficiary Population(s): Members aged 13 to 17 and their families/caregivers
Overview of Campaign Strategy and Goals: This campaign aims to provide age-appropriate information to teens to help them navigate the health system, promote wellness, and make an investment in their health to set them up for healthy adulthood. Our strategy includes the following components: • Work with the Department of Education and local school systems to develop and implement a curriculum on navigating the health system and managing self-care. • Work with schools to implement No One Eats Alone, an initiative to prevent depression, suicide, and bullying and reduce social isolation in middle schools. • Partner with schools on health and wellness classes with topics such as vaping, hygiene, diabetes education, appropriate preventive care and healthy decision making, and healthy eating. We will hold exercise programs and provide books to promote health literacy for summer reading programs. • Partner with schools, community action agencies, Providers, and community-based organizations (CBOs) to communicate the importance of vaccines for teens. This includes partnering with the American Cancer Society and its Health Plan Learning Collaborative on Adolescent Immunization and the Human Papillomavirus Vaccinate Adolescents against Cancers (HPV VACs) program supporting quality tools and evidence-based interventions to increase HPV vaccination rates. • Partner with the national Truth Initiative to deploy an innovative program, This is Quitting, to address teen vaping. Participants receive interactive daily text messages tailored to their target sign up and/or quit date that encourage and motivate them, while offering skill-building exercises, coping strategies, and information about risks. • Partner with a local CBO to encourage use of contraception to avoid unwanted pregnancies and to address systemic racism in reproductive health care. • Deploy a comprehensive suicide prevention strategy that uses predictive modeling and evidence-based practices to identify suicide risk, determine the best course of intervention, and monitor treatment progress to improve outcomes. The program is based on the Zero Suicide framework and incorporates industry-standard assessments and tools such as the Columbia Suicide Severity Rating Scale, PHQ-9, Safety Planning, and Caring Contacts. • Member incentives for adolescent well-visits and immunizations
Reason for choosing this Campaign: About 25% of our anticipated Members are teens. This campaign will encourage teens to have a medical home and empower them to achieve wellness through healthy decisions, healthy eating, and exercise. We recognize the challenges teens face, especially following the pandemic. For example, Mississippi continues to have one of the highest teen birth and STD infection rates in the country. We selected the Truth Initiative based on proven results. Research indicates that about 75% of This is Quitting participants set a quit date, and almost 50% reported reductions in vaping. Likewise, Zero Suicide has shown demonstrated results; just one year of implementing Zero Suicide, a Medicaid affiliate saw an 8% decrease in suicide attempts among the foster care population.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): Distribute materials at in-person school events and health fairs, through text messages, and on social media. Materials will also be available on our public website and shared with Members and Providers through welcome, training, and onboarding materials.
Tools for measuring engagement: We will have specific measures for each effort and initiative contributing to the overall health and wellness of teen Members. For example, the Truth Initiative reports will measure effectiveness regarding quitting and reduction in vaping use. We will look at HEDIS measures for preventive and chronic care filtered by age and compared year over year to measure impact. For example, we will look at Vaccination and HEDIS immunization rates by age and geography.
Will a staffing investment be made for this Campaign? [ ] Yes [X] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

Health Literacy Campaign: Summary Chart
Campaign Title: Maternal and Child Health
Target Beneficiary Population(s): Pregnant Members and newborns through 1st year of life
Overview of Campaign Strategy and Goals: This campaign aims to improve birth outcomes and infant mortality rates through awareness about the importance of prenatal, postpartum, and Well-Child care. Our strategy includes the following components: • Promote completion of notification of pregnancy (NOP) forms by staff, Providers, and Members to help understand a Member's needs for her pregnancy or newborn. We will provide personal outreach, support completing the form, and financial incentives. • Enrollment of all Members into our Maternal and Child Health Program, which offers education and resources matched to individual Member needs. • Text messaging on important pregnancy milestones, appointment reminders, perinatal depression signs and symptoms, and available resources to address pregnancy risks, including information on SUD in pregnancy programs and resources. • 24/7 access to virtual lactation consultants and doulas. • Identifying a Pediatrician for the Member's newborn before delivery and providing planning calendars and reminders for appropriate newborn and well-child care. • Community Baby Showers in partnership with local CBOs to deliver information about the importance of prenatal visits, dangers of smoking and alcohol use during pregnancy, nutrition, infant and postpartum care, lead poisoning, the importance of well-child visits and EPSDT, safe sleep practices, and children's developmental milestones. Mothers will receive diapers, a lactation starter kit, and an infant personal care kit. • Provide financial support to a CBO that provides education for families and professionals affected by sudden infant death syndrome and sudden unexpected infant death to expand and enhance training and education, sponsor research, and raise awareness. • Partner with a local non-profit and our Provider network to provide education and training and ensure all Members can access high-quality family planning care when they need it, how they need it, and where they live. • Member incentives for prenatal care, postpartum care, and well-child visits.
Reason for choosing this Campaign: As reported by the CDC National Center for Health Statistics, Mississippi has the worst infant mortality rate in the country (8.71). This is corroborated by the 2021 March of Dimes Report Card which issued a failing grade for preterm births and showed no improvement or worsened rates from last year. The report also indicated the preterm birth rate among Black women is 44% higher than all other women.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): Information on a healthy pregnancy and healthy delivery will be mailed to pregnant Members and reinforced through follow-up phone outreach or in-person visits by Community Health Workers (CHWs). Other methods of communicating this important messaging will include texting, online tools and resources, and community partnerships to act as trusted messengers equipped with approved materials for distribution.
Tools for measuring engagement: We will measure engagement through active participation in our Maternal and Child Health Programs and utilization reports, including prenatal, postpartum, and well-child visits.
Tools for measuring impact: Impact will be measured through HEDIS measures, including Timeliness of Prenatal and Postpartum Care, Well-Child Visits, and Immunizations.
Will a staffing investment be made for this Campaign? [ ] Yes [X] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

Health Literacy Campaign: Summary Chart
Campaign Title: Behavioral Health Awareness and Access to Care
Target Beneficiary Population(s): Members with behavioral health (BH) diagnoses
Overview of Campaign Strategy and Goals: The goal of this campaign is to increase Member engagement in BH services. Our strategy includes the following components: • Promote integration of BH and primary care services to ensure Members can recognize and address their whole health. This includes training for PCPs on integration, addressing mild to moderate BH needs, referral and follow-up for more complex BH needs, whole-person care to improve the support they can offer to their Members with BH needs, and access to telehealth services. • Implement the national Stamp Out Stigma program. Stamp Out Stigma is an initiative led by the Association for Behavioral Health and Wellness to reduce the stigma regarding mental illness and SUD. • Partner with the national Beyond Differences program to address social isolation among adolescents. Beyond Differences is a student-led social justice movement that works in middle schools and provides social and emotional learning curricula for the No One Eats Alone program. These resources would be funded by our plan's charitable foundation. • Leverage Community Health Workers (CHWs) and Peer Supports embedded in the communities they serve to help Members access BH services and support recovery efforts. • Promote awareness of opioid use disorder and risks through Member and Provider training and education campaigns, including public health campaigns promoted in the community. • Provide access to online tools, including our online and mobile self-care resources which will provide educational supports to help Members learn more about their BH diagnoses, track their symptoms, and receive motivational ideas and tools to work toward solutions. e-Learning programs support depression, anxiety, overuse of drugs or alcohol, and complex BH conditions in a safe, confidential environment. We encourage caregivers to use it for their own support or to understand their loved one's BH diagnosis better.
Reason for choosing this Campaign: BH diagnoses are often more prevalent than heart disease, diabetes, arthritis, and asthma. Looking at an adult Medicaid population in a similar market in 2020, 4 of the top 5 chronic conditions were BH-related (SMI, ADHD, Anxiety Disorders, and Depression). The opioid crisis has made clear the devastating effects of substance use disorder and the COVID-19 pandemic has further increased BH issues.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): Our efforts will ensure comprehensive training for staff, Members (and their families, caretakers, etc), Providers (and their staff), and community stakeholders on Stamp Out Stigma; BH needs in the Medicaid and CHIP population; availability of CHWs, Peer Supports, and other resources; and how to access care and support. Materials will be made available on our public website and shared with Members and Providers through welcome, training, and onboarding materials. We will implement social media campaigns on Stamp Out Stigma and BH awareness through Facebook and other social media.
Tools for measuring engagement: We will measure engagement through utilization reports, including BH visits, pharmacy data, and follow up care. We will also measure engagement through PCP utilization of BH resources and supports, such as eConsults for BH related conditions and BH referrals and enrollment in online tools and resources.
Tools for measuring impact: Impact will be measured through CAHPS satisfaction survey data as well as HEDIS measures, including Follow up After Emergency Department Visit for Mental Illness and Engagement in Treatment for BH and SUD.
Will a staffing investment be made for this Campaign? [ ] Yes [X] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

4.2.3.7: TELEHEALTH

Telehealth has grown immensely during the COVID-19 pandemic. The Division is seeking innovative proposals form Offerors about their ability to support and ensure the most efficient use of telehealth for Members and Providers, especially considering the rural nature of much of the MississippiCAN and CHIP populations. The Offeror should be specific about methods of technical assistance it plans to provide to Members and Providers. For more information, see Section 4, Covered Services and Benefits, of Appendix A, Draft Contract.

Our Telehealth Approach and Experience

We are experienced in administering telehealth services through our Medicaid programs nationwide and will provide telehealth services for MSCAN and CHIP Members in full compliance with all DOM policies. Telehealth services have become more abundant and cross a greater sector of health services than ever before. Their use became accelerated with the onset of the COVID-19 pandemic when many Providers in a number of health disciplines turned to telehealth to continue to provide services to their patients. Our analysis of telehealth adoption pre and post the onset of the COVID-19 pandemic indicates that, nationwide, our Medicaid health plan affiliates have gone from serving 80,154 Members to over 3.68 million Members via telehealth. For behavioral health services, the number of participating telehealth Providers has increased from just over 2,000 to over 30,000 participating Providers, with over one million Members now using telehealth for behavioral health services. As telehealth technology platforms become more widespread, patients, payers, and Providers have grown accustomed to using telehealth. Guidelines and protocols across the country have been continuously refined to assure quality and accountability, while new approaches to the use of telehealth have exploded in the health care industry. We have been at the forefront of this wave of telehealth use and innovation.

We have invested heavily in telehealth technology and created partnerships that have expanded our use of telehealth across all our Medicaid affiliates. Table 4.2.3.7.A below summarizes some of the recent lessons learned and our successes in the use of telehealth. These experiences, coupled with our investments in telehealth, will inform the goals for our telehealth plans in MSCAN and CHIP. We will develop our innovative telehealth plans and policies and present them to DOM for approval within 60 days of contract award.

Table 4.2.3.7.A Telehealth Lessons Learned and Demonstrated Success Across Medicaid Affiliates

Lessons Learned	Example of Demonstrated Success
Telehealth can expand access by bringing medical and behavioral health care to Members living in rural areas.	In one of our affiliates that has piloted a telehealth technology in rural areas, nearly 10% of eligible Members accessed medical and behavioral health services through the pilot in the first year, with half of the visits provided to children.
Telehealth can reduce ED visits by providing 24/7 access to medical care.	A telehealth technology partner helped reduce inappropriate ED use by 72% in a Medicaid affiliate similar in size and scope to Mississippi, with 98% of Members reporting high satisfaction.
Telehealth produces savings in medical costs for demand driven (urgent) care.	Across our national network, a telehealth technology vendor produced over $86 million in savings over traditional office-based care for urgent visits in 2021.
Telehealth can help to close gaps in care, particularly in areas of screening, exams, and PCP engagement.	A telehealth program achieved improvement in care gaps in the following HEDIS measures: Chlamydia Screening (>13.6%); Lead Screening in Women (>10.5%); and Postpartum Visits (>23%). The program increased Provider engagement from 18.9% to 35.5%.
Telehealth specialty consults can increase a PCP's ability to manage chronic illness, improve health outcomes, and lower costs.	An affiliate found that since 2016, 80% of specialty care e-consults to PCPs resulted in an avoided specialty care visit. A retrospective matched comparison group analysis conducted in June 2021 found that e-consults reduced spending by almost $400 Per Member Per Month (PMPM) compared to the control group.
Telehealth can greatly increase engagement of Members experiencing behavioral health issues through the engagement of Members and their Caregivers with virtual care management support.	Our proposed partnership with Mindoula will allow us to offer a 24/7/365 "boots on the ground" approach that provides tech-enabled, personalized support to Members with behavioral health conditions across our affiliates. Mindoula's program has demonstrated the lower cost of care by 30% to 50% through reductions in hospital admissions/readmissions and ED utilization.
Telehealth is a valuable tool in crisis stabilization for Members experiencing an urgent behavioral health issue or mental health crisis.	A program in one of our affiliates demonstrated an 89% reduction in inpatient hospital utilization and substantial cost savings for first responder agencies and payers while increasing Member access to local behavioral health Providers.
Telehealth can provide vital support to PCPs providing Medication Assisted Treatment (MAT) to manage opioid	Project ECHO MAT programs across the country have led to a significant uptake in the number of PCPs prescribing MAT for Members living with

Lessons Learned	Example of Demonstrated Success
use disorders.	opioid use disorders. We have numerous affiliates across the country supporting Project ECHO projects with PCPs to expand access to MAT.
Telehealth produces improved perinatal outcomes by increasing the participation of childbearing women in pre and postnatal care, while supporting them with Care Management, education, and outreach.	One affiliate reported a 13% increase in prenatal care and a 32% increase in post-partum care using a Mobile Application for mothers and newborns, with an average savings of $850 per newborn enrolled. Another affiliate reported a 14% reduction in hospital stays for Members using the same Mobile Application, coupled with Care Management provided by the affiliate.
Telehealth can improve health literacy for segments of the Member population.	One affiliate demonstrated $850 in savings Per Member Per Year in claims for newborns whose mothers using a Mobile Application that connects them to experts for advice and support.

Telehealth Goals for MSCAN and CHIP

Our telehealth approach is designed to offer technology solutions to Members and Providers for a broad range of Member needs (e.g., primary care, behavioral health, chronic conditions, perinatal care), while also breaking down access and health literacy barriers that can impede health equity. We present the goals for our telehealth program for MSCAN and CHIP below, including the specific telehealth offerings that will support those goals, ensuring the most efficient use of telehealth for Members and Providers.

Providing Care Where and When it is Needed. We will use telehealth to enhance in-person visits to ensure that our MSCAN and CHIP Members have access to care where and when they need it. This includes our commitment to cover all eligible medical and behavioral telehealth services that are currently provided by MSCAN and CHIP network Providers, according to the policies set forth by DOM. Across our affiliates from April 2020 through March 2021, ***98.5% of our Medicaid telehealth claims came from network Providers rather than vendors.*** We expect the percentage of our telehealth claims with network Providers in Mississippi be consistent with this national statistic. We are aware of the technology improvements that have been made in Mississippi's FQHCs, through funding from the Health Resources and Services Administration (HRSA), which has allowed them to enhance their telehealth capabilities. ***In 2020, we distributed $4.7 million to FQHCs across the country to help them build telehealth capacity***. Similarly, we are committed to assisting any MSCAN or CHIP Provider that is eligible to apply for additional State, Federal, or other grants to build telehealth capacity.

In addition to providing regularly scheduled telehealth visits throughout our network, we will offer telehealth services that offer 24/7 care, including urgent care, behavioral health crisis intervention, and 24/7 population-focused Care Management. These telehealth initiatives include:

A partnership with a telehealth services company that provides ***regularly scheduled telehealth visits with PCPs, specialty Providers, and behavioral health Providers*** as well as 24/7 access for urgent medical care. This company will recruit Mississippi Providers across the State to be part of its network, with the goal of supporting and empowering Mississippi Providers to offer telehealth services to their patients. Members will be able to use a Mobile Application to schedule a telehealth visit with their selected Provider or an on-demand visit with the next available Provider for 24/7 access. The Member will be able to provide a satisfaction score and offer feedback on their experience through a Mobile Application.

A program that deploys cellular-enabled tablets to allow critical physical health practitioners, hospitals, EDs, and first responders, such as police and EMTs, to ***reach a behavioral health clinician immediately on-demand to deliver real-time behavioral health crisis stabilization and therapy services to Members in their greatest moment of need.*** We created this program to extend support to any community member experiencing a behavioral health crisis, regardless of payer or insurance status. This program reduces barriers and can assist with the delivery of behavioral health care to areas with less access.

Improving Access to Care in Rural Communities. Many rural communities have long faced barriers to high-speed internet. This is often a limiting factor for the PCPs in these areas to use telehealth to treat patients remotely or provide access to virtual specialists from their practice. Through partnership with AT&T, we will support Providers with the application process for expedited access to Federal FirstNet, a nationwide wireless

broadband service featuring highly competitive rates and faster, more reliable internet service. An affiliate plan in 2020 outreached to more than 355 Providers, including 34 FQHCs, about signing up for FirstNet. We hope to establish a relationship with C Spire in Mississippi to offer Members discounted equipment for home wifi. Through these efforts, we will help Mississippi FQHCs and rural Providers offer telehealth services more effectively and maintain pace with the evolving methods of care delivery.

We recognize Members living in rural areas may have difficulty getting to a doctor's office to seek care. In addition to helping rural PCPs develop and use telehealth, we will pilot a Virtual Primary Care Program for Members living in the northwestern region (15 counties) of Mississippi. We will use claims data to identify Members with low PCP engagement and reach out to see if they would be interested in receiving virtual primary care through the Virtual Primary Medical Care Program. We will provide the necessary technology for the Member to use the service. We will evaluate the effectiveness of the pilot by measuring Member satisfaction, medication adherence, select HEDIS measures, and ED utilization.

Supporting PCPs and PCMHs. To expand Provider capacity to serve Members with complex needs, we will offer peer-to-peer e-consults. This solution is interoperable with all existing Electronic Health Record (EHR) platforms and will enable PCPs and PCMHs to virtually consult with specialists in more than 40 adult and pediatric specialties, using an asynchronous, store-and-forward, and clinical response system.

In addition to e-consults, we will encourage Providers to use local Project ECHOs to practice at the top of their license, acquire new skills and competencies (including increasing culturally competent and equitable care), and treat Members with common complex conditions instead of referring to a specialist. We will partner with entities such as the University of Mississippi Medical Center to develop a Project ECHO training program to educate PCPs/PCMHs on treating patients with chronic pain using non-pharmacological multi-modal treatment plans to help reduce opioid dependency and prevent opioid use disorder. We will educate our PCPs/PCMHs about local Project ECHO opportunities, such as courses in Hepatitis C, HPV Vaccination, and Pediatric Dentistry.

Improving Outcomes for BH Conditions through Better Coordination and Integration. In addition to using Project ECHOs to support PCPs and PCMHs to expand MAT in Mississippi, we will partner with Mindoula to offer proven programs to improve care and outcomes for Members living with behavioral and co-occurring physical conditions. This company combines 24/7/365 "boots on the ground" Care Management with a virtual clinical team to support Members enrolled in any of their condition-specific programs, including assisting Members in obtaining the needed clinical and social services that will support their daily living and help manage the crisis. Available programs include those focused on violence reduction, suicide prevention, substance use disorders (including among pregnant women), and complex population health management.

We will partner with a trauma-informed care telepsychiatry group that provides virtual services to children with serious behavioral conditions. Its roster includes more than 100 psychiatrists and other behavioral health professionals. We plan to pilot with this telepsychiatry group to promote timely post-discharge follow-up for children.

Improving Care for Members with Chronic Conditions. We will leverage technologies to support DOM's Comprehensive Quality Strategy focus area of improving care for Members with chronic conditions. We will partner with UMMC to offer an interdisciplinary program to educate, engage, and empower Members living with diabetes, hypertension, and/or congestive heart failure. UMMC will use ***remote patient monitoring*** to help patients take charge in monitoring and managing their health. For each participating Member, the program provides continuous monitoring of disease-specific biometrics, Care Management, daily educational sessions, and medication management. Clinical information for participants is shared electronically with their PCPs to ensure continuity of care. The program generally lasts five to ten months for each participant, depending on their level of engagement.

We will partner with Vigilant Health, a Mississippi-based company, to offer a value-based comprehensive health management program in all 82 Mississippi counties for Members with one or more of the following twelve chronic conditions:

- Diabetes
- Hypertension
- Dyslipidemia
- Mental Health
- Chronic Kidney Disease
- Stroke
- Peripheral Vascular Disease
- Ischemic Heart Disease
- Congestive Heart Failure
- Chronic Lung Disease
- Cancer
- Pregnancy

The Vigilant model is designed to integrate the highest standards of medical science, good medical practice, deep insights into human behavior, and population science into a unified whole that is simple in its application for clinicians and powerful in its results for patients and payers. Vigilant combines live audiovisual interactions between its patients and care team with in-person care and comprehensive education to deliver superior care to remote and rural areas that lack physician access. Vigilant also uses audiovisual encounters to facilitate collaboration with community physicians. They have successfully used interactive, real-time video as part of their clinical program for major regional and national clients to improve health outcomes for patients and cost outcomes for payers. Their specialized diabetes program has demonstrated a decrease in medical paid claims of $2,742 per participant and improvements in HbA1c, blood pressure, and cholesterol control. Severely out of control diabetes (HbA1c > 9.0) decreased by 73%, hospitalization rates decreased by 50%, and ED utilization rate decreased by 23% among program uses.

Improving Perinatal Outcomes. We recognize that perinatal outcomes are a significant focus in DOM's Comprehensive Quality Strategy. We will offer the following technologies to support improved Member engagement, access to Providers, and perinatal outcomes.

Technology Support for Pregnant Mothers. We will work with a technology partner to offer education, reminders, and intensive Care Management to reduce pre-term births using the partner's proven tech-enabled model. This program includes not only technological support for pregnant mothers but also deploys Community Health Workers across the State to provide additional support to Members when needed.

On-Demand Access to Maternal and Pediatric Experts. Our Maternal and Child Health Program will offer Members a platform for on-demand access to maternal and pediatric experts for lactation support and Member education. In addition to 24/7 on-demand support, Members can opt to receive educational information relating to their pregnancy via push notifications, email, text, and social media, which promote awareness of things like access to relevant social services, education about C-sections and epidurals, and prenatal nutrition. These notifications are designed to inform Members about key health care decisions (e.g., prenatal care, postpartum visits, immunizations) while simultaneously reminding them of available services, with instructions on how and when to use those services.

On-Demand Access to Virtual Doulas. Also through our Maternal and Child Health Program, Members will have access to on-demand 24/7 video visits with certified doulas who support birth parents and their partners throughout the birth journey. Doulas will provide guidance on creating a birth plan, refer to appropriate prenatal care, encourage healthy behavior during pregnancy, teach pain management and patient empowerment strategies, and prepare parents for breastfeeding. During labor and delivery, doulas will be available on-demand to maintain or adjust the birth plan, advocate for the birthing parent, and support the birthing parent, and partner with comfort and patient empowerment techniques. Postpartum doula and lactation consultants will work collaboratively to support new parents with physical, emotional, and psychological challenges, and consult new parents on postpartum recovery, infant feeding, newborn care, encouraging newborn visits, and, when necessary, provide a direct referral to other specialists within the network.

Virtual Group Prenatal Care. We will offer pregnant Members access to virtual group prenatal care based on Centering Pregnancy principles in order to make this vital service accessible to Members in all parts of the State. Each group includes a 10-session program designed to deliver holistic care for patients spanning clinical, behavioral, and social assessments and support. Our partner to offer this service has agreed to a value-based contract to ensure participants see improved outcomes.

Culturally Competent Digital Health Solution. As an additional resource to Black expectant and new mothers in Hinds County (the county with the highest rate of pre-term births in Mississippi), we will offer a platform connecting these mothers with critical resources to drive positive pregnancy outcomes. This platform is aimed

at equalizing maternal health outcomes for Black women using a culturally competent digital health solution that provides virtual and in-person connections with peer support specialists. It is designed to meet the specific clinical, social, and cultural needs that Black women face throughout the perinatal episode. It aims to improve Member engagement in prenatal and postnatal care, assist Members in managing their chronic conditions, and improve their access to care. The Mobile Application also monitors symptoms and uses health analytics to detect problems at their onset. Curated content and lifestyle tips speak directly to the experience of Black expectant mothers.

Program for Pregnant Women with Substance Use Disorder. We will offer a telehealth Care Management program designed to help women who are using opioids or other illicit drugs. This program works closely with the local Provider community and supports Members with 24/7 virtual and in-person team-based Care Management, including support from certified Peer Recovery Specialists and Nurse Educators, to reduce costs and improve outcomes.

Improving Health Equity

Member Technical Assistance to Close the Technology Gap. We will educate Members about telehealth options upon enrollment through the New Member Welcome Packets and through ongoing online and written information and staff outreach. The New Member Welcome Packets will include an explanation of benefits for telehealth services and how/where they can be used, and our online Provider Directory will identify Providers who offer virtual visits. We will also offer Members an on-demand video series covering topics such as what to expect from a telehealth visit and tips for preparing for a telehealth visit. Our Care Management team will assess Members and their Caregivers for their telehealth preferences, resources, technology literacy, and ability and comfort with accessing virtual care and using related devices. We will train residential and personal care staff on how to help Members with functional limitations determine whether telehealth is appropriate or necessary and how to support them when using telehealth services, devices, and assistive technologies. Members of our Care Management team will include in the care plan Member-preferred telehealth services and, if needed, training for both Members and their Caregivers.

We will also offer smartphones with limited data plans to Members in Care Management who do not qualify for the federal SafeLink program. This resource is especially useful for Members with complex or chronic conditions to make sure they can access virtual care to manage their health. To help overcome internet barriers and Wi-Fi access issues in more remote areas, we will assist Members in locating available hot spots and using Care Grants to add minutes to our Members' personal or SafeLink phones.

Member Technical Assistance to Close the Health Literacy Gap. To help support health literacy, we will offer our Members our web-based interactive health education program that offers educators, parents, students, and caregivers ready access to videos, digital books, and parent guides on health topics to increase knowledge about health-related topics. Multilingual education is available to address nutrition, smoking, fitness, bullying, diabetes, and more. Lessons are designed to help educators deliver quality health education to youth in elementary, middle school, and high school. Using this web-based program, we aim to improve the health of children and youth in all Mississippi communities by helping them develop the knowledge, skills, and habits needed for lifelong health.

We will also deploy our seasonal flu prevention program, which is aimed at educating and coordinating access for annual flu vaccinations, especially for vulnerable populations. We have developed a multi-modal deployment strategy that includes text messages, emails, and outbound calls.

Telehealth Adoption Strategies and Tools

In addition to the telehealth programs we discuss above that will help us achieve our goals, we have tools and processes to support technology use and adoption by our staff, Members, and Providers. Those tools and processes are discussed below, as well as a description of our process to evaluate our telehealth program and strategy.

At the start of the COVID-19 pandemic, we quickly developed and deployed a **virtual Care Management** platform that uses HIPAA-compliant video communications via a version a video conferencing platform. This

will allow our Care Managers to engage with Members virtually and securely and has proven to provide efficient virtual face-to-face access to Members who need to engage in meetings with Care Managers and other Providers as they develop individualized care plans.

Our Care Managers will also use **online appointment scheduling software** to allow them to make and manage appointments with participating Providers for Members. Care Managers will be able to set up appointments while working with a Member, avoiding the need for multiple calls to and from Provider offices. They can securely attach documentation to the Member appointment for specific screenings (e.g., EPSDT), helping to close gaps in care. We will also assist Providers in managing appointments and reducing no-show rates by sending reminders and follow-up messages to our Members.

Provider Technical Assistance. Beyond the opportunities and assistance described above (e.g., Project ECHOs, e-consults, assistance with FirstNet application process), as part of Provider orientation and ongoing training opportunities (e.g., workshops, webinars, Provider newsletters), we will provide training to all Providers on the availability of telehealth programs and services, how to access them, which services and care needs are appropriate for telehealth, and the importance of Member choice in determining the way they receive services. Our Provider training and technical assistance offerings will also include a video series on telehealth topics, such as choosing a telehealth platform, developing and maintaining a telehealth presence, and other telehealth technical requirements, such as workflows, coding, and billing. Our Provider Relations team will offer specialized telehealth trainings by Provider type.

Program Monitoring and Evaluation. We will regularly analyze telehealth utilization data on a monthly basis across our platforms (internal claims and partner utilization data) to determine where gaps in use are occurring or where potential ineffective use of telehealth may be occurring (by Provider type, geographic location, and health population). Specifically, we will track and analyze telehealth utilization using procedure codes such as GT modifiers, patient sites, and places of service. Led by our VP of Population Health and Clinical Operations, we will take a cross-functional approach (e.g., involving our Provider Network team, Provider Relations team, Care Management team, Quality Management team, Director of Health Equity, and PCMH Director) to use the analysis to further understand not just what gaps exist and where they exist, but also why they exist.

In addition to internal monitoring, we will seek input from other sources such as Member and Provider Advisory Committees, participation on the Mississippi Telehealth Board of Directors, special focus groups, Member telehealth satisfaction surveys, and Provider satisfaction surveys. These evaluations will be coupled with health outcome and utilization data to determine the efficiency and effectiveness of our telehealth solutions and to proactively prevent and address any inefficiencies surrounding the use of telehealth services. Using our affiliates' success and lessons learned, we are committed to partnering with DOM to ensure the efficient, appropriate, and effective use of telehealth during the pandemic and in a post-COVID-19 pandemic world.

[END OF RESPONSE]

4.2.3.8 USE OF TECHNOLOGY

The Division is aware that Offerors have access to numerous technologies that could be used to the benefit of the Division. The Offeror is asked to describe how it can leverage its technology to give the Division more insight in the following areas and any other areas the Offeror has technology that may normally be underutilized by state Medicaid programs:
1. Data gathering and analysis

Our Management Information System (MIS) will support the Mississippi Division of Medicaid (DOM) and Federal reporting requirements by providing integrated, secure data management capabilities for data gathering, validation, analysis, and reporting activities. Our MIS design is informed by the CMS Medicaid Information Technology Architecture (MITA) with integrated components and industry-standard application, data, and communication interfaces, meeting CMS interoperability standards. We employ microservices, accessible via open Application Programming Interfaces (APIs) to service application functions and gather and transmit data. ***The architecture of our MIS enables us to provide all data necessary to give DOM insight and transparency into our operations and overall program efficacy.***

An Integrated Reporting and Analytics Platform

Management teams and staff located in Mississippi will have access to our large-scale Reporting and Analytics Platform. This family of integrated decision tools provides resources and capabilities for standard and ad hoc reporting, data visualization, and online Key Performance Indicator (KPI) dashboards. Reporting to our VP of Finance, our Data and Analytics Manager will lead a team of highly experienced Data Analysts responsible for supporting the development and execution of all standard and ad hoc reports as part of our contract with DOM. Finance Analysts will provide technical assistance for financial reporting. This dedicated team of Mississippi-based staff will utilize this information to report on all datasets in our platform. The foundation of our Reporting and Analytics Platform is a comprehensive Enterprise Data Warehouse (EDW) that systematically receives, integrates, and transmits internal and external administrative and clinical data. Examples of data gathered in the EDW include:

- Claims data from Providers including physical health and BH services and labs
- Member and Provider grievances and appeals
- Member information, such as eligibility history, demographics, service utilization, and Member satisfaction
- Provider information, such as participation status, specialty, and demographics
- Care and utilization management information, such as Health Risk Screenings, Comprehensive Health Assessments, Member care plans, clinical guidelines, referrals, authorizations, and social determinants of health (SDOH)
- Financial information to support quality and value-based purchasing (VBP) programs
- Clinical information, such as Admission, Discharge, and Transfer (ADT) transactions for real-time notification of inpatient admissions
- Population health information, such as immunization registries and health disparity and equity data, including by race/ethnicity

The integration of EDW within our MIS means that our reports will be based on the most accurate, complete, and timeliest transactional data available for high-speed reporting to DOM across a broad expanse of data. Our EDW is Open Database Connectivity (ODBC) compliant, allowing our Data Analysts to produce ad hoc reports that DOM may request. ***Our Reporting and Analytics Platform enables us to offer full transparency to DOM.***

Gathering Data from Multiple Sources and Systems. We will collect data from internal and external sources and systems using industry-standard application, data, and communication interfaces. The Change Data Capture and Real Time Repository (RTR) capabilities of our MIS integrate and consolidate data we receive. RTRs are high-performance databases designed for conveying updated information to both our internal and external-facing applications. We use data management best practices and tools such as reference data management and metadata management, which ensure data is represented and stored accurately, completely, and uniquely (e.g., eliminates data discrepancies or duplicates). Our approach to data management and governance ensures our staff will have access to timely data that is understandable, clean, consistent, and reliable.

We have invested in gathering timely, valued information about our Members. We will intentionally gather input from multiple sources to inform our programs and use external data on communication preferences, socio-

economic, demographic, and geographic indicators, providing a complete view of each Member. ***All of this information will be combined to get a full picture of the individual and population-level health needs of our Membership, going beyond traditional means to capture Member and community data, including over 200 external SDOH data elements.***

Data Analysis and Ability to Generate Ad Hoc Reports. The Report Builder function of our Reporting and Analytics Platform will allow authorized users to access EDW's data dictionary, organized by subject area (e.g., claims, Provider, Member) for the development of ad hoc reports. Users can query and report on any data element housed in EDW to support ad hoc reports required by DOM. Report Builder offers authorized users an intuitive graphical interface that clearly identifies data without the need to learn coding or query languages. This will enable our staff to fulfill any additional DOM report requests, both ad hoc and recurring. Our staff can also draw upon a library of over 12,000 existing Medicaid Managed Care reports covering administrative, operational, clinical quality, service delivery, compliance, and financial aspects of health plan activities. This library of pre-built ad hoc report templates allows users to create their own reports by subject area in a guided fashion.

Systematic Data Validation. Within our EDW, we will perform validation processes to ensure the completeness and timeliness of data. If errors occur during these validation processes, alerts are sent to our EDW support teams, who immediately triage the data issues for prompt resolution. For example, our EDW performs quality checks horizontally, vertically, referentially, and temporally (trending) to ensure data quality. Additionally, our data quality controls include multiple levels of accountability, from data lineage tracking to active data cataloging, helping to ensure that valid, reliable, and accurate data are obtained. Our EDW provides the master cross reference of our data names and formats and systematically maps each data element name and contextual use information with equivalent metadata for each production application. Through the EDW's centralized repository of code lists, we enforce all industry-standard code sets and formats, including HIPAA-mandated sets. For data formats not governed by industry standards, we enforce formats used in the system of record of that data element.

Clinical Data and Interoperability Gateway

To deliver information closer to the point of care, Providers, hospitals, and Health Information Exchanges (HIEs) can interface with our Clinical Data Interoperability Gateway for HHS Office of National Coordinator (ONC) standards-based data interchanges, including Health Level Seven (HL7) Fast Health Care Interoperability Resources (FHIR), ADT data, Continuity of Care Document (CCD)/Consolidated-Clinical Document (C-CDA) exchange, and other standardized health information transactions. For example, we will leverage this gateway to gather data through bi-directional data exchange with Providers' Electronic Health Record (EHR) systems. We will automate data extraction from the EHR and deliver insights right back into the Providers' systems, enhancing our ability to address care gaps at the point of care, conduct efficient quality monitoring, and gather additional health information, including about Member SDOH. In addition, this gateway will enable us to work with strategic data partners and state HIEs for bi-directional clinical data exchange, such as the daily receipt of critical ADT data. We will work with a diverse group of Mississippi stakeholders and Providers to evaluate the right State HIE partners to implement strategic connections with real-time ADT data feeds and additional use cases. We are committed to supporting and expanding the existing infrastructure within Mississippi and are in active conversations with potential partners to explore additional HIE and ADT use cases. This type of data exchange will allow us to conduct dashboard reporting and monitor ADT intake volumes and utilization trends.

Homeless Management Information System (HMIS) Connectivity

We will serve as a partner and stakeholder on coordinated entry through the State's continuums of care (COC) HMIS, ***a major innovation in data sharing in Mississippi***. The HMIS offers a centralized referral process for chronically homeless Members. We will collaborate with the COC to engage in bidirectional data sharing with their HMIS. ***Our partnership will help Care Managers identify homeless and housing insecure Members and enhance both our and the COC's ability to identify needs and better coordinate and dispatch resources.*** An affiliate health plan used their state's HMIS as part of their housing program. After six months, the number of

Members at our affiliate who were homeless ***decreased by more than 24%***, and the rate of homelessness decreased by more than 8%.

SDOH Data Sharing

We will offer a financial incentive to Providers for sharing Member SDOH data by submitting appropriate ICD-10 billing Z codes with claims. Incenting Providers to share SDOH data as a component of our approach to data gathering increases our capacity to identify and refer Members to community-based organizations to address social barriers. Providers will be able to access a Z Code Utilization Dashboard through our secure Provider Portal to assist in identifying social barriers through the use of Z codes on claims.

2. Efficacy of initiatives and programs

Our EDW will serve as the foundation for our initiative and program efficacy reporting capabilities. Our population health staff will have access to the same Reporting and Analytics Platform described above to generate standard and ad hoc reports, data visualizations, and dashboards to assess and share program efficacy. Our staff will analyze data sources such as HEDIS, CAHPS, assessments, grievance and appeal data and trends, Performance Improvement Project data, surveys, and qualitative data related to the experiences of our Members, Providers, and community stakeholders to determine the efficacy of our programs and inform program design. Our dedicated team of Mississippi-based Data Analysts will use our Reporting and Analytics Platform to evaluate trends in the state and develop required reports on the efficacy of our Population Health Management programs for MSCAN and CHIP. Such reports will include:

- Health disparities among subpopulations
- Targeted health outcomes
- Member participation in health promotion and disease prevention initiatives
- Percent of Members in each risk stratification level
- Member utilization of inpatient and emergency department services

Centralized Data Science Organization

In addition to the data and reporting support provided by our Data Analytic staff who will be locally based, our centralized Data Science Resource Center, composed of data scientists and experts in the fields of predictive modeling, machine learning, and algorithm development, will be leveraged to support initiative and program analysis. This dedicated organization will use data such as Member demographics, claims history, and census data to create transparent, cutting-edge predictive models that use high-level statistical and machine learning algorithms to offer support in making well-informed business and program decisions. Our data scientists have already created dozens of models that are deployed to benefit our health plan affiliates in assessing program efficacy and other operations, such as a diabetes predictive model and a readmission prevention model. These models undergo a rigorous and ongoing review process to verify results are useful, accurate, fair, and avoid reproducing social, economic, racial, or health disparities and related biases. We will use models developed by this experienced team to support our assessment of initiative and program efficacy.

Claims Data Analysis

Another way in which we assess the efficacy of our initiatives and programs is through detailed claims data analyses. Our Claims staff will utilize reporting and dashboard capabilities from our enterprise Reporting and Analytics Platform to perform regular assessments of submitted claims from Providers to conduct trend analysis and determine the efficacy of current care initiatives and programs, as well as identify potential areas of focus for new initiatives or programs. For instance, we will be able to assess year-over-year changes in the number of Emergency Department visits, informing the efficacy of our diversion program. This analysis will enable us to identify care gaps that may reveal barriers related to SDOH and preemptively make changes to address those needs. We will monitor and analyze data at aggregate and detail levels by Member and Member demographics, such as age and gender, individual Provider or facility, Provider specialty, diagnosis, etc. We will also capture, monitor, and analyze Z code utilization to view local trends and drill down to communities and SDOH categories.

Evaluating Value-Based Purchasing (VBP) Performance

Our Reporting and Analytics Platform provides us with a sophisticated set of data management and predictive analytic tools to help analyze and account for the performance of our VBP contracts. It also allows us to evaluate our overall VBP strategy in achieving our shared objectives with DOM. These tools use not only utilization data but a host of Provider performance and health outcome metrics to evaluate and fine-tune our VBP payment strategy. Please reference our response to Section 4.2.3.1 Value-Based Purchasing of the RFQ, for additional information.

National Population Health Outcomes Database

Our staff will also leverage an online repository that catalogs evidence-based population health initiatives and programs deployed across our affiliate health plans nationwide. This database will serve as a central location to learn about these programs and assess program evaluations and outcomes. The tool fosters a culture of innovation, evidence-based practice, and knowledge sharing, and we will leverage it to implement innovative best practices and interventions in Mississippi to improve health performance measures that result in better health outcomes for Members.

3. Transparency

Our goal is to ensure transparency and accountability for how we manage Members within the MSCAN and CHIP programs while ensuring adherence with privacy, security, and compliance regulations. We will work collaboratively with DOM on approaches and solutions to accessing our systems and data, including relevant data from our Subcontractors.

Multi-Modal Approach to Information and Data Sharing

We will utilize a multi-modal approach to providing data, reporting, and system access to DOM for the purposes of transparency. These capabilities include:

- Secure file exchanges through the use of Secure File Transfer Protocol (SFTP) and use of Application Programming Interfaces (APIs) as required by DOM.
- Remote access and queries to data, as well as configurable dashboards, through our Cloud Reporting Suite, an extension of our Reporting and Analytics Platform.
- Secure, role-based web portals for shared access (DOM, MDCPS, other community partners) to Member health information to ensure successful coordination among multiple care entities and Providers.
- DOM Support Team provided by our local Data Analysts who will provide system demonstrations, in-depth reviews, and/or virtual or in-person training to DOM staff on how to access and use data throughout our systems.

Secure File Exchanges. We will share data and report directly with DOM through SFTP services, including but not limited to: Call Center Reports, Grievance and Appeal Files/Reports, EPSDT Reports, HEDIS Data, Financial Reports, Claims Reports, Member Encounter Data, Third Party Liability Reports, and Clinical Data. By having our data maintained, managed, and protected in our centralized EDW, DOM can be assured we will respond to data requests in a timely and secure manner. We will work with DOM to use APIs to exchange clinical information more frequently and securely.

System Read-Only Access. In [redacted] we will provide DOM with secure, read-only portal access to view care management and utilization management data, including approval and denial information. Role-based portal access will be provided to DOM and other partners as needed to support information sharing among entities. To ensure secure access, we will work with DOM on a HIPAA-compliant, auditable access management process to ensure only authorized users receive access.

Supporting the Needs of Children and Youth in Foster Care. Further, we will partner with the Mississippi Department of Child Protective Services (MDCPS) to provide access to our secure, role-based portals for shared

access to Member health information for children and youth in foster care. The information contained within the Member's record will help Providers, MDCPS caseworkers, and care managers improve care coordination, eliminate waste, and reduce errors by providing a Member's medical history and health interactions as they progress through the clinical process. Users can view key Member contacts, allergies, medications, claims history, and more. Role-based access controls will enable us to limit and easily edit what information is shown in the Member's record to specific users based on defined user roles (e.g., Provider, caseworker, consenter).

DOM Support Team

Should DOM need further information or would like to receive demonstrations or support with our systems, we will provide concierge access services for DOM staff during normal business hours. Our ***virtual or in-person concierge service*** will offer an opportunity for DOM staff to receive demonstrations or trainings from experienced Data Analysts on how to access and utilize Member data and information available in our MIS. Upon DOM's request, a member of our Support Team will respond to coordinate a demonstration with DOM.

Other Potential Technology to Support DOM

While claims data remains an excellent indicator of health plan performance as well as the overall health of a given population, state Medicaid programs typically do not receive a report of this information until the service has occurred and payment has been issued. As a component of our continuous efforts to pursue timelier data sharing to allow for greater transparency, we are in the process of exploring ways to share real-time prior authorization (PA) data with state Medicaid agencies, building off industry interoperability standards and FHIR-based APIs. This PA data would enable state Medicaid partners a view into upcoming claims and costs trends, the overall health of the population, and potential trends in Fraud, Waste, and Abuse for denied PAs. For example, through this PA interface, DOM would be able to see a rise in births resulting in NICU stays, indicating higher upcoming costs and the potential need for maternal health interventions. We will partner with DOM to share timelier PA information and explore further use cases for the real-time exchange of data through APIs.

[END OF RESPONSE]

4.2.3.9: POTENTIAL PARTNERSHIPS

The Division is requiring consistent, deeply developed partnerships between contractors and local organizations during the next contracting cycle, especially in addressing health equity and Social Determinants of Health. This requirement is discussed through Appendix A, Draft Contract. The Offeror must use the Potential Partnership: Summary Chart, included in Appendix E, to name four (4) potential partners.
The Offeror should also include potential partnerships to be utilized for Care Management closed-loop referrals and warm hand offs. This requirement is discussed in detail in Section 7, Care Management, of Appendix E. The Offeror must use the Care Management Potential Partnership: Summary Chart, included in Appendix D, to name four (4) potential referral partners.
The Offeror may not duplicate potential partners in answering either part of this request. The Offeror should not include in its answer any information regarding any current or prior relationship with a proposed partner. The Offeror's explanation for choosing the Offeror should describe how work with the proposed partner directly connects to requirements of Appendix A, Draft Contract, and this RFQ, with no reference to any other contract or lines of business of the Offeror.

See **Attachment 4.2.3.9 Appendix D Potential Partnerships**.

4.2.3.9: Potential Partnerships (Unmarked): 10 points available

Use the Potential Partnerships: Summary Chart on the following page for each Potential Partnership the Offeror is including in its response to this section. The Offeror must include four (4) potential partnerships its response.

Additionally, use the Care Management Potential Partnership: Summary Chart for each Care Management Potential Partnership the Offeror is including in its response to this section. The Offeror must include four (4) potential partnerships its response.

The Offeror may not duplicate potential partners in answering either part of the section.

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Potential Partnership: Summary Chart	
Name of Organization: Community Action of South Mississippi	**Type of Organization (community-based organization or government):** Community-Based Organization (Community Action Agency)
Goal of partnership: The goal of our partnership with Community Action of South Mississippi will be to address health disparities and non-medical risk factors through health literacy programs and workforce development initiatives. Community Action of South Mississippi is a community action agency (CAA) located in Moss Point, Mississippi. CAAs are long-standing community servants that administer programs to address poverty. We will leverage our health plan resources and data to support Community Action of South Mississippi's work and partner to develop targeted initiatives. As a member of the Mississippi Association of CAAs, Community Action of South Mississippi will become a model partner, representative of the partnerships that we will establish with other CAAs to address the greatest needs statewide.	
Expected financial commitment to project/partnership: [redacted]	
Scale of project (local, statewide): Initially, local to Jackson County with the potential to expand statewide through other CAAs.	**Population(s) targeted by the partnership:** Residents of Jackson County served by the local CAA.

Potential Partnership: Summary Chart	
Name of Organization: Diaper Bank of the Delta	**Type of Organization (community-based organization or government):** Community-Based Organization
Goal of partnership: The goal of our partnership with Diaper Bank of the Delta is to enhance the reach of this already successful organization to benefit pregnant and postpartum women and children across the State. In addition to diapers and wipes, Diaper Bank of the Delta provides formula, clothes and toys, feminine hygiene products, breastfeeding information, car seat assistance, prenatal and parenting information, and early literacy support. The organization offers a community doula program, pregnancy support, and lactation support program. In addition to their current offerings, we will support the Diaper Bank in addressing other critical social determinants of health for pregnant women, such as food insecurity, helping to meet Members where they are via a single-stop resource hub. We will provide financial assistance to the Diaper Bank so they can purchase vehicles and provide mobile services and resources to reach individuals who do not have transportation. We will enter into a data exchange partnership with the Diaper Bank to support warm hand-offs for our Members that may be accessing their services and to help us reach Members that may not be engaged through the health risk screening process. With the data we receive from the Diaper Bank, we will be able to track the health improvements of the Members they serve to identify impactful interventions.	
Expected financial commitment to project/partnership: [redacted]	
Scale of project (local, statewide): Scaling from the Delta Region to statewide.	**Population(s) targeted by the partnership:** Pregnant and postpartum women and children.

Potential Partnership: Summary Chart	
Name of Organization: Extra Table	**Type of Organization (community-based organization or government):** Community-Based Organization
Goal of partnership: The goal of our partnership with Extra Table is to address food insecurity, one of the primary non-medical risk factors for Mississippians. Extra Table was established in 2009 by restaurateur Robert St. John to stock food pantries and soup kitchens in Mississippi with nutritious food. To date, Extra Table has provided about 1 million meals and distributed about 6 million pounds of healthy food. In 2020, Extra Table provided these services in 49 Mississippi counties and distributed about 19,000 nutritional snack packs for kids. Extra Table is interested in offering pop-up meals statewide to encourage hot meals in a family setting. We will strengthen and expand Extra Table's current offerings by increasing the volume and capacity of its food pantries. We will use our SDOH data to help Extra Table target the most impactful areas to add new food pantries, and we will provide the distribution boxes, so Extra Table can focus solely on supplying food. We will also partner with Extra Table to identify how to most efficiently distribute healthy meals after disasters, such as tornadoes and floods.	
Expected financial commitment to project/partnership: [redacted]	
Scale of project (local, statewide): Statewide.	**Population(s) targeted by the partnership:** Adults and children experiencing food insecurity.

Potential Partnership: Summary Chart	
Name of Organization: But God Ministries	**Type of Organization (community-based organization or government):** Community-Based Organization (faith-based)
Goal of partnership: The goal of our partnership with But God Ministries (BGM) is to enable the establishment of a medical clinic in Jonestown. BGM is a faith-based organization that began by helping Haiti following the earthquake in 2010, establishing medical clinics, a lab, two dental clinics, a mobile malnutrition center, and a mobile medical clinic. BGM applied its model to the Mississippi Delta in 2016, establishing the Hope Center in Jonestown. The Hope Center includes a dental clinic, Montessori pre-school, economic development center, and legal clinic.	
Expected financial commitment to project/partnership: [redacted]	
Scale of project (local, statewide): Jonestown.	**Population(s) targeted by the partnership:** Residents of Jonestown and the surrounding area.

Care Management Potential Partnerships: Summary Chart	
Name of Organization: Mississippi Programs of HOPE	**Type of Organization (community-based organization or government):** Community-Based Organization
Type of Referral(s) to be sent to this partner: We will refer youth who are aging out of foster care and in need of housing to Mississippi Programs of HOPE. Mississippi Programs of HOPE was established by the State Commission on Juvenile Justice in 2020. HOPE stands for Housing and transportation; Opportunities for treatment; Parent, child, and family supports; and Economic security. This partnership would provide housing vouchers for youth that are aging out of foster care, along with life skills training and case management.	
Population target(s) for referral to this partner: Youth aging out of foster care	

Care Management Potential Partnerships: Summary Chart	
Name of Organization: Ever Reaching Community Outreach	**Type of Organization (community-based organization or government):** Community-Based Organization
Type of Referral(s) to be sent to this partner: We will refer Members to Ever Reaching Community Outreach (ERCO) when we identify a need for food or clothing and reside in one of the 15 counties served by ECRO. ECRO is a grassroots, faith-based movement that operates a food pantry and donation center to help feed, clothe, and provide assistance to thousands of people each year across 15 counties in Mississippi.	
Population target(s) for referral to this partner: Our Members identified needing food or clothing in the 15 counties in the metro-Jackson area that ECRO serves.	

Care Management Potential Partnerships: Summary Chart	
Name of Organization: Mississippi SIDS & Infant Safety Alliance	**Type of Organization (community-based organization or government):** Community-Based Organization
Type of Referral(s) to be sent to this partner: We will refer Members in need of a crib to provide a safe sleep environment for an infant to Mississippi SIDS and Infant Alliance. Infants who do not have a safe sleep environment are at 40 times greater risk for sudden infant death syndrome (SIDS). Our partnership with the Mississippi SIDS and Infant Safety Alliance will aim to reduce the risk and rates of SIDS by providing families with a safe sleep environment. The Alliance also provides training and education, sponsors research, and raises awareness about SIDS and SUIDS.	
Population target(s) for referral to this partner: Pregnant women and caregivers of infants	

Care Management Potential Partnerships: Summary Chart	
Name of Organization: Shower Power Mississippi	**Type of Organization (community-based organization or government):** Community-Based Organization
Type of Referral(s) to be sent to this partner: We will refer Members in Jackson experiencing homelessness to Shower Power Mississippi to receive a shower along with food and necessities, clothing, and hygiene items. Shower Power will refer eligible Members to their affiliate, Project HOPE, for low-income housing assistance.	
Population target(s) for referral to this partner: Members in Jackson who are experiencing homelessness.	

[END OF RESPONSE]

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magnolia health™

Response to Request for Qualifications
Mississippi Division of Medicaid Coordinated Care

RFQ # 20211210
RFx # 3150003991
Management Qualification
Magnolia Health Plan, Inc.

Transforming the health of the community, one person at a time.

4.3 MANAGEMENT FACTORS

4.3.1 CORPORATE BACKGROUND AND EXPERIENCE

4.3.1.1 Corporate Background
4.3.1.1.1 Biographical Information
Use the form included in Appendix F to respond to this section.

Please see **Attachment 4.3.1.1.1 Appendix F** for our response to this section.

APPENDIX F: Corporate Background and Experience

The forms in this Appendix must be used by the Offeror to respond (either in whole or in part, depending on the instructions in the RFQ) to the following:

- 4.3.1.1 Corporate Background
- 4.3.1.2 Corporate Experience

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4.3.1.1: Corporate Background

The Offeror must use the form provided on the next page to detail its corporate background, as required by 4.3.1.2.2, Corporate Background.

Responses to 4.3.1.1.2, Corporate Resources must be provided as described in the RFQ.

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Biographical Information				
General Background Information				
Date Business was Established: February 14, 2007				
Legal Business Name as Reported to the Internal Revenue Service: Magnolia Health Plan, Inc.				
Doing Business As Name (if applicable): Not Applicable	**Tax Identification Number (required):** 20-8570212			
Ownership Type (public company, partnership, subsidiary, etc.): Magnolia is a Mississippi Corporation and wholly-owned subsidiary of Centene Corporation. Centene is a publicly traded health care corporation that is listed on the New York Stock Exchange (NYSE: CNC).				
Number of Personnel Currently Engaged in Operations: 341 Employees	**Total Number of Employees:** 341 Employees			
Professional accreditations pertinent to the services provided by this RFQ: 2017-2020 NCQA Accreditation 2020-2023 NCQA Accreditation				
Location of the Principal Place of Business				
Address Line 1 (Street Name and Number): 111 East Capitol Street				
Address Line 2 (Suite, Room, etc.): Suite 500				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Location of place of performance of the proposed Contract				
Address Line 1: 111 East Capitol Street				
Address Line 2: Suite 500				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds County	
Contractual Termination				
Has the Offeror been a party to any contractual termination within the past five (5) years? [X] Yes [ ] No **If yes, attach a narrative explanation for each termination including date, market, population covered, circumstances of termination, and contact information for the state entity that was party to the contract.** Please see ***Attachment 4.3.1.1.a – Contract Termination*** following Appendix F for a narrative explanation.				

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Contractual Termination
Has the Offeror been a party to any contractual termination within the past five (5) years? [X] Yes [ ] No **If yes, attach a narrative explanation for each termination including date, market, population covered, circumstances of termination, and contact information for the state entity that was party to the contract.**

Magnolia Health Plan, Inc. has never been a party to any contractual termination. In the spirit of transparency, Magnolia Health Plan, Inc would like to disclose that our parent company, Centene Corporation has been party to contract terminations through subsidiary health plans.

Oklahoma Complete Health

The Oklahoma Health Care Authority (OHCA) terminated its contracts with all SoonerSelect managed care providers on June 4th 2021. Among the contracts terminated, was the contract with Oklahoma Complete Health, a Centene subsidiary. The terminations were issued subsequent to Oklahoma Supreme Court decision 2021 OK30, on June 1, 2021 which held that a voter-approved constitutional amendment to expand Medicaid did not authorize the SoonerSelect program and that OHCA did not have legislative approval to proceed with the program. The populations covered from this contract were statewide SoonerCare Children, Deemed Newborns, Pregnant Women, Parent and Caretaker Relatives, and Expansion Adults. SoonerCare Eligibles who are Former Foster Children, Juvenile Justice Involved, in Foster Care or Children Receiving Adoption Assistance. For additional information on the contract termination please reach out to Susan Geyer, Director of Financial Resources, Oklahoma Health Care Authority, 405-522-7300.

4.3.1.1.2 Corporate Resources
The Offeror may answer the following questions using narratives, charts, and lists as appropriate.
• Describe the Offeror's Computer and Technological Resources

Magnolia uses a Management Information System (MIS) comprised of computer and technological resources supported and supplied by our parent company, Centene Corporation (Centene). Through Centene, Magnolia has 37 years' experience operating continually refreshed systems designed exclusively for managed care programs in Medicaid, CHIP, Long Term Services and Supports (LTSS), and Medicare. Our MIS captures and maintains all data necessary for the Mississippi Coordinated Access Network (MSCAN) and CHIP programs and will be supported by over 3,700 nationwide Information Technology (IT) professionals focused exclusively on publicly funded health care programs. Our ISO 27001-certified MIS complies with all HIPAA, HITECH, and Mississippi and federal regulations and supports bi-directional data exchanges via a secure HIPAA Electronic Data Interchange (EDI) and file exchange subsystem that includes our Clinical Data and Interoperability Gateway for Health Level 7 (HL7) connectivity to Health Information Exchanges (HIEs), Providers, Hospitals, and certified Electronic Health Record (EHR) systems.

Nationwide MIS Designed to Serve Medicaid

Leveraging technology as a platform designed to be nimble and expansive to transform the health of our communities and provide quality care to Members and service to our Providers.

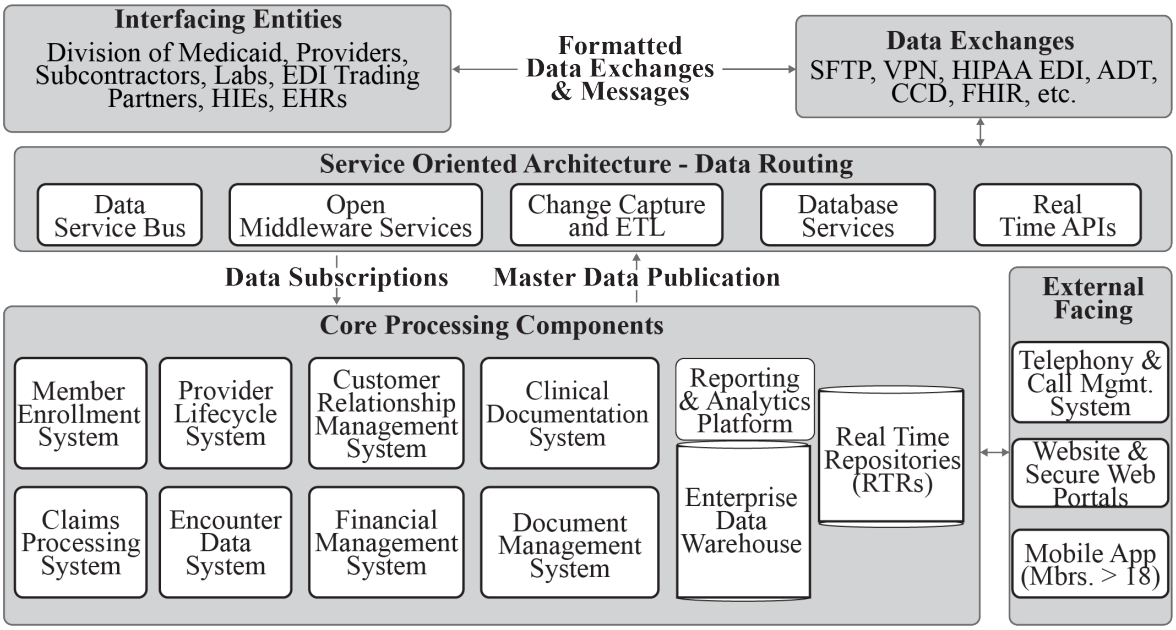
14.8 Million Medicaid Members Nationwide	**125+ Million** Claims Processed Annually	**125+ Million** Claims Processed Annually	**43 Million** Claims Processed via Machine Learning	**Over 300 Million** Encounter Records Annually	**3,700** Information Technology Staff
Over 300 Million Encounter Records Annually	**550,000** ADTs Captured & Processed Weekly	**23+ State HIEs** Connected to HIEs in Over 23 States	**Interoperability** Standards for 21st Century Cures Act using HL7 FHIR, CCD, etc.	**3 Data Centers** Locally Dispersed in CA, MO, and NY	**ISO 27001** Certified Security Program

Centene owns and operates two redundant and geographically dispersed, HIPAA-compliant enterprise data centers that house all core application data and voice and data networking infrastructure specifically designed for managed Medicaid health care administration. We will be expanding to three data centers for enhanced levels of continuity and service resiliency for our operations in Mississippi. Today, our scalable MIS supports over 15 million Medicaid and CHIP Members nationwide, including approximately 172,000 Medicaid recipients in Mississippi.

Overview of MIS Core Systems

Our integrated MIS capabilities and a diagram outlining our core systems are summarized in **Figure 4.3.1.1.2.a** below.

Figure 4.3.1.1.2.a: Magnolia MIS Core Systems



Member Enrollment System (Unified Member View – UMV). All eligibility, enrollment, and disenrollment data are received from DOM and loaded into our Member Enrollment System, UMV. UMV serves as the source of truth in our MIS for all informational aspects of our Members' relationship with Magnolia across multiple demographic and clinical data sets and current and historical benefits. UMV employs a master data management approach to collecting, updating, matching, quality-assuring, storing, and distributing Member enrollment data we receive from DOM and other State partners to our MIS components needing that information.

Provider Lifecycle System. Our Provider Lifecycle System is used to support all our core Provider functions, including prospecting, recruiting, enrollment, data management, and ongoing engagement. The system stores all unique Provider identifiers, including taxonomies, Tax IDs, National Provider ID (NPIs), Medicaid IDs, etc., and includes all demographic and location data, such as specialties, locations, office hours, phone numbers, accessibility, and capacity. The system is integrated with our Customer Relationship Management (CRM) system, enabling Provider Services Call Center support for Provider inquiries, outbound campaigns, and targeted outreach. This integration also allows for unified Provider communications management across all modalities (phone, fax, email, or web).

Customer Relationship Management (CRM) System. CRM enables us to identify, engage, and serve our Magnolia Members, Providers, and State partners in a holistic and coordinated fashion across the breadth of their wellness, clinical, administrative, and financial matters. CRM affords a 360-degree view of our relationship with Members and Providers for our Customer Service Representatives (CSRs). This integration helps eliminate inconsistencies and ensures that our staff have access to the information they need to support and assist Members and Providers. For example, CSRs can view a calling Member's information across all historic and current Magnolia eligibility spans, view any care gaps, and assist Members with completing screenings. Our Grievance and Appeals System is integrated with CRM to capture, track, report, and manage grievances and appeals.

Telephony and Call Management System. Our Telephony System enables seamless and efficient call answering, monitoring, and reporting capabilities. The Telephony System, along with our Call Manager Software, provides automatic call distribution (ACD) across our Member call queues.

Clinical Documentation System. Our Clinical Documentation System is our Member-centric platform for collaborative care and utilization management. The system houses a Member's care plan, which displays the Member's identified health problems, treatment goals and objectives, and milestone dates. The system's design supports a unique profile for each Member, including Member demographics, care plans, referrals, authorizations, case notes, and preferences including language, and preferred communication method. The integration with our Enterprise Data Warehouse (EDW) and Centelligence Reporting and Analytics Platform enables access to unified data from a variety of sources, allowing Magnolia staff to profile, measure, and monitor Members.

Reporting and Analytics Platform (Centelligence). Centelligence is our comprehensive family of integrated decision tools that provide expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with drill-down capabilities. Through Centelligence, we report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, Performance Improvement Project informatics, and other critical aspects of our operations. Centelligence includes a suite of predictive modeling solutions incorporating evidence-based, proprietary care gap/health risk identification applications that identify and report significant health risks at the population, Member, and Provider levels. The foundation of our data integration and reporting strategy is a comprehensive EDW that systematically receives, integrates, and transmits internal and external administrative and clinical data. EDW supplies the data needed for Centelligence's reporting and analytic applications while orchestrating data interfaces among our core applications. Housing all information in the EDW allows staff to generate standard and ad hoc reports from a single data repository.

Claims Processing System. We use a premier health plan administrative Claims Processing System to support accurate claim adjudication for complex benefit plans and multiple Provider reimbursement models. We use our Claims Processing System for medical and behavioral health (BH) processing, as well as Medicare Advantage administration, and for our Exchange family of individual insurance products, enabling a uniform approach to coordinated benefits administration. Together with our other integrated software, our Claims Processing System fully supports HIPAA standard EDI and Electronic Funds Transfer (EFT) capabilities, as well as detailed, real-time clinical edits and advanced Fraud, Waste, and Abuse detection.

Encounter Data System (EDS). Our encounter operations are supported by an industry-leading encounters workflow system specifically designed for managed Medicaid encounter processing which edits claims data, creates encounter submissions files, loads inbound response files, and tracks and reports encounter data status. EDS is configured to meet specific program requirements as defined by the state. Encounter rules and edits are set up in our EDS to ensure encounters are HIPAA-compliant 837 transactions.

Financial Management System. We use financial management software to record and report financial, administrative data related to the MSCAN and CHIP programs. All financial transactions are auditable per Generally Accepted Accounting Principles (GAAP) guidelines, and historical data can be obtained via online queries and reports.

Document Management System. Our Document Management System is designed to automate and accelerate the processing of paper and faxed authorization requests, assessments, care plans, survey questionnaires, and other paper-based correspondence. The system incorporates a full-featured, secure inbound/outbound fax communications system with enterprise-level document scanning, Optical Character Recognition (OCR), indexing, and routing workflow capabilities to streamline and automate the capture and processing of paper-based documents.

Technology Experts to Support Key Magnolia Operations

Magnolia and Centene believe that technological innovation allows us to drive quality results while improving Member outcomes and Provider satisfaction. For this reason, we have continually made investments in IT resources and solutions that better enable our staff to make data-informed decisions to impact health outcomes for Mississippians in need. Our computer and technological resources, coupled with highly trained experts and organized teams, support the following key operational, clinical, and administrative functions for Magnolia:

- **Product and Digital Health Care Systems:** This team develops IT roadmaps for our core business systems (i.e., Clinical Documentation System – TruCare Cloud, CRM, etc.), externally-facing systems such as public websites, secure Member, and Provider Portals, and our Member mobile application.
- **Infrastructure & IT Operations:** This team oversees our enterprise architecture and focuses on ensuring our IT infrastructure meets all business capacity needs, including any required build-out and expansion of data centers, to ensure the stability, scalability, and performance of the computing environment. This team also has responsibility for business services, production operations, administrative services, and quality assurance to ensure all IT services are operational and maintain service levels. The team monitors and operates our IT infrastructure 24/7 to ensure operational efficiency and continually formulates technology solutions to address new business strategies. Working with other IT teams, they evaluate current demand for

IT services and project future needs; overseeing change management processes to ensure the controlled production release of business services; and is responsible for disaster recovery, responding to any unplanned business interruption. The team ensures the stability and performance of Centene's data and voice networks and supports the information and telecommunication services for all service centers, ensuring a highly available, HIPAA-compliant MIS.

- **IT Security:** This team works with our Chief Information Security Officer (CISO) to provision, manage, and oversee user accounts accessing our systems, administers and audits network and application security for employees; monitor Internet activity, providing threat detection and ensuring MIS security and HIPAA compliance via physical, technical, and administrative safeguards.
- **Health Plan and Corporate Services:** This team maintains all solutions to deliver claims processing (including claims configuration, testing, and deployment), as well as Provider data management within our Provider Lifecycle System and encounter data production within our Encounter Data System. This team also manages our internal enterprise IT systems such as our internal company Intranet, content management sites, finance, and human resource systems.
- **IT Engagement, Planning, and Portfolio Management:** These teams work as a bridge between our IT and operational teams to ensure services, enhancements, and new functionality is delivered as needed to support our staff, Members, Providers, and DOM. These departments are responsible for the development and oversight of all methodologies and best practices related to IT Project and Portfolio Management Organization (PMO), Business Process Improvement, and Agile development.
- **IT Business Integration:** This team is comprised of IT integration leads responsible for communicating strategy and implementing new initiatives, collecting feedback, framing local Magnolia requirements, and resolving any implementation issues.
- **Healthcare Enterprises:** This team is responsible for the IT operations of Centene's specialty health businesses (e.g., Nurse Advice Line, Dental, Vision), including Magnolia's affiliated subcontractors, integrating Specialty Company data and systems into the overall MIS infrastructure.
- **Enterprise Data and Analytic Solutions (EDAS):** This department manages our Centelligence data integration, warehousing, and reporting and analytics platform, including the ongoing operation of our EDW; our Centelligence analytics applications for predictive modeling, assessments, and risk profiling; decision support tools that assist in identifying opportunities for care support; as well as a comprehensive array of interactive Business Intelligence reports and dashboards. EDAS is composed of an experienced team of data scientists who are responsible for the development and implementation of new data models to identify patterns in datasets using high-level statistics and machine learning algorithms to predict outcomes, inform operations, drive efficiency, improve Member health, and reduce unnecessary utilization and spending.

Enhancements and Innovative IT Solutions

As technology matures, we have capitalized on IT developments with an accelerating rate of innovation, building new functions upon a proven MIS. Below we highlight several innovations in IT solutions and computer resources we have implemented to support our staff, Members, and Providers since 2018.

Enhanced System and Data Architecture. Our MIS design is informed by CMS' Medicaid Information Technology Architecture with a standards-based Service Oriented Architecture. We employ microservices, accessible via open Application Programming Interfaces (APIs), for a growing number of functions. For example, when our Provider staff update Provider data in our Provider Lifecycle System, the change transaction triggers an update in our online Find a Provider directory typically within minutes via a microservice to a Real-Time Repository (RTR). RTRs are high-performance databases designed for conveying updated information to our internal- and external-facing applications and portals. Further, we are enabling our systems, data, and reporting functions through the use of secure cloud environments to improve accessibility and performance.

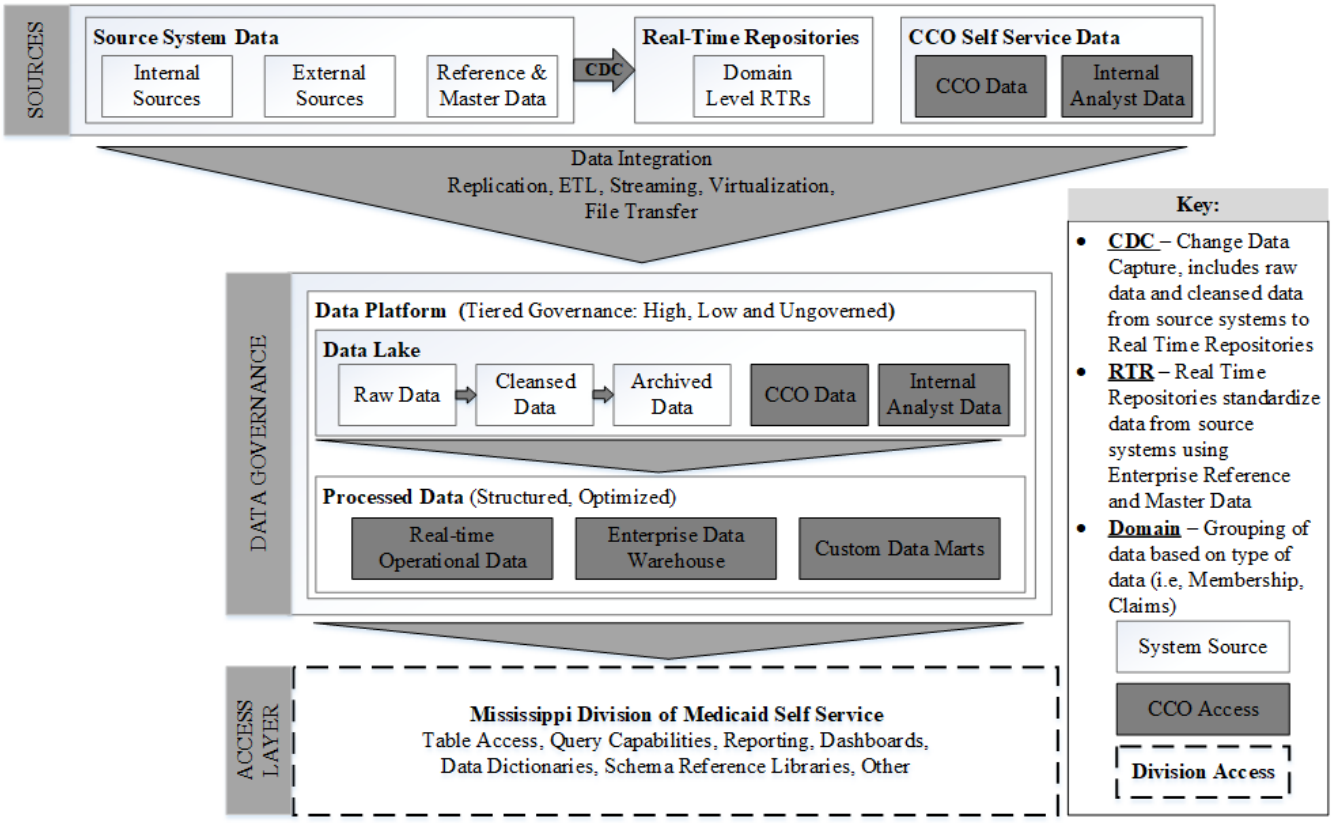
Systems Designed for Interoperability. As mentioned above, our expanded Clinical Data and Interoperability Gateway has allowed us to enhance our data sharing capabilities through bi-directional exchange with Provider EHR platforms, state HIEs, and other partners. Using FHIR, APIs, HL7, and other interoperability standards has allowed us to automate extraction of EHR data and deliver insights back into EHRs at the point of care, as well as receive real-time Admission, Discharge, and Transfer (ADT) data from hospitals and HIEs, all in the service of empowering Members' care teams with more information to inform care and improve outcomes.

Advanced Reporting and Analytic Capabilities. Our Centelligence reporting and analytics platform is our proprietary, comprehensive family of integrated decision tools providing resources and capabilities for standard and ad hoc reporting, data visualization, and online Key Performance Indicator dashboards. The integrated nature of our MIS and our EDW enables us to report on and develop dashboards for all datasets in our platform, including Member, Provider, claims, population health, health equity, clinical, and care and utilization management data.

- Centelligence powers our suite of predictive modeling solutions incorporating evidence-based, proprietary care gap/health risk identification applications that identify and report significant health risks at population, Member, and Provider levels. For instance, our machine learning-powered Social Risk Model uses Member and public data sources to predict Member-level risk attributed to social factors to target Members at risk for adverse health outcomes due to their social, economic, and environmental conditions and track outcomes over time. Scores aggregate at geographic levels and heat maps are generated with identification of leading social indicators that are correlated with poor health outcomes.
- We also make reporting and dashboards available to our Providers to support them in their pursuit of quality care. For instance, our Provider Analytics dashboard on our secure Provider Portal offers Providers cost and utilization trends, quality performance, patient loyalty, disease prevalence, readmissions, and health trends to help them identify and prioritize Member needs, and develop targeted actions to improve quality. Further, we also enable Providers to access their patient disease registries to view critical information including evidence-based care gaps, and quality and population health management improvement opportunities.

- To offer additional levels of transparency to state agencies and other agencies, we have developed a secure, cloud-based version of our Centelligence reporting and analytics platform, enabling authorized external users to securely access table-level data sets in EDW, with the ability to view, filter, sort, drill down, and extract the information to serve monitoring and decision support needs. Users will be able to query up-to-date information, generate reports, and view configurable dashboards to quickly display data in a manner that is useful for the end user, as displayed in **Figure 4.3.1.1.2.b** below.

Figure 4.3.1.1.2.b: Overview of Magnolia's Advanced Reporting and Analytic Capabilities



Enhancing Call Center Technology. We recently expanded the functionality and capabilities available to our call center staff through our Customer Relationship Management (CRM) system. These enhancements seamlessly integrate data from other core systems and create workflows, and suggested next best actions to equip our CSRs with the information and tools needed to provide smarter and more agile customer service for Members and Providers. We will also be further enhancing our call center technology through the implementation of Amazon Connect. The integration of Amazon Connect will provide enhanced tools including skills-based routing to our CSRs, real-time and historical analytics, as well as intuitive management tools to simplify call center operations and improve CSR efficiency.

Using Machine Learning and Automation to Drive Efficiencies. To proactively prevent deficiencies to claims processing standards, we are applying Artificial Intelligence (AI) capabilities through machine learning and robotics to enhance many of our claims and other processes to further ensure faster and more accurate payment. We use machine learning to automatically perform tasks and improve capabilities as more data is received, without the need for additional programming.

- We are leveraging AI-powered chatbots and virtual assistants as avenues for enhancing Member communications and meeting them where they are. These chatbots will provide human-like and natural communication capabilities to offer real-time assistance for Members with questions about navigating our public website, accessing services, Portal setup, and more.
- In addition, we will be leveraging natural language processing technology and partnerships with Provider EHR systems to scan unstructured notes in Provider EHRs to further enhance our data collection abilities and use it to ultimately drive toward improved health outcomes, closure of care gaps, and a deeper understanding of population risks.

Secure Portal Enhancements to Improve Engagement and Satisfaction. We have recently made several capability enhancements to our secure Member and Provider Portals in order to support Member health literacy and engagement in their care, as well as reduce the administrative burden on the part of the Providers. For instance, we modernized the user interface of our Member Portal for ease of navigation and enabled Members to have access to a digital version of their ID Card, which is automatically updated when changes are made and can be downloaded to their digital wallet, providing Members with easy access to their benefit information. Providers are now able to track where individual claims stand in the payment process with a helpful tracking visual, a self-service option, so they do not have to spend time calling into our Provider services helpline. Additionally, we recently enhanced our web-based prior authorization (PA) capability in our Provider Portal. The tool features built-in system logic to allow Providers to complete Medical Necessity Reviews for select outpatient procedures when submitting a PA request with auto-determination rules to quickly approve or route PA requests for further review based on criteria. The tool then provides a timely response to the Provider, reducing overall turnaround time on authorizations. As additional support, our Auth Digital Assistant uses machine learning technology to automatically examine all PA requests submitted via the Provider Portal against years of PA review history to identify requests that can be approved instantly, ultimately reducing Provider burden and improving PA review speed.

• Describe the Offeror's Current Products and Services

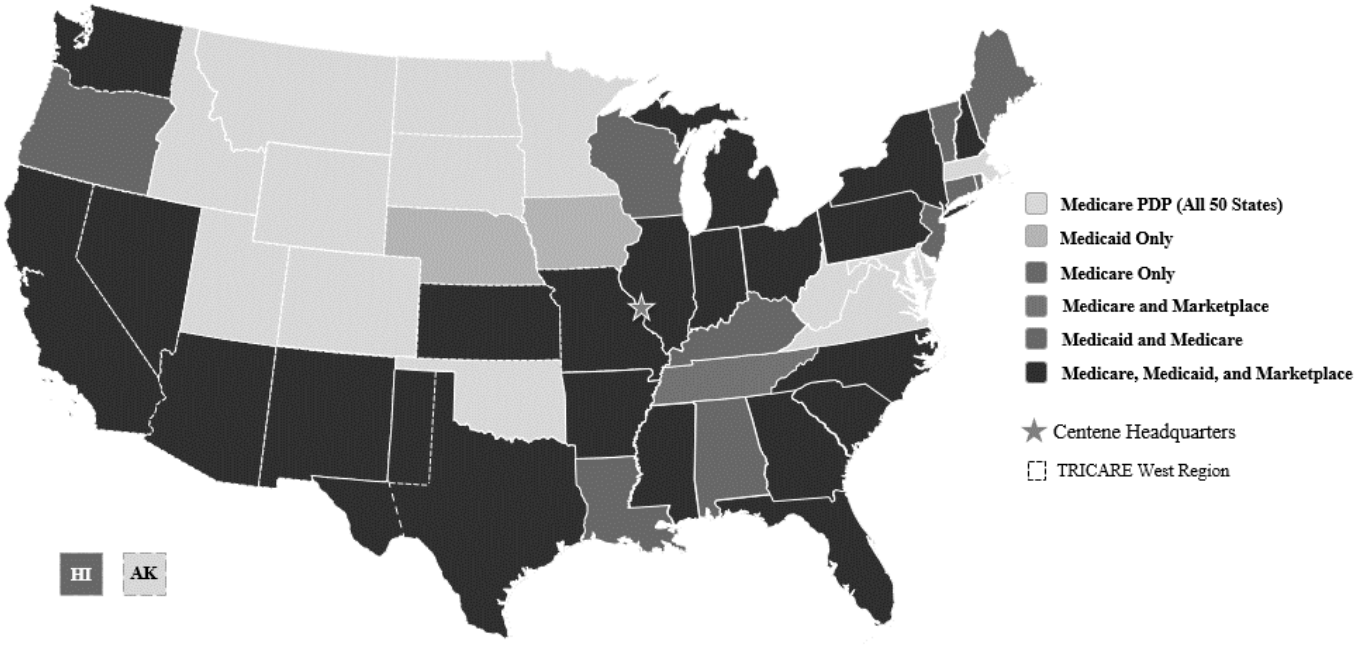
Magnolia's Current Products and Services

As a locally-headquartered, community-rooted CCO, Magnolia is proud to have served Mississippians for over 11 years. We have partnered with DOM to serve Mississippi Coordinated Access Network (MSCAN) Members since the inception of the State's managed care program more than ten years ago. In addition, we bring experience serving individuals across the state through the CHIP program, as a Medicare Advantage plan, as a Dual Eligible Special Needs Plan (D-SNP), and through Mississippi's Marketplace. We bring our experience, lessons learned, best practices, evidence-based programs, and operational efficiencies to deliver better health outcomes on a local level, in alignment with DOM's goals.

Product Type	Years Offered	Current Membership
Medicaid (MSCAN)	2011 – Present	166,273 (Jan. 2022)
CHIP	2015 – 2018	N/A
Medicare	2017 – Present	28,429
D-SNP	2018 – Present	12,652 (Jan. 2022)
Exchange/Marketplace	2015 – Present	114,875

Magnolia's local operations are backed by our parent company, Centene Corporation (Centene). Centene has more than 36 years' experience in managed care and currently serves more than 26.6 million individuals across the United States, including Medicaid; Medicare, including Medicare Advantage, Special Needs Plans (SNPs), and Prescription Drug Plans (PDPs); Marketplace; correctional care, and TRICARE. **Figure 4.3.1.1.2.c** shows Centene's offerings across the nation.

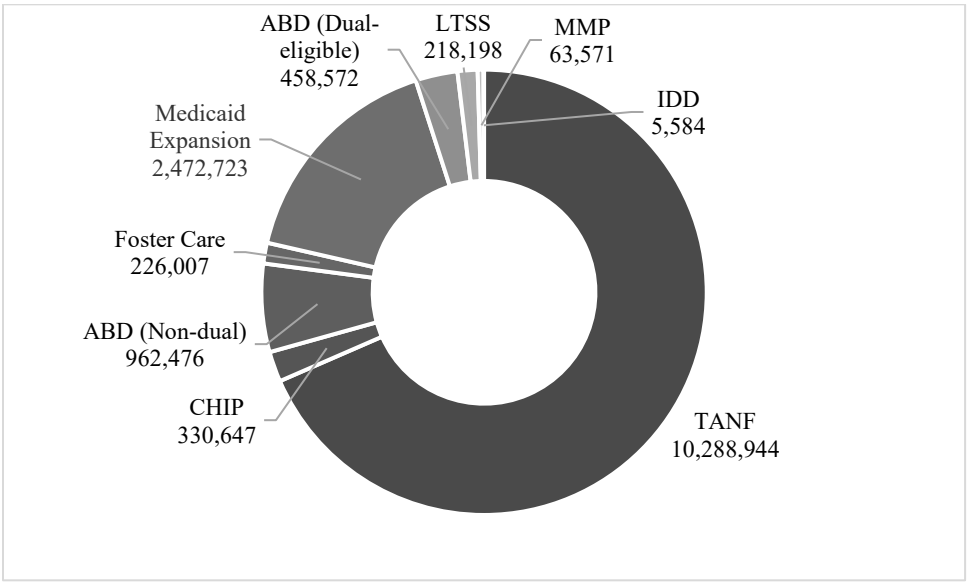
Figure 4.3.1.1.2.c Centene Presence by State



Total Membership	Medicaid	TRICARE	ACA Marketplace	Commercial	Medicare PDP
26,536,500	14,768,500	2,874,700	2,177,000	468,500	4,064,400
	Medicare	Correctional	International	Non-risk Membership	
	1,248,300	167,600	763,500	4,000	

Figure 4.3.1.1.2.d below shows Centene's membership by Member type, demonstrating our vast experience serving diverse types of Medicaid and CHIP members.

Figure 4.3.1.1.2.d: Centene Membership by Member Type



Magnolia currently provides all MSCAN covered benefits listed in Section 4 of Appendix A, Draft Contract. We also have experience providing all covered CHIP services identified in Section 4 of Appendix A. In addition to providing all required covered services, Magnolia is proposing to offer the following value-added benefits to our Members:

Value Add Name	Description
Vision Benefit for Members Over 21	Maintaining a healthy vision is key to our members' health goals. Our Vision Value-Added Benefit offers one eye exam per year and one pair of eyeglasses every calendar year for each Member.
Boys and Girls Club Membership	We will cover membership fees to local Boys and Girls Club for members ages 6-18. Membership programs in academics, character, leadership and in health will allow Members to grow their knowledge and implement what they learn into healthier lives.
YMCA Membership	Magnolia will cover membership fees to a local YMCA for members over age 18. Memberships offer families a variety of fitness programs and programs designed to help Members learn, grow and thrive in their community.
Weight Watchers	We will offer free six-month membership, including access to e-tools, to qualified Members identified through Care Management.
Community Baby Showers	As part of our maternal health program, Magnolia hosts baby shower events across the state. Baby Showers are conducted in a classroom environment led by our Care Management team and assisted by our dedicated member staff. Topics include prenatal care, nutrition, the risk of smoking and benefits of smoking cessation, baby care items (e.g., car seats, cribs, diapers, etc.), the progress of a fetus throughout pregnancy, the importance of regular follow-up with medical providers, common health issues that occur during pregnancy, and a review of our plan's programs. These will be provided in the community where our members reside.
Care Kits	Care Kits for Foster Care Members will provide basic care items that can travel with children transitioning into Foster Care. The kits will be age-appropriate and culturally sensitive. The items are supplied in a sturdy duffle bag or backpack and will include items such as a blanket, hot/cold tumbler, dental kit, earbuds, and a journal and pen. Infants and young children receive more age-appropriate items. The Care Kits will provide the Foster Member comfort and give them something of their own to alleviate some of the loss and stress that occurs when a child enters care. Sample contents in our NICU Kit include newborn clothing and essentials (e.g., baby onesie, socks, bibs, diapers and baby wipes, suction pump, pacifier, and thermometer), and delivery/postpartum educational materials such as safe sleep practices. Contents in the Sickle Cell Kit include Member materials on understanding Sickle Cell Disease; digital thermometer, hot/cold pack, water bottle, color-coded arm bands, and bracelets that help adults and children communicate their pain levels (i.e., blue is mild, yellow is medium, and red is severe pain). Care Kits for Members discharging from an inpatient stay will receive a kit that includes a medication planner, stress ball, important phone numbers sheet, member tip sheet, and transportation brochure for our Members who are being discharged and transitioned from a PRTF or inpatient psychiatric or rehabilitation facility.
Car Seat Installation	Magnolia staff have been certified to train parents in proper car seat installation. Car seats can be provided as needed using Care Grants.
Care Grants	Magnolia Care Managers are empowered to meet identified Member needs in real-time using Care Grants. Funds may be used for things such as emergency utility assistance, pest control, car seats, and diapers.
Magnolia Works (Member Employment and Education Program)	Magnolia offers education and employment supports to provide members with tools to locate and keep employment. The benefit includes GED training and testing, ESL classes, interview coaching, and financial literacy classes. The training and on-going supports to the member will increase employment opportunities and retention. We are partnering with HBCUs and other higher education facilities to cover the entire state of Mississippi.
Connections Plus (Expanded Phone Access Program)	Magnolia will offer smartphone distribution programs, such as Connections Plus®, which provides pre-programmed cell phones to certain high-risk Members or their parents/ guardians enrolled in Care Management who lack reliable phone access. This provides 24-hour instant access, allowing them to make calls to and receive calls from their Providers, care managers, pharmacies, important family contacts, our 24/7 nurse advice line, and 911. Additionally, Members can use their phone's alarm feature to remind them to take medications, a functionality beyond that which is available through a standard mobile phone. Requires prior authorization.
Postpartum Home Health Nursing for Wound Care	We will offer 90 days of home health nursing for wound care for c-sections and slow-health vaginal wounds, lowering ED visits and unnecessary provider visits while improving the members recovery in the comfort of their home.
OTC Allowance	Every head of household enrolled with Magnolia is eligible to receive $10 worth of OTC items each month. The OTC benefit includes traditional products (e.g., pain relievers, vitamins), eyeglass kits,

Value Add Name	Description
	reading glasses, and assistive aid devices such as pill containers and magnifying glasses. Providing these necessities allows the members to live a life with less pain, allows for the member to read their prescription labels with vision aids, and improves the Members daily life.
Virtural Group Prenatal Classes	Our Pregnant Members identified as high-risk will be eligible to receive virtual group prenatal classes based on the Centering Pregnancy Model, reducing the complications of high-risk pregnancies.
Expanded Transportation Benefit	Magnolia's Expanded Transportation Benefit provides additional transportation services to grocery and/or food pantry with a limit of 3 round trips per month, reducing food disparities for our Members in Mississippi by lowering barriers to healthier foods.
Room to Breathe (Asthma)	Magnolia's Room to Breathe benefit reduces in-home exposures to asthma attacks, improving quality of life and decreasing the need for ED and other physical and/or behavioral health visits, with an estimated cost savings of $1,184 annually. Eligible Members may receive the following household items and services: (1) $100 allowance for hypoallergenic bedding, (2) medical masks, (3) carpet cleaning services, and (4) HEPA filter vacuum cleaner.
Expanded Transportation Benefit	Our Expanded Transportation Benefit will provide additional transportation services to grocery stores and food pantries with a limit of 3 round trips per month, reducing food insecurity for our Members in Mississippi by lowering barriers to accessing healthy foods.
CHIP Non-Emergent Transportation (NET)	We will provide CHIP Members with NET to and from medical appointments, including the scheduling of rides.
Preventive Dental Care During Pregnancey and Postpartum	We will provide all dental services except cosmetic visits/procedures to include six month cleanings, fillings, extractions, and restorative services

• Describe the Offeror's Intangible Assets

In accordance with the definition of "Intangible Assets" set forth in the State of Mississippi's Department of Finance and Administration Capital Asset Reporting policy and in GASB Statement No. 51 *Accounting and Financial Reporting for Intangible Assets*, Magnolia does not have Intangible Assets.

• Describe any unique and/or innovative resources in which the Offeror specializes

Magnolia's Innovative Resources

To fulfill our vision to ***transform the health of the community, one person at a time***, Magnolia has worked alongside DOM for over a decade, providing comprehensive managed care services to Medicaid Members across Mississippi. As a locally-based, quality-driven organization, Magnolia brings a deep understanding of the unique needs and preferences of Mississippi Medicaid and CHIP populations, their families, and the Providers and community-based organizations that work with us to serve them. Through both our local experience and the expertise of our parent company, Centene, we have a deep understanding of the needs of and challenges faced by Members in foster care and those who serve them.

As a local organization that will be staffed and operated by hundreds of Mississippians across the State, we are dedicated to improving and investing in the future of health care in. We will invest $1 million to enable William Carey University (WCU) to develop the WCU College of Medicine (COM) Institute of Primary Care in Hattiesburg. We selected to partner with WCU COM because of their community-based training model and commitment to educate and train osteopathic physicians, nurses, and other primary care providers who are dedicated to serving the medically underserved and diverse populations of Mississippi. The Institute will recruit and train students primarily from Mississippi and the Gulf South region and offer continuing education and residency resources to address the physician shortage in the region. This world-class facility will allow for advanced training in high-quality value-based care geared toward the specific needs of Mississippians including diabetes, hypertension, and cardiovascular disease. The development of the Institute will result in better quality and more quantity of physicians to improve outcomes and quality of life for all Mississippians and decrease cost outcomes for the State.

Innovation is the foundation of our ***Population Health Management (PHM)*** framework. Applying clinical, public health, and analytics best practices, we identify local needs, including SDOH needs and disparities, and develop innovative, community- and Provider-anchored solutions designed to serve our diverse Membership. This organizational commitment to innovation is evidenced through our targeted programs and strategic partnerships, several of which are described in this section. As the state enters the next generation of Medicaid and CHIP managed care through the CCO program, Magnolia is fully committed to continuing to partner with DOM, other state and local agencies, other managed care plans, Providers and community organizations across the state of Mississippi, and other entities that touch our Members. We will continue to identify ways to improve the health and well-being of those we are honored to serve, with particular emphasis on rural and underserved populations, including individuals with behavioral health needs. ***Below, we highlight some of the unique and innovative resources we offer that align with DOM's priorities to:***

Investing in Mississippi

- Improve quality through efforts such as performance improvement projects, value-adds, value-based purchasing, health literacy campaigns, and care management
- Advance innovation through collaborative efforts with DOM and with other health plans
- Address barriers to access, both geographic and those based on social determinants of health (SDOH)
- Demonstrate a true commitment to improving the lives of Mississippians, both through delivery of care and investments in communities and in human capital

Table 4.3.1.1.2 provides an overview of the resources that will be discussed in detail below. Resources have been organized alphabetically for ease of review.

Table 4.3.1.1.2 Overview of Magnolia's Unique and Innovative Resources

			
• 24/7 BH Crisis Line • ADHD Pilot Program • Advancing MOMs • Ask Me 3 • Asthma Programs • BH Chatbot • Care Kits • Caregiving Collaborations • Centene Institute for Advanced Health Education • Choose Tomorrow • Dedicated Foster Care Team • Early Childhood Intervention Program • ED Diversion Program • Fluevention • Krames • Member Orchestration • Member to Care • MTM • My Health Pays • My Route to Health • myStrength • NET Mobile App • Online Appt Scheduling • OpiEnd • Project Awareness Program • Raising Well • Readmission Reduction Program • Remote Patient Monitoring • Schizophrenia Chronic Condition Management • Sickle Cell Care Management • Sickle Cell Hydroxyurea Medication Adherence Program • Start Smart for Your Baby • Tobacco Cessation • Vigilant Health	• BH on Board • CPESN • Lead Poisoning Prevention and Healthy Homes • Maternal Health Partnerships • MS SHINE Network • MS State Dept of Health-Dental Health Event • Partnerships with Local Housing Authorities	• Aledade • Babylon • Babylon360 • Community Resource Support Database • ConnectionsPlus • Get Well Network • Health Equity Improvement Model • Magnolia Works • MS Programs of HOPE • NEST • Partnerhips to Address Food Insecurity • Program Believe • SafeLink • School Care • SDOH Mini Screen • Shower Power • VBP • Z-Code Utilization Dashboard	• Boys and Girls Clubs • Community-Led Transportation Pilot Program • COVID-19 Community Supports • COVID-19 Support Program • Diaper Bank of the Delta • Health Equity Tools • Maggie's Kids Club • School Based Partnerships • SDOH Help Line • Shoes from the Heart Ministry

Improving Quality and Clinical Outcomes: ***Chronic Care, Prevention, and Care Management (CM)***

24/7 BH Crisis Line. Magnolia's BH Crisis Line is fully staffed by BH licensed clinicians available to handle BH crisis-related calls. The Crisis Line staff have access to a full listing of Magnolia resources and can refer callers to such resources. Call Center staff are trained to quickly identify signs indicating a crisis call or other urgent or emergent situation in which escalation is appropriate.

ADHD Pilot Program. Our current ADHD Care Management program provides integrated CM services to members ages 6 to 12 with an ADHD diagnosis and prescribed an ADHD medication. We have most recently entered into an innovative partnership with UMMC to pilot a pediatric ADHD workgroup and program to support the healthy development of children and adolescents with ADHD. The ADHD CM team follows up with Members to ensure HEDIS care gaps are being met and to ensure the quality of care with Members who have ADHD. The team provides education to the Member's parents or guardians about ADHD and the

management of symptoms and educates on the importance of follow-up appointments. The team also tracks appointment attendance and assists with scheduling appointments as needed.

Advancing MOMs. Through Start Smart and our continuous quality approach, we are constantly looking to improve services and outcomes for our pregnant Members and newborns. This includes identification and implementation of innovative programs and partnerships with demonstrated success. Anchored by Start Smart, our new Advancing Maternal Outcome Movement (MOMs) will be focused on ensuring equitable outcomes for moms and babies of all races and ethnicities statewide. Advancing MOMs has five main components to improving service delivery and access to care:

- Enhanced pregnancy identification and risk stratification analytics to help us detect at-risk pregnancies sooner, prevent preterm births, and reduce racial disparities. The maternity analytics platform uses AI-based algorithms to scrub data for more than 3,000 early pregnancy identifiers to detect pregnancies earlier and uncover more data about moms and babies at risk. The platform reports identifying 98% of moms before delivery and 70% in the first trimester and use of this platform has shown a 19% reduction in unnecessary C-sections, 10% reduction in preterm birth, and 9% reduction in NICU use.
- 24/7 access to virtual lactation consultants and doulas statewide for all pregnant moms, and virtual group prenatal care based on Centering Pregnancy principles to drive positive outcomes for higher risk pregnancies.
- Comprehensive care for substance-exposed pregnancies through Mindoula. Mindoula will offer a virtual peer support care community that helps expectant mothers with SUD alleviate the fear of stigma when accessing care. Each Member will be assigned a Clinical Team that includes a Psychotherapist, Certified Peer Recovery Specialist, Resource Advocate and Nurse Educator. The program also offers resources to safely stabilize medications and SDOH before birth.
- A culturally competent digital health platform connecting Black expectant and new mothers with critical resources to drive positive pregnancy outcomes. This platform will support the perinatal period for women to improve and overcome disparities in access to care and pregnancy outcomes for Black women.
- Education, reminders, and intensive Care Management to reduce pre-term births using a partner's proven tech-enabled model. This program includes not only technological support for pregnant mothers, but also deploys Community Health Workers across the State to provide additional support to Members when needed.

Ask Me 3. To improve patient-Provider communications, we will train our Providers on evidence-based interventions, including the teach-back technique and promote ***Ask Me 3®,*** which is intended to help patients better understand their health conditions and what actions they need to take to stay healthy by asking three specific questions during Provider visits: 1) What is my main problem?; 2) What do I need to do?; and 3) Why is it important to me?

Asthma Programs. Magnolia recognizes the importance of medication management for Members with asthma to reduce the need for rescue medication, ED visits, inpatient hospital stays, and potential death related to this diagnosis. The table below describes interventions Magnolia's implemented to address barriers in AMR, as identified through root cause analysis.

Intervention	Description
Pharmacy: Member Facing	Magnolia's Pharmacy Team mails letters to Members identified in the AMR population. The letter provides a review of the member's current medications. The review identified that an inhaled steroid for long-term control of asthma was not being utilized and suggested the member/guardian speak with their Provider about the addition of an inhaled steroid for long-term control.
Pharmacy: Provider Facing	Magnolia's Pharmacy team mails or faxes letters to Providers of Members identified in the AMR population as having asthma which includes a medication therapy review by a Health Plan Pharmacist and encourages the Provider to consider adding a controller agent or inhaled corticosteroid if appropriate.
Quality: Provider Facing	Magnolia's Quality Improvement team distributes Provider education periodically for the AMR HEDIS measure which includes the description of the measure, tips for rate improvement and Member education and talking points.
Population Health: Member Facing	The population health team outreached Members identified in the AMR population to encourage participation in Care Management or Disease Management for assistance with their care and education on how to live with a chronic disease that is manageable.

BH Chat Bot. We will conduct a pilot of a BH Chatbot from X2AI. Developed by clinicians and researchers, the chatbot will be able to respond to Members with depression, anxiety, or other mental health needs by triaging the right level of care, conducting standardized assessments, providing with them self-help content, or even connecting them on-demand to 5,000 standby counselors across the country or scheduling appointments later for support.

Care Kits. We will provide Care Kits to help Members during transitions and to learn more about their diagnoses. Available Kits are described below.

- ***Care Kits for Foster Care Members*** will provide basic care items that can travel with children transitioning into Foster Care. The kits will be age-appropriate and culturally sensitive. The items are supplied in a sturdy duffle bag or backpack and will include items such as a blanket, hot/cold tumbler, dental kit, earbuds, and a journal and pen. Infants and young children receive more age-appropriate items. The Care Kits will provide the Foster Member comfort and give them something of their own to alleviate some of the loss and stress that occurs when a child enters care.
- Sample contents in our ***NICU Kit*** include newborn clothing and essentials (e.g., baby onesie, socks, bibs, diapers and baby wipes, suction pump, pacifier, and thermometer), and delivery/postpartum educational materials such as safe sleep practices.
- Contents in the ***Sickle Cell Kit*** include Member materials on understanding Sickle Cell Disease; digital thermometer, hot/cold pack, water bottle, color-coded arm bands, and bracelets that help adults and children communicate their pain levels (i.e., blue is mild, yellow is medium, and red is severe pain).
- ***Care Kits for Members discharging from an inpatient stay*** will receive a kit that includes a medication planner, stress ball, important phone numbers sheet, member tip sheet, and transportation brochure for our Members who are being discharged and transitioned from a PRTF or inpatient psychiatric or rehabilitation facility.

Caregiving Collaborations® Program. Magnolia offers the Caregiving Collaborations program for parents and caregivers to support their ability to care for their child and recognize needs and how to address them through knowledge, tools, and resources. For example, as part of the Caregiving Collaborations program, we created the My Caregiver Journal. This journal is designed to help caregivers stay organized. Caregivers can use the journal at doctor visits and to keep track of important information and daily routines such as medication list, medical history, contact information for PCPs and other Providers, emergency contact information, and allergies.

Centene Institute for Advanced Health Education. The health of our communities is intrinsically tied to the health of our Members. The Centene Institute provides empowering interprofessional continuing education to our Providers at no cost through leading-edge and research informed educational activities, equipping them to deliver current therapies and better health outcomes. The Centene Institute has developed 13 educational activities, including live courses, internet enduring material, virtual live courses, and repeated seminar series to date, and develop new content each month. Four activities are already accredited through Washington University in St. Louis that provided over 155 accredited continuing education hours for physicians, nurses, and/or pharmacists, including (1) Pain Management and Opioids (41% increased knowledge and 50% retained knowledge associated with opioid prescribing practices); (2) Evolving Care of the Prenatally Opioid Exposed Neonate (58% increased knowledge and 28% retained knowledge associated with treatments of opioid-exposed neonates); (3) Treating Pregnant Women with Addiction (47% knowledge increase and 50% knowledge retention); and (4) Supporting Patients with Alcohol Use Disorder.

Choose Tomorrow®. Our comprehensive state-wide suicide prevention strategy, Choose Tomorrow, uses predictive modeling and evidence-based practices to identify suicide risk, determine the best course of intervention, and monitor Members' treatment progress in improving outcomes. The program is based on the Zero Suicide framework and incorporates industry-standard assessments and tools such as the Columbia Suicide Severity Rating Scale, PHQ-9, Safety Planning, and Caring Contacts. Choose Tomorrow includes pragmatic guidance for network providers through training and toolkits to ensure the entire system of care is working to identify and prevent suicide. As part of Choose Tomorrow, we will offer the Suicide Safer Care training to FQHCs, CMHCs, and Rural Health Centers, as well as other providers in our network. In 2020, we delivered 35 trainings to 1,704 participants in 16 states to address the public health crisis of suicide. After completing training, participating providers demonstrated gains in knowledge and level of comfort in assessing and caring

for individuals at risk of suicide. Our Medicaid affiliate in Washington saw an 8% decrease in suicide attempts among the foster care population after just one year of implementing Zero Suicide, and we anticipate similar successes for Mississippi Members.

Dedicated Foster Care Team. Due to the urgent needs and sensitive nature of the Foster Care population, Magnolia has a dedicated group of care managers that work with our Foster Care members. This team outreaches to Child Protective Services (CPS) caseworkers (and resource parents as permitted by the caseworker) about Foster Care members' upcoming well-baby and well-child due dates and appointments. This team provides onsite education at every CPS office in the state covering topics, such as well-baby and well-child, immunizations, and other preventive services. Our dedication to this population has resulted in Magnolia managing the majority of the foster care membership.

Early Childhood Intervention Program. Magnolia identifies and refers all newborns and Members up to 21 with NICU stays, developmental delays, and special needs to our Early Childhood Intervention program. Through this program, Magnolia's Population Health and Quality teams offer a range of resources, supports, and events that include Diaper Days and Baby Showers, birthday card reminders for immunizations, diaper bags, NICU kits, immunization schedule magnets, breastfeeding classes, Adopt-a-School programs, Care Management services, and Private Duty Nursing (PDN) services when appropriate.

ED Diversion Program. Magnolia's ER Diversion Program addresses unnecessary ER use to comprehensively manage our highest ER utilizers. CM staff provide education about appropriate ER use and availability of our 24/7 Nurse Advice Line, link the Member to a medical home, and accompany the Member to the PCP visit to facilitate communication.

Fluvention. Our seasonal, award-winning Fluvention Program is aimed at educating and coordinating access for annual flu vaccinations and flu prevention, especially for vulnerable populations. We recently evaluated the effectiveness of our Fluvention materials to determine which types of Member outreach are most impactful among high-risk members. In response, we developed a multi-modal Fluvention deployment strategy that includes text messages, emails, and outbound calls. Through our parent company, Centene, we developed a dashboard to track real-time Member engagement metrics and flu vaccination rates. We also deployed educational materials to help Members distinguish COVID-19 and flu symptoms. From 2018/19 to 2019/20, the cumulative flu vaccination rate for Magnolia Medicaid Members increased by 5.9% (from 18.4% to 19.5%). Our cumulative vaccination rate for 2020/21 (15.21%) was lower than our rates in 2018 and 2019, which we attribute to impacts from the COVID-19 pandemic.

Krames Health Library. Our Krames health library is available on our public website and is free to Members and the broader community. Adhering to the principles of health literacy, this extensive library of evidence-based, peer-reviewed information provides a flexible, web-based solution for delivering education at the point of care and on-demand, with over 4,000 health-related topics in multiple languages. Krames uses health literacy principles to increase readability and comprehension and motivate healthy behaviors. The library is easily accessible to Members via our website, is searchable and easy to navigate, and includes health sheets to explain conditions along with over 2,000 drug information sheets with information on prescription, over-the-counter, and nutritional products.

Member Orchestration. Magnolia Customer Services Representatives can use Member Orchestration to understand who our Members are, how they engage with Magnolia, and how best to support them through their health care journey. It begins with an integrated Member data profile which includes a history of interactions and touchpoints with our Member. Customer Services may view recent interactions (i.e., Member used the Member Portal, received mailer from Magnolia, or has placed a call to the call center). Member Orchestration allows us to honor a member's engagement preference – such as email, text, or phone – while optimizing messaging through all appropriate channels to consistently engage members.

Member to Care Program. Subcontracted non-emergency transportation (NET) drivers often have unique insight into changes to a Member's health and circumstances as they are the regular link between Members and their medical appointments and frequently have conversations with Members throughout the trip. Many Members use the same driver on a daily or weekly basis, building consistency, continuity of care, and reliability

as members grow to know and trust their regular driver. This relationship allows drivers to quickly identify potential issues and serve as an early alert system for the Member's care manager, which could prevent further health issues and reduce the overall cost of care. Whether they notice an atypical no-show, signs of elder or child abuse, an indication of poor home conditions or food insecurity, or a marked degradation in health, NET drivers are cognizant of concerns and can report issues to the care manager in real-time. Drivers can also communicate reminders for screenings, tests, and vaccines. Through our NET Broker, we will train drivers on how to observe and recognize members with potential issues, as well as proper communication for screenings, tests, and vaccines. Drivers can use the NET Broker's IT platform to document evaluation and communication notes, which the NET Broker will forward to the Care Manager for follow-up with the Member.

MTM Program. Magnolia's Medication Therapy Management (MTM) program, in partnership with retail pharmacies across the state, is designed to address HEDIS care gaps and improve medication adherence. Our MTM program will use pharmacy claims data (provided by the PBA) to generate Member-specific alerts to retail pharmacists related to medication adherence for diabetes, hypertension, cholesterol (statins), antidepressants, and HIV as well as gaps in care related to statin therapy for patients with diabetes and will promote the use of maintenance inhalers for Members with Asthma and COPD. A retail pharmacist who receives an alert will outreach to the Member either face-to-face or telephonically to address the care gap or adherence concern.

My Health Pays Incentive Program. My Health Pays is our award-winning Member incentive program that offers financial rewards to Members actively engaged in healthy behaviors and decision-making based on local trends, state priorities, and past performance. Magnolia has extensive experience tailoring Member incentives to encourage participation and promote personal responsibility and desired health outcomes. My Health Pays aims to motivate Members to obtain recommended preventive care and medically necessary follow-up services and empower them to live healthier lives by increasing their self-management skills. Members are automatically enrolled in My Health Pays; there is nothing they need to do except start completing activities. Magnolia Members can earn rewards by completing healthy activities like annual doctor visits, annual cancer screenings, flu vaccinations, annual comprehensive diabetes care, infant well visits, notifying us of pregnancy, and accessing prenatal and postpartum care. After the first activity is completed, a Visa® Prepaid Card is sent to the Member with their reward amount pre-loaded. Subsequent rewards are added to the card automatically. My Health Pays rewards can be used for eligible purchases at Walmart and to cover payments for services such as childcare, telecommunications, utilities, education, rent, transportation services.

$4.7 Million

From 2019 to 2020, Magnolia Members earned a total of $4.7 million in My Health Pays rewards incentives for healthy behaviors such as receiving well visits, immunizations, and cancer screenings.

My Route to Health. To help support health literacy across Mississippi, Magnolia offers the My Route to Health Literacy and health education program. The My Route to Health Literacy website offers educators, parents, students, and caregivers ready access to videos, digital books, and parent guides on health topics to increase knowledge about health related topics and literacy. Current materials are available in English and Spanish and address nutrition, smoking, fitness, bullying, diabetes, and more. Health books and lesson plans are designed to help educators deliver quality health education to youth in elementary, middle school, and high school. Through My Route to Health Literacy, Magnolia aims to improve the health of Mississippi communities through health education, helping children and youth to develop the foundation for lifelong health.

myStrength. Magnolia offers myStrength, a customizable self-care resource that provides educational support to improve mental health and overall well-being for populations experiencing behavioral health conditions. myStrength fosters personal responsibility and healthy lifestyles by enabling Members to learn more about their diagnoses, track their symptoms, and receive motivational ideas and tools to work toward solutions. Members can engage in personalized e-Learning programs to help overcome behavioral health conditions such as depression, anxiety, overuse of drugs or alcohol, and serious emotional disorder in a safe, confidential environment. We also encourage caregivers to enroll and utilize myStrength for support for themselves or to better understand the behavioral health diagnosis of their child or family Member. myStrength can be accessed through a computer and mobile application.

Non-Emergency Transportation (NET) Mobile App. Through our NET Broker, we will offer a Mobile app that Members can use to manage their NET trips without calling the Member Services request line. In addition to using the app to request a new trip, Members can also use the app to: cancel rides that are no longer needed; request gas mileage reimbursement trips; review details about upcoming rides (for example, the ride status, NET mode, and the transportation provider's name and contact information); and view and update their contact information.

Online, Real-Time Appointment Scheduling. Magnolia uses Appointment Wizard for real-time Member appointment scheduling. Through Appointment Wizard, we assist Providers in managing appointments and reducing no-show rates. Appointment Wizard allows Customer Service Representatives (CSRs) or Care Managers to schedule appointments with participating Providers and issue text or email reminders for members. Staff have access to an online appointment-scheduling portal and can set up appointments while on the phone or while meeting with members, without the need for multiple calls to and from Provider offices. Magnolia staff can securely attach documentation to the Member appointment for specific care gaps (e.g., EPSDT needs) to ensure a thorough Member office visit.

OpiEnd Program. Our award-winning OpiEnd™ Program coordinates timely, cost-effective, integrated services to minimize inappropriate and excessive use of opioids and prevent occurrence or exacerbation of an Opioid Use Disorder (OUD). OpiEnd aims to improve the lives of Members at risk for or diagnosed with an OUD, across the prevention-to-recovery continuum. This is completed through the following programmatic elements:

- **Opioid Risk Classification Algorithm Score:** We use the Opioid Risk Classification Algorithm (ORCA™) score to identify Members at risk if developing an OUD. This machine learning predictive model facilitates early intervention and helps us to determine which interventions and program outreach will be most impactful.
- **Specialized Care Management:** When a Member is identified as being at risk for, or having an OUD, we assign a Care Manager with expertise in serving Members with substance/opioid use. Care Mangers use motivational interviewing to assess Member readiness to change and engage them in the right services using American Society of Addiction Medicine (ASAM) criteria.
- **Provider Education:** We offer Pain Management and Opioid continuing education and the ASAM Treatment of Opioid Use Disorders training to all network Providers free of charge.

OpiEnd Outcomes

Magnolia saw a 14.2% decrease in adult Members receiving opioids and a 6.3% decrease in adult Members receiving benzodiazepines from 2019 to 2020.

Project Awareness Program. Magnolia offers a specialized care management program for Members with HIV/AIDS. Through this program, we provide Members with mail-order pharmacy services so they can receive medications in unmarked packaging, protecting their privacy and increasing compliance for Members who do not want to go into a pharmacy. Magnolia partners with clinics across the state, including Open Arms, G.A. Carmichael, Garfield, and the University of Mississippi Medical Center (UMMC) to facilitate quick and confidential access to care and HIV/AIDS education. We also provide these Members with Safelink and Connections Plus phones to ensure they have access to Care Management services and resources.

Raising Well. Magnolia's award-winning Raising Well program helps children classified as overweight or obese according to BMI percentiles achieve long-term physical health improvement by working with parents to create a supportive home environment where healthy lifestyle changes can occur. Through this program, coaching is provided by registered dietitians and exercise physiologists who use evidence-based guidelines to educate Members on healthy eating and exercise behavior change. Using social media content, we promote the enjoyable aspects of health and fitness with thematic content, such as Motivational Monday, Work-out Wednesday, and Foodie Friday. Coaches provide connections to resources within the members' own communities via a detailed community resource tool, including linking Members to specific area resources such as YMCAs and Boys and Girls Clubs.

Readmission Reduction Program. Our Readmission Reduction Program aims to reduce preventable readmissions by working to ensure optimal transitional care from hospitals and nursing facilities to homes. Our

team engages Members when they transition and provide education on available resources, such as the 24/7 Nurse Advice Line, care management and pharmacy services, and others; assistance with scheduling follow-up appointments and transportation; SDOH resource referrals; and home health supports such as durable medical equipment. The program focuses on placing post-hospitalization outreach calls to Members to ensure they have and understand their discharge instructions, follow up with a primary care Provider, and receive medication reconciliation. Additionally, recognizing that the most effective results come from working together, Magnolia partners with Merit Health Systems and St. Dominic to reduce preventable readmissions.

Remote Patient Monitoring. This program serves Members with previous claims for testing supplies in the last 12 months who have been diagnosed with Type I or II diabetes. Upon enrollment, Members receive their welcome kit with a glucometer, testing strips, and instructions in the mail and begin testing their glucose levels and receiving real-time strip readings. In the event of a potentially dangerous reading or testing non-compliance, Members receive a call to promote adherence to recommended treatments, offer coaching, and/or triage their needs. Members automatically receive test strip refills as they are used and recorded, increasing testing efficiencies and decreasing waste and testing barriers. Program goals include improving glycemic control, reducing preventable healthcare utilization, promoting Member adherence to treatment guidelines, and improving self-management skills.

Improving Quality

Magnolia Members enrolled in remote patient monitoring for Diabetes experienced a 6% average decrease in glucose levels and a 15% reduction in ED visits compared to those not enrolled in the program.

Schizophrenia Chronic Condition Management. We will utilize our Schizophrenia Chronic Condition Management Program to support members with Schizophrenia. Launched in 2021 by an affiliate Medicaid plan, this clinically integrated, comprehensive program reduces the level of physical health and BH utilization and costs among Members. Through a wrap-around Member-centric approach, we address whole-person needs, medication adherence, and unmet social needs. The program is designed to enhance Members' understanding and ability to self-manage their chronic disease and improve the practice pattern of network providers.

Sickle Cell Care Management. Recognizing the high prevalence of Sickle Cell Disease (SCD) in Mississippi, Magnolia created our Sickle Cell Care Management program in 2017 to improve the health and quality of life of our Members with SCD through a two-pronged approach. First, we engage Members to develop and improve disease self-management strategies, connect them to a PCP who can help manage SCD, and remove barriers to care. Second, we educate Providers about SCD and best practices for treatment to increase the number of Providers comfortable with treating SCD, improve the delivery of culturally appropriate care, and reduce disparities. Our Sickle Cell care management team provides support and oversight of coordination of efforts for Members with SCD, caregivers, and health care Providers to meet the complete medical needs of Members with an added focus on those Members identified as complex or high utilizers.

Sickle Cell Hydroxyurea Medication Adherence Program. To increase the number of 90 day fills and Member adherence with hydroxyurea, Magnolia launched a Sickle Cell medication adherence program in 2020. Through this program, Magnolia identifies Members that are non-adherent with hydroxyurea through utilization reports. Once identified, Members receive a letter with tips on medication adherence (e.g., using a pillbox or setting an alarm, switching to 90 day fills, and signing up for pharmacy auto-refill reminders). The Member's Provider also receives a letter notifying them of their patient's non-adherence. Magnolia's Pharmacy team follows up with the member/family to discuss and address barriers to adherence and benefits of switching from a 30 day fill to a 90-day fill and to offer case management services. From Q1 2020 to Q3 2021, Magnolia has seen a 5% increase in Member adherence with hydroxyurea and a 6% increase in 90 day fills.

Start Smart for Your Baby® (Start Smart). Start Smart is Magnolia's award-winning maternal and child health program designed to establish a strong foundation for moms and babies through person-centered care, coordination of care, and provision of care management, case management, and social supports. All pregnant Members are enrolled in our Start Smart perinatal management program that serves as the umbrella for all of our perinatal and neonatal management efforts to improve birth outcomes. This program is a whole health approach to maternal and child healthcare that provides a range of perinatal interventions and support targeted to each Member's specific needs and level of risk from conception through the first year of life. This includes connecting Members to SDOH services and supports and government programs such as SNAP and WIC. In 2019, Centene received the Medicaid MCO Best Practices and Innovative Initiatives for Women's Health and nine additional children and women's health awards since 2009. Start Smart core components are described in the call-out box with more detailed descriptions of targeted programs to support pregnant Members and their newborns described here.

Award-Winning Program

In 2019, Centene received the Medicaid MCO Best Practices and Innovative Initiatives for Women's Health and nine additional children and women's health awards since 2009.

- **Start Smart for Your Baby® Baby Showers.** As part of Start Smart, Magnolia hosts baby shower events across the state. Baby Showers are conducted in a classroom environment led by our CM team and assisted by CHWs. Topics include prenatal care, nutrition, the risk of smoking and benefits of smoking cessation, baby care items (e.g., car seats, cribs, diapers, etc.), the progress of a fetus throughout pregnancy, the importance of regular follow-up with medical Providers, common health issues that occur during pregnancy, and a review of Magnolia programs.
- **Start Smart for Your Baby® Perinatal High Risk Maternal Health Program.** For pregnant Members, our Start Smart program staff coordinate with the Mississippi State Department of Health's (MSDH) Perinatal High Risk Management/Infant Services System Program to identify, refer, and coordinate care for those who meet program criteria. Magnolia staff contacts the MSDH case manager to provide Member information (with appropriate consent) such as assessment results and determine roles and responsibilities for coordinating the member's care. For Members with serious BH conditions, the care manager facilitates the integration of BH and medical services, including preventive services.
- **Start Smart for Your Baby® Healthy Mother's Journey.** An extension of our Start Smart for Your Baby program, our Healthy Mother's Journey is an integrated program of medical and behavioral professionals to help Members with identified or reported substance use during pregnancy through telephonic outreach, engagement, and care management for up to 12 months. These services are provided by Magnolia Integrated Care Management Team, which includes Care Management and MemberConnections Community Health Workers for outreach. The Healthy Mother's Journey team uses person-centered care and coordinates substance use disorder (SUD) services for the mother to decrease or eliminate the SUD. Healthy Mother's Journey partners with addictions programs throughout the state to connect Members to the experts. Members will be identified through self-referrals, care management referrals, pharmacy data, and physician referrals. Members can also be identified up to 6 months postpartum and be referred by Utilization Management, particularly NICU, and medical/behavioral case managers, Providers, or self. When a Member is identified as using substances during pregnancy, the Integrated Care Management Team will make outreach to the Member and invite them to participate in the

Start Smart Core Components

- Early identification of pregnancy
- Risk screening and stratification
- Tailored outreach and education
- Community Baby Showers and Events
- Member incentives
- Complex case management for high risk
- Specialized management of BH and SUD
- NICU management and follow up
- Home visit programs
- On-demand virtual access to maternal and pediatric experts for lactation support
- 24/7 access to on-demand Doula support
- First Year of Life Program to guide Members through medical milestones
- Provider education and incentives
- Community partnerships

Highlight: Start Smart Baby Shower

In March 2021, Magnolia hosted a Baby Shower and COVID-19 vaccination event. 21 Magnolia Members attended the drive-through Baby Shower where they were able to ask questions about their benefits, pregnancy, or receive assistance with SDOH needs. Each Member received diaper bags, healthy snacks, and literature about WIC, immunizations, and the Start Smart for Your Baby program and additional benefits. During this event, 27 Members from the community received their first dose of the COVID-19 vaccine and 1 Member received their second dose.

Healthy Mother's Journey program. The care management program will use motivational interviewing, harm reduction, the Edinburgh Depression Screening Scale as well as depression management, substance abuse, and BH intervention strategies to care for the Member. The Healthy Mother's Journey program will keep a network of Providers who specialize in working with this population as referral sources and linkages for the women and youth in the program.

- **Start Smart for Your Baby® NICU Program.** Magnolia's Community Health Worker (CHW) staff deliver information and resources in person to help our moms and newborns during this stressful and uncertain time. Our NICU program includes providing electric breast pumps with overnight delivery, NICU kits, in-person education, and Synagis® for NICU graduates. The NICU kit we provide to these moms includes the American Academy of Pediatrics book Your Baby's First Year, a double electric breast pump, and education about reducing readmission risks such as hand washing, safe sleeping habits, avoiding smoking, and exposure to those with colds or flu. Since 2019, we have delivered 515 NICU kits to mothers.
- **Puff Free Pregnancy.** Puff Free Pregnancy is a smoking cessation program designed for pregnant members. Magnolia implemented the program in 2016. This program employs a unique approach based on clinical guidelines published by the American Congress of Obstetricians and Gynecologists (ACOG) and U.S. Public Health Service and research of current programs and best practices.

Tobacco Cessation. Magnolia identifies and refers Members who indicate they smoke to our Smoking Cessation Program, which provides health coaching and smoking cessation support, including direct connections to resources such as the Mississippi Tobacco Quitline. Magnolia also partners with the Mississippi Tobacco Free Coalition and provides educational presentations on subjects such as tobacco cessation, the dangers of vaping and "Juuling" and associated health risks. Through a national contract with our parent company, Centene, we are also partnering with the national Truth Initiative to deploy an innovative program – This is Quitting – to address youth e-cigarette use. This is Quitting is an evidence-based vaping cessation text messaging program. Participants receive interactive daily text messages tailored to their target sign-up and/or quit date that encourages and motivates them while offering skill-building exercises, coping strategies, and information about risks and the benefits of quitting. Research indicates that about 75% of This is Quitting participants set a quit date and almost half reported reductions in vaping.

Vigilant Health. We will align with DOM in making improving health and cost outcomes related to chronic conditions a major priority for our health plan. Vigilant Health, a Mississippi company with industry leading clinical results, has a national scope and growing national recognition. We will partner with Vigilant to offer a value-based comprehensive health management program in all 82 Mississippi counties for Members with one or more of the following twelve chronic conditions:

- Diabetes
- Hypertension
- Dyslipidemia
- Mental Health
- Chronic Kidney Disease
- Stroke
- Peripheral Vascular Disease
- Ischemic Heart Disease
- Congestive Heart Failure
- Chronic Lung Disease
- Cancer
- Pregnancy

The Vigilant model is designed to integrate the highest standards of medical science, good medical practice, deep insights into human behavior, and population science into a unified whole that is simple in its application for clinicians and powerful in its results for patients and payers. The Vigilant Program will have the following components:

- Community physician participation, leadership, and collaboration
- Clinics for Members in every Mississippi county staffed with dedicated care managers and patient engagement specialists
- Intensive medical management including customized plans of care for the population as a whole and for each individual Member developed and care navigation and management guided by data analytics and the plans of care
- A technology platform built to measure clinical and economic results, drive performance improvement, guide quality management activities, and manage utilization
- Live patient encounters through remote communications media and technology, including telemedicine.
- Reduction of barriers to access through the elimination of waits for appointments

- Health education and wellness programs

Vigilant has a 22-year track record of clinical and economic results in Mississippi, including disadvantaged individuals in underserved rural and urban communities. The Vigilant program eliminates health disparities in the individuals enrolled in its programs related to socioeconomic status, education, neighborhood, and physical environment, employment, and social support. Their specialized diabetes program has demonstrated a decrease in medical paid claims of $2,742 per participant and improvements in A1c, blood pressure, and cholesterol control. Severely out of control diabetes (A1c > 9.0) decreased by 73%, hospitalization rates decreased by 50%, and ED utilization rate decreased by 23% among program uses.

Collaborative Innovation

BH on Board. We deploy cellular-enabled tablets to allow critical medical practitioners, hospitals, EDs, first responders, and schools without telehealth capabilities to reach a BH clinician immediately on-demand, delivering real-time BH crisis stabilization and therapy services. First responders will collect the name and date of birth from the person in crisis, and we will receive claims data indicating a crisis visit. Using this information, we will connect Members who used BH on Board to care management for follow-up. The BH clinician completing the crisis telehealth service will also complete an unmet social need mini-screen and make a closed-loop referral to needed community-based resources.

Community Pharmacy Enhanced Services Network (CPESN) Partnership. To complement our MTM program described above, Magnolia is partnering with the CPESN, comprised of roughly 60 independent pharmacies throughout Mississippi, to address Member-specific care gaps and adherence for chronic conditions including: diabetes adherence and gaps in care for diabetic patients that need statin therapy, asthma/COPD adherence and gaps in care for Members requiring a maintenance inhaler for better disease control; anxiety and depression adherence and education; ADHD adherence, education, and Provider follow-up visits; and statin use in patients with cardiovascular disease. We will also partner with CPESN to provide HbA1c point of care testing in CPESN-member pharmacies, which will offer Members with diabetes another convenient option to a physician visit. CPSEN will share the HbA1c testing results with the Member, the Member's PCP, and us.

Lead Poisoning Prevention and Healthy Homes. Magnolia partners with the Mississippi Department of Health to support lead poisoning prevention efforts. For example, our Community Connections team conducts home safety assessments and works directly with the state to refer Members and their families to the Health Homes Mississippi program. We also use our SDOH database to assist Members with safe living arrangements when a lead issue is identified.

Maternal Health Partnerships. Further supporting our programs are proposed partnerships to better understand and address the specific needs of Mississippi residents through collaborative innovation. We will partner with Safe Sleep Mississippi and Mississippi SIDS & Infant Safety Alliance to promote safe sleep education and resources, such as access to a Cribette, Halo Sleepsack, and Safe Sleep educational material. An affiliate Medicaid plan saw a 50.7% lower infant mortality over a two-year pilot of a similar partnership. We will partner with Converge and our Provider network to provide education and training and ensure all people can access high-quality family planning care when they need it, how they need it, and where they live.

Mississippi S.H.I.N.E. Network. The Mississippi S.H.I.N.E. Project (MS SHINE) is a community-based health networking effort that engages a wide variety of health and social service agencies to provide health outreach and services to over 30,000 individuals annually, serving the following counties: Adams, Amite, Claiborne, Copiah Covington, Franklin, Humphreys, Issaquena, Jefferson Davis, Jefferson, Lawrence, Lincoln, Marion, Pike, Sharkey, Simpson, Walthall, Warren, Wilkinson, and Yazoo. Magnolia has partnered with MS SHINE Project to provide the following at schools and communities:

- Healthy eating activities demonstrate to participants/members how to plan and prepare healthy meals provide healthy recipes/books. MS SHINE Project and Magnolia have provided healthy fruits, vegetables, and snacks.
- Facilitated physical fitness activities at housing authorities, schools and community centers, demonstrating how to plan and execute an effective exercise routine for their fitness levels, diabetes, asthma, and dental health and needs. MS SHINE provides toothbrushes, toothpaste, dental floss, and other resources and

Magnolia provides health education material addressing diabetes, asthma, and dental health. We also distribute various exercise materials for later reference.

- In our partnership, MS SHINE Project demonstrates healthcare checks such as blood pressure, blood sugar, BMI, and more to keep people aware of their options for detecting and solving health issues before they become serious. They also provide blood pressure and glucose meters to any participant who is found to be chronic and in need of medical supplies. Magnolia provides health education material on various diseases that address the health issue. We also support Members in accessing preventive follow-up care with a local Provider.

Mississippi State Department of Health – Dental Health Event. Magnolia is partnering with the Mississippi State Department of Health Regional Oral Health consultants to coordinate and co-host oral health classes and demonstration events in north Mississippi counties at schools, Boys and Girls Clubs, summer camps, health fairs, and back-to-school events.

Partnerships with Local Housing Authorities. Quarterly, Magnolia partners with local housing authorities to coordinate health fairs for the residents and after-school educational activities for children. For example, we partnered with Columbus Housing Authority in North MS to host a "Summer Camp was fun" day during one of their Summer Camp Programs. Meridian Health care's mobile clinic came and completed EPSDT screenings for 42 children and we had blown up water slides and held games and activities in collaboration with Columbus Parks and Recreation. There were 17 vendors that gave school supplies, healthy snack items, pedometers, jump ropes, and outside toys for the children to play with. A local Karate instructor came and demonstrated Karate moves and talked about the importance of respecting others and using self-control. We completed EPSDT screenings for all participants and during the screening process, we discovered one young girl that was extremely anemic and were able to connect to appropriate services. Similarly, in Central Mississippi, we partnered with Springboard to Opportunities and attended their after-school/summer and back-to-school programs to provide health education presentations to children in private low-income housing units and housing authority units. We have taken our mascot, Maggie, to do line dance classes to show kids (and adults) that exercise can be fun and leave a health education activity book along with the accompanying parent guide for their caregiver. We also regularly do classes at these same units for kids and adults on growing their own fresh vegetables in container gardens and leave behind the corresponding activity book for kids with guides for caregivers.

Improving Access

Aledade. Magnolia recognizes that access to timely, quality and equitable care is a challenge for Medicaid Members in rural communities due to health care business models that are built on unsustainable financing arrangements, clinical delivery models that are highly fragmented in-patient care, SDOH, and health disparities in Medicaid populations that disproportionately impact outcomes. To promote long term sustainable business models for independent and small PCPs and increase access to primary care and quality outcomes for Members living in rural areas, Magnolia partnered with Aledade, a national leader in convening and managing physician-led Accountable Care Organizations (ACOs), to implement a value-based purchasing (VBP) model tailored for PCPs practicing in rural Mississippi communities. This VBP model supports small, independent, rural PCPs with participating in advanced alternative payment models by aggregating small practices that often lack enough patient volumes and experience to enter responsibly into value-based arrangements. Since implementation in July 2020, 27 practices, including 17 FQHCs spanning 32 counties, eight in the Delta region. Under this model, Magnolia and Aledade seek to:

- Promote population health outcomes, including addressing SDOH barriers and ensuring quality and equable access to care
- Co-design and deploy Provider enablement solutions (e.g., e-Consults, patient outreach, SDOH supports, etc.) that create sustainable economic value for practices and the communities they serve
- Design and invest in sustainable business models for rural practices and PCPs that help mitigate funding volatility, promote revenue and savings opportunities, and contain the cost of health care

Through this partnership, we support Providers with Provider enablements that are tailored to meet the needs of

rural practices and the Medicaid population. Under this arrangement, we are piloting RubiconMD, an eConsults platform that meets members' needs beyond primary care and enables asynchronous, store-and-forward consults between PCPs and specialists.

Babylon Health. We will offer Members access to Babylon Health's virtual care platform. Babylon's platform utilizes leading-edge digital technology and artificial intelligence symptom checking tools to first triage Members and determine the correct point of care. Through Babylon, Members can initiate two-way video and/or audio consultation for pediatric and adult urgent care needs as well as behavioral health services, including talk therapy, psychiatric care, prescription management, and preventative care, while maintaining accessibility for Members with disabilities or limited English proficiency. Babylon assists Members in finding and scheduling an appointment with Magnolia network Providers and refers the Member to the appropriate next point of care where appropriate (e.g., in-person PCP or specialist). For coordination of care, virtual visit and follow-up care information is shared with the member's PCP. Supporting Member self-management and health education, Members can utilize self-guided risk assessment and health management tools. For example, Members can input their health data to better understand possible long-term risks and preventative measures to reduce risks. Based on their symptoms and concerns, Members are connected with a Provider for a telehealth virtual visit, from which they may be given a diagnosis and treatment plan, as well as medications as necessary. Further, Members can also utilize the Babylon mobile app to set medication and symptom tracking reminders, helping them be active in their health.

Babylon 360 Virtual PCP Program. To reduce SDOH barriers and increase Member engagement and access to primary care for Members living in 15 counties in northwestern MS, Magnolia is piloting Babylon 360, an innovative virtual value-based program designed to increase access, improve quality, decrease costs, and advance health equity. Through this value-based model of care, Members can choose to be reassigned to a Babylon virtual PCP or continue to receive care from their local PCP. Magnolia's care management team and Babylon's boots-on-ground Care Advisors will co-manage the member's care by providing care coordination, Member education on available Magnolia benefits, community resources, and care management programs. Babylon's Care Advisors engage Members where they are and will go door to door to support the members. Babylon will also offer members' primary care access in their homes through their virtual care platform, thus eliminating transportation barriers, reducing wait times for care, and potentially enhancing Member and Provider engagement. Magnolia, in partnership with Babylon, will evaluate PCP engagement and metrics including Member satisfaction, medication adherence, screenings, select HEDIS measures, ED utilization, and Provider success in engaging Members to ensure successful outcomes. We will provide the technology necessary (e.g., provide SafeLink and Connections Plus phone services) for the Member to engage with their virtual PCP.

Community Resource Support Database. Magnolia believes that meeting the social and basic needs of our Members removes underlying barriers to health and care needs. To help assist our integrated care teams quickly identify, refer, and follow-up with Members in need of community, social services, and government benefits matching their needs, Magnolia created a comprehensive Community Resource Support Database. Created for Mississippians by Mississippians, our statewide manual is a searchable online database of vetted and current health and wellness resources that will be accessible by our CM staff, Members, caregivers, and Providers. The database will be available in numerous languages to connect Members to local programs and resources that best fit their needs, including housing and transportation. We provide closed-loop referral tracking and coordination using validated data to ensure quality and users reliability. Additionally, staff have access to easy-to-read and easy-to-understand reporting, enabling us to track, trend, and report on Member needs and utilization. Care Managers can also use these features to gain a deeper understanding of population and individual Member needs.

ConnectionsPlus Phone Program. Our ConnectionsPlus® Program provides pre-programmed cell phones to certain high-risk Members, or their parents/guardians enrolled in care management who are not eligible to receive a SafeLink phone. This provides 24-hour access for our members, allowing them to connect with their Providers, Care Management staff, nurse advice line, and 911. This also helps reduce inappropriate emergency department visits and hospital admissions through improved access to health care information and treating Providers.

Get Well Network. Get Well Network is a global digital health company that focuses on patient engagement and uses digital technology to improve the healthcare experience for patients, their families, and clinicians. Through a partnership, we will pilot SDOH screening and resource coordination as part of the maternity Member engagement strategy for pregnant mothers. Community-based virtual navigators to engage maternity Members and address infant mortality and adverse maternal outcomes through care coordination, transportation for medical visits, and other social services.

Magnolia Works. Magnolia Works is our workforce development and employment support program developed to address employment barriers in our population. As part of this program, Magnolia will be a referral source in identifying individuals who meet the qualifications of the SNAP Education & Training program and will help them complete the registration. Through Magnolia Works, we will partner with community colleges and local organizations on workforce and job readiness opportunities for our members. Potential partnerships may include:

- Jackson College partnership (partnering to increase participation in certificate programs)
- Partnerships with community colleges
- Partnerships with HBCUs
- GED vouchers as a value-added benefit for members

Mississippi Programs of HOPE. These programs represent housing and transportation, opportunities for treatment, family support, and economic security. They address SDOH risk factors such as caretaker support and inadequate housing. Our proposed partnership would support housing vouchers for youth aging out of foster care and life skills training and case management. We would develop handbooks for juvenile justice- and youth court-involved parents and guardians, as well as juvenile court judges and officials. We would also provide financial support for Camp Hope, a new program for children in Mississippi who experienced domestic violence or neglect.

Partnerships to Address Food Insecurity. Through the Mississippi Farm to School Network, Magnolia p rovides sponsorship and educational activities for children and youth. We also partner with the United States Department of Agriculture, Mississippi Department of Education, and the Department of Housing and Urban Development to provide educational materials and support with exercise and physical activity at feeding sites. We propose establishing a partnership with Extra Table Feeds, a CBO that uses 100% of its fundraising for food procurement and distribution efficiently and effectively, ensuring a constant source of healthy food from great veggies to canned food and lean proteins like tuna and peanut butter to Members in “hot zones.” To date, Extra Table has provided about 1 million meals and distributed about 6 million pounds of healthy food in 2020 across 49 Mississippi counties, including about 19,000 nutritional snack packs for kids. Our partnership will strengthen and expand Extra Table’s current offerings by supporting food pantries and increasing their volume and capacity. Our plan would use our data to identify areas of need to help Extra Table target the appropriate areas to add new food pantries and maximize its resources to serve its client’s needs. We will also support the distribution of food via “Kroger Sacks” (cardboard boxes that contain the donations); providing the boxes could save food pantry resources to increase the percentage of funds going to the food rather than to packaging. We will also collaborate with Extra Table to research providing and quickly distributing healthy meals in areas suffering environmental disasters such as flooding or tornados. Extra Table has experience providing a one-pot cooking solution and a hot meal for single mothers and their families. Ever Reaching Community Outreach

(ERCO) is a grassroots movement that operates a food pantry and donation center to help feed and clothe and provide furniture and housewares and other assistance to over 2,000 families each year across 15 counties in Mississippi. This partnership would help ERCO expand into two additional counties with facilities for intake, navigator meeting rooms, and clothing and food storage. Our plan would also pay for food boxes and a van to deliver diapers, formula, and fresh produce in these counties.

Program Believe. Program Believe assists the most under-served, vulnerable, and low-income communities along the Mississippi Gulf Coast with educational resources and immigration legal services that are affordable and impactful. Our partnership would provide financial support for after-school support and summer enrichment, classes such as citizenship and basic computer skills, and educational programs to learn English or attain a GED to disenfranchised individuals experiencing health disparities. Other critical services include application support for DACA, naturalization, and American Citizenship Certificates, immigration petitions for relatives, and adjustment of Green Card status or replacement.

SafeLink Phone Program. Each month, Members with SafeLink phones receive 3 GB of data, unlimited text messages, and unlimited calls to connect with CM staff, our 24/7 nurse advice line, and the member's primary care Provider. Members also receive texts and personalized wellness goals. As of March 2021, 3,663 Magnolia Members were active subscribers to SafeLink. For those who qualify, Magnolia will offer Members expanded benefits of up to 1GB per month beyond their SafeLink allowance.

SchoolCare. Supporting bi-directional communication and coordination with our schools, Magnolia will partner with an innovative school-based EHR solution, SchoolCare, which enables school nurses to document visits and report on care delivered in schools. The platform provides Magnolia with actionable insights on our pediatric Members through near real-time monitoring of medical, behavioral, and social needs. For example, SchoolCare will provide Magnolia a report flagging at-risk Members with either three or more school nurse visits in the week prior. Our Care Management team will then triage Members identified to be high-risk for ED visits for outreach and engagement to prevent ED visits and promote appropriate management of clinical needs. SchoolCare also has the potential to allow Magnolia to incorporate an additional layer of outreach to our current outreach efforts by encouraging parents/guardians of Members to complete visits through SchoolCare, including a child and adolescent well-care visits and immunizations. Parents/guardians of Members can receive communication directly from the platform to encourage them to complete a visit, which Magnolia can support scheduling. The SchoolCare partnership is an opportunity to promote the expansion of care coordination among pediatric members, leverage an additional data source, and identify clinical and non-clinical needs to drive the development of local district-wide wellness programs and other public health initiatives to address social determinants of health.

SDOH Mini Screen. The SDOH Mini Screen consists of six questions designed to identify needs related to food, housing, utilities, transportation, safety, employment, and social support. A Member may complete the Mini Screen through the mobile-enabled Member Portal. Members also have the option to take the SDOH Mini Screen by being warm transferred to our Care Management team, who will capture and address any immediate needs using our community resource tool. The team will document any identified social needs in the customer relations management system and save the member's Mini Screen into TruCare Cloud. The team can address the member's social needs through multiple interventions, including deploying a MemberConnections Community Health Worker to assist the Member or alerting the member's Care Manager.

Shower Power. Shower Power delivers mobile hygiene services to people experiencing homelessness, demonstrating caring and restoring dignity by providing resources needed for self-care. Our partnership includes working collaboratively to identify Members who would benefit from weekly interventions provided by Shower Power to conduct screening, determine the person's SDOH needs, and help connect them to needed resources.

Value Based Payment (VBP) Programs. Through our VBP programs, Magnolia builds collaborative relationships with our Providers and work together towards a shared goal of improving quality of care. Providers that participate in VBP are rewarded for performance against HEDIS quality measures that are focused on prevention, access to care, and appropriate treatment. To help drive system wide improvement and reduce Provider administrative burdens, our VBP measures are aligned with State priority areas, goals, and

quality strategy. [redacted]

Magnolia's Behavioral Health VBP Program will encourage behavioral health Provider engagement of moderate to high-risk Members in appropriate care settings. Working in collaboration with Community Mental Health Centers (CMHCs), we will financially incent participating behavioral health Providers to engage members, administer baseline and follow-up assessments, initiate treatment, and deliver timely follow-up care that results in demonstrated improvements in select behavioral health HEDIS measures and Member outcomes. Magnolia will provide participating CMHCs with enhanced utilization and performance reports that allow them to track their success and address improvement opportunities. Members will receive behavioral health and substance use disorder (SUD) screening, along with increased engagement focused on initiation of treatment and medication adherence. The program is backed by Quartet Health, our analytics partner, which aggregates heath and assessment data from multiple sources to support program reporting and reduce Provider administrative burden.

Z Code Utilization Dashboard. The Z Code Utilization Dashboard provides a view of national trends, helps us drill down to the community level and SDOH category, and analyzes trends by Providers and members. The Dashboard will be available to Providers via our secure Provider Portal to support data transparency and increase closed-loop referrals. We will continue to capture and monitor all Z codes and work towards the compliance requirements to reimburse all Z codes as defined by the State.

Demonstrating our Commitment to Improving the Lives of Mississippians

Boys and Girls Club. Magnolia has a longstanding partnership with the Boys and Girls Clubs in Mississippi for after-school programs, summer programs, parent night meetings, EPSDT screenings, and health fairs. At the after-school and summer programs, Magnolia provides children's books to help educate Members and the community on eating healthy, exercise, bullying, and chronic conditions such as asthma and diabetes. During the summer programs, Magnolia will conduct healthy eating recipe demonstrations and MaggieCIZE exercise session. Working with Choices for Children Mobile Unit, Magnolia coordinates EPSDT screenings at Boys and Girls Clubs. Additionally, Magnolia presents information during parents' night meetings, including information about Magnolia's benefits/services, EPSDT, chronic conditions, transportation, and how to access appropriate services.

Community-led Transportation Pilot Program. Magnolia is supporting a community-led transportation program in Holmes County. The Holmes County Community-Led Transportation Program is a community enterprise that was designed and is led by community stakeholders to identify and address gaps in transportation services for county residents, which was started with seed funding from our parent company. In addition to public transit, the program uses a similar volunteer driver model to provide transportation services that complement NET services by addressing SDOH, such as trips to the grocery store, pharmacy, or employment. Whenever possible, we will credential volunteer drivers for the Holmes County program, ensuring that the driver requirements and vehicle standards in Mississippi Administrative Code, Title 23, Part 201 are met, so that they can also provide volunteer NET services to our Members.

COVID-19 Community Supports. In response to the COVID-19 pandemic, Magnolia partnered with Community Based Organizations (CBOs) across Mississippi to provide relief to individuals and families impacted by SDOH such as food insecurity and housing instability. Donations include:

- 750 Walmart Gift Cards were donated to various CBOs and Providers
- 200 Amazon Gift Cards donated to various CBOs
- $46,000 donated to local food banks and the Centene corporate charitable foundation made a large donation to MS food network
- Donated 500 masks to Child Protective Services Case Workers
- Donated 20,000 masks to the MS Dental Association to be distributed to their affiliated dental practices
- Provided 200 Samsung cell phones to Providers for their patients who did not have a reliable phone for telehealth services

- Hand Sanitizer Donations at various community events throughout 2020 and 2021
- Magnolia also donated PPE to Providers and other front-line workers that enabled critical services to safely continue

Magnolia provided assistance to network Providers in Mississippi who were seeking relief amid the COVID-19 pandemic through the Small Business Administration (SBA) and the CARES Act. Magnolia promoted and shared access to a dedicated online portal of Provider Financial Support & Resources, where network Providers can research benefits they may be eligible for and work directly with experts to apply for them. The program helped Providers apply for various benefits, including small business loans, a paycheck protection plan, and various grants they may be eligible for. This includes Federally Qualified Health Centers (FQHCs), behavioral health Providers and community-based behavioral health organizations, Centers for Independent Living (CILs), and long-term service and supports organizations operating on the front lines. This resource also helped Providers explore additional funds through state offered loans and grants by working with nationally recognized healthcare consultants, organizations, state government agencies, and former SBA executives. In addition to the online portal, Provider partners will have access to webinars and one-on-one consulting with key experts.

Diaper Bank of the Delta. Magnolia has partnered with the Diaper Bank of the Delta to sponsor numerous community events. We organized two "Shoes from the Heart" events and fit approximately 260 children with new shoes and socks to start the school year. We have been key sponsors of the "Big Latch" fun run and picnic to bring awareness to breastfeeding. Magnolia has hosted healthy lifestyle classes with the Parent Academy, another outreach of the Diaper Bank. We have partnered to host three diaper give-a-ways and have another scheduled for November 15. We also partner to host Period Poverty awareness events and are working to establish personal hygiene closets in local schools. The Diaper Bank of the Delta offers several programs to support parents including:

- Baby University – a nine-week parenting program for new mothers
- Crossroads Baby Café – a once-a-week drop in for breastfeeding mothers
- A depot for mothers to donate breast milk

Maggie's Kids Club. Maggie's Kids Club, formed in 2016, currently has over 425 children enrolled. Children receive a welcome letter, a Kids Club ID card, and a Kids' Club Activity Book. In addition, we mail a book to the children quarterly on topics such as asthma, diabetes, bullying, eating healthy and exercising, etc. and a birthday card on their birthday. Parents also receive information on EPSDT services, Well-Baby and Well-Child services, immunizations, nutrition, physical activity, asthma, diabetes, bullying, and lead screenings. Through our Kids Club we also host birthday parties, Christmas parties, and Family Fun Days with fun activities for children, along with educational information for parents/guardians around well-baby and well-child services, immunizations, nutrition, physical activity, asthma, diabetes, bullying, lead screening and other seasonal topics. Our Kid's Club mascot, Maggie the Magnolia attends events and conducts line dances (MaggieCIZE). Our Kids Club is open to any child in the state, not only Magnolia members.

School-Based Partnerships. Magnolia has strong partnerships with school districts and schools across Mississippi. Below are several examples of activities and school-based engagements:

- Fairview Elementary School – Partnered with Tobacco Coalition to host a vaping presentation (2021)

- No One Eats Alone - Franklin Academy (2020); Kreole Primary Elementary School and Escatawpa Upper Elementary School
- Oxford Elementary – Supplied 500 books for school counselors to use in their back-to-school registration packets (2020)
- Corinth Elementary – Supplied 300 books for the reading program in the library and 150 books for Excel by 5's new student backpack program
- (2020) Tupelo Middle School – Supplied 300 Fresh View on Diabetes books to the school nurse for diabetic students
- Magnolia is working with a mobile unit (Choices for Children) to conduct EPSDT screenings in school-based sessions
- Magnolia is supporting Coastal Family Health with back to school immunizations for school-aged children
- Magnolia partners with school nurses or school administrators to conduct health eating classes, exercise events with our mascot, Maggie the Magnolia, school assembly programs, and more.
  - 28th Street Elementary School (Family Fun Night, healthy eating classes)
  - N.R. Burger Middle School (Provided health eating collateral during Back to School Immunizations)
  - Petal School Clinic (Provided healthy eating collateral during Back to School Immunizations)
  - Hattiesburg High School Campus Clinic (healthy eating material distributed during Well-Screenings)
  - Lopez Elementary School (provided healthy eating collateral during immunization screenings)

SDOH Help Line. Mississippians have access to our toll-free SDOH helpline Monday through Friday from 9:00 a.m. to 6:00 p.m. to anyone needing assistance with non-medical risk factors (i.e., housing, utilities, childcare, and food). A national team of diverse Peer Coaches identifies the caller's needs, conducts the SDOH mini screen, assists with goal setting, and connects Members to local resources. We close the loop on all referrals through personal contact and evaluate the quality of referral services. All calls will be documented in our Community Resource Support Database. The helpline staff follow-up with every caller to ensure they received the needed assistance to close the loop. For Members in CM, the assigned Care Manager is alerted and will provide appropriate follow-up incorporating all needs and services in the Member's care plan.

Shoes from the Heart Ministry. Magnolia partners with Shoes from the Heart to conduct a shoe give-a-way to middle-school aged children and distribute health education resources. For the 2021 school year, Magnolia is partnering with Shoes from the Heart Ministry and a local Desoto County church to host a back-to-school shoe give-a-way.

• Describe additional resources of the Offeror

Throughout this section and the entirety of this RFQ response, Magnolia has described many of our innovative programs, services, and resources. These resources have enabled and will continue to enable Magnolia to provide best-in-class care and services to our MSCAN and CHIP Members. In addition to the many innovative programs and resources listed above, Magnolia leverages the expertise of our parent company, Centene, to bring national best practices to Mississippi. Centene offers several Centers of Excellence (COEs), including but not limited to:

COE	Description
Coordination of Benefits (COB) Center of Excellence	Magnolia leadership will collaborate with Centene's COB Center of Excellence to develop and implement innovative TPL approaches that help contain health care costs and reduce Provider administrative burden. The COB Center of Excellence focuses on receiving and validating other insurance, updating COB business rules, process optimizations, COB analytics, and post-pay recovery. This team of experts is comprised of Medicaid cost avoidance and payment integrity specialists from across our affiliated health plans. These subject matter experts identify and implement procedural and systemic enhancements for our TPL and cost avoidance processes that each health plan will customize in their state in collaboration with Providers and regulators. In addition, as part of our philosophy of continuous improvement, they develop innovative solutions to proactively identify TPL and increase cost avoidance results. The investments made by the COB Center of Excellence in TPL innovation and continuous improvement have yielded millions of dollars in efficiencies and savings that have helped each of our affiliate health plans operate effective TPL programs.
Foster Care Centers of Excellence	The Foster Care Centers of Excellence (FCCOEs) is accountable for service delivery and motivated to improve the efficiency and quality of care for children entering into foster care and those receiving ongoing care. Providers that understand the needs of foster children from the start will be beneficial for physical and

	behavioral health outcomes, leading to healthier lives. Partnering with MDCPS, we will identify Providers that are skilled and willing to serve the foster and adoption population. Understanding that dedicated Providers, when available, have a better understanding of the needs of foster youth and their enhanced skill set benefits the youth in care. We will use performance data and a package of financial and non-financial incentives to motivate identified Providers, including direct sharing of savings resulting from improved efficiencies and quality of care. We will fund a gain-sharing pool for each FCCOE based on its cost-effectiveness goals. FCCOEs will have the potential to share gains for hospital services and/or physician services based on the two components of the incentive program: quality outcomes and cost-effectiveness. Those with the best total performance outcomes will receive preferential PCP Member assignment through our default assignment process. The Plan may assist the FCCOE to facilitate information flow and facilitate face-to-face coordination with Members, Medical Consenters, care coordinators, and physical and behavioral health Providers. We will also offer dedicated Provider Service and Utilization Management staff support; specialized education/training programs; free and complete EDI Trading Partner support for all HIPAA EDI transactions (e.g., claims, authorizations, remittance advice) via clearinghouse or direct submission to us via our Provider Portal, patient roster and disease registry support, and Provider performance data; and support for standard Electronic Medical Record Continuity of Care Document data interfaces.
Neonate Center of Excellence	The Neonate COE was created in order to support the best possible services for neonates, their families and caregivers, and their providers, thereby improving clinical care and outcomes. The goals of the Neonate COE are to optimize NICU utilization, reduce NICU cost of care, increase neonate engagement in care management, improve quality of life for NICU graduates, and reduce service utilization of NICU graduates up to 60 days post-discharge. The COE provides a team of clinical experts specializing in newborn care who provide clinical guidance and support to Magnolia and affiliate plans. Through utilization management decision-making support, analytics and benchmarking, sharing of best practices, and specialized training, the COE will support Magnolia in delivering high-quality, intensive neonatal services.

[END OF RESPONSE]

4.3.1.2 CORPORATE EXPERIENCE

The Corporate Experience Section must present the details of the Offeror's experience with the type of service to be provided by this RFQ and Medicaid experience. Using the provided form in Appendix F, provide information about states the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.
If the information requested above is not available, the Offeror must provide a narrative explanation, not to exceed three (3) pages. Acceptance of the explanation provided is at the discretion of the Division.

Please see **Attachment 4.3.1.2 Appendix F** for our response to this section.

4.3.1.2: Corporate Experience

Use the following form to provide information for any states that the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.

If the Offeror has no current or recent clients, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support information provided. Acceptance of the explanation provided is at the discretion of the Division.

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Corporate Experience: Current and/or Recent Client				
Client's Name: State of Mississippi - Division of Medicaid				
Client Location				
Address Line 1: 550 High Street				
Address Line 2: Suite 100				
City: Jackson	**State:** MS	**Zip Code:** 39201		**County:** Hinds County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Sharon Jones				
Title: Director of Managed Care Operations				
Phone Number: 601-359-3789		**Email Address:** Sharon.jones@medicaid.ms.gov		
Work Details				
Number of covered lives: As of January 2022, Magnolia Health Plan, Inc. covers 166,273 Mississippians for MississippiCAN.				
Time period of contract: Originated January 2011 through January 2014. In December 2012, pregnant women were added to the contract. An option for renewal was selected by the State of Mississippi Division of Medicaid through June 2014. In July 2014 through June 2017. In December 2015, inpatient hospitals were added to the contract. An option was elected by DOM for renewal through June 2018. The current contract period began July 2017 with a termination date of June 2020. An option was elected by DOM for renewal through June 30, 2021, followed by an additional election by DOM for another extension to June 30, 2022.				
Total number of staff hours expended during time period of contract: From 2011 to 2013 Magnolia staff expended 923,520 hours during the time period of the contract. From 2016 Magnolia staff expended 2589600 hours during the time period of the contract. From 2017 to 2022 staff expended 3,546,400 hours during the time period of the contract. In total, from 2011 to 2022, Magnolia Health Plan staff have gained 7,059,520 hours of experience through interacting with MississippiCAN.				
Personnel requirements: In addition to support from Centene Corporation, we have 341 current employees. Key positions include: Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Medical Director, Chief Information Officer, Compliance Officer, Project Manager, Provider Services Manager, Member Services Manager, Quality Management				

Director, Utilization Management Coordinator, Complaint/Grievance Coordinator, Claims Administrator, and other key personnel approved through the Division of Medicaid.
Geographic and population coverage requirements: Our statewide experience in Mississippi has grown from 2011, where Magnolia served approximately 33,000 Members, to 2022, where we serve a MississippiCAN membership of 172,917 through our current contracts and other government-funded programs. Our experience includes the following: SSI, DHS, Breast/Cervical Cancer, Disabled Child L[redacted]ing at Home, Working Disabled, TANF Adults, Pregnant Women, Infants ages 0-1, Behavioral Health, Quasi-CHIP, TANF Kids, Inpatient Hospital, Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Provided medical (including inpatient hospital), behavioral health (BH), pharmacy, vision, and dental services as well as: SSI, DHS, Breast/Cervical Cancer, Disabled Child Living at Home, Working Disabled, TANF Adults, Pregnant Women, Infants ages 0-1, Behavioral Health, Quasi-CHIP, TANF Kids, Inpatient Hospital.

Corporate Experience: Current and/or Recent Client				
Client's Name: Arizona Health Care Cost Containment System				
Client Location				
Address Line 1: 801 E. Jefferson Street				
Address Line 2: N/A				
City: Phoenix	**State:** AZ	**Zip Code:** 85034		**County:** Maricopa County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Meggan LaPorte				
Title: Chief Procurement Manager				
Phone Number: 602-417-4538		**Email Address:** procurement@azahcccs.gov		
Work Details				
Number of covered lives: **<u>Arizona Complete Health</u>** **Q4 2021 AHCCCS Complete Care (ACC) Contract:** 377,416 **Q4 2021 Regional Behavioral Health Authority:** 19,548 **<u>Care1st Health</u>** Q4 2021 AHCCCS Complete Care (ACC) Contract: 81,803				

Time period of contract:
Arizona Complete Health
AHCCCS Complete Care (ACC) Contract: Originated 2005; current term: 10/2021-9/2027
Regional Behavioral Health Authority: Originated 2015; current term 10/2015-9/2022

Care1st Health
AHCCCS Complete Care (ACC) Contract: Originated 2003; current term 10/2021-9/2027

Total number of staff hours expended during time period of contract:
834 employees. Average 1,734,720 health plan staff hours per year.
Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.

Personnel requirements:
State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including:
• Total membership, including the population type.
• Member health conditions and demographics.
• The number of contracted Providers and infrastructure of Provider community
• State-specific program features

Geographic and population coverage requirements:
Arizona Complete Health
AHCCCS Complete Care (ACC) Contract: Central and South geographic service areas. Member populations include TANF, Expansion, SSI Dual, SSI Non-Dual.
Regional Behavioral Health Authority: South geographic service area. Member populations include SPMI/SED, Non-SPMI/SED.

Care1st Health
AHCCCS Complete Care (ACC) Contract: North and Central geographic service areas. Member populations include SSI Non-Dual, Expansion, and TANF.

Publicly funded contract cost:
[redacted]

Description of work performed under this contract

Through the AHCCCS Complete Care (ACC) contract, Arizona Complete Health provides physical health, pharmacy, dental, and vision services, as well as behavioral health services for dual members. *Individuals with SPMI/SED receive full Medicaid benefits under the Regional Behavioral Health Authority contract.

Through the Regional Behavioral Health Authority contract, Arizona Complete Health provides physical health, pharmacy, dental, and vision services, as well as behavioral health services for members with SPMI/SED.

Through the AHCCCS Complete Care (ACC) contract, Care1st Health provides acute care services including physical health, pharmacy, dental, and vision services as well as general mental health/substance use disorder services.

Corporate Experience: Current and/or Recent Client				
Client's Name: Arkansas Department of Human Services				
Client Location				
Address Line 1: 70 Main Street				
Address Line 2: Director's Office				
City: Little Rock	**State:** AR	**Zip Code:** 72201	**County:** Pulaski	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Cindy Gillespie				
Title: Secretary, Department of Human Services				
Phone Number: 501-682-86418		**Email Address:** cindy.gillespie@dhs.arkansas.gov		
Work Details				
Number of covered lives: Q4 2021: 15,004				
Time period of contract: Originated 2018; current term 1/2021-9/2022				
Total number of staff hours expended during time period of contract: 605 employees. Average 1,258,400 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features				
Geographic and population coverage requirements: Statewide. Member populations include IDD/BH.				
Publicly funded contract cost:				

[redacted]
Description of work performed under this contract
Through the Provider-Led Arkansas Shared Savings Entity (PASSE) contract, Arkansas Total Care provides acute care services, including physical health, pharmacy, dental, and vision services as well as general mental health/substance use disorder services.

Corporate Experience: Current and/or Recent Client				
Client's Name: California Department of Health Care Services				
Client Location				
Address Line 1: 1501 Capitol Ave				
Address Line 2: N/A				
City: Sacramento	**State:** CA	**Zip Code:** 95814	**County:** Sacramento County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Michelle Retke				
Title: Chief, Managed Care Operations				
Phone Number: 916-449-5083	**Email Address:** Michelle.retke@dhcs.ca.gov			
Work Details				
Number of covered lives: **<u>California Health & Wellness</u>** Q4 2021 Medi-Cal Managed Care Contract (Imperial): 69,379 Q4 2021 Medi-Cal Managed Care Contract (Northern Counties): 155,233 **<u>Health Net Community Solutions, Inc.</u>** Q4 2021 Medi-Cal Medicaid Managed Care Contract (Los Angeles): 1,019,017 Q4 2021 Medi-Cal Medicaid Managed Care Contract (Kern, Stanislaus, San Joaquin, and Tulare Counties): 289,408 Q4 2021 Medi-Cal Medicaid Managed Care Contract (Sacramento): 124,723 Q4 2021 Medi-Cal Medicaid Managed Care Contract (San Diego): 83,434 Q4 2021 Cal MediConnect MMP (Los Angeles and San Diego Counties): 7,567				
Time period of contract: **<u>California Health & Wellness</u>** **Medi-Cal Managed Care Contract (Imperial):** Originated 2013; current term 11/2013-12/2022 **Medi-Cal Managed Care Contract (Northern Counties):** Originated 2013; current term 11/2013-12/2022				

Health Net Community Solutions, Inc.
Medi-Cal Medicaid Managed Care Contract (Los Angeles): Originated 1996; current term 12/2003-12/2022
Medi-Cal Medicaid Managed Care Contract (Kern, Stanislaus, San Joaquin, and Tulare Counties): Originated 1996; current term 11/2013-12/2022
Medi-Cal Medicaid Managed Care Contract (Sacramento): Originated 1996; current term 4/2008-12/2022
Medi-Cal Medicaid Managed Care Contract (San Diego): Originated 1998; current term 7/2010-12/2022
Cal MediConnect MMP (Los Angeles and San Diego Counties): Originated 2014; current term 1/2020-12/2022

Total number of staff hours expended during time period of contract:
2,536 employees. Average 5,274,880 health plan staff hours per year.
Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.

Personnel requirements:
State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including:
• Total membership, including the population type.
• Member health conditions and demographics.
• The number of contracted Providers and infrastructure of Provider community
• State-specific program features

Geographic and population coverage requirements:
California Health & Wellness
Medi-Cal Managed Care Contract (Imperial) covers Imperial County, CA. Member populations include TANF, SSI Non-Dual, SSI Dual, Expansion.
Medi-Cal Managed Care Contract (North) covers the Northern counties in CA. Member populations include TANF, SSI Non-Dual, SSI Dual, Expansion.

Health Net Community Solutions, Inc.
Medi-Cal Medicaid Managed Care Contract (Los Angeles) covers Los Angeles County, CA. Member populations include TANF, Expansion, SSI Non-Dual, SSI Dual, LTC Non-Dual, LTC Dual.
Medi-Cal Medicaid Managed Care Contract (Kern, Stanislaus, San Joaquin, and Tulare Counties) covers Kern, Stanislaus, San Joaquin and Tulare counties in CA. Member populations include TANF, Expansion, SSI Non-Dual, SSI Dual.
Medi-Cal Medicaid Managed Care Contract (Sacramento) covers Sacramento County, CA. Member populations CA. Member populations include TANF, Expansion, SSI Non-Dual, SSI Dual.
Medi-Cal Medicaid Managed Care Contract (San Diego) covers San Diego County, CA. Member populations include TANF, Expansion, SSI Non-Dual, SSI Dual, LTC Non-Dual, LTC Dual.
Cal MediConnect MMP (Los Angeles and San Diego Counties) covers Los Angeles and San Diego counties. Member populations include dual-eligible Medicare-Medicaid members.

Publicly funded contract cost:
[redacted]

[redacted]

Description of work performed under this contract

Through their Medi-Cal Medicaid Managed Care Contracts, California Health & Wellness and Health Net Community Solutions, Inc. provide managed care services including physical health, behavioral health, and LTSS services (Los Angeles and San Diego only) as well as dental, vision, and pharmacy.

Through the Cal MediConnect MMP Three-Way Contract with State Medicaid and CMS, Health Net Community Solutions, Inc. provides Medicare and Medi-Cal benefits including medical, vision, behavioral health, MLTSS, pharmacy, medical equipment and supplies and substance abuse programs.

Corporate Experience: Current and/or Recent Client				
Client's Name: Florida Agency for Health Care Administration				
Client Location				
Address Line 1: 2727 Mahan Drive				
Address Line 2: MS #50				
City: Tallahassee	**State:** FL	**Zip Code:** 32308	**County:** Leon County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Jessica Lane				
Title: Medical Healthcare Program Analyst, Plan Management Operations				
Phone Number: 850-412-4051	**Email Address:** Jessica.lane@ahca.myflorida.com			
Work Details				
Number of covered lives: **<u>Sunshine State Health Plan</u>** **Q4 2021 Statewide Medicaid Managed Care FP060:** 1,581,621 **<u>Staywell (WellCare of Florida)</u>** **Q4 2021 Statewide Medicaid Managed Care FP061:** 179,481. *Effective 10/2021, this contract is integrated into affiliate Sunshine State Health Plan.*				
Time period of contract: **<u>Sunshine State Health Plan</u>**				

Statewide Medicaid Managed Care FP060: Originated: 2009; current term: 10/2018-9/2023

Staywell (WellCare of Florida)
Statewide Medicaid Managed Care FP061: Originated: 1994; current term: 10/2018-9/2023.
Effective 10/2021, this contract is integrated into affiliate Sunshine State Health Plan.

Total number of staff hours expended during time period of contract:
3,241 employees. Average 6,741,280 health plan staff hours per year.
Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.

Personnel requirements:
State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including:
• Total membership, including the population type.
• Member health conditions and demographics.
• The number of contracted Providers and infrastructure of Provider community
• State-specific program features

Geographic and population coverage requirements:
Sunshine State Health Plan
Statewide Medicaid Managed Care FP060: Statewide. Member populations include TANF, LTC, Foster Care, SSI.

Staywell (WellCare of Florida)
Statewide Medicaid Managed Care FP061: 10 of 11 regions throughout Florida. Member populations included TANF/SSI Non-Dual, Behavioral Health, LTC. *Effective 10/2021, integrated into affiliate Sunshine State Health Plan.*

Publicly funded contract cost:
[redacted]

Description of work performed under this contract

Through the Florida Statewide Medicaid Managed Care program, Sunshine State Health Plan (and legacy Staywell) provides Medicaid managed care services including, but not limited to, medical, dental, behavioral health, pharmacy, vision, and non-emergency transportation. Provide LTC services to both dual and non-dual eligible ABD/SSI members 18 years and over who meet nursing facility level of care, including those who are 1) age 18-64 and eligible for Medicaid due to a disability; 2) age 65 and over. Services include, but are not limited to: HCBS including a participant directed option, assisted living facility services and nursing facility care; assistive care; attendant care; intermittent and skilled nursing; hospice; physical, occupational, respiratory and speech therapy. Acute care covered to the extent not covered under Medicare or other insurance.

Corporate Experience: Current and/or Recent Client				
Client's Name: Florida Agency for Health Care Administration				
Client Location				
Address Line 1: 2727 Mahan Drive				
Address Line 2: MS #50				
City: Tallahassee	**State:** FL	**Zip Code:** 32308	**County:** Leon County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Katie Wetherington				
Title: Government Operations Consultant III				
Phone Number: 850-412-4066	**Email Address:** Katie.wetherington@ahca.myflorida.com			
Work Details				
Number of covered lives: Q4 2021 (SSHP DSNP FP093): 1,244 Q4 2021 (WellCare DSNP FP095): 38,410 Q4 2021 (WellCare AZ DSNP FP108): N/A. Contract effective 1/2022.				
Time period of contract: **<u>Sunshine State Health Plan</u>** **DSNP FP093 (Medicaid Only):** Originated: 2013; current term: 1/2021-12/2025 **DSNP FP095 (Medicaid Only) – formerly under WellCare of Florida:** Originated: 2006; current term: 1/2021-12/2025 **DSNP FP108 (Medicaid Only)** – **WellCare of Arizona**: Originated: 2022; current term: 1/2022-12/2025				
Total number of staff hours expended during time period of contract: 3,241 employees. Average 6,741,280 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community				

• State-specific program features
Geographic and population coverage requirements: **<u>Sunshine State Health Plan</u>** **DSNP FP093 (Medicaid Only):** Statewide. Member populations include DSNP (Medicaid Only) **DSNP FP095 (Medicaid Only) – formerly under WellCare of Florida:** Miami-Dade County, Florida. Member populations include SSI Dual.
Publicly funded contract cost: [redacted].
Description of work performed under this contract
Through the Medicaid portion of its D-SNP contract, Sunshine State Health Plan provides services to dual-eligible members, including, but not limited to, Medicare Part A, Part B, and Part D (hospital, medical, and prescription), behavioral health, dental, hearing, vision services, non-emergency transportation, and 24/7 nurse advice line.

Corporate Experience: Current and/or Recent Client				
Client's Name: Office of Children's Medical Services				
Client Location				
Address Line 1: 4052 Bald Cypress Way				
Address Line 2: N/A				
City: Tallahassee	**State:** FL	**Zip Code:** 32399		**County:** Leon County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Andrea Gary				
Title: Chief, Bureau of Administration				
Phone Number: 850-245-4738		**Email Address:** Andrea.gary@flhealth.gov		
Work Details				
Number of covered lives: Q4 2021: 96,396				
Time period of contract: Florida Children's Medical Services: Originated: 2019; current term: 2/2019-1/2024				
Total number of staff hours expended during time period of contract: 3,241 employees. Average 6,741,280 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a*				

single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: Children's Medical Services: Statewide. Member populations include Medicaid Special Needs Children, Children with Special Health Care Needs
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the Children's Medical Services Contract, Sunshine State Health Plan (Formerly WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida) provides Medicaid managed care services for children with special health care needs who are eligible for Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program).

Corporate Experience: Current and/or Recent Client				
Client's Name: Florida Healthy Kids Corporation				
Client Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	**State:** N/A	**Zip Code:** N/A		**County:** N/A
Mailing Address (P.O. Box): P.O. Box 980	**City:** Tallahassee	**State:** FL	**Zip Code:** 32302	**County:** Leon County
Direct Contact for Client				
Name: Austin Noll				
Title: Chief Operating Officer				
Phone Number: 888-955-8771		**Email Address:** nolla@healthykids.org		
Work Details				
Number of covered lives: Q4 2021: N/A. Contract not active.				
Time period of contract:				

Sunshine State Health Plan **Florida Healthy Kids Corporation Medical Services**: Originated: 2012; last term: 1/2015-12/2019 **Staywell (WellCare of Florida)** **Florida Healthy Kids Corporation Medical Services**: Originated: 2012; last term: 1/2015-12/2019
Total number of staff hours expended during time period of contract: 3,241 employees. Average 6,741,280 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: **Sunshine State Health Plan** **Florida Healthy Kids Corporation Medical Services**: Statewide. Member population included CHIP. **Staywell (WellCare of Florida)** **Florida Healthy Kids Corporation Medical Services**: Statewide. Member population included CHIP.
Publicly funded contract cost: [redacted].
Description of work performed under this contract
Through the Florida Health Kids Corporation Medical services contract, Sunshine State Health Plan and Staywell (WellCare of Florida) provided managed care services for children ages 5 to 19 in all regions. Services include, but are not limited to, medical, behavioral health, pharmacy, and limited vision.

Corporate Experience: Current and/or Recent Client				
Client's Name: Georgia Department of Community Health				
Client Location				
Address Line 1: 2 Peachtree Street				
Address Line 2: 36th Floor				
City: Atlanta	**State:** GA	**Zip Code:** 30303	**County:** Fulton County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A

Direct Contact for Client	
Name: Lynette Rhodes	
Title: Executive Director	
Phone Number: 404-646-7513	**Email Address:** lrhodes@dch.ga.gov
Work Details	
Number of covered lives: Q4 2021: 998,529	
Time period of contract: **Peach State Health Plan:** Originated 2006; current term: 7/2017-6/2022 **WellCare of Georgia:** Originated: 2006; current term: 7/2020-6/2022 – *integrated into affiliate Peach State Health Plan (above) effective 5/2021*	
Total number of staff hours expended during time period of contract: 555 employees. Average 1,154,400 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*	
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features	
Geographic and population coverage requirements: Statewide. Populations include TANF and CHIP.	
[redacted]	
Description of work performed under this contract	
Through the Georgia Families contract, Peach State Health Plan (and formerly WellCare of Georgia) provides managed care services including medical, behavioral health, dental, vision, pharmacy, and limited non-emergency transportation.	

Corporate Experience: Current and/or Recent Client
Client's Name: Department of Human Services Med-QUEST Division
Client Location
Address Line 1: 1001 Kamokila Boulevard
Address Line 2:

Suite 317				
City: Kapolei	**State:** HI	**Zip Code:** 96707		**County:** Honolulu County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Jon Fujii				
Title: Healthcare Services Branch Administrator				
Phone Number: 808-692-8083		**Email Address:** jfujii@dhs.hawaii.gov		
Work Details				
Number of covered lives: Q4 2021 QUEST: 39,808 Q4 2021 CCS: 5,096				
Time period of contract: **QUEST Integration:** Originated: 2008; current term: 7/1/2021-12/31/2026, plus three optional 12-month extensions **Community Care Services (CCS):** Originated: 2013; current term: 7/2021-6/2024, plus two optional 12-month extensions				
Total number of staff hours expended during time period of contract: 190 employees. Average 395,200 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features				
Geographic and population coverage requirements: **QUEST Integration:** Statewide. Member populations include ABD, CHIP, TANF, Expansion. **Community Care Services (CCS):** Statewide. Member populations include SPMI/SED.				
Publicly funded contract cost: [redacted]				
Description of work performed under this contract				
Through the QUEST Integration contract, Ohana Health Plan provides managed care services including medical, pharmacy, behavioral health, dental (under 21), vision, transportation, long term services and supports, and/or other (housing support/supportive employment). Through the Community Care Services (CCS) program, Ohana Health Plan provides managed care services to case manage, authorize, and facilitate the delivery of behavioral health services to Medicaid				

eligible adults who have serious mental illness (SPMI/SED) or serious and persistent mental illness (SPMI) who are in QUEST Integration (QI) health plans.

Corporate Experience: Current and/or Recent Client				
Client's Name: Iowa Medicaid Enterprise (IME)				
Client Location				
Address Line 1: 1305 East Walnut				
Address Line 2: 5th Floor				
City: Des Moines	**State:** IA	**Zip Code:** 50319-0114	**County:** Polk County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Elizabeth Matney				
Title: State Medicaid Director				
Phone Number: 515-256-4640	**Email Address:** ematney@dhs.state.ia.us			
Work Details				
Number of covered lives: Q4 2021: 327,224				
Time period of contract: Originated 2019; current term 7/2019-6/2025				
Total number of staff hours expended during time period of contract: 740 employees. Average 1,539,200 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features				
Geographic and population coverage requirements: Statewide. Member populations include TANF, CHIP, LTC Dual, LTC Non-Dual, SSI Dual, SSI Non-Dual, Expansion				

Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the Iowa Health Link Contract MED-20-001, Iowa Total Care provides managed care services including integrated medical, behavioral health, vision, transportation, and pharmacy services.

Corporate Experience: Current and/or Recent Client				
Client's Name: Illinois Department of Family & Human Services				
Client Location				
Address Line 1: 401 South Clinton Street				
Address Line 2: N/A				
City: Chicago	**State:** IL	**Zip Code:** 60607	**County:** Cook County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Keshonna A. Lones, MHA				
Title: Bureau of Managed Care Account Manager				
Phone Number: 312-793-5274		**Email Address:** Keshonna.lones@illinois.gov		
Work Details				
Number of covered lives: Q4 2021 Health Choice: 870,759 Q4 2021 YouthCare: 36,849 Q4 2021 MMAI: 17,750				
Time period of contract: **Meridian Health Plan of Illinois** **Health Choice:** Originated: 2014; current term: 1/2018-12/2022 **YouthCare:** Originated: 2020; current term: 2/2020-12/2025 **Medicare-Medicaid Alignment Initiative:** Originated: 2014; current term: 1/2018-12/2022 **IlliniCare:** **Health Choices**: Originated 2011; last term:1/2018-12/2021 – *as of 1/23/2020, due to acquisition-related divestiture, this is no longer an affiliate contract, although it remains relevant to our contracts to provide managed care services since January 1, 2018.*				
Total number of staff hours expended during time period of contract: 1,569 employees. Average 3,263,520 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				

Personnel requirements:
State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including:
• Total membership, including the population type.
• Member health conditions and demographics.
• The number of contracted Providers and infrastructure of Provider community
• State-specific program features

Geographic and population coverage requirements:
Meridian Health Plan of Illinois
Health Choice: Statewide. Member populations include LTC Non-Dual, SSI Kids, LTC Dual, SSI, Expansion, TANF, Behavioral Health (IMD)
YouthCare: Statewide. Member populations include Foster Care.
Medicare-Medicaid Alignment Initiative: Statewide. Member populations include MMP.

IlliniCare
Health Choices: Statewide. Member populations included ABD, TANF, LTC, Waivers, IDD, Medicaid Expansion, Dual eligible members receiving LTSS who opt out of MMAI program.

Publicly funded contract cost:
[redacted]

Description of work performed under this contract

Through the Health Choices program, Meridian provides managed care services, including medical, behavioral health, dental, vision, non-emergency transportation, and pharmacy. LTSS, including HCBS provided for certain waivers except for members with IDD. MLTSS services include nursing home care, supportive living, HCBS Waiver services for members who qualify, mental health services, substance abuse services, and non-emergency transportation services.

Through the YouthCare program, Meridian provides managed care services to members in or formerly in foster care, including medical, behavioral health, dental, vision, non-emergency transportation, and pharmacy.

Through the MMAI program, Meridian provides managed care services for ABD dual-eligibles including medical, behavioral health, pharmacy, dental, vision, and non-emergency transportation.

Corporate Experience: Current and/or Recent Client

Client's Name:
Indiana Family & Social Services Administration

Client Location

Address Line 1: 402 W. Washington St.				
Address Line 2: Room W374, MS07				
City: Indianapolis	**State:** IN	**Zip Code:** 46204		**County:** Marion County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Meredith Edwards				
Title: Director, Quality and Outcomes Section				
Phone Number: 317-234-5780		**Email Address:** Meredith.edwards@fssa.in.gov		
Work Details				
Number of covered lives: Q4 2021 Hoosier Healthwise: 184,317 Q4 2021 HoosierCare Connect: 35,837 Q4 2021 Healthy Indiana Plan: 127,172				
Time period of contract: **Hoosier Healthwise:** Originated: 1995; current term: 1/2021-12/2022. New contract awarded effective 1/2023 for 4 years with 2 one-year renewals for a total of 6 years. **HoosierCare Connect:** Originated: 2015; current term: 4/2021-3/2025 **Healthy Indiana Plan:** Originated: 2011; current term: 1/2021-12/2022. New contract awarded effective 1/2023 for 4 years with 2 one-year renewals for a total of 6 years.				
Total number of staff hours expended during time period of contract: 430 employees. Average 894,400 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features				
Geographic and population coverage requirements: **Hoosier Healthwise:** Statewide. Member populations include TANF and CHIP. **HoosierCare Connect:** Statewide. Member populations include ABD. **Healthy Indiana Plan:** Statewide. Member populations include Expansion.				
Publicly funded contract cost: [redacted]				

[redacted]
Description of work performed under this contract
Through the Hoosier Healthwise contract, MHS provides managed care services, including medical, behavioral health, vision, and pharmacy. Through the HoosierCare Connect contract, MHS provides managed care services, including medical, behavioral health, dental, pharmacy, vision, transportation. Through the Healthy Indiana Plan, MHS provides managed care services, including medical, behavioral health, dental, pharmacy, vision, transportation.

Corporate Experience: Current and/or Recent Client				
Client's Name: Kansas Department of Health and Environment, Division of Health Care Finance				
Client Location				
Address Line 1: 900 SW Jackson St.				
Address Line 2: 9th Floor				
City: Topeka	**State:** KS	**Zip Code:** 66612	**County:** Shawnee County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Sarah Fertig				
Title: State Medicaid Director				
Phone Number: 785-296-3512	**Email Address:** Sarah.fertig@ks.gov			
Work Details				
Number of covered lives: Q4 2021: 162,665				
Time period of contract: Originated 2013; current term 1/2019-12/2023				
Total number of staff hours expended during time period of contract: 451 employees. Average 938,080 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including:				

• Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: Statewide. Member populations include LTC Non-Dual, LTC Dual, IDD, SSI Dual, SSI Non-Dual, Foster Care, CHIP, TANF
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the KanCare 2.0 Medicaid Managed Care Contract, Sunflower Health Plan provides managed care services including medical, dental, vision, behavioral health, non-emergency transportation, and LTC, including nursing facility care and HCBS.

Corporate Experience: Current and/or Recent Client				
Client's Name: Kentucky Department for Medicaid Services				
Client Location				
Address Line 1: 275 E. Main Street				
Address Line 2: N/A				
City: Frankfort	**State:** KY	**Zip Code:** 40621		**County:** Franklin County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Veronica Judy-Cecil				
Title: Senior Deputy Commissioner				
Phone Number: 502564-4321		**Email Address:** Veronica.judycecil@ky.gov		
Work Details				
Number of covered lives: Q4 2021: 481,866				
Time period of contract: Originated: 2011; current term 1/2021-12/2024				
Total number of staff hours expended during time period of contract: 295 employees. Average 613,600 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.* **Personnel requirements:**				

State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: Statewide. Member populations include SSI Dual, SSI Non-Dual, TANF, Expansion.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the Medicaid contract, WellCare of Kentucky provides managed care services including medical, behavioral health, pharmacy, dental, and vision.

Corporate Experience: Current and/or Recent Client				
Client's Name: Louisiana Department of Health				
Client Location				
Address Line 1: 628 N. 4th Street				
Address Line 2: N/A				
City: Baton Rouge	**State:** LA	**Zip Code:** 70802	**County:** East Baton Rouge Parish	
Mailing Address (P.O. Box): P.O. Box 629	**City:** Baton Rouge	**State:** LA	**Zip Code:** 70821-0629	**County:** N/A
Direct Contact for Client				
Name: Patrick Gillies				
Title: Medicaid Executive Director				
Phone Number: 225-342-9500	**Email Address:** Patrick.gillies@la.gov			
Work Details				
Number of covered lives: Q4 2021: 539,242				
Time period of contract: Originated: 2012; current term: 1/2015—12/2022; new contract awarded for 3 years with option to extend up to 2 years for a total of 5 years				
Total number of staff hours expended during time period of contract: 544 employees. Average 1,131,520 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a*				

single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: Statewide. Member populations include Foster Care, BH, SSI, Expansion, TANF.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the Healthy Louisiana contract, Louisiana Healthcare Connections provides managed care services including medical, behavioral health, pharmacy, vision, and non-emergency transportation.

Corporate Experience: Current and/or Recent Client				
Client's Name: Michigan Department of Health and Human Services				
Client Location				
Address Line 1: 4125 W. St. Joe Hwy				
Address Line 2: N/A				
City: Lansing	**State:** MI	**Zip Code:** 48917		**County:** Lansing County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Brandon Samuel				
Title: Contract Administrator				
Phone Number: 517-249-0439		**Email Address:** samuelb@michigan.gov		
Work Details				
Number of covered lives: **<u>Meridian Health Plan of Michigan</u>** Q4 2021 Medicaid: 558,092 Q4 2021 CMS Contract H0480 (MMP): 5,234 **<u>Michigan Complete Health</u>** Q4 2021 CMS Contract H9487 (MMP): 3,551				
Time period of contract:				

Meridian Health Plan of Michigan
Q4 2021 Medicaid: Originated 2016; current term 1/2016-9/2022
Q4 2021 CMS Contract H0480 (MMP): Originated: 2015; current term: 3/2015-12/2023

Michigan Complete Health
Q4 2021 CMS Contract H9487 (MMP): Originated: 2015; last term: 12/2022-12/2021. Through a novation, Michigan Complete Health's CMS Contract H9487 is now part of the H0480 contract.

Total number of staff hours expended during time period of contract:
593 employees. Average 1,233,440 health plan staff hours per year.
Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.

Personnel requirements:
State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including:
• Total membership, including the population type.
• Member health conditions and demographics.
• The number of contracted Providers and infrastructure of Provider community
• State-specific program features

Geographic and population coverage requirements:
Meridian Health Plan of Michigan
Medicaid: 9 of 10 regions statewide. Member populations include TANF, SSI Duals, SSI, Expansion, Children's Special Health Care Services.
MMP: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties. Member populations include MMP.

Michigan Complete Health
MMP: Macomb and Wayne counties in Michigan. Member populations include MMP.

Publicly funded contract cost:
[redacted]

Description of work performed under this contract
Through the Michigan Medicaid program, Meridian provides managed care services for Duals, Medicaid/TANF, CHIP populations.

Through CMS Contract H0480 (MMP), Meridian provides managed care services for Dual Eligibles. Services include physical health services as well as dental, vision, pharmacy, and long-term supports and services.

Corporate Experience: Current and/or Recent Client				
Client's Name: MO HealthNet	CONFIDENTIAL			
Client Location				
Address Line 1: 615 Howerton Court				
Address Line 2: N/A				
City: Jefferson City	**State:** MO	**Zip Code:** 65109		**County:** Cole County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Alexander Daskalakis				
Title: Director, Managed Care				
Phone Number: 573-751-6522		**Email Address:** Alexander.N.Daskalakis@dss.mo.gov		
Work Details				
Number of covered lives: Q4 2021 Home State Health Plan: 288,527				
Time period of contract: **Home State Health Plan:** Originated 2015; current contract 5/2017-6/2022* **Anticipating award announcement for new 1-year contract with option to extend for 4 additional 1-year periods.* **MissouriCare:** Originated 2015; current contract 5/2017-6/2022 – *as of 1/23/2020, due to acquisition-related divestiture, this is no longer an affiliate contract, although remains relevant to our contracts to provide managed care services since January 1, 2018.*				
Total number of staff hours expended during time period of contract: 332 employees. Average 690,560 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features				
Geographic and population coverage requirements: Statewide. Member populations include expansion, TANF, CHIP, and Foster Care.				
Publicly funded contract cost:				

[redacted]

Description of work performed under this contract

Through the MO HealthNet program, Home State Health Plan provides managed care services including medical, behavioral health, vision, non-emergency transportation, and dental. Behavioral health is carved out for foster care.

Corporate Experience: Current and/or Recent Client				
Client's Name: Nebraska Department of Health and Human Services				
Client Location				
Address Line 1: 301 Centennial Mall				
Address Line 2: N/A				
City: South Lincoln	**State:** NE	**Zip Code:** 68509		**County:** Lancaster County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Kristine Radke				
Title: DHHS Administrator, Plan Management, Medicaid & Long Term Care				
Phone Number: 402-471-4617		**Email Address:** Kristine.radke@nebraska.gov		
Work Details				
Number of covered lives: Q4 2021: 119,138				
Time period of contract: **Nebraska Total Care:** Originated 2017; current term 1/2017-12/2022 **WellCare of Nebraska:** Originated 2017; current contract 1/2017-12/2022 – *as of 1/23/2020, due to acquisition-related divestiture, this is no longer an affiliate contract, although remains relevant to our contracts to provide managed care services since January 1, 2018.*				
Total number of staff hours expended during time period of contract: 174 employees. Average 361,920 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements:				

State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: Statewide. Member populations include TANF, CHIP, Foster Care, SSI Dual, SSI Non-Dual, LTC Dual, LTC Non-Dual, Expansion
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the Nebraska Medicaid managed care contract, Nebraska Total Care provides managed care services including integrated medical, behavioral health, vision, transportation, and pharmacy services.

Corporate Experience: Current and/or Recent Client				
Client's Name: Department of Human Services, Division of Medical Assistance & Health Services				
Client Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	**State:** N/A	**Zip Code:** N/A		**County:** N/A
Mailing Address (P.O. Box): P.O. Box 712	**City:** Trenton	**State:** NJ	**Zip Code:** 08625-0712	**County:** Mercer County
Direct Contact for Client				
Name: Carol Grant				
Title: Deputy Director, Division of Medical Assistance & Health Services				
Phone Number: 609-588-2936		**Email Address:** Carol.grant@dhs.state.nj.us		
Work Details				
Number of covered lives: Q4 2021: 102,257				
Time period of contract: Originated: 2013; current term: 1/2022-6/2022 (evergreen contract with biannual amendments on July 1 and January 1)				

Total number of staff hours expended during time period of contract: 405 employees. Average 842,400 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: Statewide. Member populations include ABD/SSI, LTSS, TANF, Expansion.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the New Jersey Medicaid contract, WellCare Health Plans of New Jersey provides managed care services including medical, pharmacy, behavioral health, dental, vision, transportation, and long term services and supports.

Corporate Experience: Current and/or Recent Client				
Client's Name: New Mexico Medical Assistance Division				
Client Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A	
Mailing Address (P.O. Box): P.O. Box 2348	**City:** Santa Fe	**State:** NM	**Zip Code:** 87504-2348	**County:** Santa Fe County
Direct Contact for Client				
Name: Nicole Comeaux				
Title: Division Director				
Phone Number: 505-827-3100	**Email Address:** Nicole.comeaux@state.nm.us			
Work Details				
Number of covered lives:				

Q4 2021: 85,888
Time period of contract: Originated: 2019; current term 1/2019-12/2023
Total number of staff hours expended during time period of contract: 250 employees. Average 520,000 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: Statewide. Member populations include TANF, Expansion, SSI Non-Dual, SSI Dual, LTC Dual, LTC Non-Dual.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the New Mexico Managed Care for Medicaid/SCHIP contract, Western Sky Community Care provides managed care services including medical, behavioral health, dental, vision, pharmacy, non-emergency transportation, disease management and 24/7 nurse advice line.

Corporate Experience: Current and/or Recent Client				
Client's Name: New York State Department of Health, Office of Health Insurance Programs				
Client Location				
Address Line 1: One Commerce Plaza				
Address Line 2: N/A				
City: Albany	**State:** NY	**Zip Code:** 12210		**County:** Albany County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Susan Bentley				
Title: Director, Division of Health Plan Contracting and Oversight, Bureau of Certification and Surveillance				
Phone Number: 518-474-5515		**Email Address:** Susan.bentley@health.ny.gov		

Work Details
Number of covered lives: Q4 2021 Medicaid Managed Care: 1,727,578
Time period of contract: Originated: 2016; current term: 3/2019-2/2024
Total number of staff hours expended during time period of contract: 3670 employees. Average 7,633,600 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: Statewide. Member populations include Health and Recovery Plans (HARP), SSI, TANF.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the Medicaid Managed Care Model Contract and Health and Recovery Program (HARP), New York Quality Health Care Corporation (dba Fidelis Care) provides managed care services related to New York State's publicly funded programs including, but not limited to, medical, dental, behavioral health, pharmacy, vision, and LTSS.

Corporate Experience: Current and/or Recent Client				
Client's Name: New York State Department of Health				
Client Location				
Address Line 1: Corning Tower				
Address Line 2: Room 2378				
City: Albany	**State:** NY	**Zip Code:** 12237		**County:** Albany County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Catherine Doran				
Title: Program Coordinator				

Phone Number: 518-486-9272	**Email Address:** Catherine.doran@health.ny.gov
Work Details	
Number of covered lives: Q4 2021 Essential Plan Program (EP): 268,694	
Time period of contract: Originated: 2016; current term: 1/2021-12/2025	
Total number of staff hours expended during time period of contract: 3670 employees. Average 7,633,600 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*	
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features	
Geographic and population coverage requirements: Statewide. Member populations include Expansion.	
Publicly funded contract cost: [redacted]	
Description of work performed under this contract	
Through the Essential Plan Program (EP) contract, New York Quality Health Care Corporation (dba Fidelis Care) provides managed care services related to New York State's publicly funded programs including, but not limited to, medical, dental, behavioral health, pharmacy, and vision.	

Corporate Experience: Current and/or Recent Client				
Client's Name: New York State Department of Health, Office of Health Insurance Programs				
Client Location				
Address Line 1: One Commerce Plaza				
Address Line 2: N/A				
City: Albany	**State:** NY	**Zip Code:** 12210		**County:** Albany County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Gabrielle Armenia				
Title:				

Director, Bureau of Child Health Plus and Market Place Consumer Assistance	
Phone Number: 518-473-0566	**Email Address:** Gabrielle.armenia@health.ny.gov
Work Details	
Number of covered lives: Q4 2021 Child Health Plus (CHP): 132,190	
Time period of contract: Originated: 2016; current term: 3/2019-2/2024	
Total number of staff hours expended during time period of contract: 3670 employees. Average 7,633,600 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*	
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements and account for variables that affect staffing, including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features	
Geographic and population coverage requirements: Statewide. Member populations include CHIP.	
Publicly funded contract cost: [redacted]	
Description of work performed under this contract	
Through the Child Health Plus (CHP) contract, New York Quality Health Care Corporation (dba Fidelis Care) provides managed care services related to New York State's publicly funded programs including, but not limited to, medical, dental, behavioral health, pharmacy, and vision.	

Corporate Experience: Current and/or Recent Client				
Client's Name: New York State Department of Health				
Client Location				
Address Line 1: One Commerce Plaza				
Address Line 2: N/A				
City: Albany	**State:** NY	**Zip Code:** 12210		**County:** Albany County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Joseph Shunk				

Title: Plan Manager, Division of Health Plan Contracting & Oversight	
Phone Number: 5118-474-6965	**Email Address:** Joseph.shunk@health.ny.gov
Work Details	
Number of covered lives: Q4 2021 MLTC: 18,760	
Time period of contract: Originated: 2016; current term: 7/2018-12/2026	
Total number of staff hours expended during time period of contract: 3670 employees. Average 7,633,600 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*	
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features	
Geographic and population coverage requirements: Statewide. Member populations include LTC.	
Publicly funded contract cost: [redacted]	
Description of work performed under this contract	
Through the Managed Long Term Care contract, New York Quality Health Care Corporation (dba Fidelis Care) provides managed care services related to New York State's publicly funded programs including, but not limited to, medical, dental, behavioral health, pharmacy, vision, and LTSS.	

Corporate Experience: Current and/or Recent Client				
Client's Name: North Carolina Department of Health and Human Services, Division of Health Benefits				
Client Location				
Address Line 1: 1985 Umstead Drive, Kirby Building				
Address Line 2: 2501 Mail Service Center				
City: Raleigh	**State:** NC	**Zip Code:** 27699-2501		**County:** Wake County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				

Name: Cassandra McFadden	
Title: Deputy Director of Standard Plans, Division of Health Benefits, NC Medicaid	
Phone Number: 919-500-0814	**Email Address:** Cassandra.McFadden@dhhs.nc.gov
Work Details	
Number of covered lives: Q4 2021 Carolina Complete Health: 218,474 Q4 2021 WellCare of North Carolina: 355,222	
Time period of contract: **Carolina Complete Health:** Originated: 2021; current term 7/2021-6/2022 **WellCare of North Carolina:** Originated: 2021; current term 7/2021-6/2022	
Total number of staff hours expended during time period of contract: **Carolina Complete Health:** 314 employees. Average 653,120 health plan staff hours per year. **WellCare of North Carolina:** 279 employees. Average 580,320 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*	
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features	
Geographic and population coverage requirements: **Carolina Complete Health:** Regions 3, 4, and 5. Member populations include TANF, ABD Non-Dual, LTSS. **WellCare of North Carolina:** Statewide. Member populations include TANF, ABD Non-Dual, LTSS.	
Publicly funded contract cost: [redacted]	
Description of work performed under this contract	
Through the North Carolina Medicaid Managed Care Services contract, Carolina Complete Health and WellCare of North Carolina provide managed care services, including integrated physical health, behavioral health, pharmacy services, and LTSS. Dental services are carved out.	

Corporate Experience: Current and/or Recent Client
Client's Name: Ohio Division of Medicaid
Client Location
Address Line 1: 50 W Town Street

Address Line 2: Suite #400				
City: Columbus	**State:** OH	**Zip Code:** 43215		**County:** Franklin County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Amanda Jenkins				
Title: Contract Manager, Office of Managed Care				
Phone Number: 614-852-3622		**Email Address:** MedicaidBuckeye@medicaid.gov		
Work Details				
Number of covered lives: Q4 2021 Medicaid Managed Care: 436,252 Q42021 MyCare Ohio Plan (MMP): 26,986				
Time period of contract: Medicaid Managed Care: Originated: 2004; current term: 8/2021-6/2024 MyCare Ohio Plan (MMP): Originated: 2014; current term: 7/2020-6/2022				
Total number of staff hours expended during time period of contract: 931 employees. Average 1,998,880 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features				
Geographic and population coverage requirements: Medicaid Managed Care: Statewide. Member populations include TANF, Expansion, ABD Adult, ABD Child. MyCare Ohio Plan (MMP): 12 counties in Ohio. Member populations include MMP.				
Publicly funded contract cost: [redacted]				
Description of work performed under this contract				
Through the Medicaid Managed Care plan, Buckeye Community Health Plan provides managed care services including comprehensive physical health services, behavioral health services, dental, vision, and pharmacy. Through the MyCare Ohio Plan (MCOP), Buckeye Community Health Plan provides managed care services to full duals in 12 Ohio counties, including behavioral and physical health services as well as LTSS. Ohio State Plan services include high-touch care management for members, HCBS when				

individuals are enrolled in the Waiver, Medicare Parts A, B, and D services, and pharmacy products covered by Ohio Medicaid, if not under Medicare Part D.

Corporate Experience: Current and/or Recent Client				
Client's Name: Oregon Health Authority Department of Human Services				
Client Location				
Address Line 1: 500 Summer Street NE				
Address Line 2: E-20				
City: Salem	**State:** OR	**Zip Code:** 97301-1097	**County:** Marion County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Rosa Frank				
Title: CCO Account Representative				
Phone Number: 971-388-8995	**Email Address:** Rosa.frank@dhsoha.state.or.us			
Work Details				
Number of covered lives: Q4 2021: 59,056				
Time period of contract: Originated: 2014; current term: 1/2020-12/2024				
Total number of staff hours expended during time period of contract: 255 employees. Average 530,400 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features				
Geographic and population coverage requirements: Lane, Clackamas, Multnomah, Washington, partial Linn, and partial Douglas Counties. Member populations include TANF, ABD Dual, ABD Non-Dual, Expansion, Cover All Kids.				
Publicly funded contract cost: [redacted]				

Description of work performed under this contract
Through the Community Care Organization (CCO) 2.0 contract, Trillium Community Health Plan provides managed care services including physical health, behavioral health, oral health, and transportation services. Benefits vary by program: CCOA includes Physical, Mental and Dental benefits; CCOB includes Physical, Mental benefits; CCOE includes Mental benefits; and CCOG includes Mental and Dental benefits.

Corporate Experience: Current and/or Recent Client				
Client's Name: Pennsylvania Department of Human Services, Office of Long-Term Living				
Client Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	**State:** N/A	**Zip Code:** N/A		**County:** N/A
Mailing Address (P.O. Box): P.O. Box 8052	**City:** Harrisburg	**State:** PA	**Zip Code:** 17105	**County:** Dauphin County
Direct Contact for Client				
Name: Jamie Buchenauer				
Title: Deputy Secretary				
Phone Number: 717-514-0059		**Email Address:** jbuchenau@pa.gov		
Work Details				
Number of covered lives: Q4 2021: 267,826				
Time period of contract: Originated: 2018; current term 1/2018-12/2022				
Total number of staff hours expended during time period of contract: 582 employees. Average 1,210,560 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features				
Geographic and population coverage requirements: Statewide. Member populations include LTSS Non-Dual, LTSS Dual, SSI Dual.				
Publicly funded contract cost:				

[redacted]
Description of work performed under this contract
Through the Community Health Choices agreement, PA Health & Wellness provides managed care services for all 5 Zones statewide supporting Managed LTSS Medicaid and dual eligible members receiving LTSS, meeting certain income and level of care requirements. Services include physical health HCBS, institutional LTC services, medical, pharmacy, dental and vision. Behavioral health is carved out.

Corporate Experience: Current and/or Recent Client				
Client's Name: South Carolina Department of Health & Human Services				
Client Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	**State:** N/A	**Zip Code:** N/A		**County:** N/A
Mailing Address (P.O. Box): P.O. Box 8206	**City:** Columbia	**State:** SC	**Zip Code:** 29202	**County:** Richland County
Direct Contact for Client				
Name: Robert M. Kerr				
Title: Director, SCDHHS				
Phone Number: 803-898-2580		**Email Address:** polattyj@scdhhs.gov		
Work Details				
Number of covered lives: Q4 2021 SC Health Connections Medicaid Managed Care Contract: 232,492 Q4 2021 Healthy Connections Medicare-Medicaid Plan: 4,773				
Time period of contract: **<u>Absolute Total Care</u>** **SC Health Connections Medicaid Managed Care Contract:** Originated: 2007; current term: 7/2018-6/2024 **Healthy Connections Medicare-Medicaid Plan:** Originated: 2015; current term: 1/221-12/2023 **<u>WellCare of South Carolina</u>** **SC Health Connections Medicaid Managed Care Contract:** Originated: 2013; current term: 7/2018-6/2021 – *effective 4/2021, this contract integrated into affiliate Absolute Total Care Medicaid contract above*				
Total number of staff hours expended during time period of contract: 331 employees. Average 688,480 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a*				

single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.

Personnel requirements:
State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including:
• Total membership, including the population type.
• Member health conditions and demographics.
• The number of contracted Providers and infrastructure of Provider community
• State-specific program features

Geographic and population coverage requirements:
Absolute Total Care
SC Health Connections Medicaid Managed Care Contract: Statewide. Member populations include TANF and ABD.
Healthy Connections Medicare-Medicaid Plan: 41 or 46 counties in South Carolina. Member populations include MMP.

WellCare of South Carolina
SC Health Connections Medicaid Managed Care Contract: Statewide. Member populations included ABD and TANF.

Publicly funded contract cost:
[redacted]

Description of work performed under this contract

Through the SC Health Connections Medicaid manged Care Contract, Absolute Total Care provides managed care services including medical, behavioral health, pharmacy, and vision.

Through the Healthy Connections Medicare-Medicaid Plan (MMP), Absolute Total Care provides Medicare and Medicaid covered services. Eligible populations are those age 65 and older, those entitled to benefits under Medicare Part A, enrolled in Parts B and D, and receiving full Medicaid benefits. This includes individuals enrolled in the Community Choice Waiver, HIV/AIDS Waiver, and Mechanical Ventilation Waiver. Other services include behavioral health and pharmacy.

Corporate Experience: Current and/or Recent Client

Client's Name:
Texas Health & Human Services Commission

Client Location

Address Line 1:
4900 North Lamar

Address Line 2:
MC-H100

City: Austin	**State:** TX	**Zip Code:** 78751	**County:** Travis County

Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A

Direct Contact for Client

Name:
Stephanie Stephens

Title:
Deputy Executive Commissioner

Phone Number: 512-428-1906	**Email Address:** Stephanie.stephens01@hhsc.state.tx.us

Work Details

Number of covered lives:
Superior HealthPlan Network
Q4 2021 CHIP RSA: 21,165
Q4 2021 STAR (3 MRSAs): 188,121
Q4 2021 STAR+PLUS: 32,567
Q4 2021 STAR (Hidalgo): 386,879

Superior HealthPlan, Inc.
Q4 2021 STAR Health: 46,243
Q4 2021 STAR/CHIP: 439,458
Q4 2021 STAR Kids: 30,861
Q4 2021 STAR+PLUS: 47,753
Q4 2021 STAR+PLUS (Dallas): 28,794
Q4 2021 STAR+PLUS MRSA: 37,123
Q4 2021 Medicare-Medicaid Plan: 8,679

Time period of contract:
Superior HealthPlan Network
CHIP RSA: Originated: 2004; current term: 9/2010-8/2022
STAR (3 MRSAs): Originated: 2004; current term: 9/2010-8/2022
STAR+PLUS: Originated: 2012; current term: 3/2012-8/2022
STAR (Hidalgo): Originated: 2012; current term: 3/2012-8/2022

Superior HealthPlan, Inc.
STAR Health: Originated: 2008 (under SHPN entity above); current term: 9/2015-8/2022
STAR/CHIP: Originated: 1999; current term: 9/2011-8/2022
STAR Kids: Originated: 2016; current term: 9/2016-8/2022
STAR+PLUS: Originated: 2011; current term: 9/2012-8/2022
STAR+PLUS (Dallas): Originated: 2011; current term: 2/2011-8/2022
STAR+PLUS MRSA: Originated: 2014; current term: 9/2019-8/2022
Medicare-Medicaid Plan: Originated: 2015; current term: 3/2015-12/2023

Total number of staff hours expended during time period of contract:
3,612 employees. Average 7,512,960 health plan staff hours per year.
Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.

Personnel requirements:

State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including:
• Total membership, including the population type.
• Member health conditions and demographics.
• The number of contracted Providers and infrastructure of Provider community
• State-specific program features

Geographic and population coverage requirements:

Superior HealthPlan Network

CHIP RSA: Central, Northeast, West Medicaid Rural Service Areas. Member populations include CHIP.
STAR (3 MRSAs): Central, Northeast, West Medicaid Rural Service Areas. Member populations include TANF.
STAR+PLUS: Hidalgo region. Member populations include ABD.
STAR (Hidalgo): Hidalgo region. Member populations include TANF.

Superior HealthPlan, Inc.

STAR Health: Statewide. Member populations include Foster Care.
STAR/CHIP: Bexar, El Paso, Lubbock, Nueces, Travis regions. Member populations include TANF, CHIP.
STAR Kids: Bexar, El Paso, Hidalgo, Lubbock, Nueces, Travis regions and MRSA West. Member populations include children and adults 20 and under.
STAR+PLUS: Bexar, Lubbock, Nueces regions in Texas. Member populations include ABD.
STAR+PLUS (Dallas): Dallas. Member populations include ABD.
STAR+PLUS MRSA: Central, West Medicaid Regional Service Areas in Texas. Member populations include ABD.
Medicare-Medicaid Plan: Bexar, Dallas, Hidalgo regions in Texas. Member populations include MMP.

Publicly funded contract cost:

[redacted]

Description of work performed under this contract

Superior HealthPlan Network

CHIP RSA: provides managed care services for CHIP members including medical, behavioral health, pharmacy, and vision.
STAR (3 MRSAs): provides managed care services for TANF members. Services include medical, behavioral health, pharmacy and vision.
STAR+PLUS: provides managed care services for ABD members both acute and LTC. Services include medical, behavioral health, pharmacy, vision, and LTC.

STAR (Hidalgo): provides managed care services for TANF members. Services include medical, behavioral health, pharmacy and vision.

Superior HealthPlan, Inc.
STAR Health: provides managed care services for Foster Care members. Services include medical, dental, vision, and behavioral health benefits.
STAR/CHIP: provides managed care services for TANF and CHIP members. Services include medical, behavioral health, pharmacy, and vision.
STAR Kids: provides managed care services for children and adults 20 and younger for both acute and LTC. Services include medical, behavioral health, pharmacy, vision, and LTC.
STAR+PLUS: provides managed care services for ABD members, both acute and LTC. Services include medical, behavioral health, pharmacy, vision, and LTC.
STAR+PLUS (Dallas): provides managed care services for ABD members, both acute and LTC. Services include medical, behavioral health, pharmacy, vision, and LTC.
STAR+PLUS MRSA: provides managed care services for ABD members, both acute and LTC. Services include medical, behavioral health, pharmacy, vision, and LTC.
Medicare-Medicaid Plan: provides managed care services for Medicare-Medicaid Plan (MMP) dual eligible members. All covered services under Medicaid and Medicare include medical, behavioral health, pharmacy, vision, and LTC.

Corporate Experience: Current and/or Recent Client				
Client's Name: Washington Health Care Authority				
Client Location				
Address Line 1: Cherry Street Plaza				
Address Line 2: 626 8th Avenue SE				
City: Olympia	**State:** WA	**Zip Code:** 98501		**County:** Thurston County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Jason McGill				
Title: Assistant Director of Medicaid Program Operations and Integrity				
Phone Number: 360-725-1093		**Email Address:** jasonmcgill@hca.wa.gov		
Work Details				
Number of covered lives: Q4 2021 Washington Apple Health Integrated Managed Care and Wraparound Contracts (K4169 & K4609): 194,544 Q4 2021 Washington Apple Health Integrated Foster Care and Foster Care Wraparound Contracts (K3249 & K4612): 28,224				
Time period of contract:				

Washington Apple Health Integrated Managed Care and Wraparound Contracts (K4169 & K4609): Originated: 2012; current term: 1/2019-12/2022 Washington Apple Health Integrated Foster Care and Foster Care Wraparound Contracts (K3249 & K4612): Originated: 2016; current term: 1/2019-12/2022
Total number of staff hours expended during time period of contract: 366 employees. Average 761,280 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features
Geographic and population coverage requirements: Washington Apple Health Integrated Managed Care and Wraparound Contracts (K4169 & K4609): North Sound, King, Pierce, Southwest, Greater Columbia, North Central, Spokane regions. Member populations include TANF, ABD, CHIP, Expansion, BH Washington Apple Health Integrated Foster Care and Foster Care Wraparound Contracts (K3249 & K4612): Statewide. Member populations include Foster Care.
Publicly funded contract cost: [redacted]
Description of work performed under this contract
Through the Washington Apple Health Integrated Managed Care and Wraparound Contracts (K4169 & K4609), Coordinated Care of Washington provides managed care services including medical, pharmacy, vision, and behavioral health. Through the Washington Apple Health Integrated Foster Care and Foster Care Wraparound Contracts (K3249 & K4612), Coordinated Care provides managed care services including medical, pharmacy, vision, and behavioral health.

Corporate Experience: Current and/or Recent Client
Client's Name: Wisconsin Department of Human Services
Client Location
Address Line 1: 1 West Wilson Street
Address Line 2: P.O. Box 309

City: Madison	**State:** WI	**Zip Code:** 53701-0309		**County:** Dane County
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Lisa Olson				
Title: Director of Medicaid				
Phone Number: 608-266-5151		**Email Address:** LisaA.Olson@dhs.wisconsin.gov		
Work Details				
Number of covered lives: Q4 2021: 60,953				
Time period of contract: Originated: 1991; current term: 1/2020-12/2023				
Total number of staff hours expended during time period of contract: 179 employees. Average 372,320 health plan staff hours per year. *Health plans with multiple contracts achieve efficiencies and economies of scale by cross-training many of their staff on more than one contract; there are a limited number of staff working solely on a single contract (unless the plan only has one contract). As a result, the health plans do not track staff resources by contract.*				
Personnel requirements: State Medicaid contract requirements, along with state and regional variation, affect the personnel requirements for each health plan. All health plans adhere to State Medicaid contract requirements, and account for variables that affect staffing including: • Total membership, including the population type. • Member health conditions and demographics. • The number of contracted Providers and infrastructure of Provider community • State-specific program features				
Geographic and population coverage requirements: Statewide. Member populations include TANF, SSI Dual, SSI Non-Dual.				
Publicly funded contract cost: [redacted]				
Description of work performed under this contract				
Through the BadgerCare Plus and Medicaid SSI contract, Managed Health Services Insurance Corp (dba MHS Health Wisconsin) provides managed care services including medical, behavioral health, vision, and dental. Non-emergency transportation was carved out September 2012, and pharmacy was carved out in 2008.				

4.3.2 OWNERSHIP AND FINANCIAL DISCLOSURE INFORMATION

For many of the requirements of this section, the Offeror should utilize forms provided in Appendix G: Ownership and Financial Disclosure Information. If a form has been provided in this RFQ to respond to a requirement, no other response will be accepted.

4.3.2.1 INFORMATION TO BE DISCLOSED

In accordance with 42 C.F.R. § 455.104(b), the Offeror shall make certain disclosures. Use the form provided in Appendix G to provide this information.

Please see **Attachment 4.3.2.1 Appendix G** for our response to this section.

APPENDIX G: Ownership and Financial Disclosure Information

The forms in this Appendix must be used by the Offeror to respond to the listed RFQ sections:

- 4.3.2.1 Information to Be Disclosed
- 4.3.2.2 When and to Whom Information Will Be Disclosed
- 4.3.2.3 Information Related to Business Transactions
- 4.3.2.4 Change of Ownership
- 4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense

For 4.3.2.6 Audited Financial Statements and Pro Forma Financial Template:

- The Offeror must respond in the manner and format stated within that section of the RFQ.
- The pro forma financial template may be found at the Division's dedicated Coordinated Care Procurement website: https://medicaid.ms.gov/coordinated-care-procurement/. The Offeror must complete the designated fields of the Excel workbook and submit as attachment to the Offeror's Qualification.

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Response to 4.3.2.1 Information to Be Disclosed (Marked) – Pass/Fail

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

1. The name and address of any individual or corporation with an ownership or control interest in the Offeror. The address for corporate entities shall include as applicable primary business, every business location, and P.O. Box address;
2. Date of birth and Social Security Number (in the case of an individual);
3. Other tax identification number (in the case of a corporation) with an ownership or control interest in the Offeror or in any subcontractor in which the Offeror has a five percent (5%) or more interest;
4. Whether the individual or corporation with an ownership or control interest in the Offeror is related to another person with ownership or control interest in the Offeror as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or control interest in any subcontractor in which the Offeror 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;
5. The name of any other managed care entity in which an owner of the Offeror has an ownership or control interest; and,
6. The name, address, date of birth, and Social Security Number of any managing employee of the Offeror.

Full disclosure through use of the following forms meets the requirements of completion of this section.

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Section 1: Ownership Interest and/or Managing Control Identification Information

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification Information				
This response applies to an entity with: [ ] Managing Control [X] 5% or More Ownership Interest (percentage owned: 100 %)				
Effective Date of Ownership: February 14, 2007				
Legal Business Name as Reported to the Internal Revenue Service: Centene Corporation				
Doing Business As Name (if applicable): N/A		Tax Identification Number (required): 42-1406317		
Primary Business Address				
Line 1 (Street Name and Number): 7700 Forsyth Boulevard				
Address Line 2 (Suite, Room, etc.):				
City: Clayton	State: MO	Zip Code: 63105	County: Saint Louis	
Mailing Address (P.O. Box): N/A	City: N/A	State: N/A	Zip Code: N/A	County: N/A
Business Location				
Address Line 1: PO Box 419071				
Address Line 2:				
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County	
Business Location				
Address Line 1: PO Box 419089				
Address Line 2:				
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County	
Business Location				
Address Line 1: PO Box 419054				
Address Line 2:				
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County	
Business Location				
Address Line 1: PO Box 419063				
Address Line 2:				
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County	

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 419069			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 419021			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 2348			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 2890			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 2066			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 2470			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 1630			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 1150			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 419078			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 419086			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 419039			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 14621			
Address Line 2:			
City: Lexington	State: KY	Zip Code: 40512	County: Fayette County
Business Location			
Address Line 1: PO Box 907			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 95741	County: Sacramento County
Business Location			
Address Line 1: PO Box 10450			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 276090			
Address Line 2:			
City: Sacramento	State: CA	Zip Code: 95827	County: Sacramento County
Business Location			
Address Line 1: PO Box 10287			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10303			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10420			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10341			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 8250			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10342			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 10343			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10422			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 8500			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10439			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10330			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10456			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10200			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 10169			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10407			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10196			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 9103			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10427			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10158			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10344			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 10198			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10223			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10406			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10346			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10348			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10350			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10413			
Address Line 2:			
City: Van Nuys	State: CA	Zip Code: 91410	County: Los Angeles County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 550			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 91410	County: Sacramento County
Business Location			
Address Line 1: PO Box 419105			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 91410	County: Sacramento County
Business Location			
Address Line 1: PO Box 2470			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 91410	County: Sacramento County
Business Location			
Address Line 1: PO Box 419101			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 91410	County: Sacramento County
Business Location			
Address Line 1: PO Box 419004			
Address Line 2:			
City: Rancho Cordova	State: CA	Zip Code: 91410	County: Sacramento County
Business Location			
Address Line 1: PO Box 279378			
Address Line 2:			
City: Sacramento	State: CA	Zip Code: 95827	County: Sacramento County
Business Location			
Address Line 1: PO Box 279377			
Address Line 2:			
City: Sacramento	State: CA	Zip Code: 95827	County: Sacramento County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 276090			
Address Line 2:			
City: Sacramento	State: CA	Zip Code: 95827	County: Sacramento County
Business Location			
Address Line 1: PO Box 279377			
Address Line 2:			
City: Sacramento	State: CA	Zip Code: 95827	County: Sacramento County
Business Location			
Address Line 1: PO Box 279410			
Address Line 2:			
City: Sacramento	State: CA	Zip Code: 95827	County: Sacramento County
Business Location			
Address Line 1: PO Box 277610			
Address Line 2:			
City: Sacramento	State: CA	Zip Code: 95827	County: Sacramento County
Business Location			
Address Line 1: PO Box 277610			
Address Line 2:			
City: Sacramento	State: CA	Zip Code: 95827	County: Sacramento County
Business Location			
Address Line 1: PO Box 279378			
Address Line 2:			
City: Sacramento	State: CA	Zip Code: 95827	County: Sacramento County
Business Location			
Address Line 1: PO Box 989000			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 980438			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 989883			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 989882			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 989732			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 989729			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 989731			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 989730			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 989727			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 985055			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 989881			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 989732			
Address Line 2:			
City: West Sacramento	State: CA	Zip Code: 95798	County: Yolo County
Business Location			
Address Line 1: PO Box 4504			
Address Line 2:			
City: Woodland Hills	State: CA	Zip Code: 91365	County: Los Angeles County
Business Location			
Address Line 1: PO Box 10086			
Address Line 2:			
City: San Rafael	State: CA	Zip Code: 94912	County: Marin County
Business Location			
Address Line 1: PO Box 10697			
Address Line 2:			
City: San Rafael	State: CA	Zip Code: 94912	County: Marin County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 9088			
Address Line 2:			
City: San Rafael	State: CA	Zip Code: 94912	County: Marin County
Business Location			
Address Line 1: PO Box 3023			
Address Line 2:			
City: Tacoma	State: WA	Zip Code: 98401	County: Pierce County
Business Location			
Address Line 1: PO Box 9003			
Address Line 2:			
City: Tempe	State: AZ	Zip Code: 85281	County: Maricopa County
Business Location			
Address Line 1: PO Box 9005			
Address Line 2:			
City: Tempe	State: AZ	Zip Code: 85281	County: Maricopa County
Business Location			
Address Line 1: PO Box 9007			
Address Line 2:			
City: Tempe	State: AZ	Zip Code: 85281	County: Maricopa County
Business Location			
Address Line 1: PO Box 9008			
Address Line 2:			
City: Tempe	State: AZ	Zip Code: 85281	County: Maricopa County
Business Location			
Address Line 1: PO Box 459090			
Address Line 2:			
City: Fort Lauderdale	State: FL	Zip Code: 33345	County: Broward County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 33240			
Address Line 2:			
City: Detroit	State: MI	Zip Code: 48232	County: Wayne County
Business Location			
Address Line 1: N/A			
Address Line 2: N/A			
City: N/A	State: N/A	Zip Code: N/A	County: N/A
Business Location			
Address Line 1: N/A			
Address Line 2: N/A			
City: N/A	State: N/A	Zip Code: N/A	County: N/A
Business Location			
Address Line 1: N/A			
Address Line 2: N/A			
City: N/A	State: N/A	Zip Code: N/A	County: N/A
Business Location			
Address Line 1: N/A			
Address Line 2: N/A			
City: N/A	State: N/A	Zip Code: N/A	County: N/A
Business Location			
Address Line 1: N/A			
Address Line 2: N/A			
City: N/A	State: N/A	Zip Code: N/A	County: N/A
Business Location			
Address Line 1: N/A			
Address Line 2: N/A			
City: N/A	State: N/A	Zip Code: N/A	County: N/A

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 3050			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 3060			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 3070			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 3080			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 3090			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 4000			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 4020			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 4030			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 8050			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 9010			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 9020			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 9030			
Address Line 2:			
City: Farmington	State: MO	Zip Code: 63640	County: St. Francois County
Business Location			
Address Line 1: PO Box 11756			
Address Line 2:			
City: Eugene	State: OR	Zip Code: 97440	County: Lane County
Business Location			
Address Line 1: PO Box 11756			
Address Line 2:			
City: Eugene	State: OR	Zip Code: 97440	County: Lane County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 11740			
Address Line 2:			
City: Eugene	State: OR	Zip Code: 97440	County: Lane County
Business Location			
Address Line 1: PO Box 50815			
Address Line 2:			
City: Saint Louis	State: MO	Zip Code: 63127	County: St. Louis County
Business Location			
Address Line 1: PO Box 50816			
Address Line 2:			
City: Saint Louis	State: MO	Zip Code: 63127	County: St. Louis County
Business Location			
Address Line 1: PO Box 270697			
Address Line 2:			
City: Saint Louis	State: MO	Zip Code: 63127	County: St. Louis County
Business Location			
Address Line 1: PO Box 1256			
Address Line 2:			
City: Troy	State: MI	Zip Code: 48099	County: Troy County
Business Location			
Address Line 1: PO Box 459086			
Address Line 2:			
City: Fort Lauderdale	State: FL	Zip Code: 33345	County: Broward County
Business Location			
Address Line 1: PO Box 459087			
Address Line 2:			
City: Fort Lauderdale	State: FL	Zip Code: 33345	County: Broward County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 459088			
Address Line 2:			
City: Fort Lauderdale	State: FL	Zip Code: 33345	County: Broward County
Business Location			
Address Line 1: PO Box 459089			
Address Line 2:			
City: Fort Lauderdale	State: FL	Zip Code: 33345	County: Broward County
Business Location			
Address Line 1: PO Box 52079			
Address Line 2:			
City: Phoenix	State: AZ	Zip Code: 85072	County: Maricopa County
Business Location			
Address Line 1: PO Box 733			
Address Line 2:			
City: Elk Grove	State: IL	Zip Code: 6009	County: Cook County
Business Location			
Address Line 1: PO Box 92050			
Address Line 2:			
City: Elk Grove	State: IL	Zip Code: 60009	County: Cook County
Business Location			
Address Line 1: PO Box 74600			
Address Line 2:			
City: Chicago	State: IL	Zip Code: 60675	County: Cook County
Business Location			
Address Line 1: PO Box 92050			
Address Line 2:			
City: Chicago	State: IL	Zip Code: 60675	County: Cook County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 7548			
Address Line 2:			
City: Rocky Mount	State: NC	Zip Code: 27804	County: Nash County
Business Location			
Address Line 1: PO Box 7548			
Address Line 2:			
City: Rocky Mount	State: NC	Zip Code: 27804	County: Nash County
Business Location			
Address Line 1: PO Box 44260			
Address Line 2:			
City: Detroit	State: MI	Zip Code: 48244	County: Wayne County
Business Location			
Address Line 1: PO Box 44287			
Address Line 2:			
City: Louisville	State: KY	Zip Code: 48244	County: Wayne County
Business Location			
Address Line 1: PO Box 436000			
Address Line 2:			
City: Louisville	State: KY	Zip Code: 40253	County: Jefferson County
Business Location			
Address Line 1: PO Box 437000			
Address Line 2:			
City: Louisville	State: KY	Zip Code: 40253	County: Jefferson County
Business Location			
Address Line 1: PO Box 438000			
Address Line 2:			
City: Louisville	State: KY	Zip Code: 40253	County: Jefferson County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 869146			
Address Line 2:			
City: Plano	State: TX	Zip Code: 75094	County: Collin County
Business Location			
Address Line 1: PO Box 940849			
Address Line 2:			
City: Plano	State: TX	Zip Code: 75094	County: Collin County
Business Location			
Address Line 1: PO Box 941209			
Address Line 2:			
City: Plano	State: TX	Zip Code: 75094	County: Collin County
Business Location			
Address Line 1: PO Box 6025			
Address Line 2:			
City: Cypress	State: CA	Zip Code: 90630	County: Orange County
Business Location			
Address Line 1: PO Box 20062			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 20132			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 20144			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 20262			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 20565			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 20654			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 20847			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 22085			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 22122			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 22377			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 22687			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 25255			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 25656			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 25857			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 25974			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 26564			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 26631			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 26632			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33622	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31224			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31357			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31358			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31359			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31364			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31365			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 31366			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31367			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31368			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31369			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31370			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31372			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31378			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 31379			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31380			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31381			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31382			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31383			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31384			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31385			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 31386			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31387			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31388			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31389			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31390			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31391			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31392			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 31394			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31395			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31396			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31397			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31398			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 313400			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 313401			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 313402			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 313403			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 313406			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 313407			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 313409			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 313411			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 313412			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 31416			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31419			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31420			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31422			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31426			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31466			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31468			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 31472			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31474			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31490			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31431			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31497			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31503			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31506			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 31507			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31508			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31509			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31529			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31531			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31533			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31572			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 31577			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31580			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31584			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31623			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31647			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31648			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31657			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification			
Business Location			
Address Line 1: PO Box 31658			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31684			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County
Business Location			
Address Line 1: PO Box 31685			
Address Line 2:			
City: Tampa	State: FL	Zip Code: 33631	County: Hillsborough County

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

[redacted]

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[redacted]

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[redacted]

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The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

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Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

[redacted]

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Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

[redacted]

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Section 1(c): Familial Relationships		
Are any individuals listed in Section 1 related to each other as a spouse, parent, child, or sibling? **[ ] Yes [X] No** If yes, provide additional information below. Duplicate this page as necessary to provide a complete disclosure.		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		
Names of related individuals:		
Relationship (e.g., sibling):		

Section 2: Disclosure of Subcontractor Information

Disclosure of Subcontractor Information				
Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5% ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure.				
This response applies to: [ ] The Offeror [X] An Owner of the Offeror				
If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above): Centene Corporation				
The person or entity named as an: [X] Ownership Interest [ ] Management Control Interest				
If there is an ownership interest, what is the ownership percentage? 100 %				
If there is a management control interest, describe that interest: N/A				
Effective Date of Ownership and/or Management Control:				
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service: Centene Management Company LLC				
Doing Business As Name (if applicable): N/A	Tax Identification Number (required): 39-1864073			
Primary Business Address				
Line 1 (Street Name and Number): 7700 Forsyth Boulevard				
Address Line 2 (Suite, Room, etc.): N/A				
City: St. Louis	State: MO	Zip Code: 63105	County: St. Louis County	
Mailing Address (P.O. Box): N/A	City: N/A	State: N/A	Zip Code: N/A	County: N/A
Additional Business Location(s): Duplicate this page to provide all locations if necessary.				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State:	Zip Code:	County: N/A	
Business Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	
Business Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	

Disclosure of Subcontractor Information				
Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5% ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure.				
This response applies to: [ ] The Offeror [X] An Owner of the Offeror				
If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above): Centene Corporation				
The person or entity named as an: [X] Ownership Interest [ ] Management Control Interest				
If there is an ownership interest, what is the ownership percentage? 100 %				
If there is a management control interest, describe that interest:				
Effective Date of Ownership and/or Management Control:				
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service: Envolve Dental, Inc.				
Doing Business As Name (if applicable): N/A		Tax Identification Number (required): 46-2783884		
Primary Business Address				
Line 1 (Street Name and Number): 8715 Henderson Road				
Address Line 2 (Suite, Room, etc.): N/A				
City: Tampa	State: FL	Zip Code: 33634	County: Hillsborough	
Mailing Address (P.O. Box): N/A	City: N/A	State: N/A	Zip Code: N/A	County: N/A
Additional Business Location(s): Duplicate this page to provide all locations if necessary.				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	
Business Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	
Business Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	

Section 2: Disclosure of Subcontractor Information

Disclosure of Subcontractor Information				
Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5% ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure.				
This response applies to: [ ] The Offeror [X] An Owner of the Offeror				
If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above): Centene Corporation				
The person or entity named as an: [X] Ownership Interest [ ] Management Control Interest				
If there is an ownership interest, what is the ownership percentage? 100 %				
If there is a management control interest, describe that interest:				
Effective Date of Ownership and/or Management Control:				
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service: Envolve Vision Benefits, Inc.				
Doing Business As Name (if applicable): N/A	Tax Identification Number (required): 20-4730341			
Primary Business Address				
Line 1 (Street Name and Number): 1151 Falls Road				
Address Line 2 (Suite, Room, etc.): Suite 2000				
City: Rocky Mount	State: NC	Zip Code: 27804	County: Nash County	
Mailing Address (P.O. Box): N/A	City: N/A	State: N/A	Zip Code: N/A	County: N/A
Additional Business Location(s): Duplicate this page to provide all locations if necessary.				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	
Business Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	
Business Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	

Disclosure of Subcontractor Information				
Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5% ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure.				
This response applies to: [ ] The Offeror [X] An Owner of the Offeror				
If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above): Centene Corporation				
The person or entity named as an: [X] Ownership Interest [ ] Management Control Interest				
If there is an ownership interest, what is the ownership percentage? 100 %				
If there is a management control interest, describe that interest:				
Effective Date of Ownership and/or Management Control:				
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service: National Imaging Associates, Inc.				
Doing Business As Name (if applicable): N/A		Tax Identification Number (required): 22-3428367		
Primary Business Address				
Line 1 (Street Name and Number): 8621 Robert Fulton Drive				
Address Line 2 (Suite, Room, etc.):				
City: Columbia	State: MD	Zip Code: 21042	County: Howard County	
Mailing Address (P.O. Box): N/A	City: N/A	State: N/A	Zip Code: N/A	County: N/A
Additional Business Location(s): Duplicate this page to provide all locations if necessary.				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	
Business Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State:	Zip Code:	County: N/A	
Business Location				
Address Line 1: N/A				
Address Line 2: N/A				
City: N/A	State: N/A	Zip Code: N/A	County: N/A	

Disclosure of Subcontractor Information (cont.)		
Are any individuals disclosed in Section 1 or 2 related to the subcontractor or an owner of the subcontractor as a spouse, parent, child, or sibling? [ ] Yes [X] No **If yes, provide the following information for each.**		
Name of Subcontractor/ Subcontractor's Owner	**Name of Offeror's Owner**	**Relationship**

Section 3: Other Disclosing Entities

Ownership Interests in the Division's Fiscal Agent, Another Managed Care Entity, or other Disclosing Entity under 42 C.F.R § 104(b)
Do any of the entities or individuals named in Sections 1.a or 1.b have an ownership and/or management control interest in the Division's Fiscal Agent? [ ] Yes [X] No Do any of the entities or individuals named in Sections 1.a or 1.b have an ownership and/or management control interest in Another Managed Care Entity? [X] Yes [ ] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [X] Yes [ ] No If yes to any question above, provide additional information below:

Name of entity/individual named in Section 1.a or 1.b	**Name of Entity in which the entity/individual has an interest**	**Describe the entity/individual's interest (Ownership or Management)**	**If the entity/individual is an owner, give the ownership percentage.**
Centene Corporation	Magnolia Health Plan, Inc.	Ownership	100%
Centene Corporation	Care1st Health Plan Arizona, Inc.	Ownership	100%
Centene Corporation	Arkansas Total Care, Inc.	Ownership	49%
Centene Corporation	California Health & Wellness, Inc.	Ownership	100%
Centene Corporation	Health Net Community Solutions, Inc.	Ownership	100%
Centene Corporation	Sunshine State Health Plan, Inc.	Ownership	100%
Centene Corporation	Peach State Health Plan, Inc.	Ownership	100%
Centene Corporation	WellCare of Georgia, Inc.	Ownership	100%
Centene Corporation	WellCare Health Insurance of Arizona, Inc. d/b/a Ohana Health Plan, Inc.	Ownership	100%
Centene Corporation	Meridian Health Plan of Illinois, Inc.	Ownership	100%
Centene Corporation	Coordinated Care Corporation d/b/a Managed Health Services (MHS) Indiana	Ownership	100%
Centene Corporation	Iowa Total Care, Inc.	Ownership	100%
Centene Corporation	Sunflower State Health Plan, Inc.	Ownership	100%

Centene Corporation	WellCare Health Insurance Company of Kentucky, Inc. d/b/a WellCare of Kentucky, Inc.	Ownership	100%
Centene Corporation	Louisiana Healthcare Connections, Inc.	Ownership	100%
Centene Corporation	Meridian Health Plan of Michigan, Inc.	Ownership	100%
Centene Corporation	Michigan Complete Health, Inc.	Ownership	100%
Centene Corporation	Home State Health Plan, Inc.	Ownership	95%
Centene Corporation	Health Net Community Solutions of Arizona d/b/a Arizona Complete Health	Ownership	100%
Centene Corporation	Nebraska Total Care, Inc.	Ownership	100%
Centene Corporation	SilverSummit Healthplan, Inc.	Ownership	100%
Centene Corporation	Granite State Health Plan d/b/a New Hampshire Health Families	Ownership	100%
Centene Corporation	WellCare Health Plans of New Jersey, Inc.	Ownership	100%
Centene Corporation	Western Sky Community Care, Inc.	Ownership	100%
Centene Corporation	New York Quality Health Care Corporation d/b/a Fidelis Care	Ownership	100%
Centene Corporation	Carolina Complete Health, Inc.	Ownership	80%
Centene Corporation	WellCare of North Carolina, Inc.	Ownership	100%
Centene Corporation	Buckeye Community Health Plan, Inc. d/b/a Buckeye Health Plan	Ownership	100%
Centene Corporation	Trillium Community Health Plan, Inc.	Ownership	100%
Centene Corporation	Pennsylvania Health and Wellness Inc.	Ownership	100%
Centene Corporation	Absolute Total Care, Inc.	Ownership	100%

Centene Corporation	WellCare of South Carolina, Inc.	Ownership	100%
Centene Corporation	Superior HealthPlan Network, Inc.	Ownership	100%
Centene Corporation	Superior HealthPlan Community Solutions, Inc.	Ownership	100%
Centene Corporation	Coordinated Care of Washington, Inc.	Ownership	100%
Centene Corporation	Managed Health Services Insurance Corporation d/b/a MHS Health Wisconsin, Inc.	Ownership	100%
Centene Corporation	Bridgeway Health Solutions of Arizona, Inc.	Ownership	100%
Centene Corporation	Centene Venture Company Alabama Health Plan, Inc.	Ownership	60%
Centene Corporation	WellCare of Alabama, Inc.	Ownership	100%
Centene Corporation	Arkansas Health and Wellness Health Plan, Inc.	Ownership	100%
Centene Corporation	Harmony Health Plan, Inc.	Ownership	100%
Centene Corporation	WellCare of Arkansas, Inc.	Ownership	100%
Centene Corporation	WellCare Health Insurance Company of America	Ownership	100%
Centene Corporation	Qualchoice Life & Health Insurance Company, Inc.	Ownership	100%
Centene Corporation	Celtic Insurance Company	Ownership	100%
Centene Corporation	QCA Health Plan, Inc.	Ownership	100%
Centene Corporation	Health Net of Arizona, Inc.	Ownership	100%
Centene Corporation	Health Net Community Solutions of Arizona	Ownership	100%
Centene Corporation	WellCare Health Insurance of the Southwest, Inc.	Ownership	100%
Centene Corporation	OneCare by Care1st Health Plan of Arizona, Inc.	Ownership	100%
Centene Corporation	WellCare of California, Inc.	Ownership	100%
Centene Corporation	Health Net Life Insurance Company	Ownership	100%

Centene Corporation	WellCare of Connecticut, Inc.	Ownership	100%
Centene Corporation	WellCare Health Insurance of Connecticut, Inc.	Ownership	100%
Centene Corporation	Centene Venture Company Florida	Ownership	60%
Centene Corporation	Ambetter of Peach State, Inc.	Ownership	100%
Centene Corporation	Centene Venture Company Illinois	Ownership	60%
Centene Corporation	WellCare of Illinois, Inc.	Ownership	100%
Centene Corporation	Centene Venture Company Indiana, Inc.	Ownership	60%
Centene Corporation	Centene Venture Company Kansas	Ownership	60%
Centene Corporation	WellCare Health Plans of Kentucky, Inc.	Ownership	100%
Centene Corporation	WellCare Health Insurance Company of Louisiana, Inc.	Ownership	100%
Centene Corporation	WellCare of Maine, Inc.	Ownership	100%
Centene Corporation	WellCare of Missouri Health Insurance Company, Inc.	Ownership	100%
Centene Corporation	WellCare Health Plans of Missouri, Inc.	Ownership	100%
Centene Corporation	WellCare of Mississippi, Inc.	Ownership	100%
Centene Corporation	Ambetter of North Carolina, Inc.	Ownership	100%
Centene Corporation	WellCare Health Insurance of North Carolina, Inc.	Ownership	100%
Centene Corporation	WellCare of New Hampshire, Inc.	Ownership	100%
Centene Corporation	WellCare Health Insurance Company of New Hampshire, Inc.	Ownership	100%
Centene Corporation	American Progressive Life and Health Insurance Company of New York	Ownership	100%
Centene Corporation	Buckeye Health Plan Community Solutions, Inc.	Ownership	100%
Centene Corporation	Health Net Health Plan of Oregon	Ownership	100%

Centene Corporation	WellCare Health Plans of Rhode Island, Inc.	Ownership	100%
Centene Corporation	Centene Venture Company Tennessee	Ownership	60%
Centene Corporation	WellCare Health Insurance of Tennessee, Inc.	Ownership	100%
Centene Corporation	Bankers Reserve Life Insurance Company	Ownership	100%
Centene Corporation	WellCare of Texas, Inc.	Ownership	100%
Centene Corporation	Selectcare of Texas, Inc.	Ownership	100%
Centene Corporation	WellCare National Health Insurance Company	Ownership	100%
Centene Corporation	Centene Venture Insurance Company Texas	Ownership	60%
Centene Corporation	WellCare Health Plans of Vermont, Inc.	Ownership	100%
Centene Corporation	WellCare of Washington, Inc.	Ownership	100%
Centene Corporation	WellCare Health Insurance Company of Washington, Inc.	Ownership	100%
Centene Corporation	WellCare Prescription Insurance, Inc.	Ownership	100%
Centene Corporation	Granite Alliance Insurance Company	Ownership	100%
Centene Corporation	Magellan Health QIO, LLC	Ownership	100%
Centene Corporation	Magellan Complete Care of Louisiana, Inc.	Ownership	100%
Centene Corporation	Merit Health Insurance Company	Ownership	100%
Centene Corporation	National Imaging Associates, Inc.	Ownership	100%
Centene Corporation	Magellan Healthcare, Inc.	Ownership	100%
Centene Corporation	Magellan Behavioral Health of Pennsylvania, Inc.	Ownership	100%
Centene Corporation	Magellan Rx Pharmacy, LLC	Ownership	100%
Centene Corporation	VRx Pharmacy, LLC	Ownership	100%
Centene Corporation	Magellan Medicaid Administration	Ownership	100%

[END OF RESPONSE]

4.3.2.2 WHEN AND TO WHOM INFORMATION WILL BE DISCLOSED

In accordance with 42 C.F.R. § 455.104(c), disclosures from the Offeror/winning Contractor are due at any of the following times: 1. Upon the Contractor submitting a qualification in accordance with the State's procurement process; 2. Annually, including upon the execution, renewal, and extension of the contract with the State; and, 3. Within thirty-five (35) days after any change in ownership of the Contractor. In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency. The Offeror must use the appropriate form in Appendix G as its response to this section

Please see **Attachment 4.3.2.2 Appendix G** for our response to this section.

Response to 4.3.2.2 When and to Whom Information Will Be Disclosed (Marked) – Pass/Fail

The Offeror attests to and affirms the following:

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

1. Upon the Contractor submitting a qualification in accordance with the State's procurement process;
2. Annually, including upon the execution, renewal, and extension of the contract with the State; and,
3. Within thirty-five (35) days after any change in ownership of the Contractor.

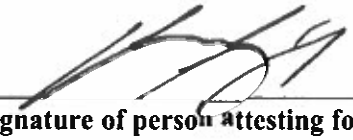
In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency.

The Offeror attests that the disclosures made as part of this application are true and correct, and the Offeror will make required disclosures as necessary for this RFQ. If the Offeror is chosen as a Contractor, the Offeror will comply with all disclosure requirements.

Magnolia Health Plan, Inc.
Name of Offeror

Aaron Sisk
Printed name of person attesting for Offeror

President and CEO
Title of person attesting for Offeror



Signature of person attesting for Offeror

2/24/2022
Date

[END OF RESPONSE]

4.3.2.3 INFORMATION RELATED TO BUSINESS TRANSACTIONS

In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about: 1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request; and, 2. 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. The Offeror must use the appropriate form in Appendix G to respond to this section

Please see **Attachment 4.3.2.3 Appendix G** for our response to this section.

Response to 4.3.2.3 Information Related to Business Transactions (Marked) – Pass/Fail

In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about:

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

2. Any significant business transactions between the Offeror 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.

The date of the request is the issue date of the RFQ.

If the Offeror has information responsive to this request, use the forms in the following pages of this Attachment to respond to this request.

If the Offeror does not have information responsive to one or both of these requests, attest to that by signing below and submitting this page as the response to this request. If the Offeror has information responsive to one of these requests and not the other, use the following attestation as applicable as well as the applicable form to respond.

The Offeror does not have:

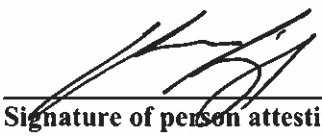
[ ] The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request.

[ ] Any significant business transactions between the Offeror 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.

Magnolia Health Plan, Inc.
Name of Offeror

Aaron Sisk
Printed name of person attesting for Offeror

President and CEO
Title of person attesting for Offeror



Signature of person attesting for Offeror

2/24/2022
Date

Business Transactions with Subcontractors	
Disclose The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request. Use additional pages as necessary.	
Name of Subcontractor: NIA / Magellan	**TIN/SSN (as applicable):** [redacted]
Address of Subcontractor: 14100 Magellan Plaza Maryland Heights, MO 63043	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Subcontractor: Envolve Vision	**TIN/SSN (as applicable):** [redacted]
Address of Subcontractor: 1151 Falls Road, Rocky Mount, NC 27804	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Subcontractor: Envolve Dental	**TIN/SSN (as applicable):** [redacted]
Address of Subcontractor: 7700 Forsyth Blvd. St. Louis, MO 63105	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Subcontractor: US Medical Management	**TIN/SSN (as applicable):** [redacted]
Address of Subcontractor: 500 Kirts Blvd, Troy, MI 48084	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Subcontractor: Envolve Pharmacy	**TIN/SSN (as applicable):** [redacted]
Address of Subcontractor: 8427 Southpark Circle Bldg. 300, Suite 400, Orlando, Florida 32819-9057	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]

Significant Business Transactions	
Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.	
Name of Entity with Whom the Transaction Took Place: NIA/Magellan	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 14100 Magellan Plaza Maryland Heights, MO 63043	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Envolve Vision	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 1151 Falls Road, Rocky Mount, NC 27804	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Envolve Dental	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 7700 Forsyth Blvd. St. Louis, MO 63105	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: US Medical Management	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 500 Kirts Blvd, Troy, MI 48084	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]

Name of Entity with Whom the Transaction Took Place: AArete Consulting	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 200 E Randolph St Ste 3010, Chicago, IL 60601	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Medagate Corp	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 303 Twin Dolphin Drive Suite 600 Redwood City, CA 94065	
Date of Transaction: 2019	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Radialogica	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 511 N. Garrison Avenue, St Louis, MO 63103	
Date of Transaction: 2019	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Harvey Dallas Printing	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 315 Carrier Boulevard, Richland, MS 39218	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]

Name of Entity with Whom the Transaction Took Place: Medical Transportation Management	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 6360 I-55 N Suite 201 Jackson, MS 39211	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Cotiviti	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 115 Perimeter Center Place, Suite 700, Atlanta, GA, 30346	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Simple Healthcare	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 5 Portofino Drive, #2101, Pensacola Beach, FL 32561	
Date of Transaction: 2017	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: MyHealth Direct	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 102 Woodmont Boulevard, Suite 400, Nashville, TN 37205	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]

Name of Entity with Whom the Transaction Took Place: Rawlings Company	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 1 Eden Pkwy, La Grange, KY 40031	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: HumanArc	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 16260 North 71st. Suite 325, Scottsdale, AZ 85254	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Vigilant Diabetes Group	
TIN/SSN (as applicable): 47-2885777	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: PO Box 321396 Jackson, MS 39232	
Date of Transaction: 2021	**Amount of Transaction:** $1,062,000
Name of Entity with Whom the Transaction Took Place: Teladoc Health	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 1945 Lakepointe Drive Lewisville, TX 75057 USA	
Date of Transaction: 2019	**Amount of Transaction:** [redacted]

Name of Entity with Whom the Transaction Took Place: Turning Point Healthcare	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 1000 Primera Boulevard, Suite 3160 Lake Mary, FL 32746	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Rx Advance	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 2 Park Central Drive Suite 300 Southborough, MS 01772	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]
Name of Entity with Whom the Transaction Took Place: Envolve Pharmacy	
TIN/SSN (as applicable): [redacted]	**The entity is a:** **[ ] Subcontractor** **[X] Wholly-Owned Subsidiary**
Address of Subcontractor: 8427 Southpark Circle Bldg. 300, Suite 400, Orlando, Florida 32819-9057	
Date of Transaction: 2021	**Amount of Transaction:** [redacted]

[END OF RESPONSE]

4.3.2.4 CHANGE OF OWNERSHIP

A change of ownership of the Offeror 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 Offeror. 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. If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract. If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the appropriate attestation included in Appendix G as its response to this section.

Please see **Attachment 4.3.2.4 Appendix G** for our response to this section.

Response to 4.3.2.4 Change of Ownership (Marked) – Pass/Fail

If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract.

If the Offeror does not have a disclosure to make that is responsive to this request, the offeror must sign below, attesting to the following:

- The Offeror does not have a disclosure that is responsive to this request.
- Should the Offeror be chosen as a winning Contractor, the Offeror will comply with the requirement to disclose any and all changes of ownership in the time and manner required by the C.F.R. and the Division.

Magnolia Health Plan, Inc.
Name of Offeror

Aaron Sisk
Printed name of person attesting for Offeror

President and CEO
Title of person attesting for Offeror

Signature of person attesting for Offeror

2/24/2022
Date

[END OF RESPONSE]

4.3.2.5 DISCLOSURE OF IDENTITY OF ANY PERSON CONVICTED OF A CRIMINAL OFFENSE

In accordance with 42 C.F.R. § 455.106(a), the Contractor shall disclose to the Division the identity of any person who: 1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and, 2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Titles XIX or XXI services program since the inception of those programs. If the Offeror does have a disclosure to make that is responsive to this section, the Offeror must use the appropriate form in Appendix G to make that disclosure and respond to this section. If the Offeror does not have a disclosure to make regarding the above, the Offeror must complete the attestation included in Appendix G as its response to this section

Please see **Attachment 4.3.2.5 Appendix G** for our response to this section.

Response to 4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked) – Pass/Fail

If the Offeror has information responsive to this request, provide that information using the form on the following page. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose make disclosures regarding this issue during the life of the Contract.

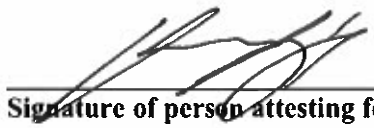
If the Offeror does not have a disclosure to make that is responsive to this request, the offeror must sign below, attesting to the following:

- The Offeror does not have a disclosure that is responsive to this request.
- Should the Offeror be chosen as a winning Contractor, the Offeror will comply with the requirement to make disclosures regarding this issue in the time and manner required by the C.F.R. and the Division.

Magnolia Health Plan, Inc.
Name of Offeror

Aaron Sisk
Printed name of person attesting for Offeror

President and CEO
Title of person attesting for Offeror


Signature of person attesting for Offeror

2/24/2022
Date

Criminal Convictions and Other Sanctions
Provide the requested information in this section for any person who: (1) Has an ownership or control interest in the Offeror OR is an agent or managing employee of the Offeror AND (2) Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Titles XIX or XXI services since the inception of those programs, OR (3) Has been convicted of a crime referenced in Miss. Code Ann. § 43-13-121(7)(c) – (h), (4) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c-h), (5) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program, (6) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program, (7) Has had his/her/its license or certification revoked, or (8) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.
Identify the person and each conviction/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Provide a copy of any documentation. Include additional copies of this page as necessary.

Name N/A	Criminal/Sanction Information N/A	Date N/A
Agency/Court/Administrative Body N/A	Resolution N/A	
Name N/A	Criminal/Sanction Information N/A	Date N/A
Agency/Court/Administrative Body N/A	Resolution N/A	
Name N/A	Criminal/Sanction Information N/A	Date N/A
Agency/Court/Administrative Body N/A	Resolution N/A	
Name N/A	Criminal/Sanction Information N/A	Date N/A
Agency/Court/Administrative Body N/A	Resolution N/A	
Name N/A	Criminal/Sanction Information N/A	Date N/A
Agency/Court/Administrative Body N/A	Resolution N/A	

[END OF RESPONSE]

4.3.2.6 AUDITED FINANCIAL STATEMENTS AND PRO FORMA FINANCIAL TEMPLATE

Audited financial statements for the contracting entity shall be provided for each of the last three (3) years, including, at a minimum:
1.Statement of income;
2.Balance sheet;
3.Statement of changes in financial position during the last three (3) years;
4.Statement of cash flow;
5.Auditors' reports;
6.Notes to financial statements; and,
7.Summary of significant accounting policies.
If the information requested above is not available, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support the explanation. Acceptance of the explanation provided is at the discretion of the Division.

Please see the following for Magnolia Health Plans Audited Financial Statements:

- **Attachment 4.3.2.6.a 2017-2018 Magnolia Health Plan, Inc. Audited Financial Statement**
- **Attachment 4.3.2.6.b 2018-2010 Magnolia Health Plan, Inc. Audited Financial Statement**
- **Attachment 4.3.2.6.c 2019-2020 Magnolia Health Plan, Inc. Audited Financial Statement**

The Offeror must also submit the following:
1. Documentation of available lines of credit, including maximum credit amount and amount available thirty (30) business days prior to the submission of the qualification; and,

Magnolia Health Plan is backed by its parent company Centene Corporation (Centene). Centene has (i) unsecured $2,000 million multi-currency revolving credit facility (the Revolving Credit Facility), which includes a $300 million sub-limit for letters of credit and a $200 million sub-limit for swingline loans and (ii) a $2,200 million unsecured delayed-draw term loan facility. The Company has an uncommitted option to increase its Company Credit Facility by an additional $500 million plus certain additional amounts based on its total debt to EBITDA ratio.

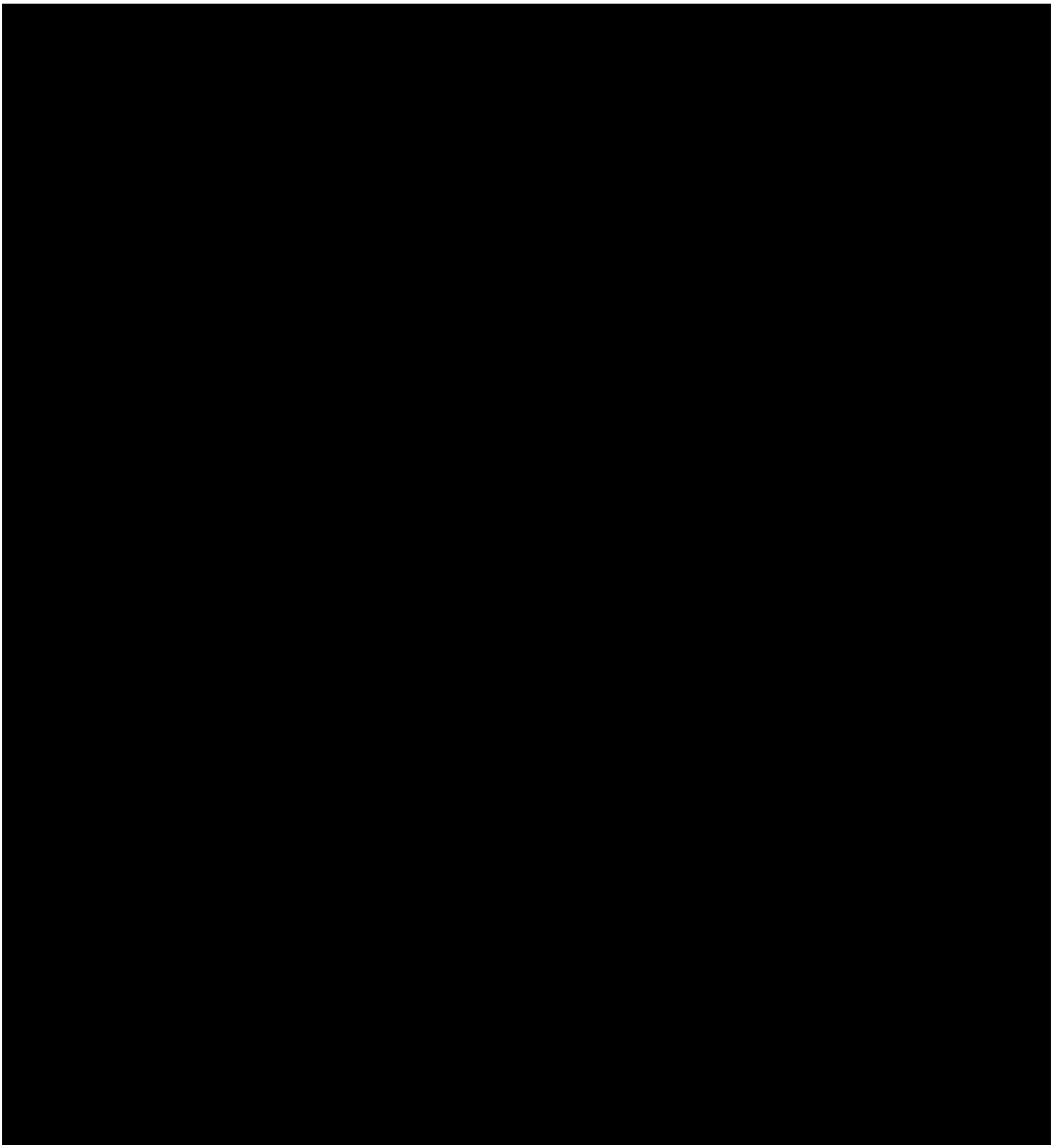
As of December 31, 2021, Centene had $149 million of borrowings outstanding under the Revolving Credit Facility, with a weighted average interest rate of1.29%. The Revolving Credit Facility and the Term Loan Facility will mature on August 16, 2026.

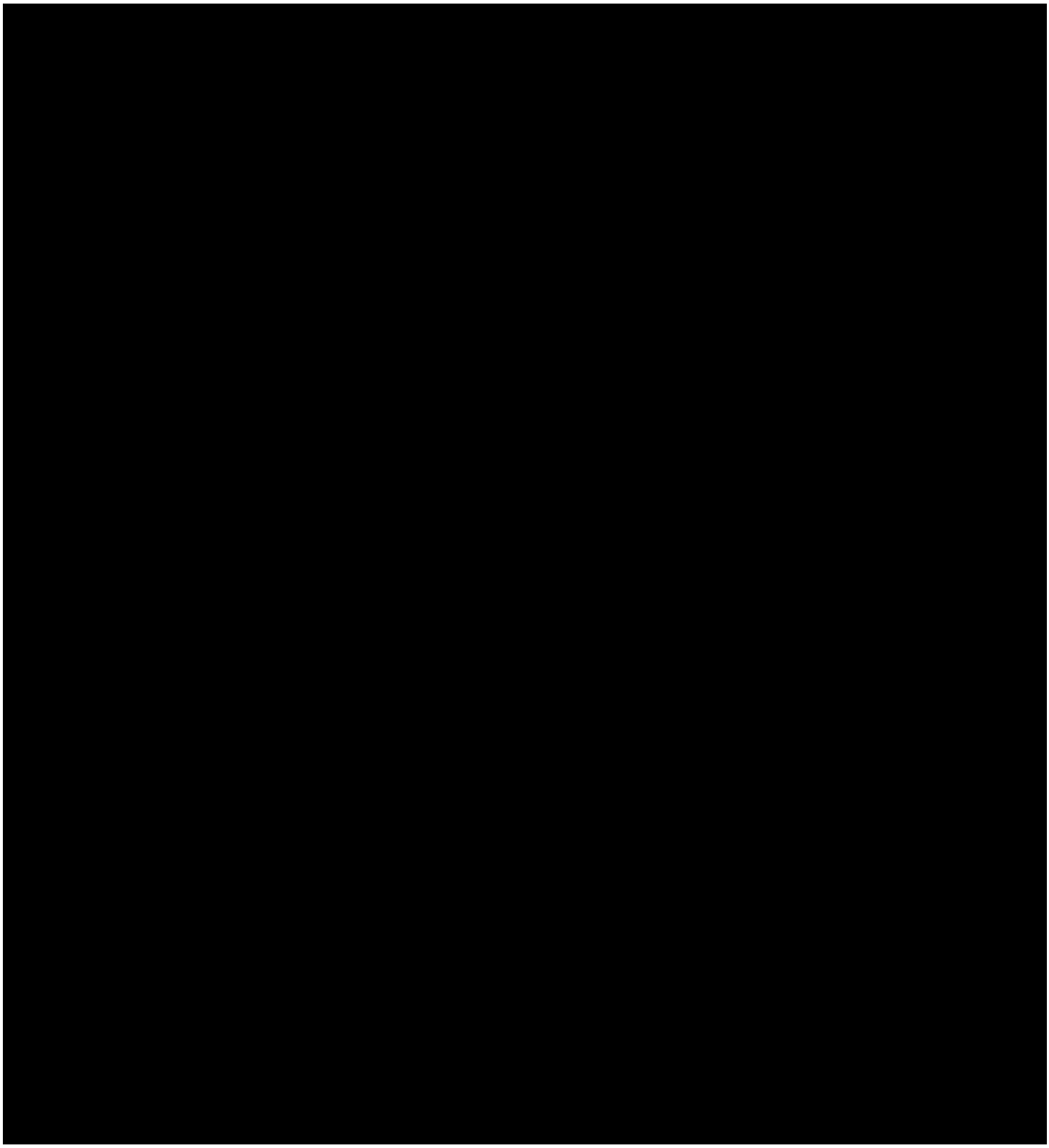
Centene has historically funded and will continue to fund Magnolia in the event the health plan has cash flow or capital needs. Centene possesses sufficient assets and reserves for contingencies and generates sufficient cash flow and positive income to support its subsidiary health plans such as Magnolia.

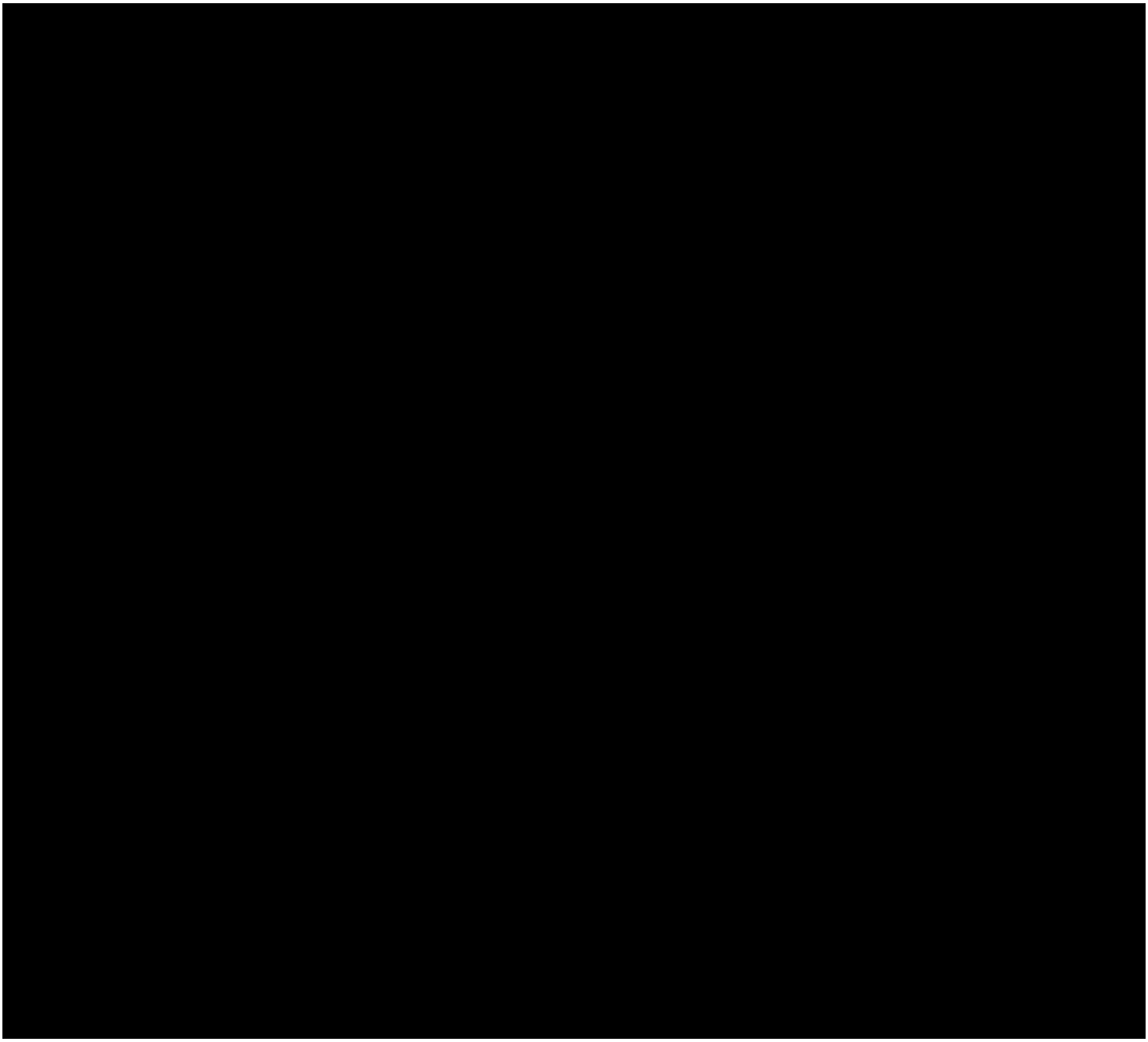
2.Three (3) year financial pro forma. Appendix G provides a link to the pro forma template to be completed by the Offeror.

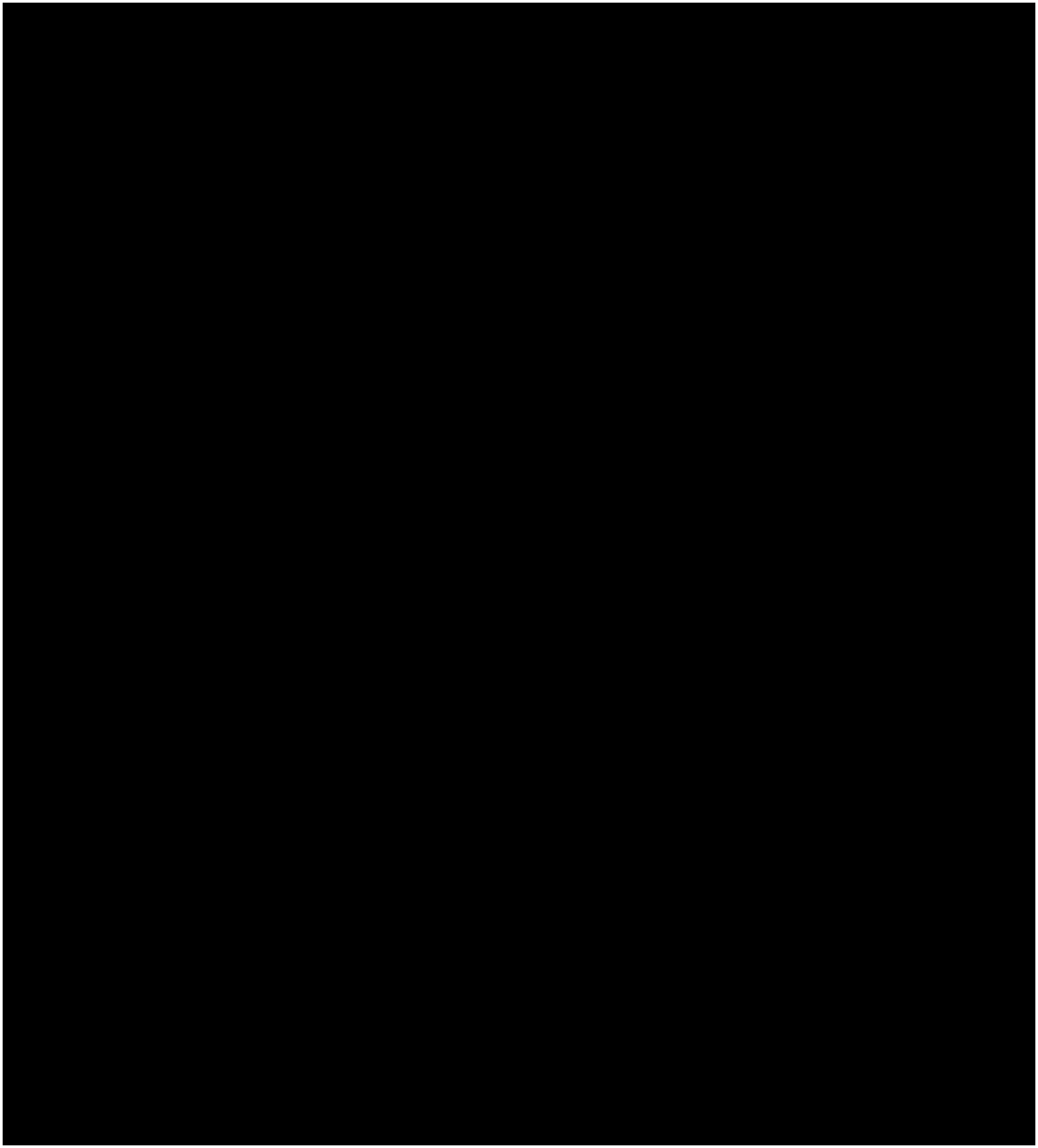
Please see **Attachment 4.3.2.6 Proforma Financial Template** for our response to this question.

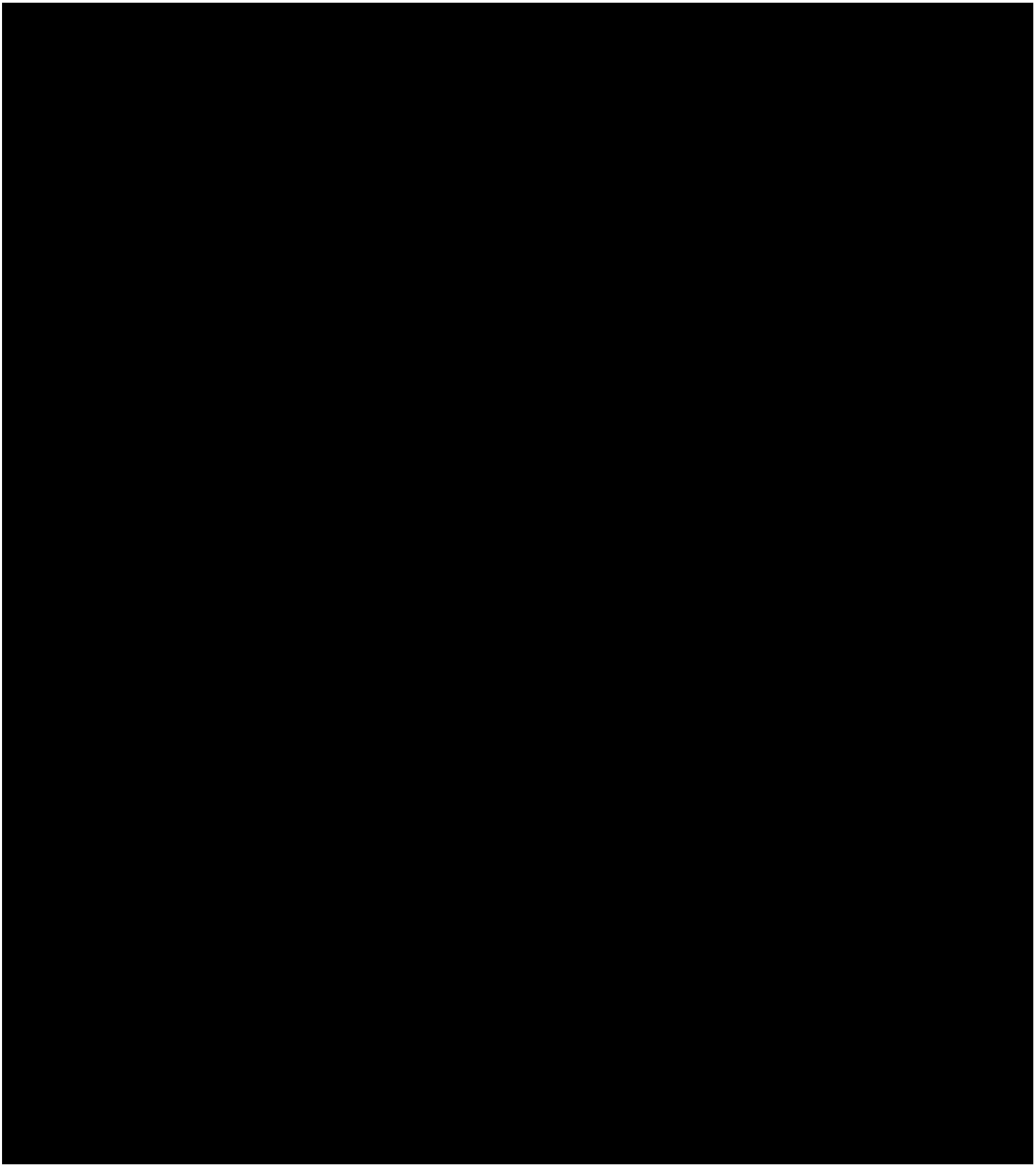
KPMG LLP
Suite 900
10 South Broadway
St. Louis, MO 63102-1761

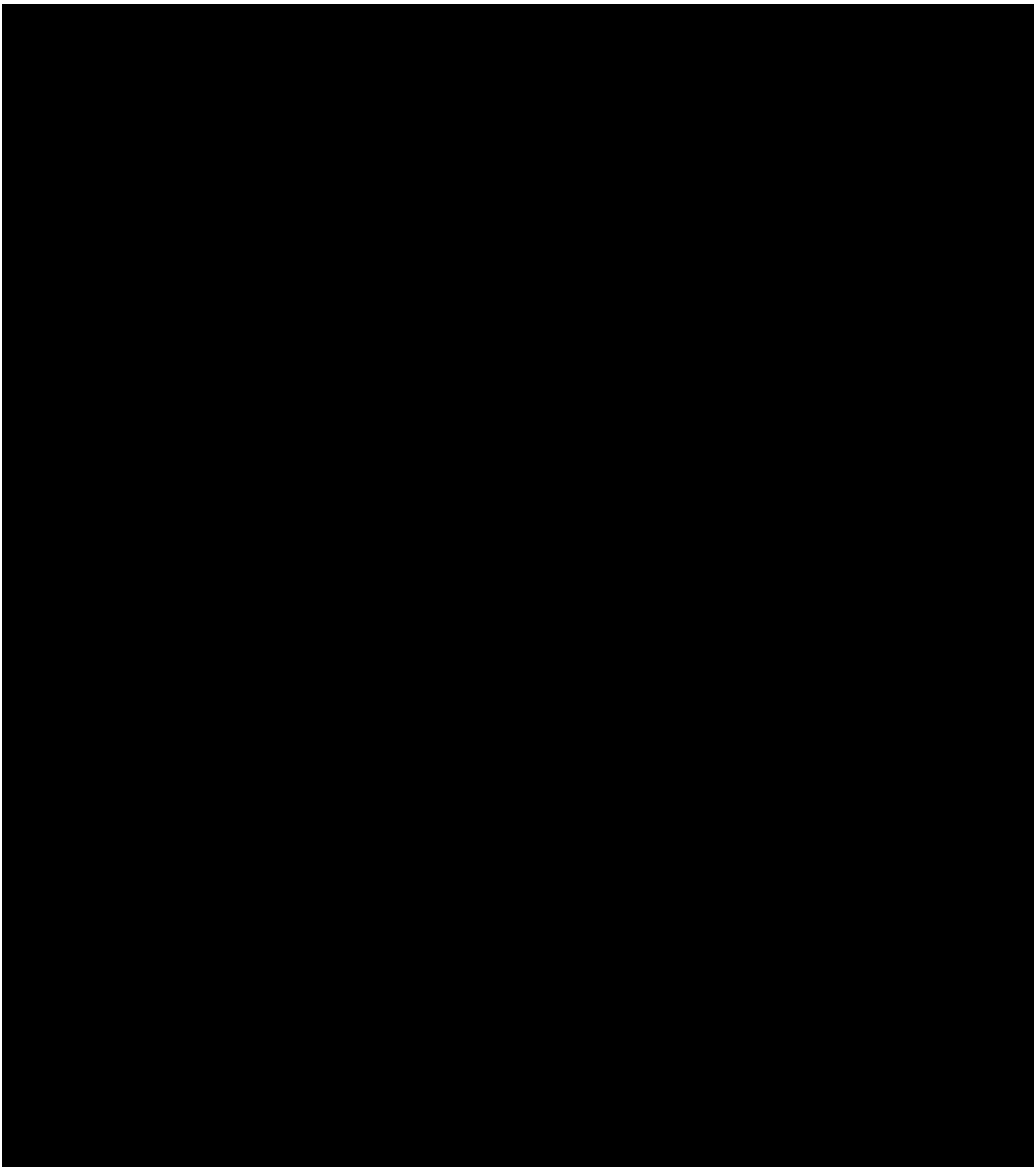


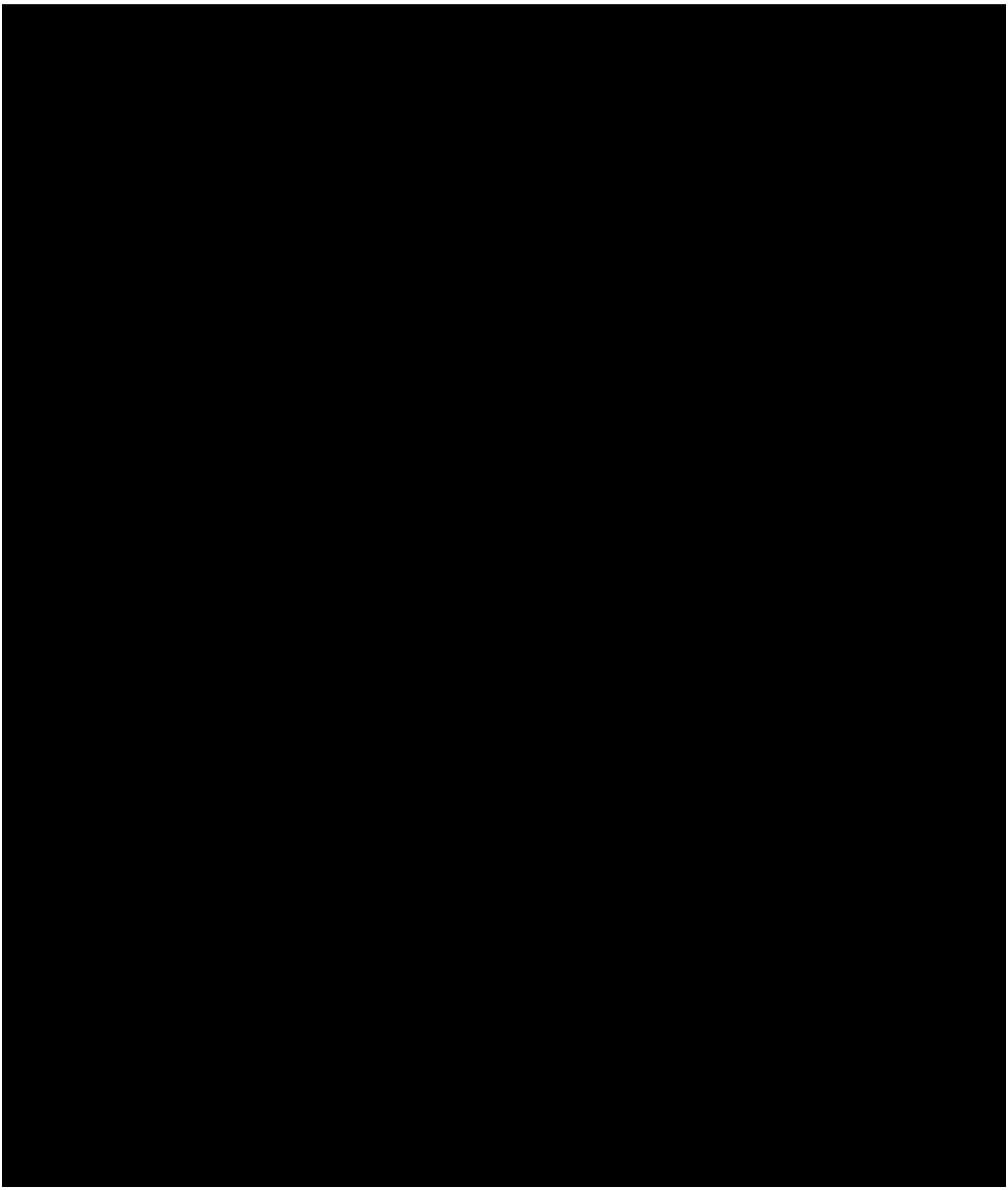


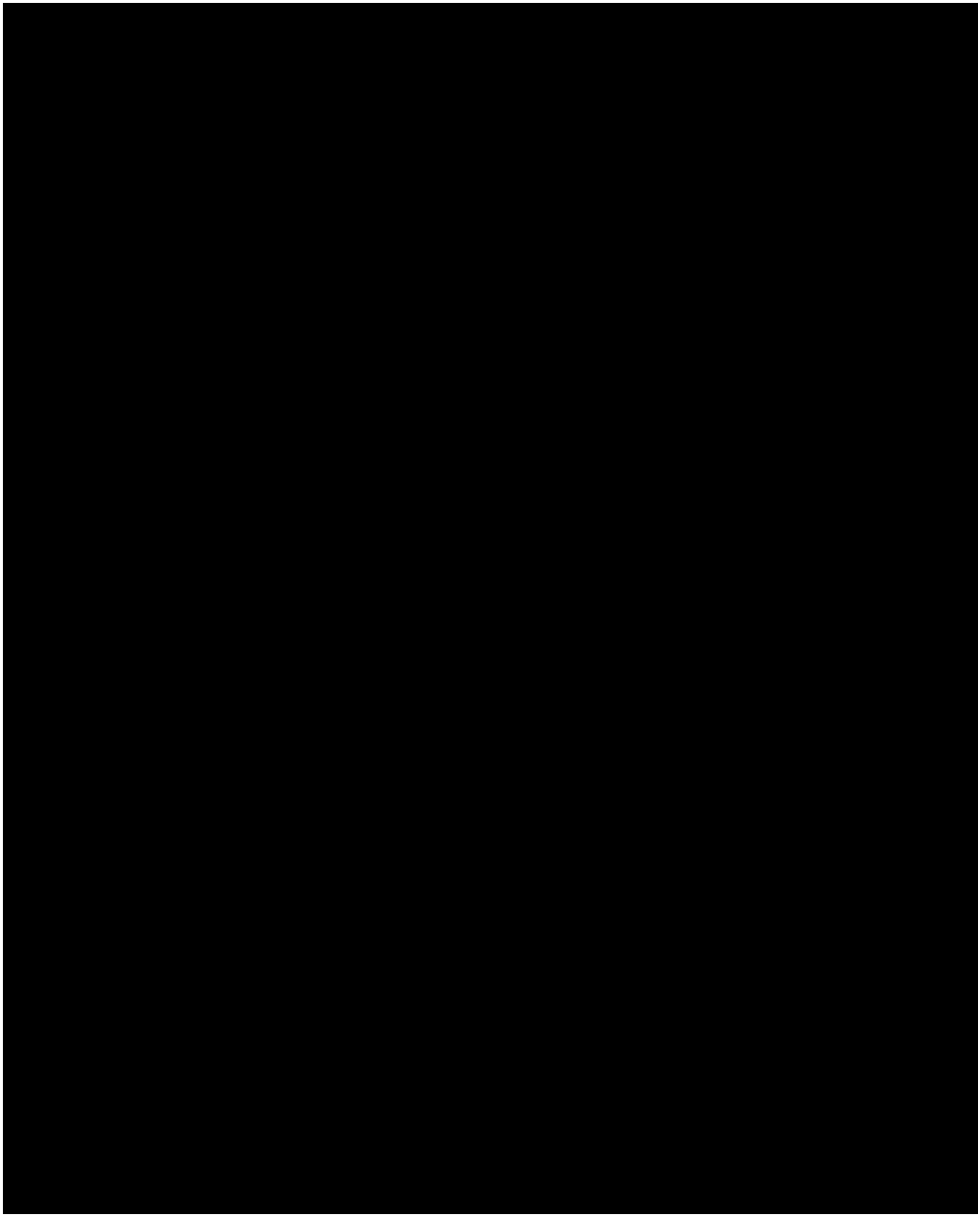


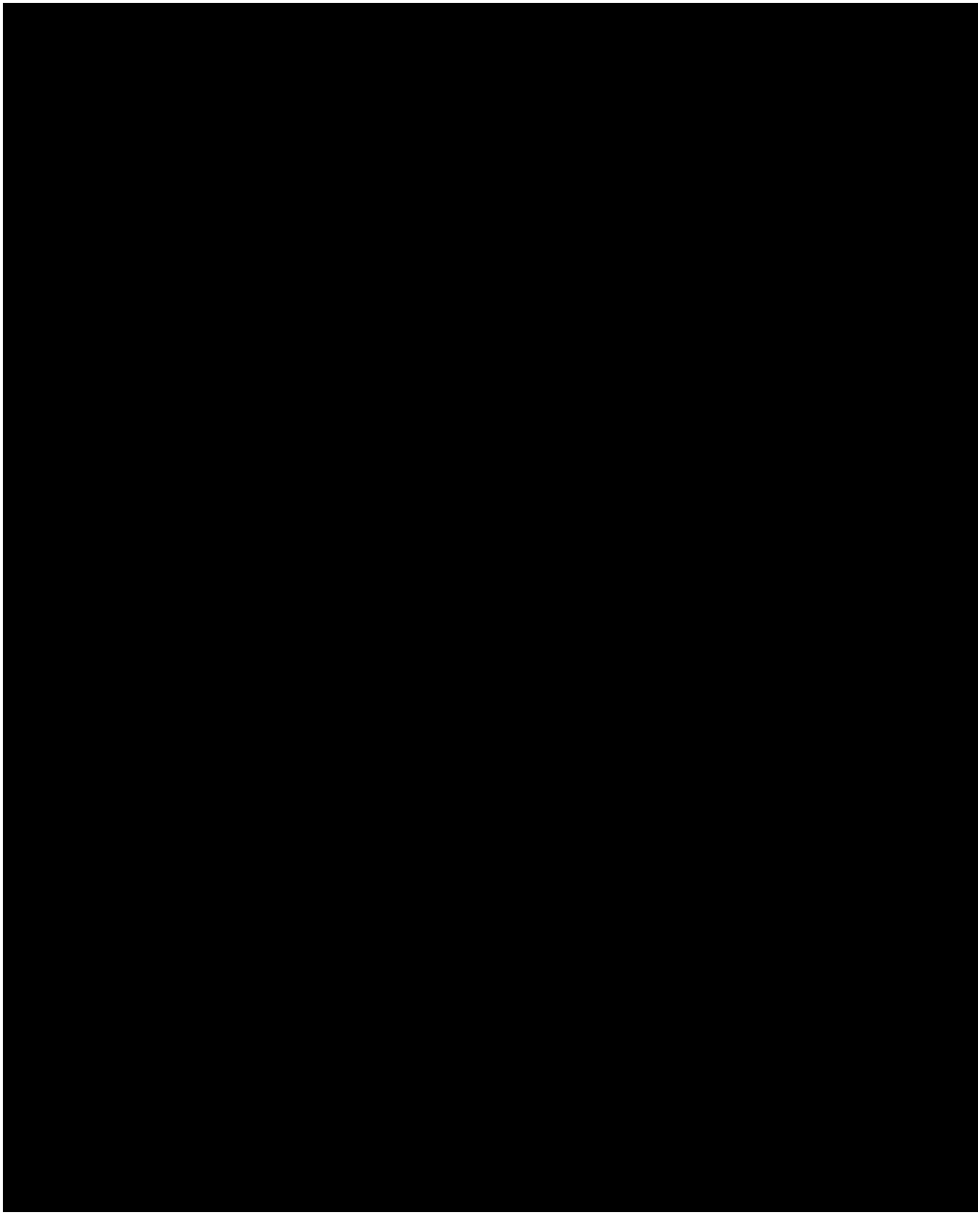


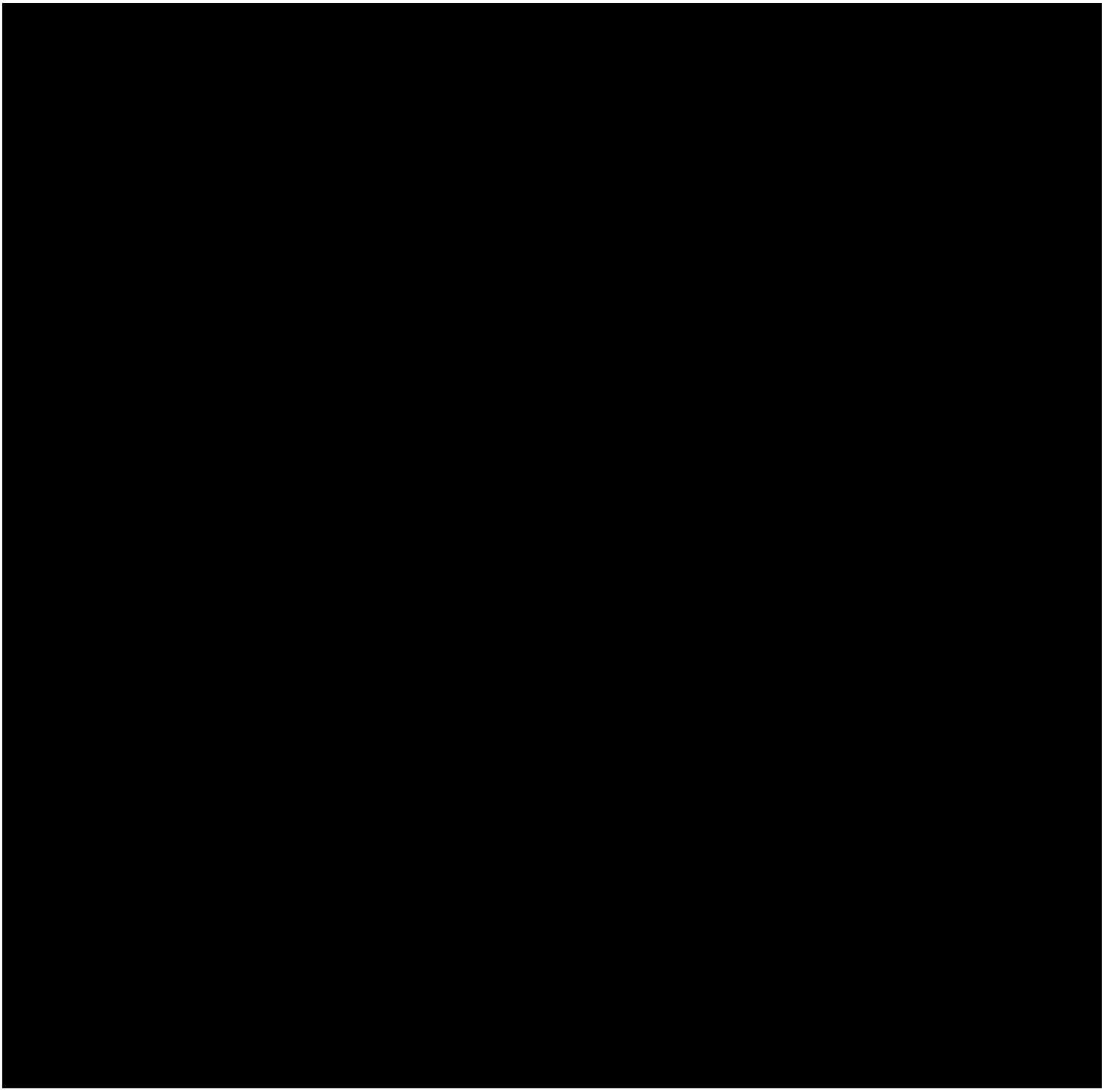


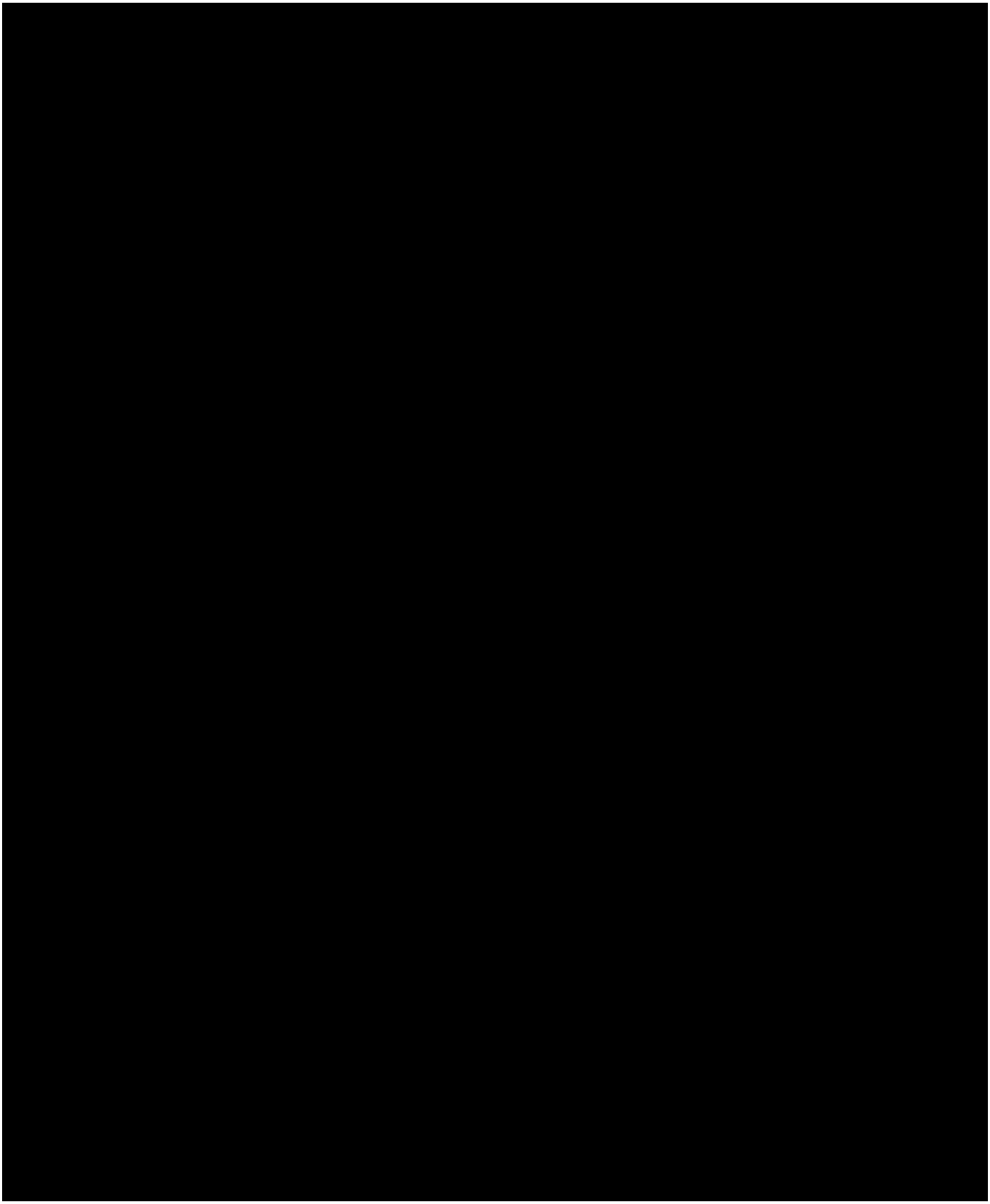


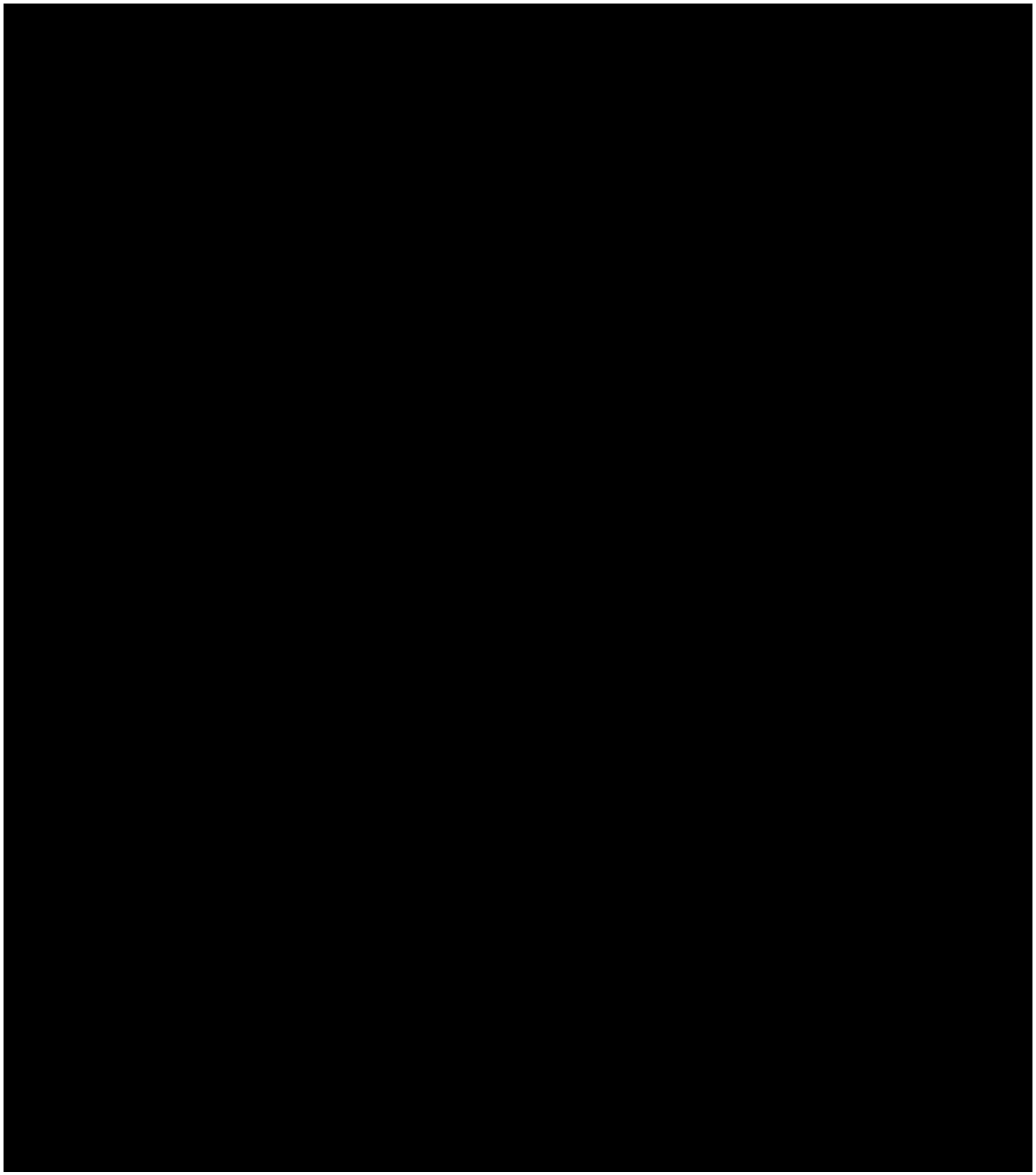


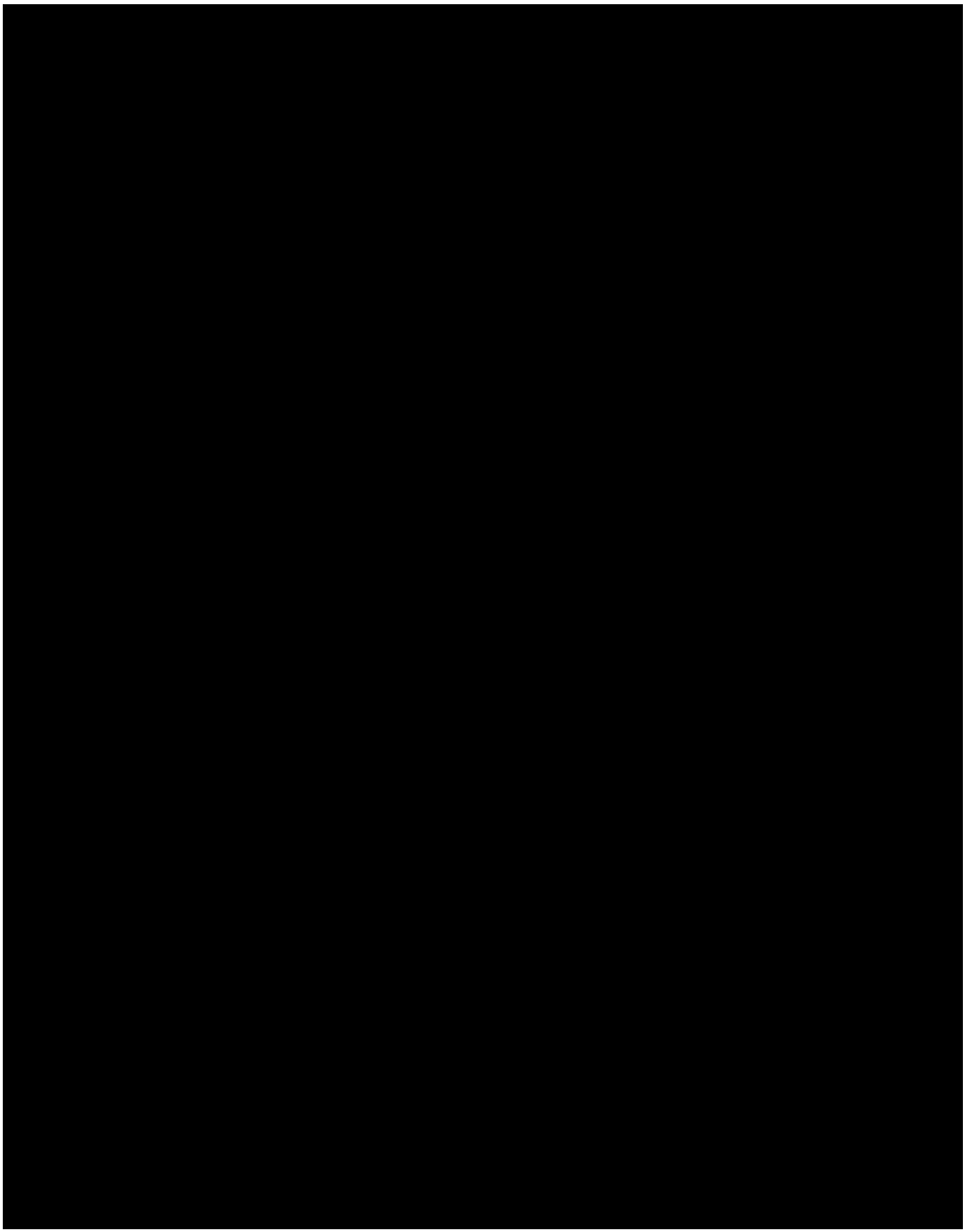


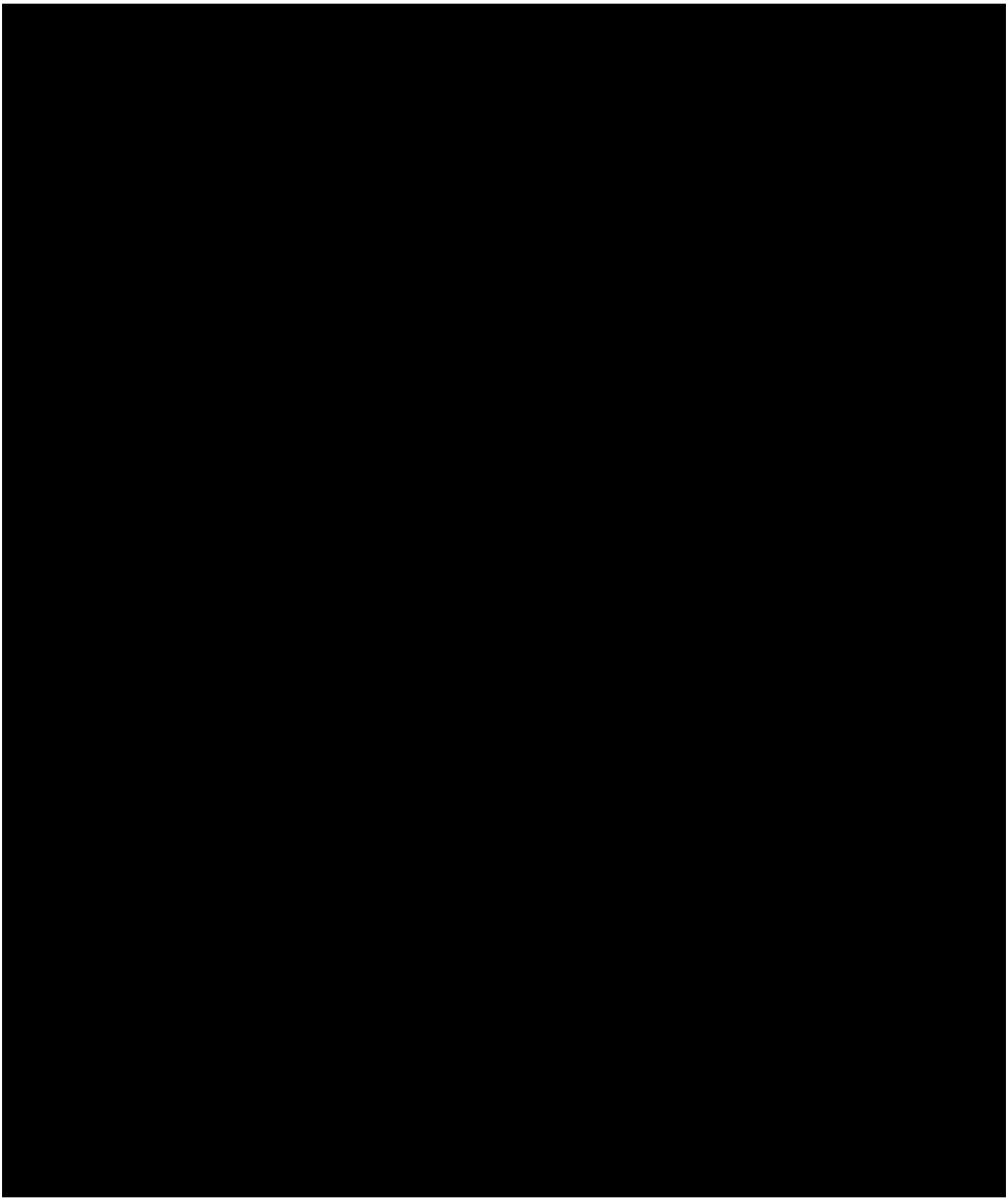


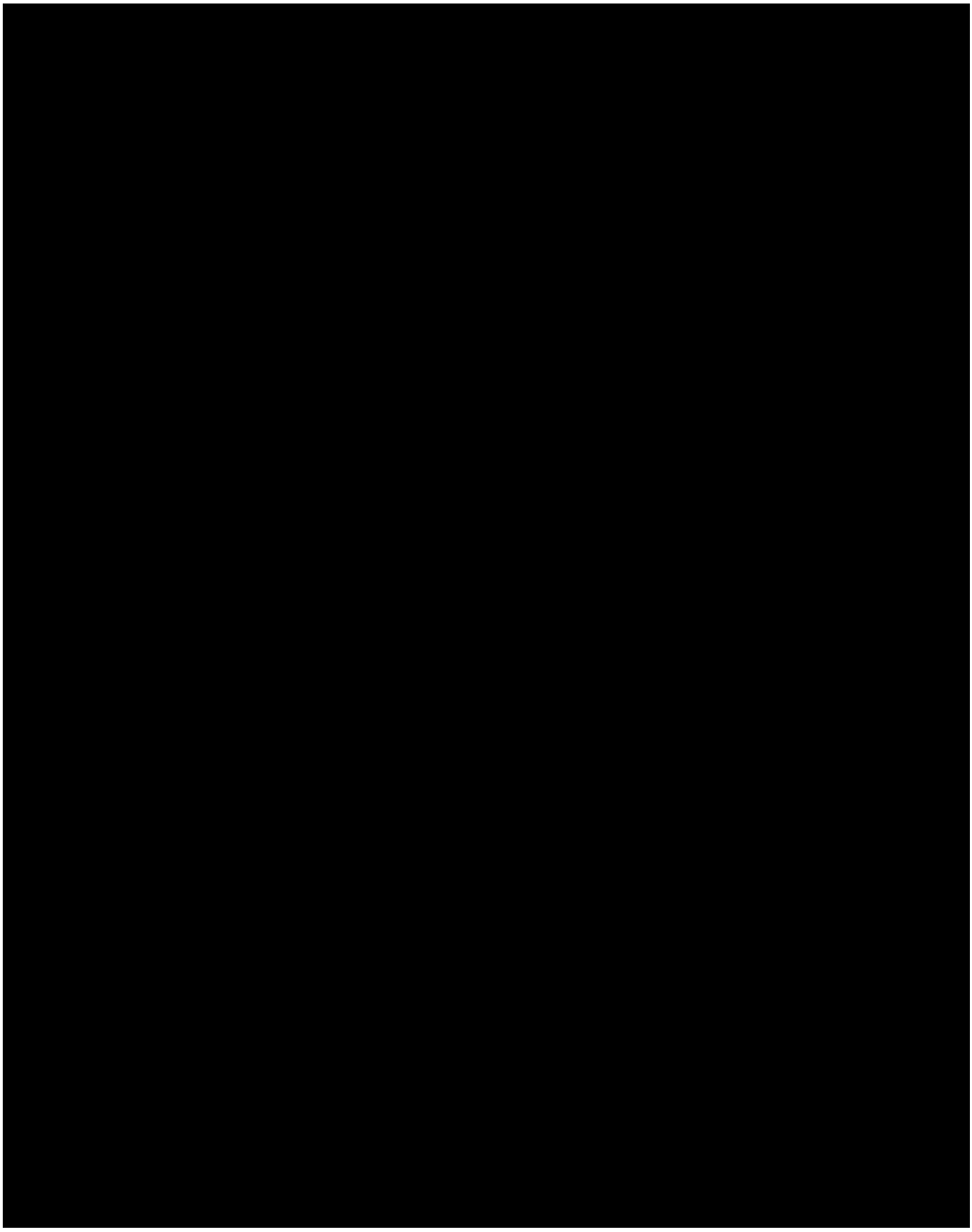


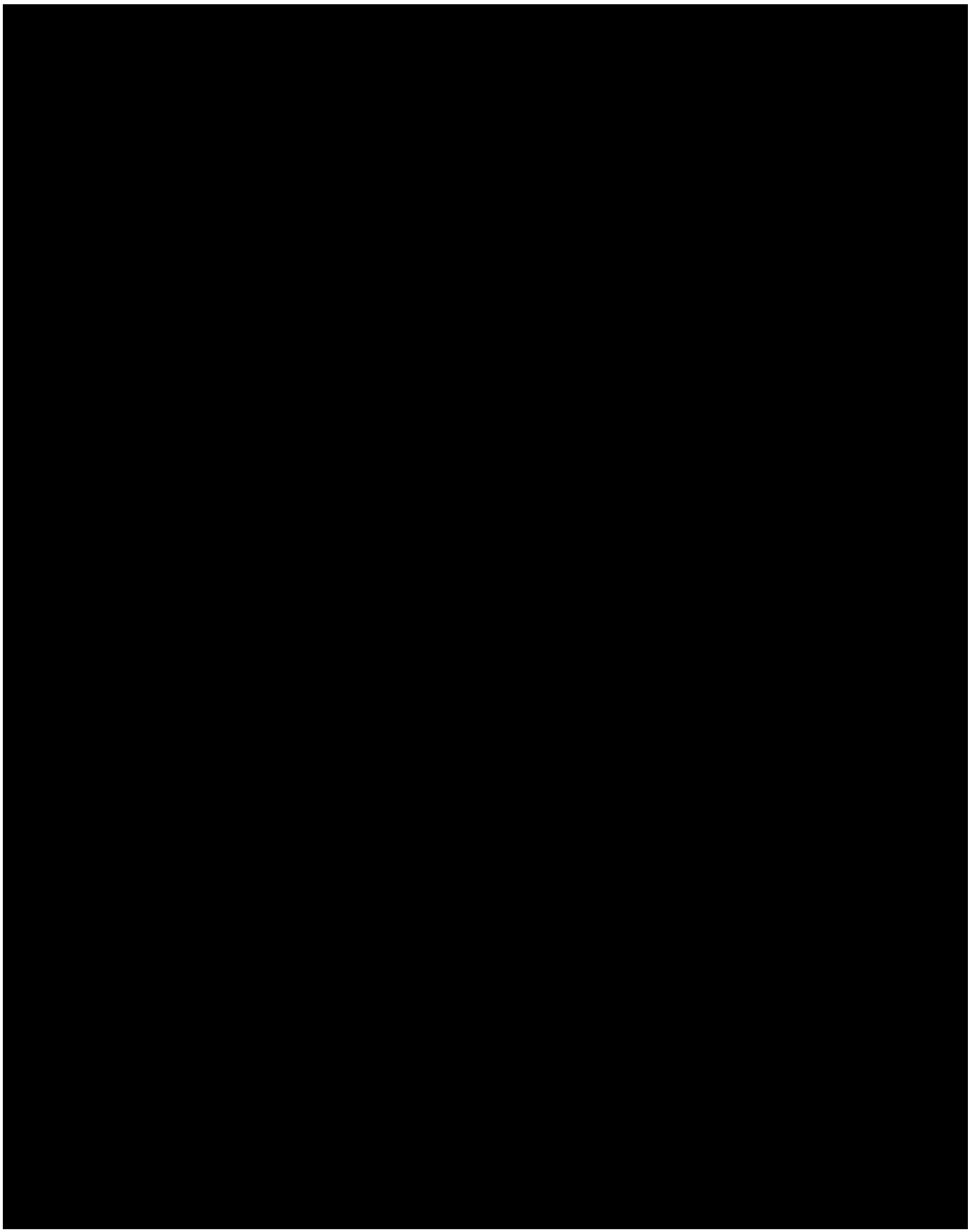


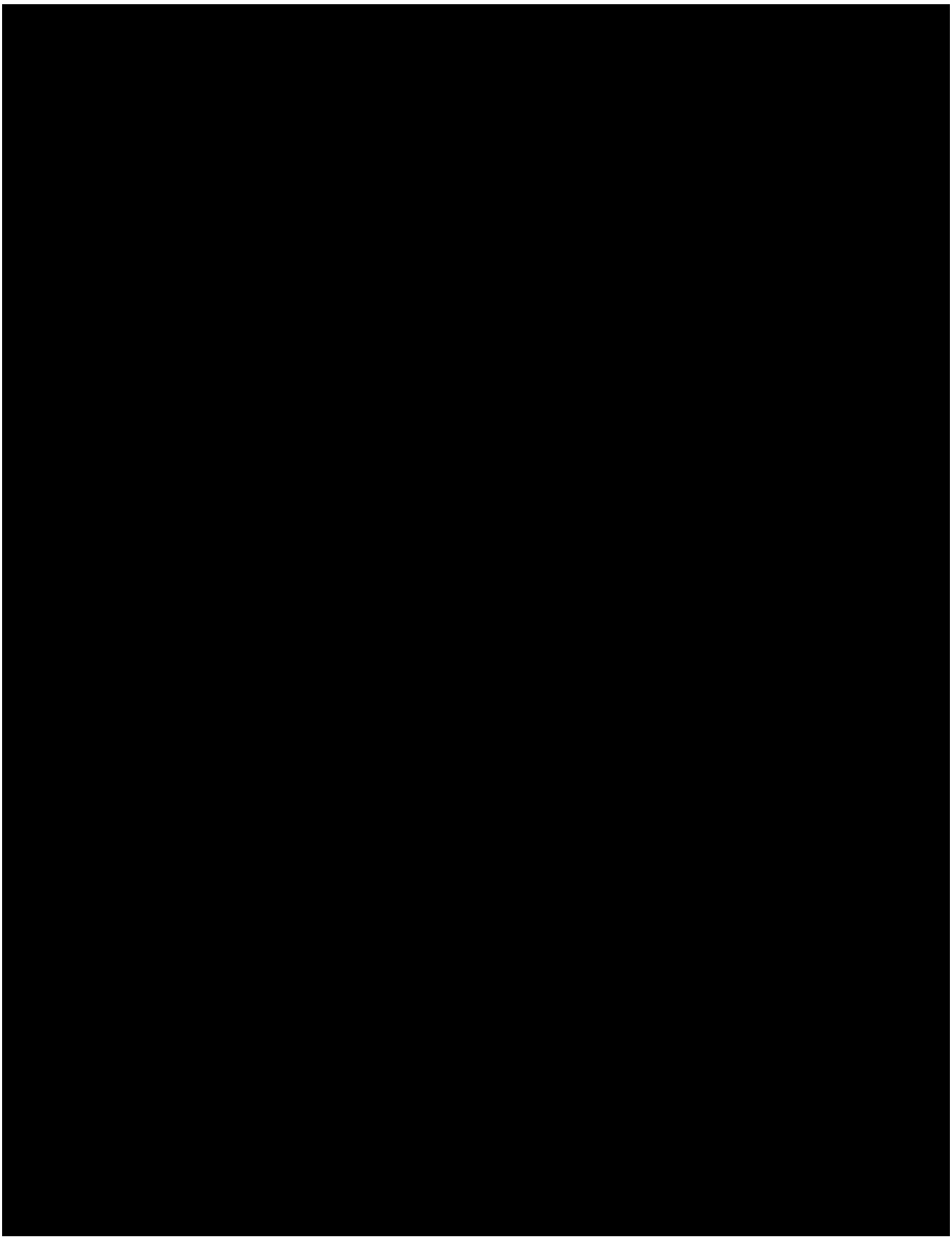


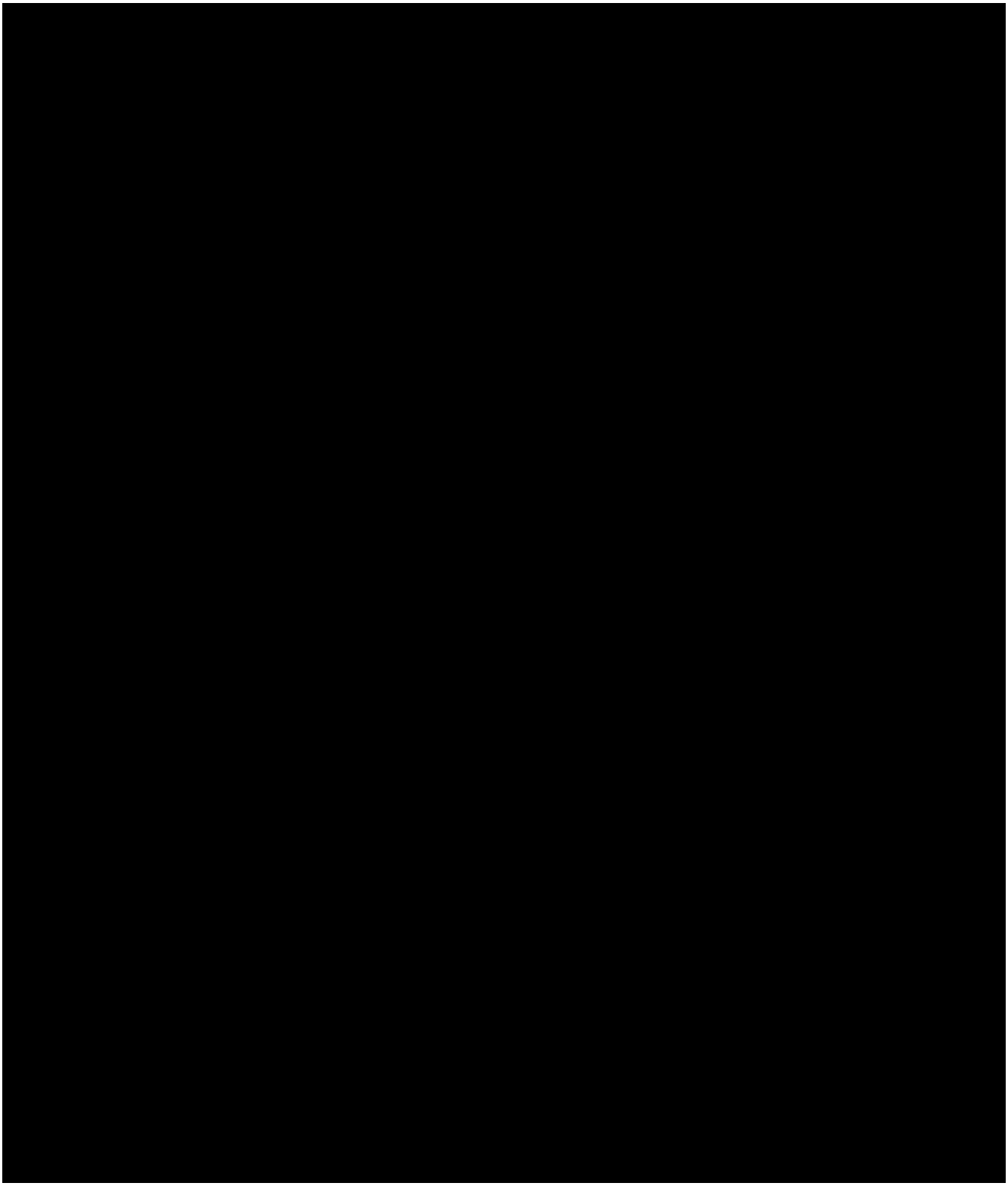


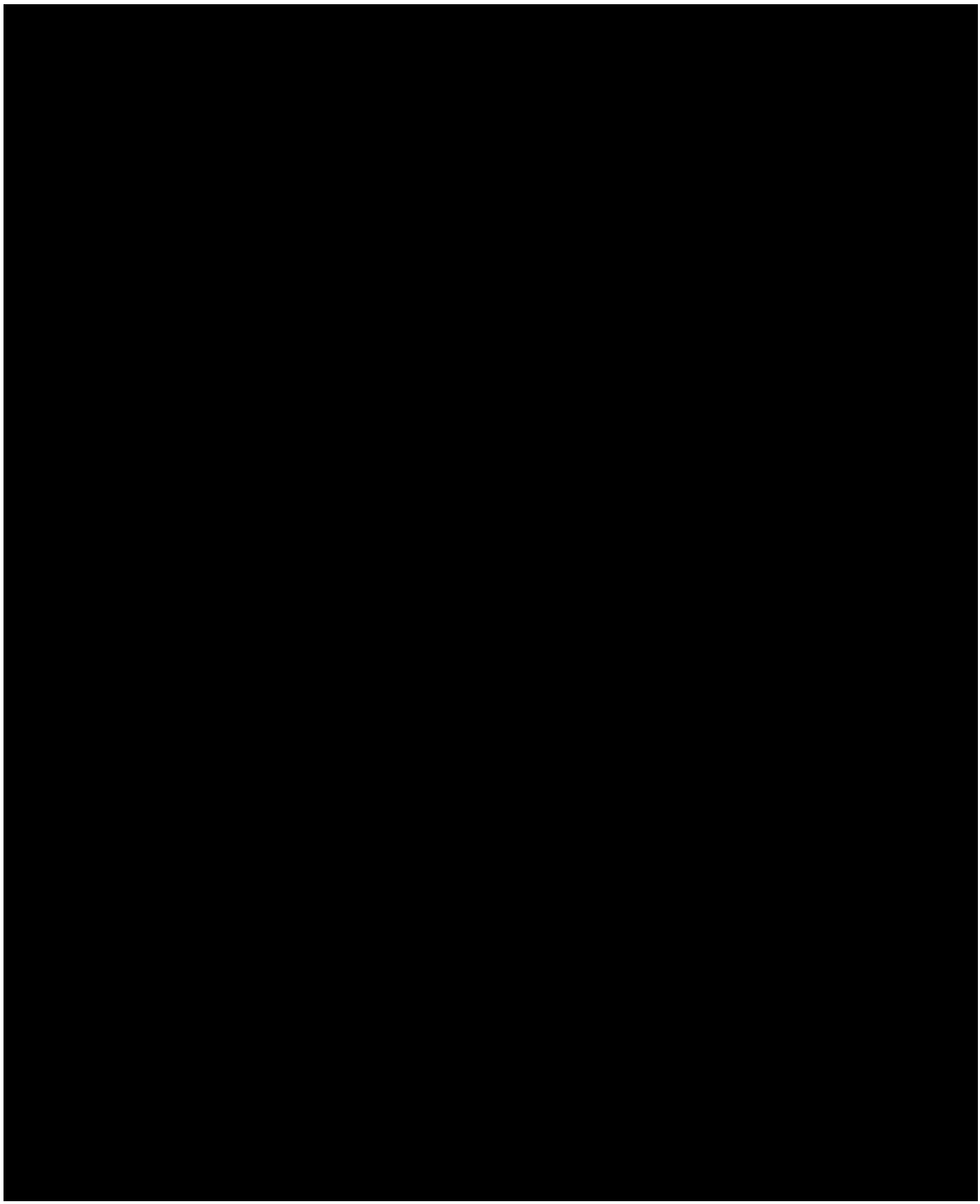


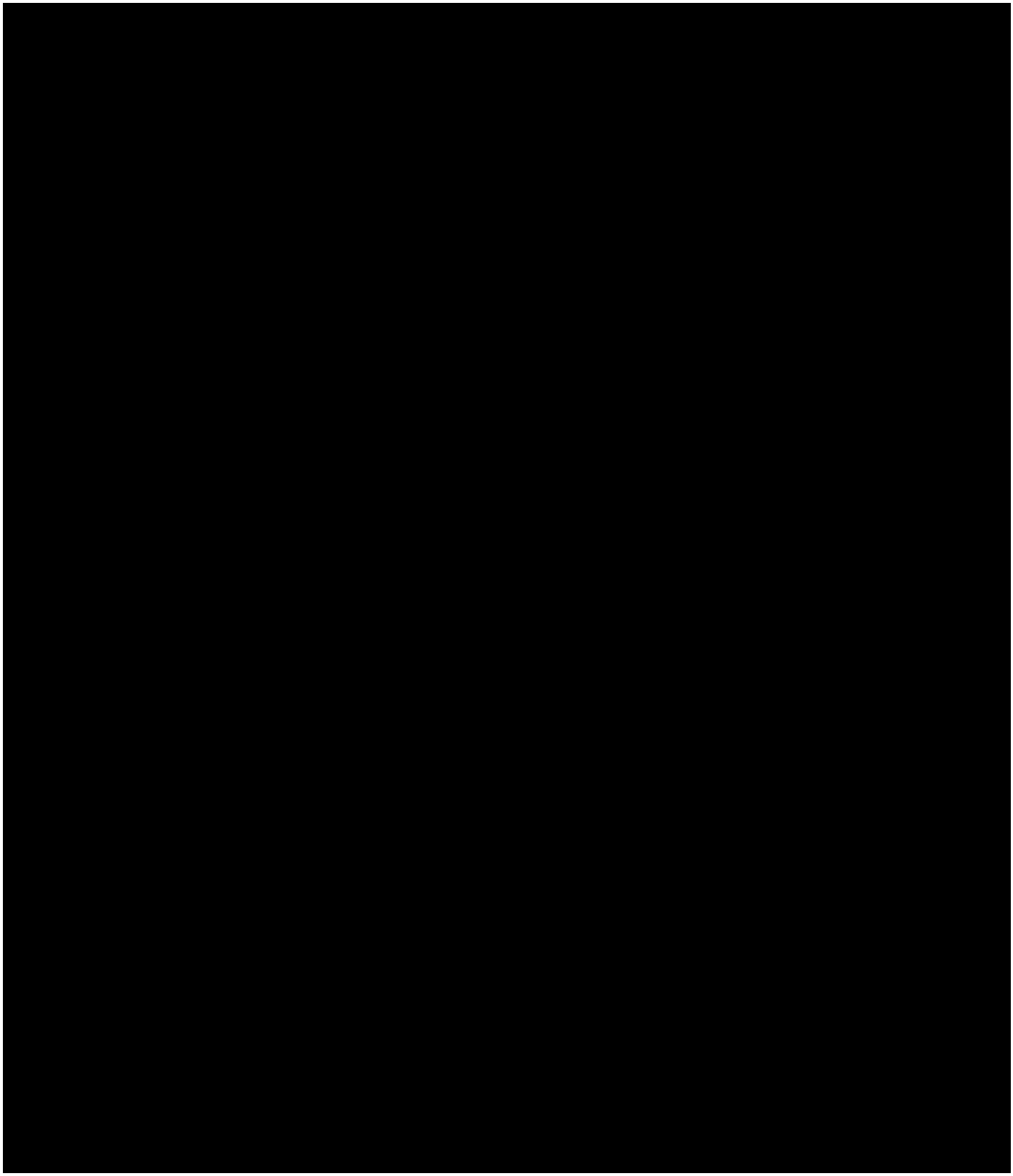


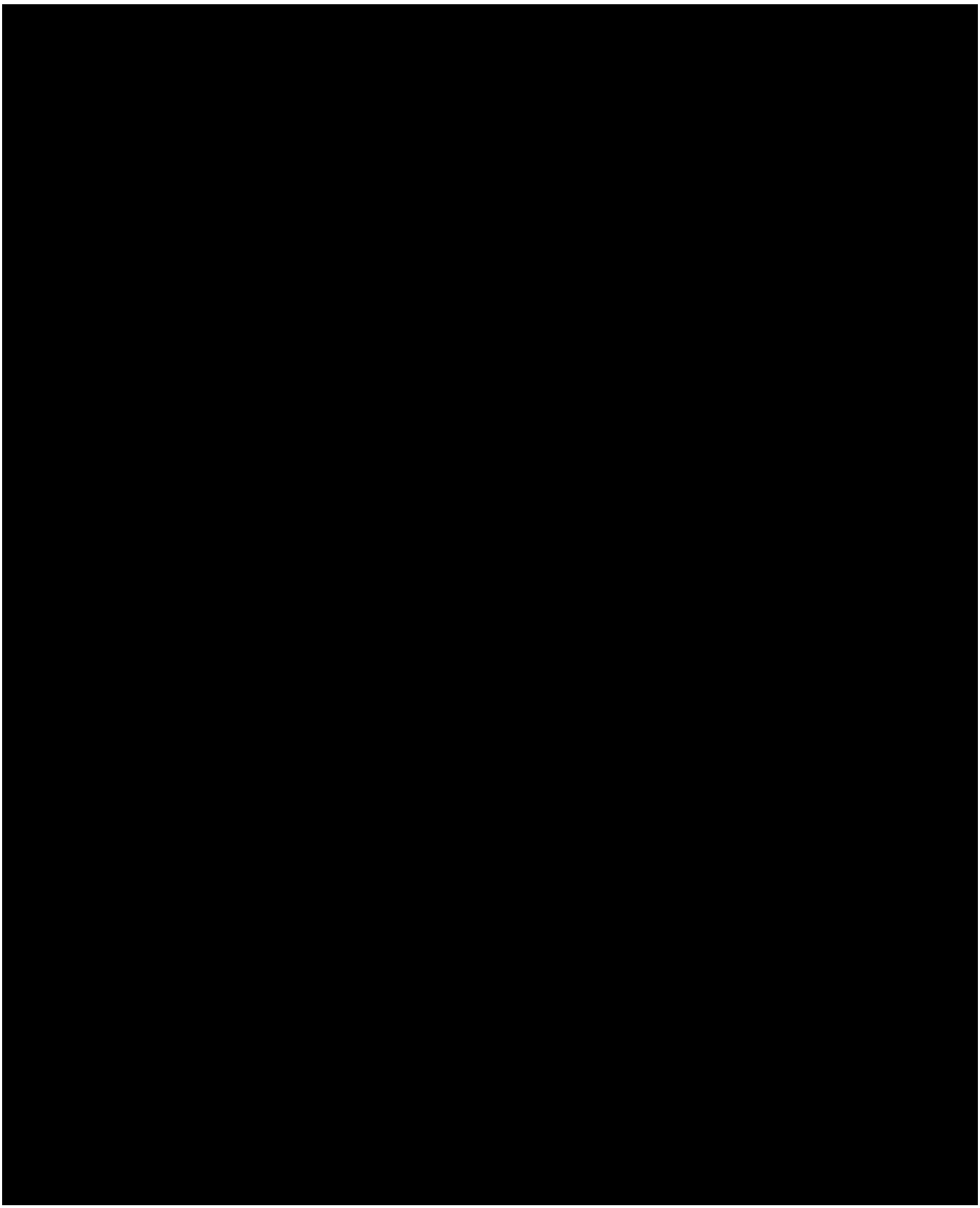


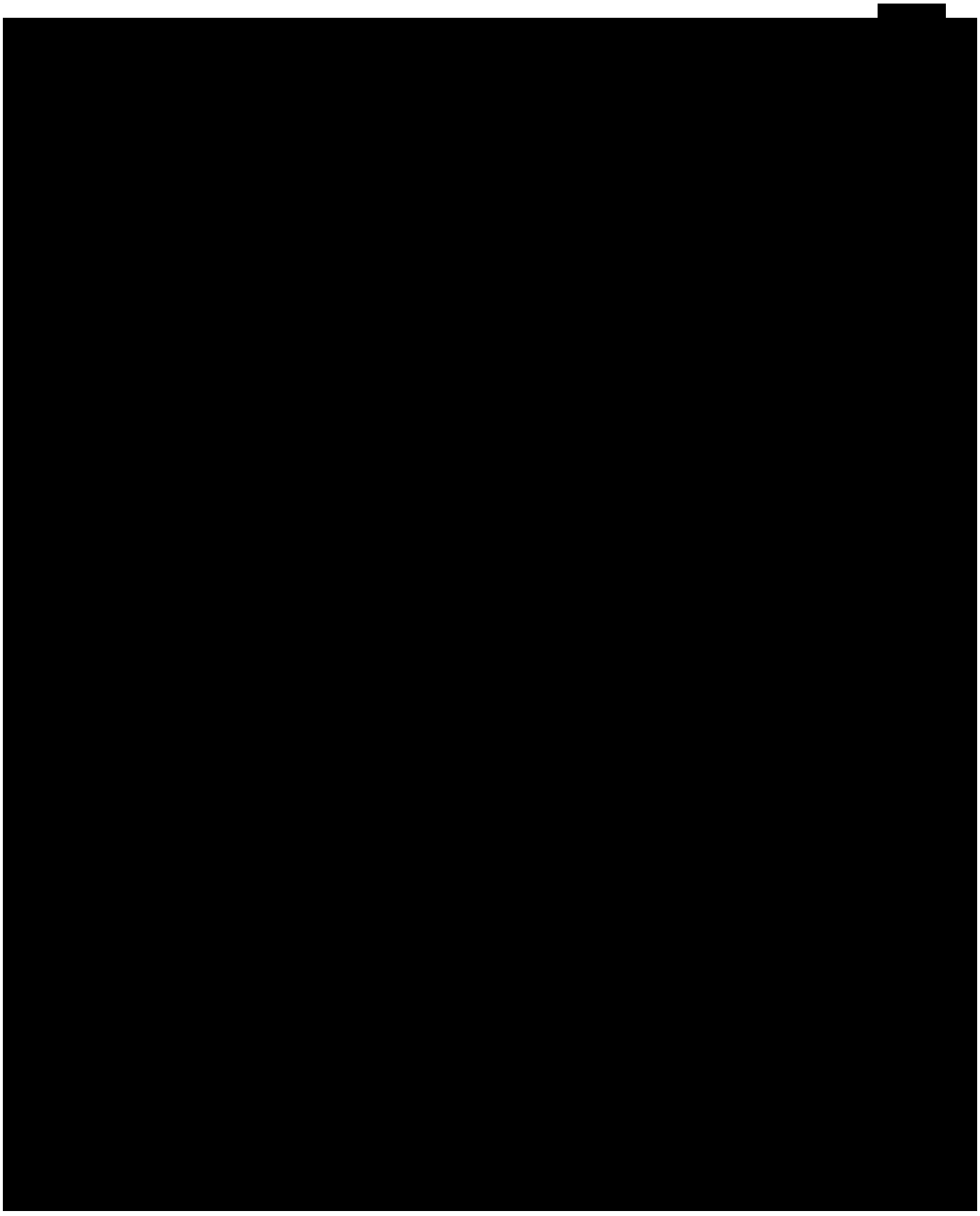


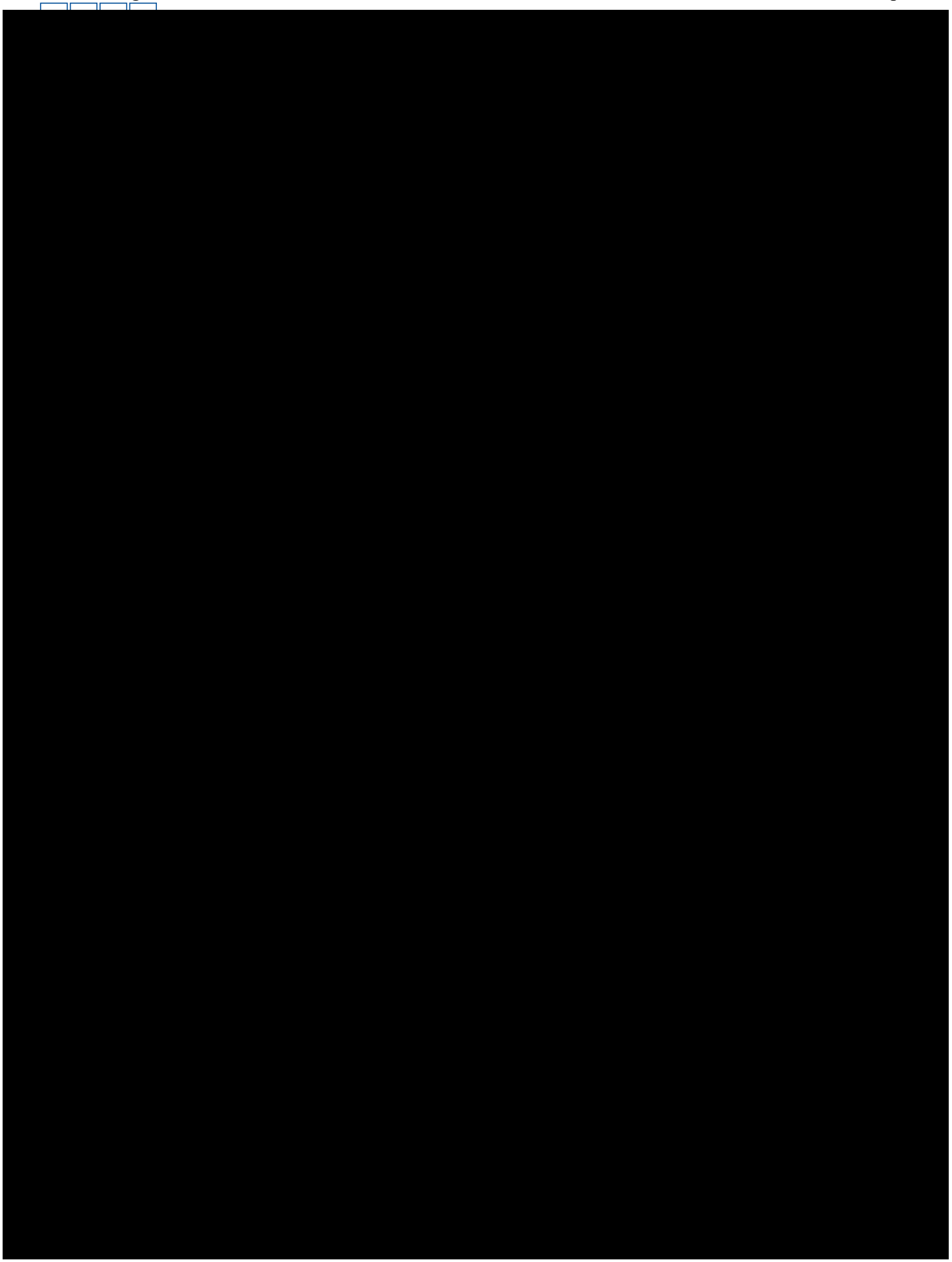


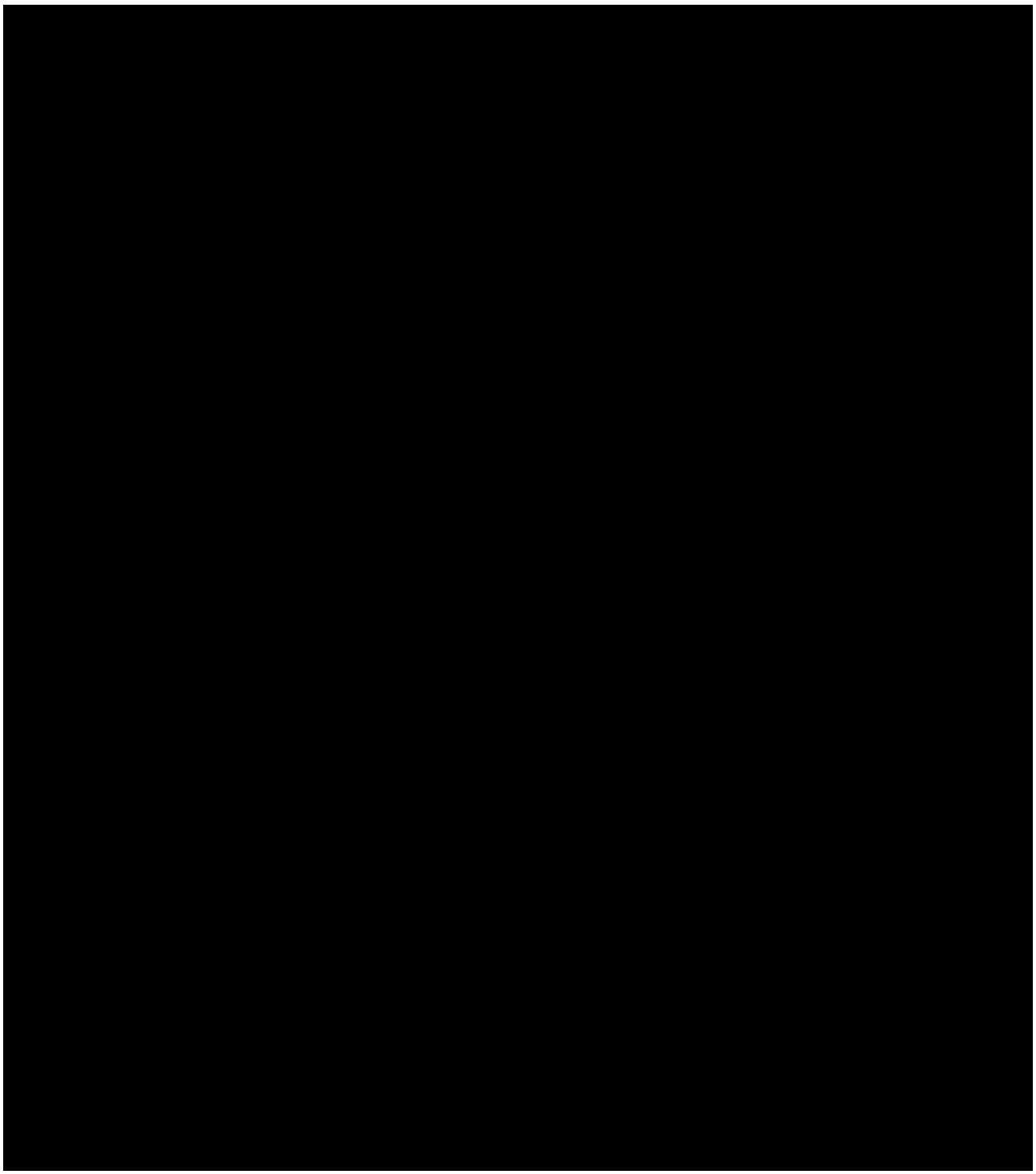




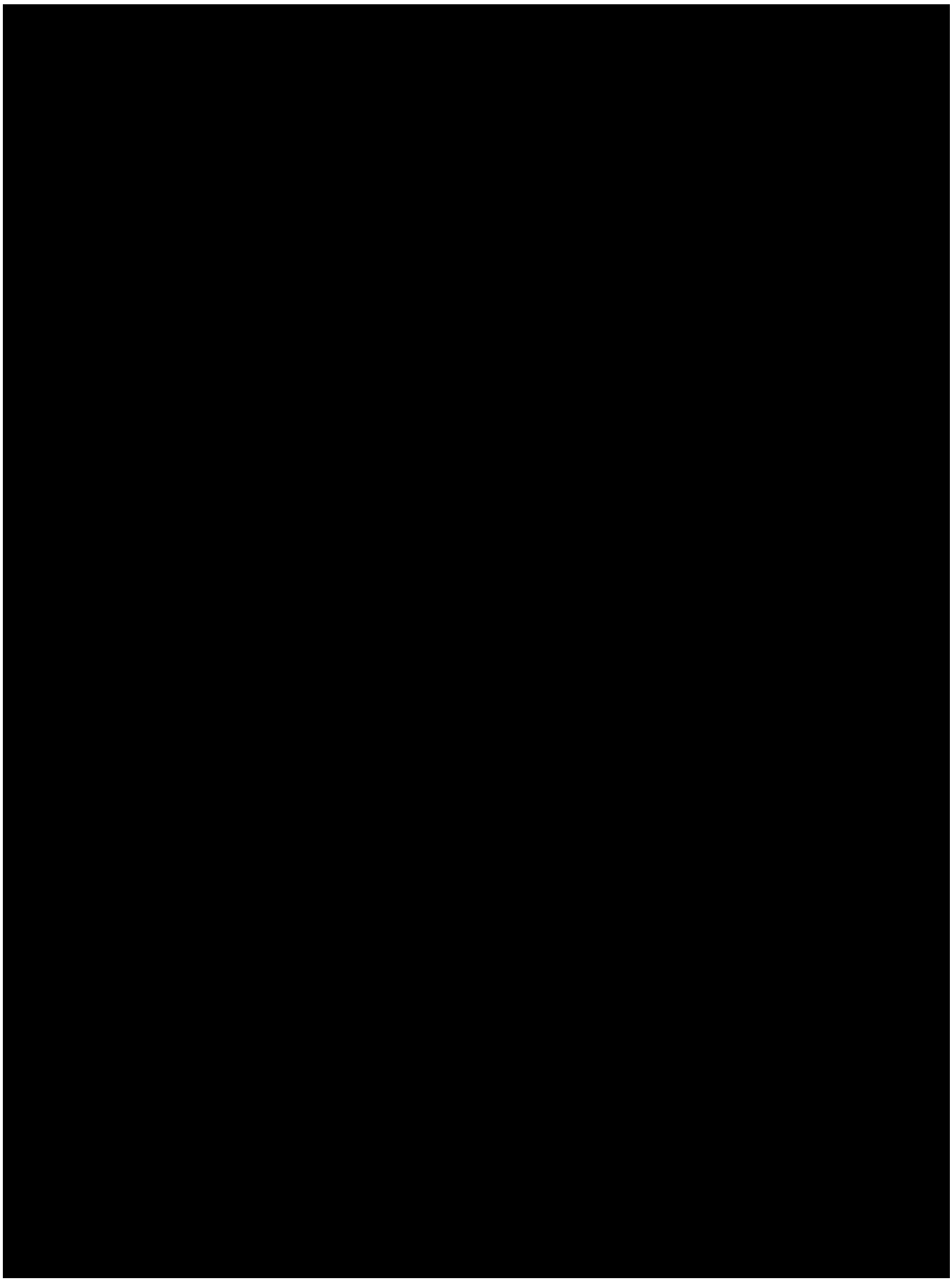


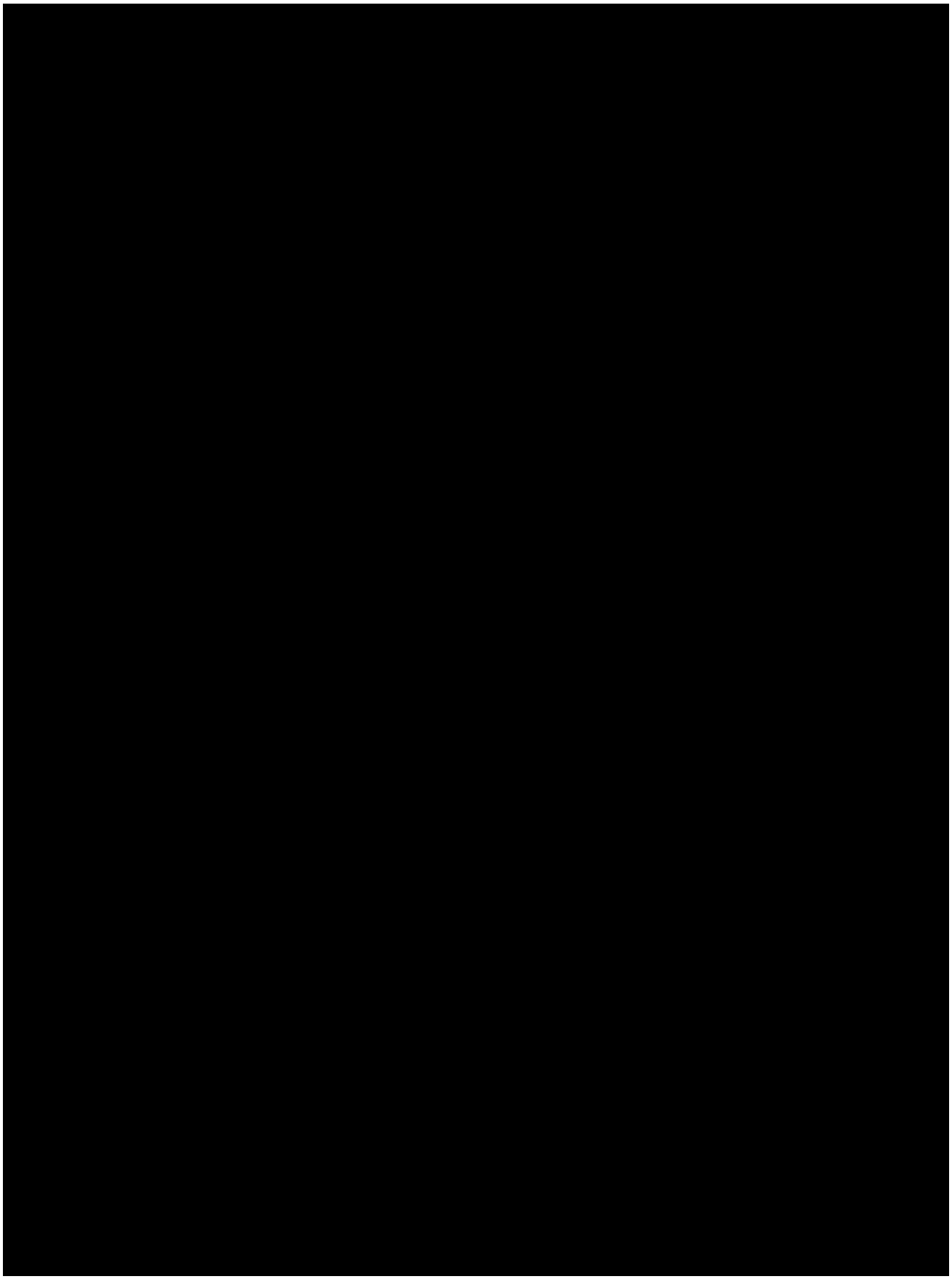


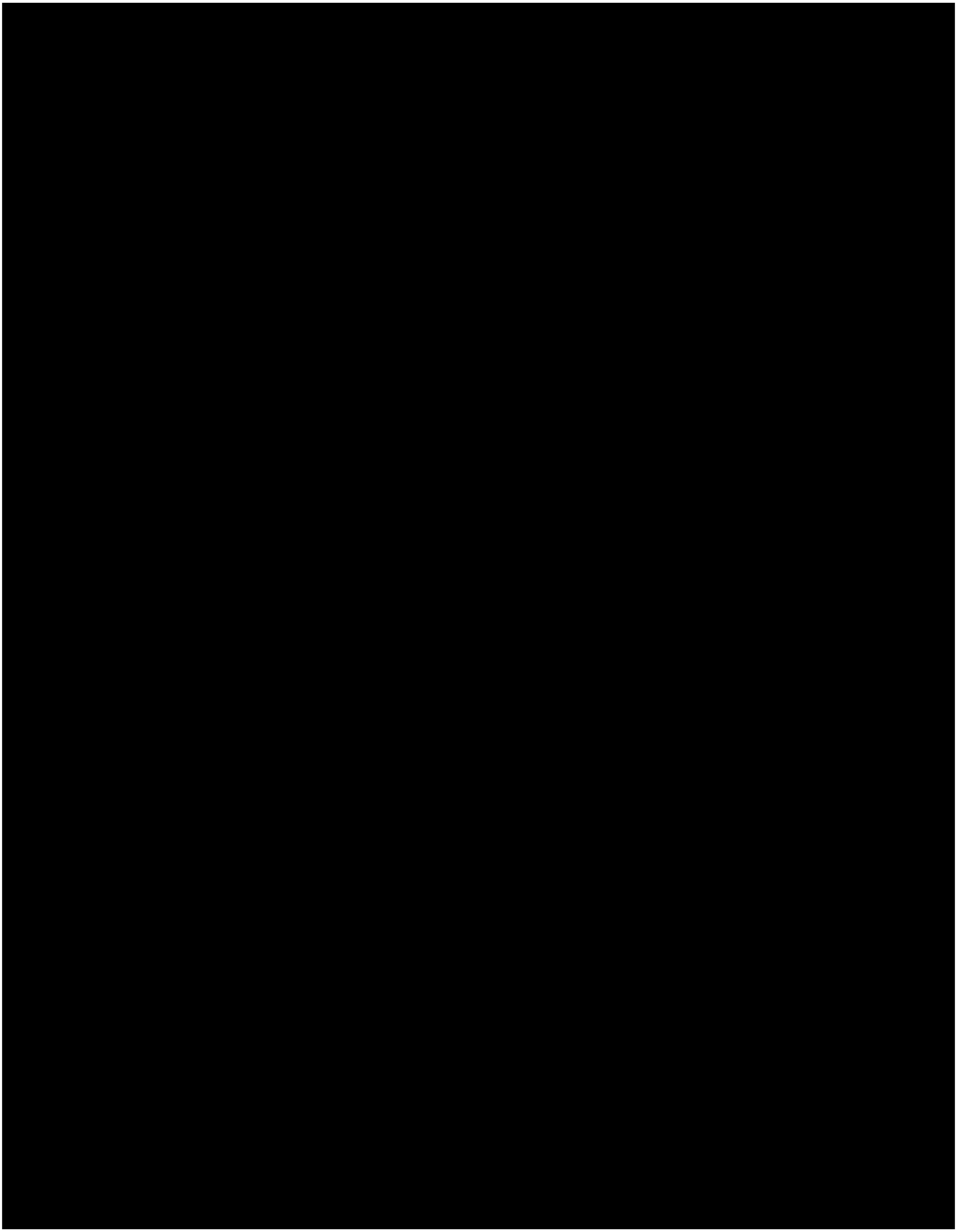


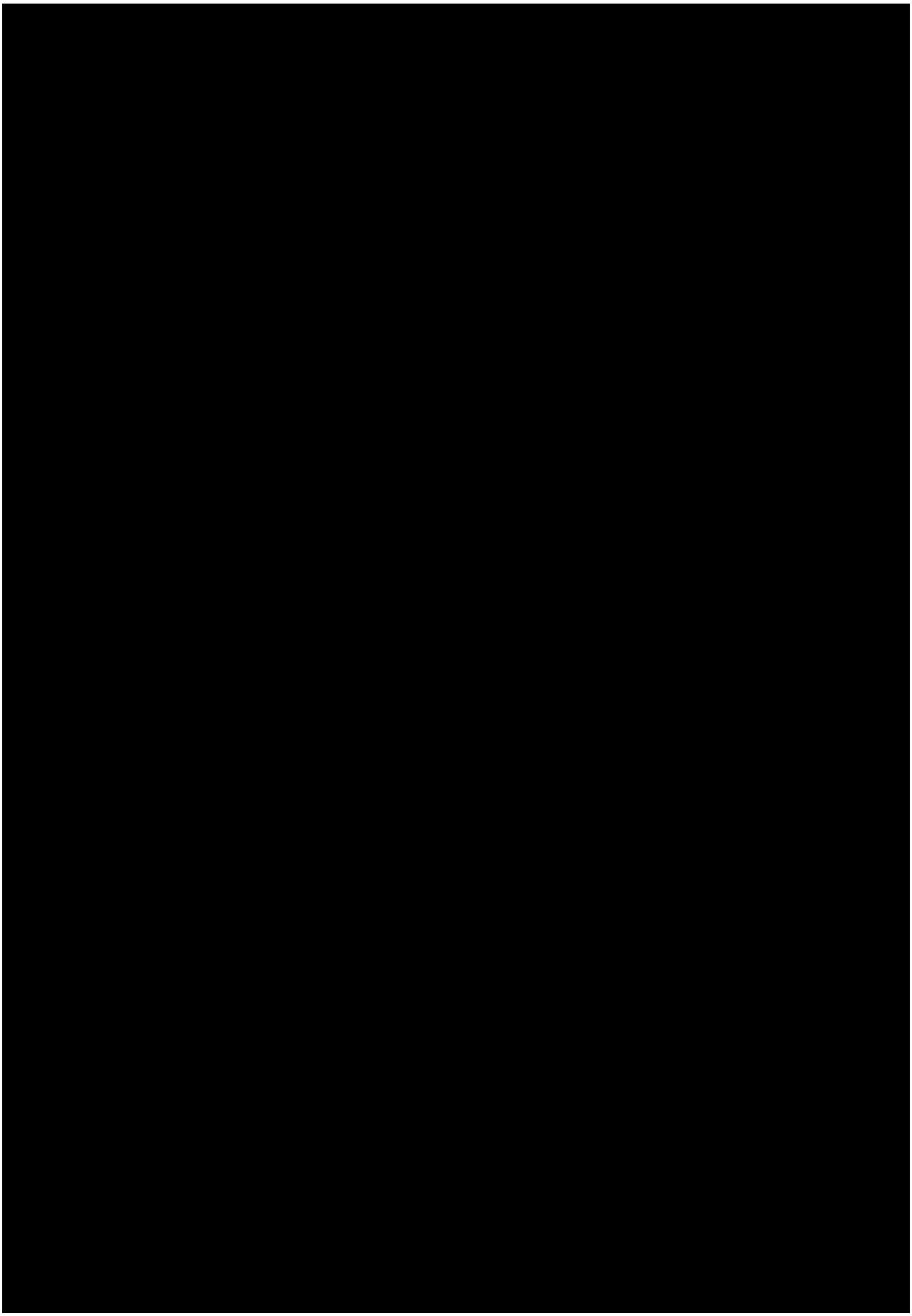


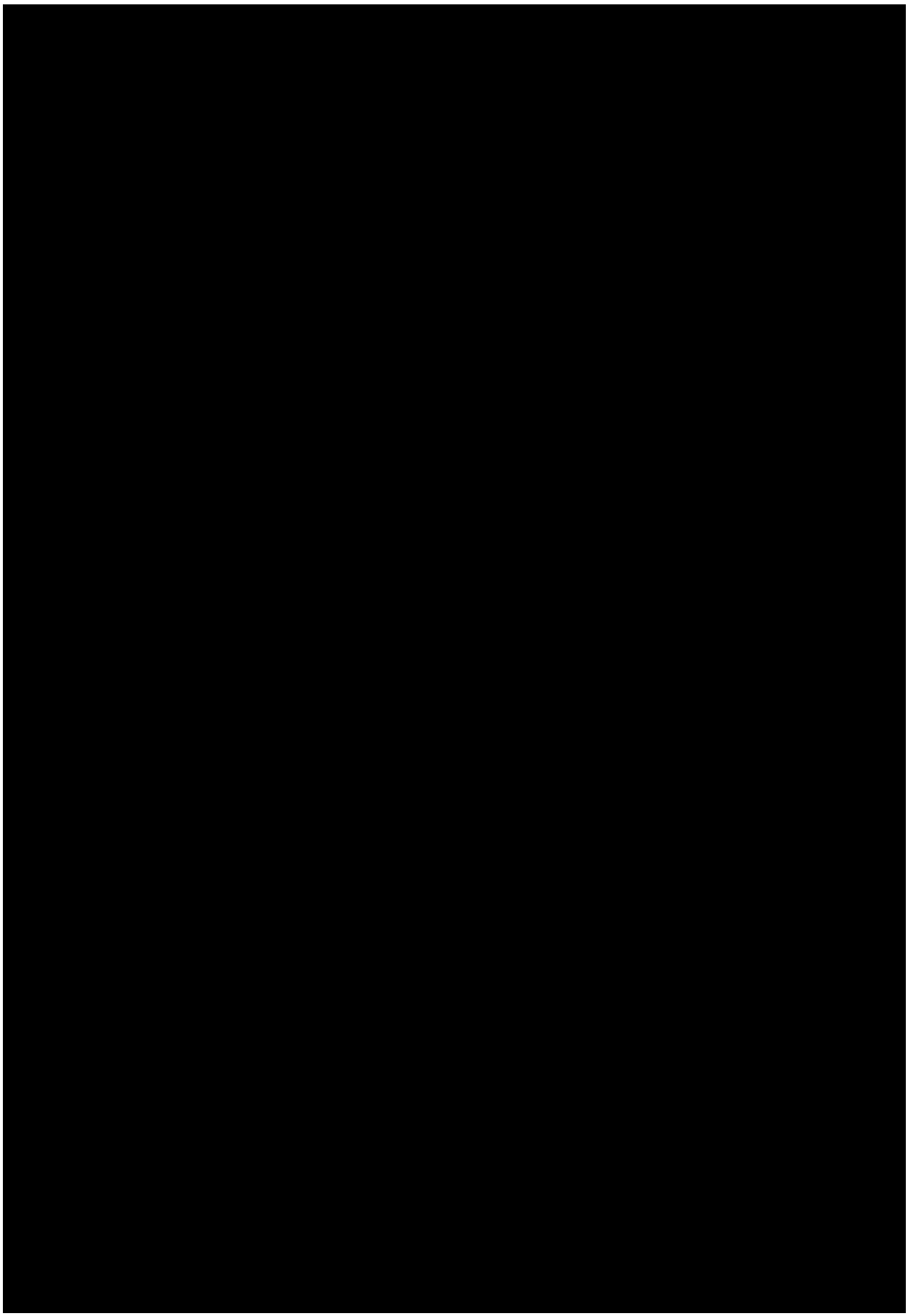
See notes to statutory-basis financial statements

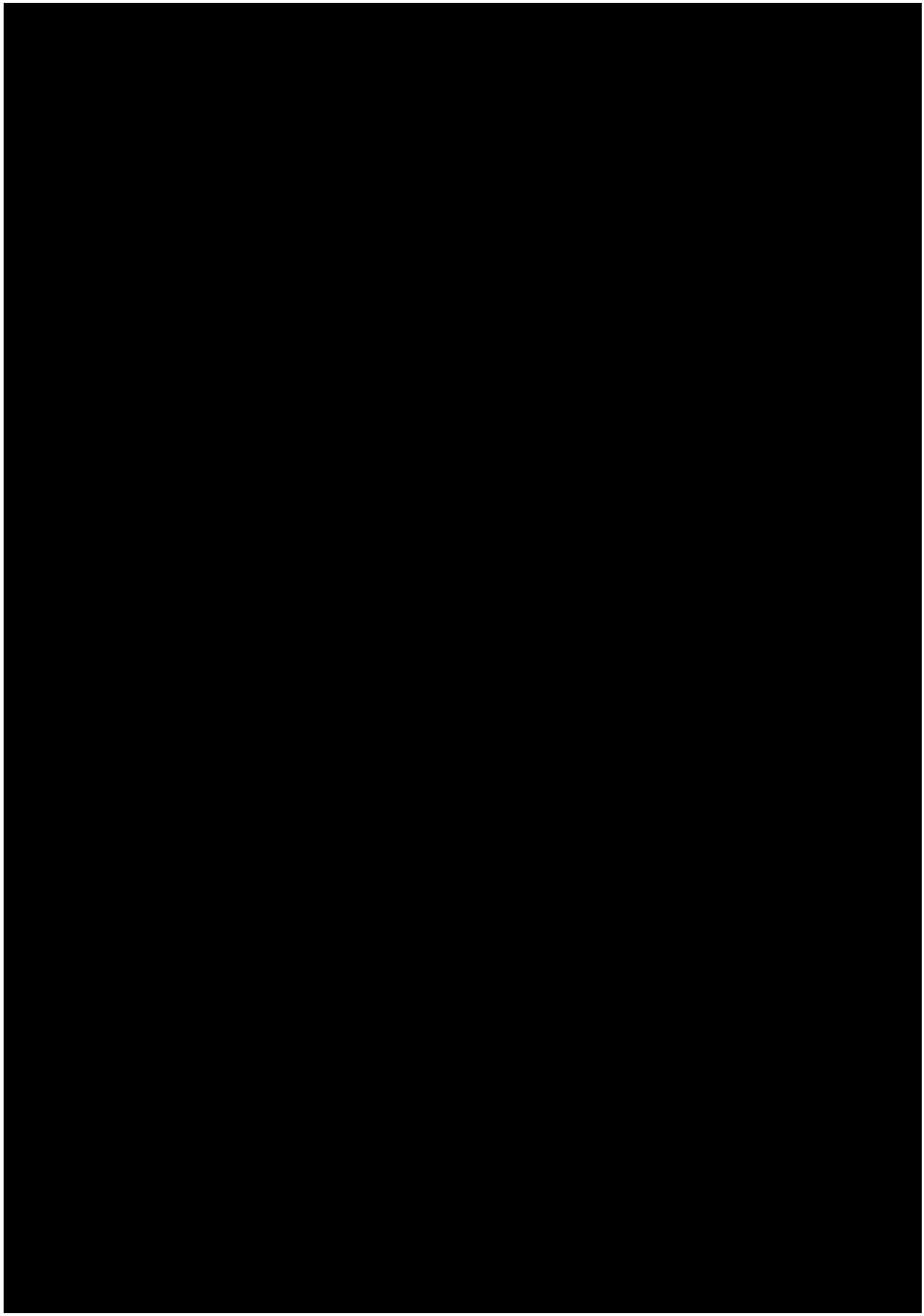


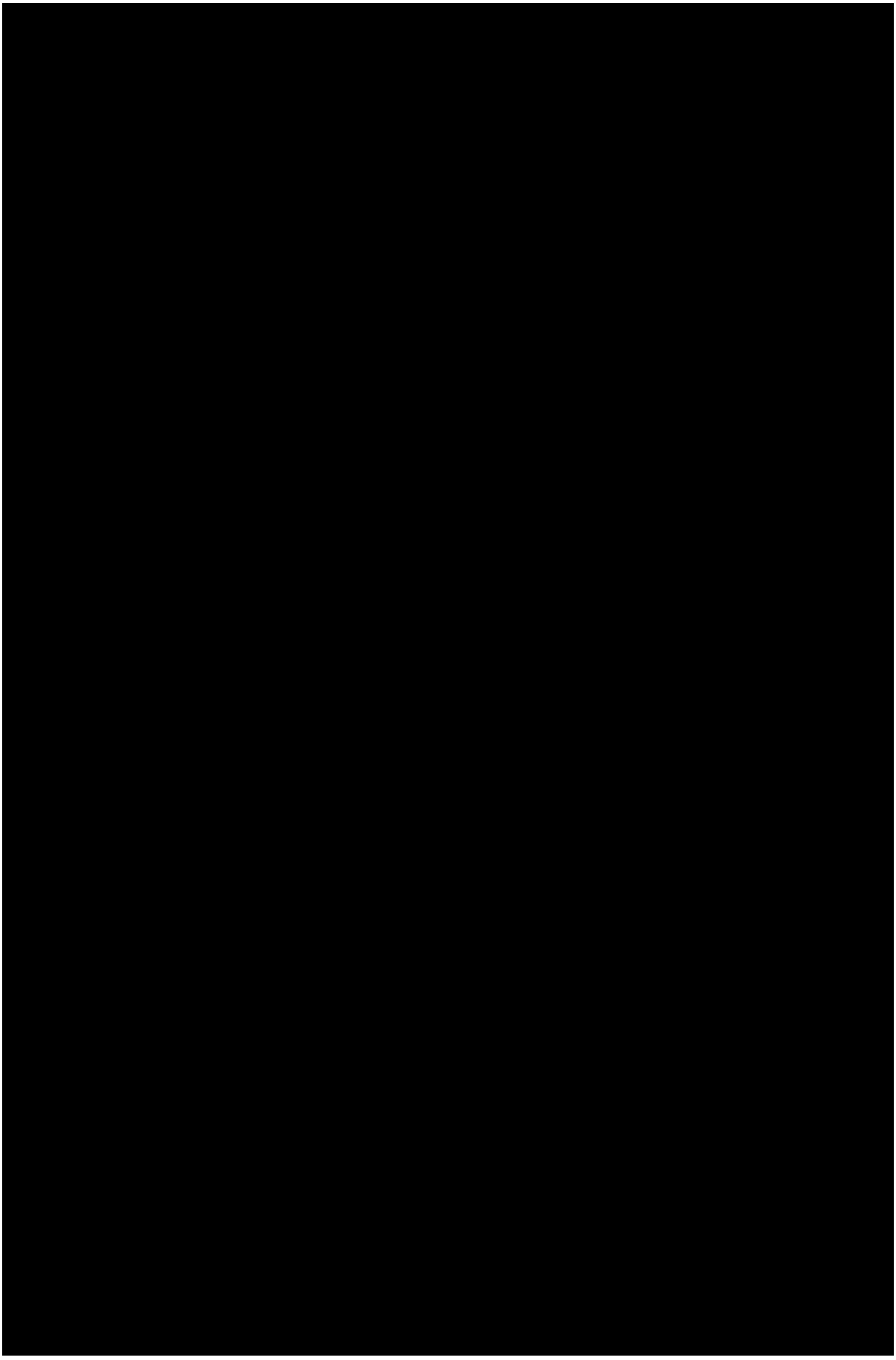


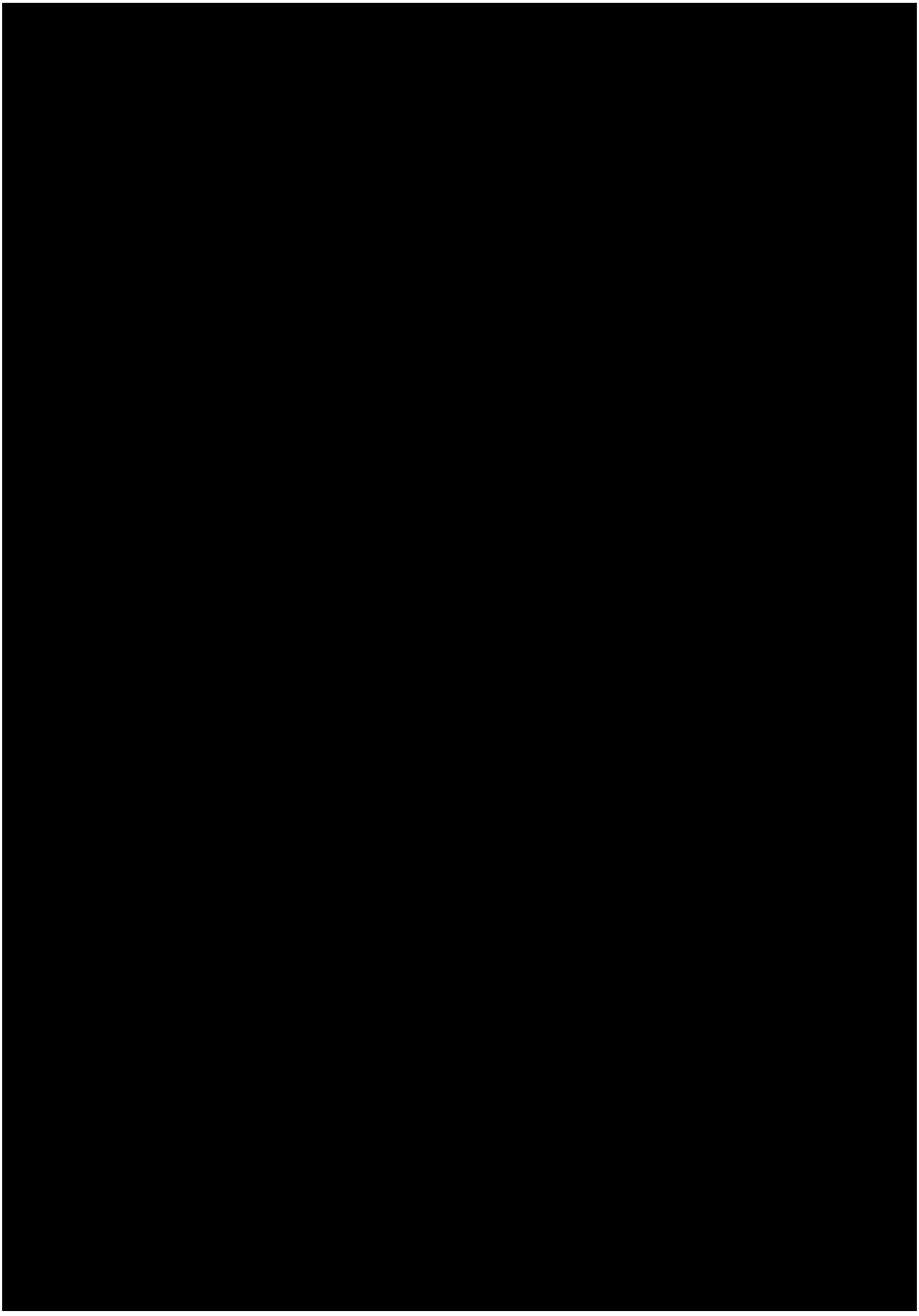


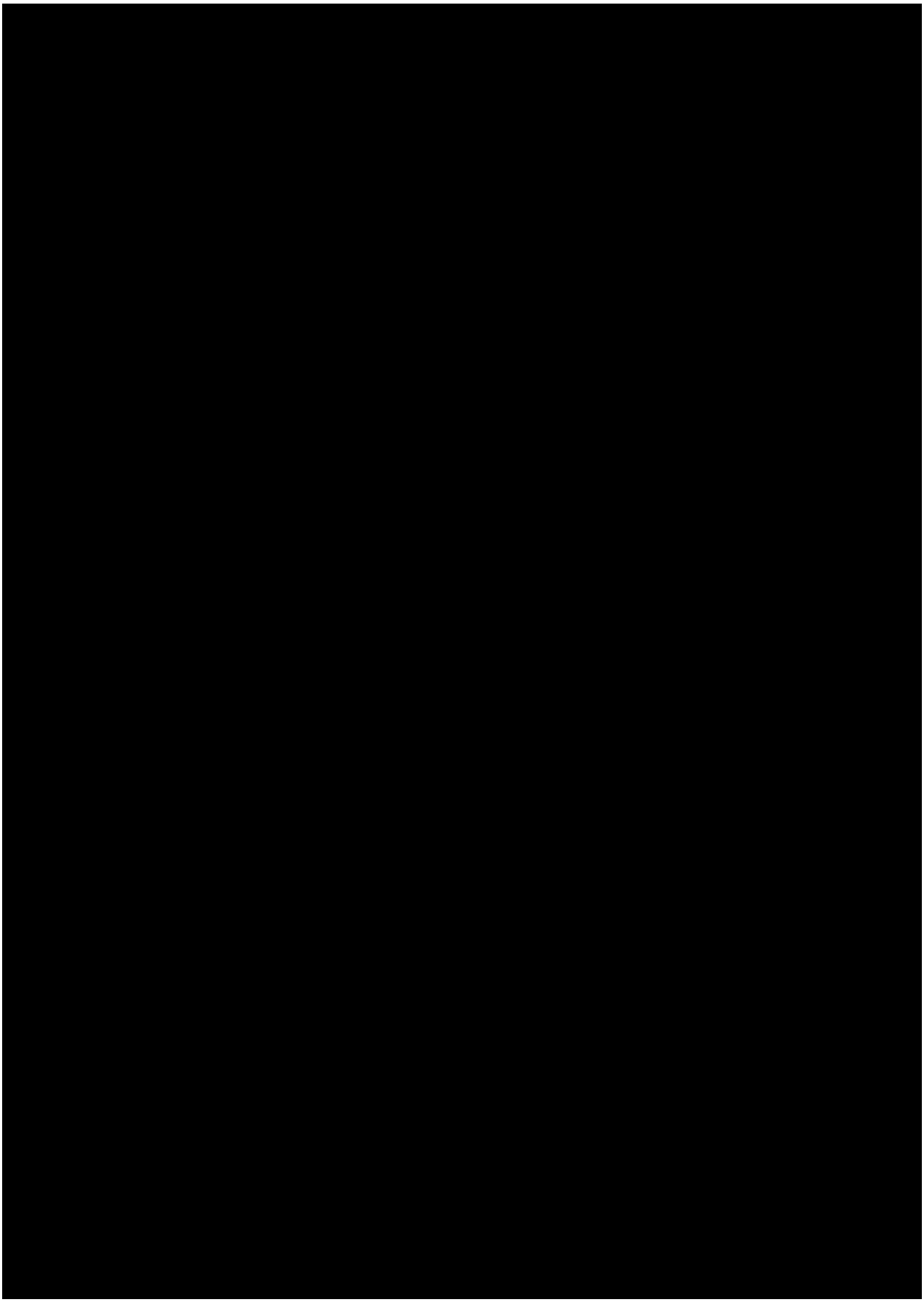


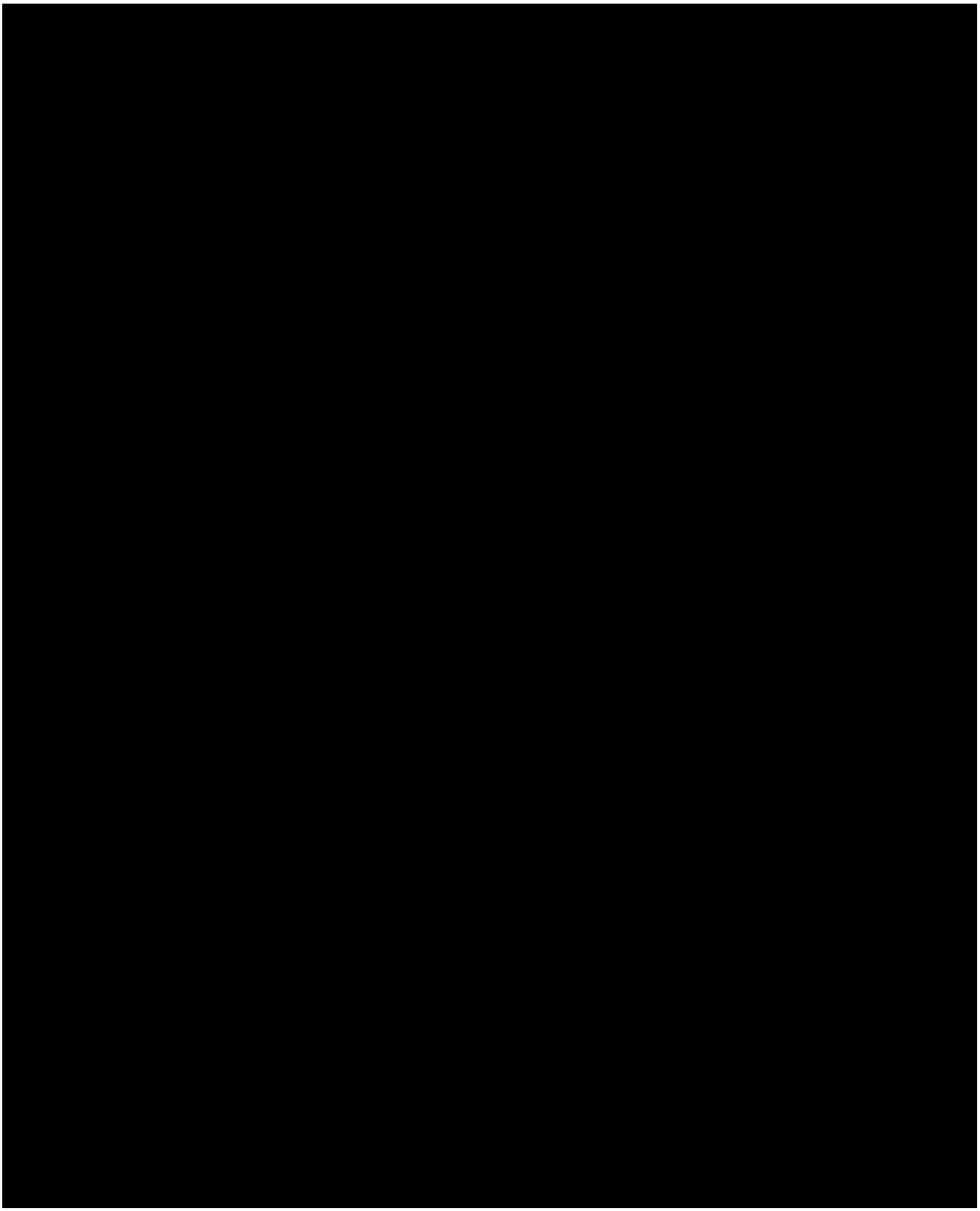


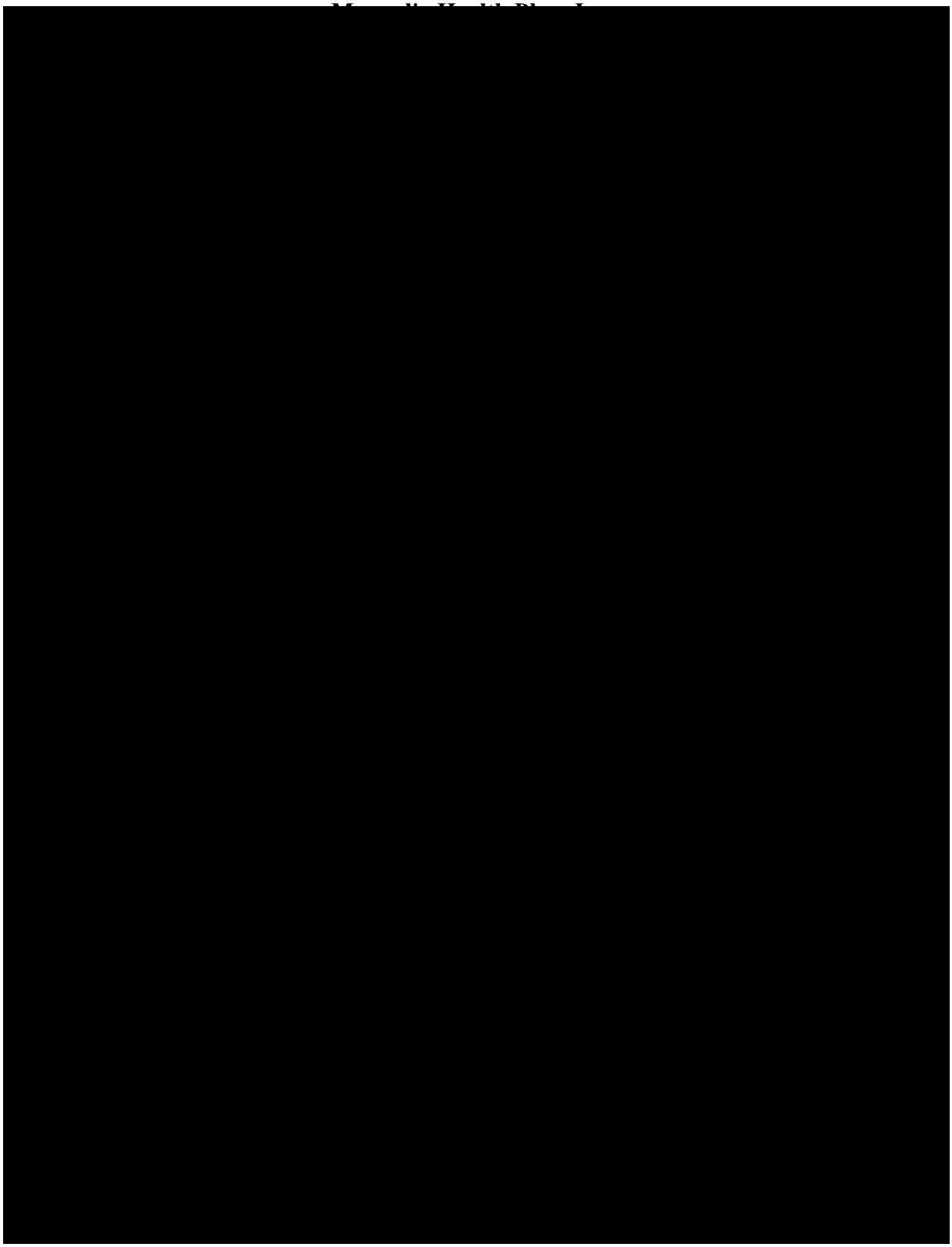


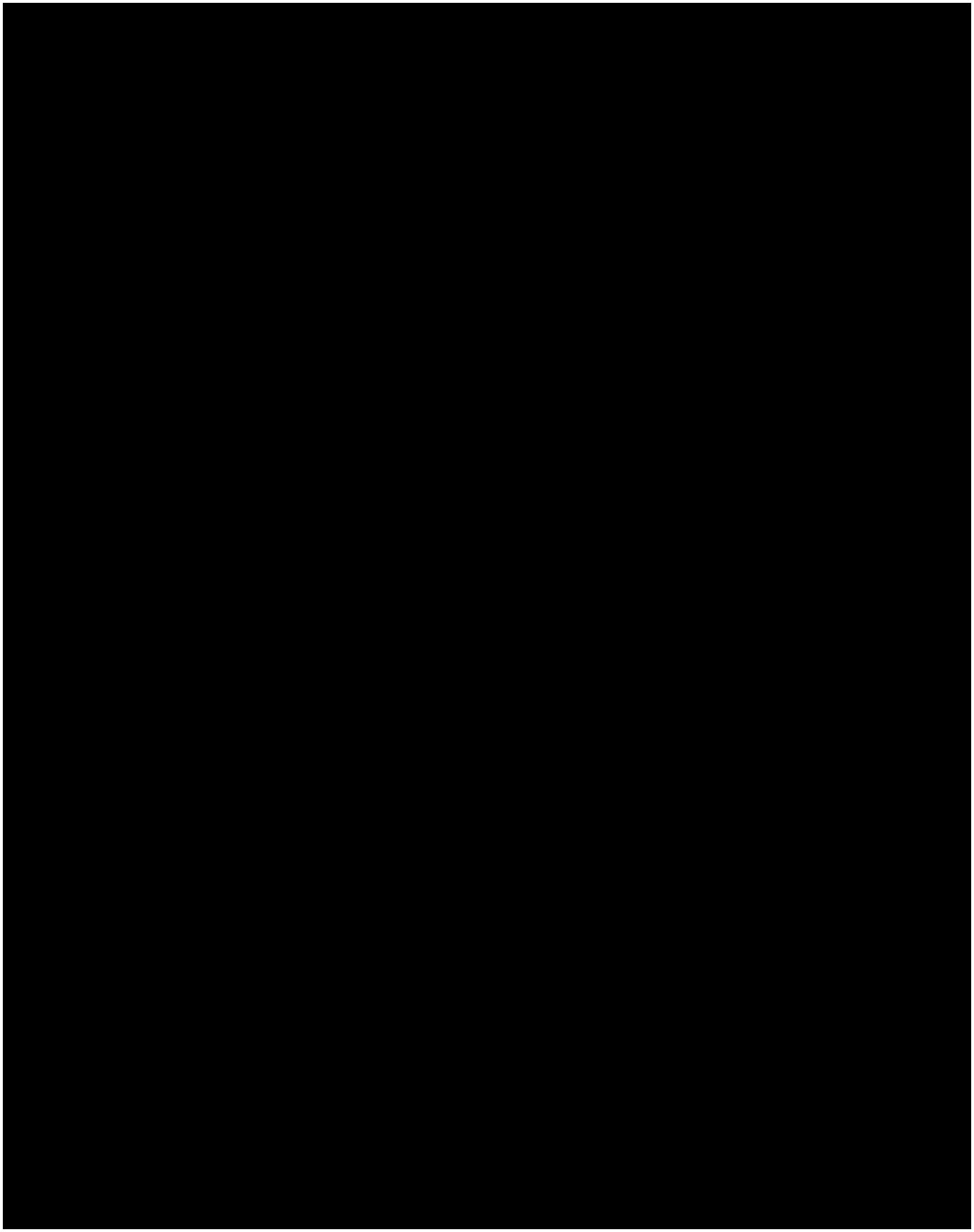


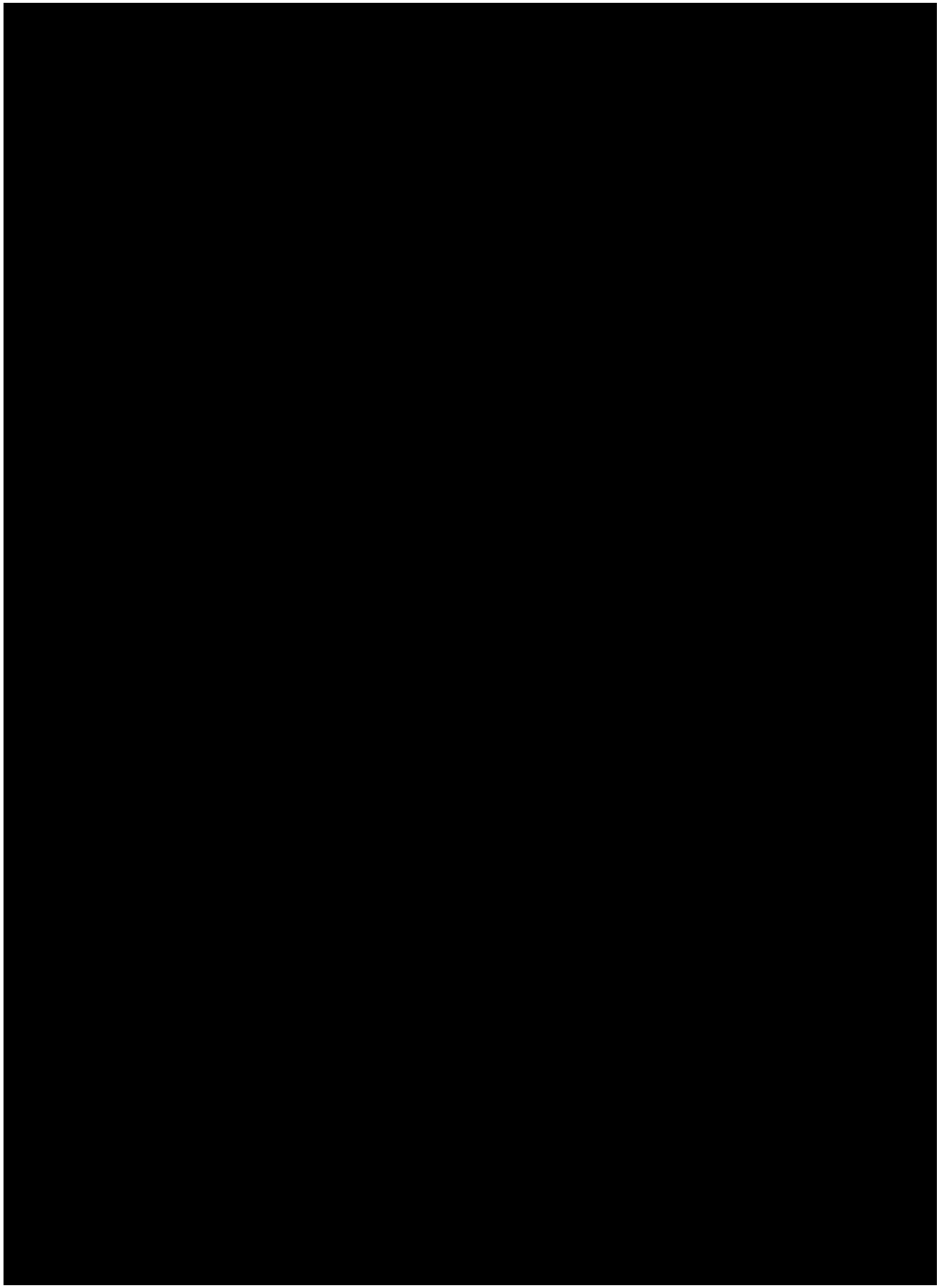


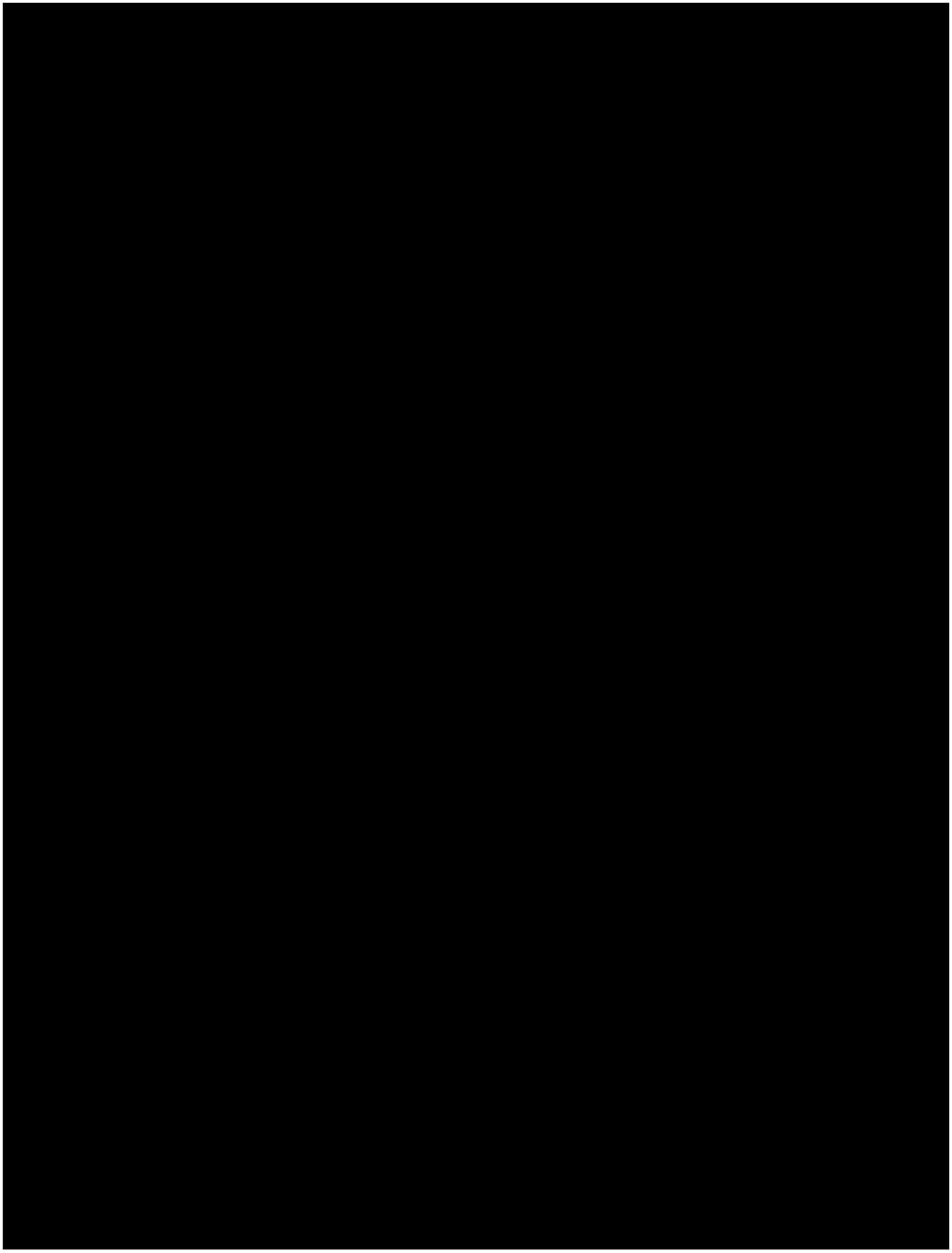


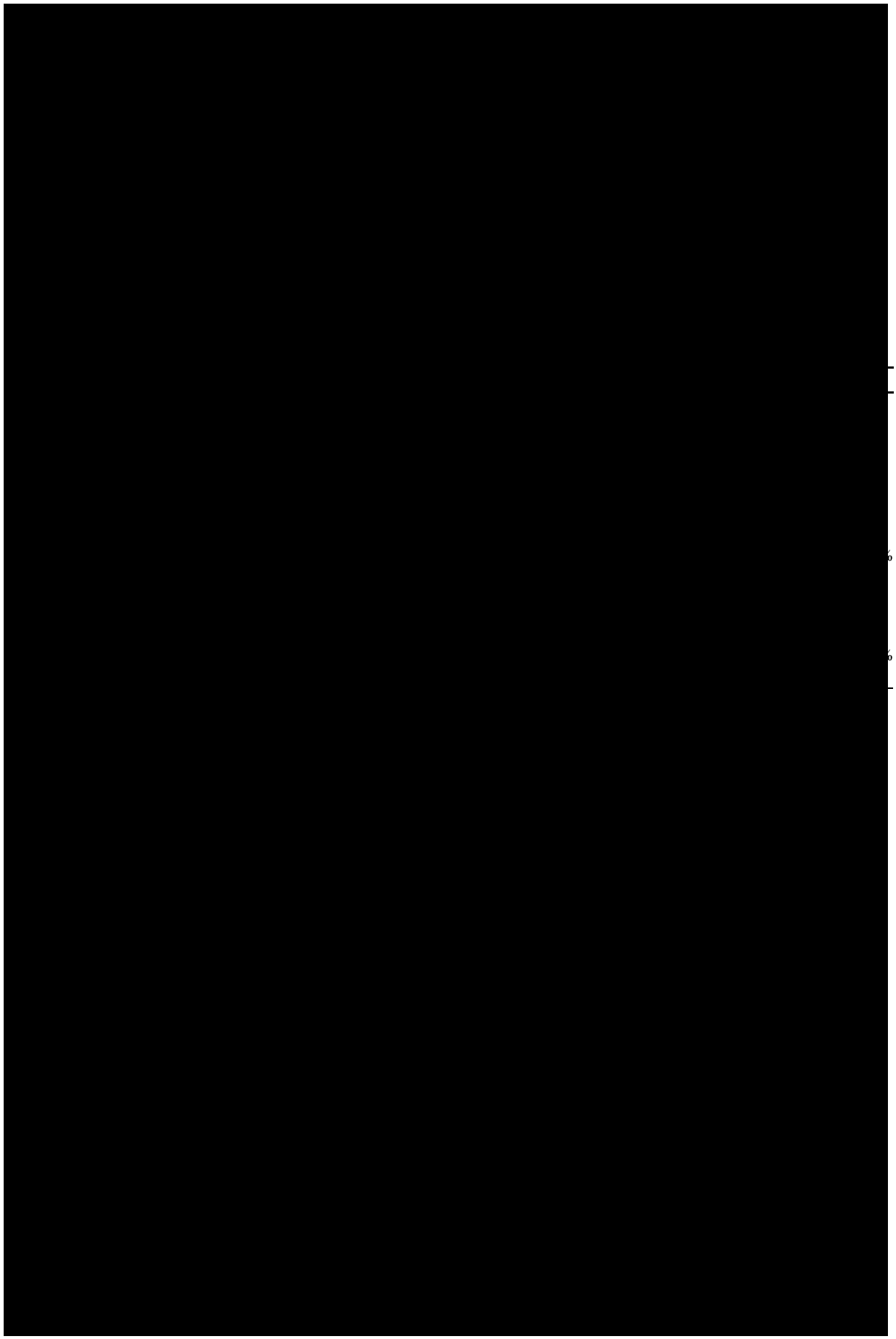


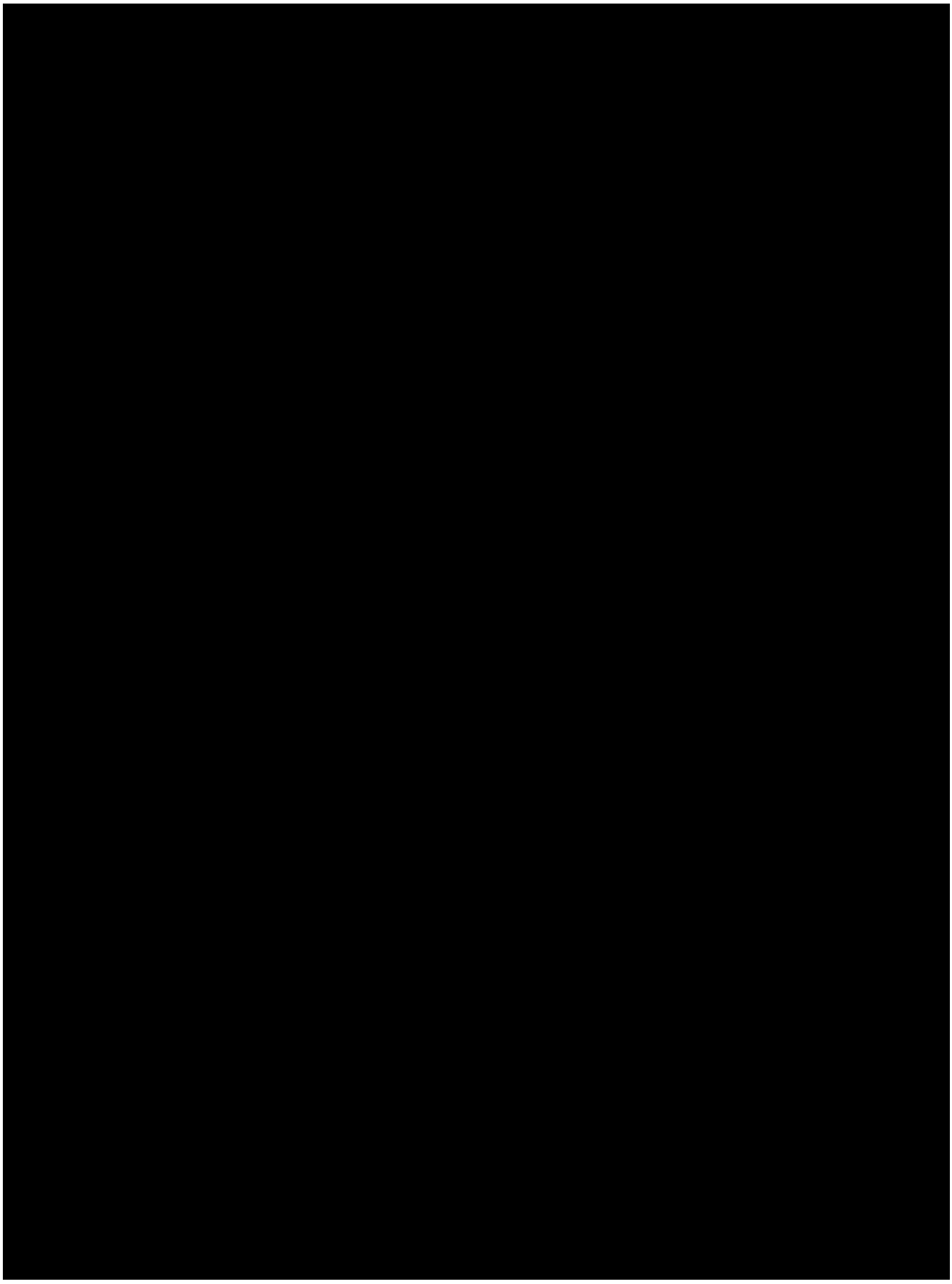


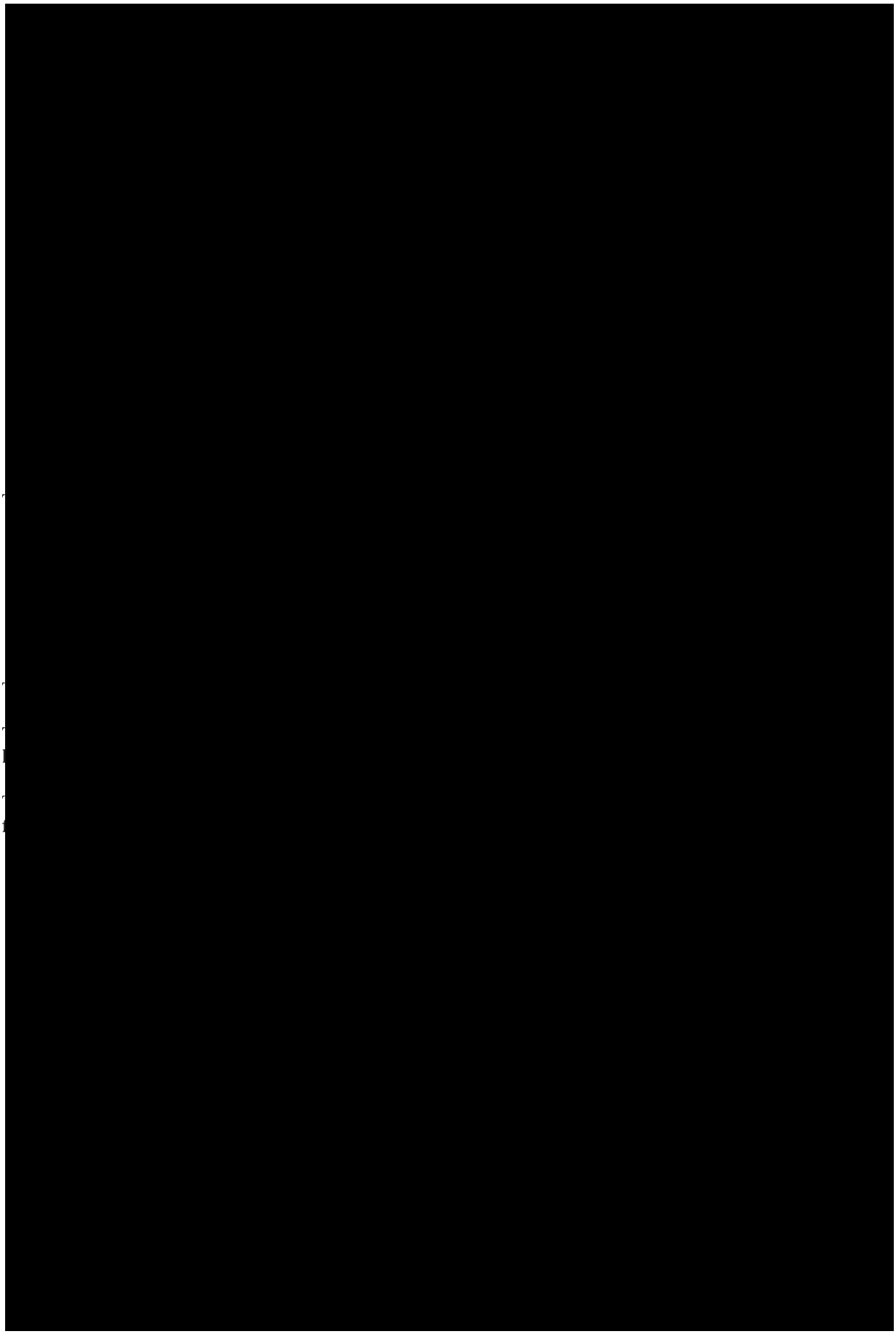


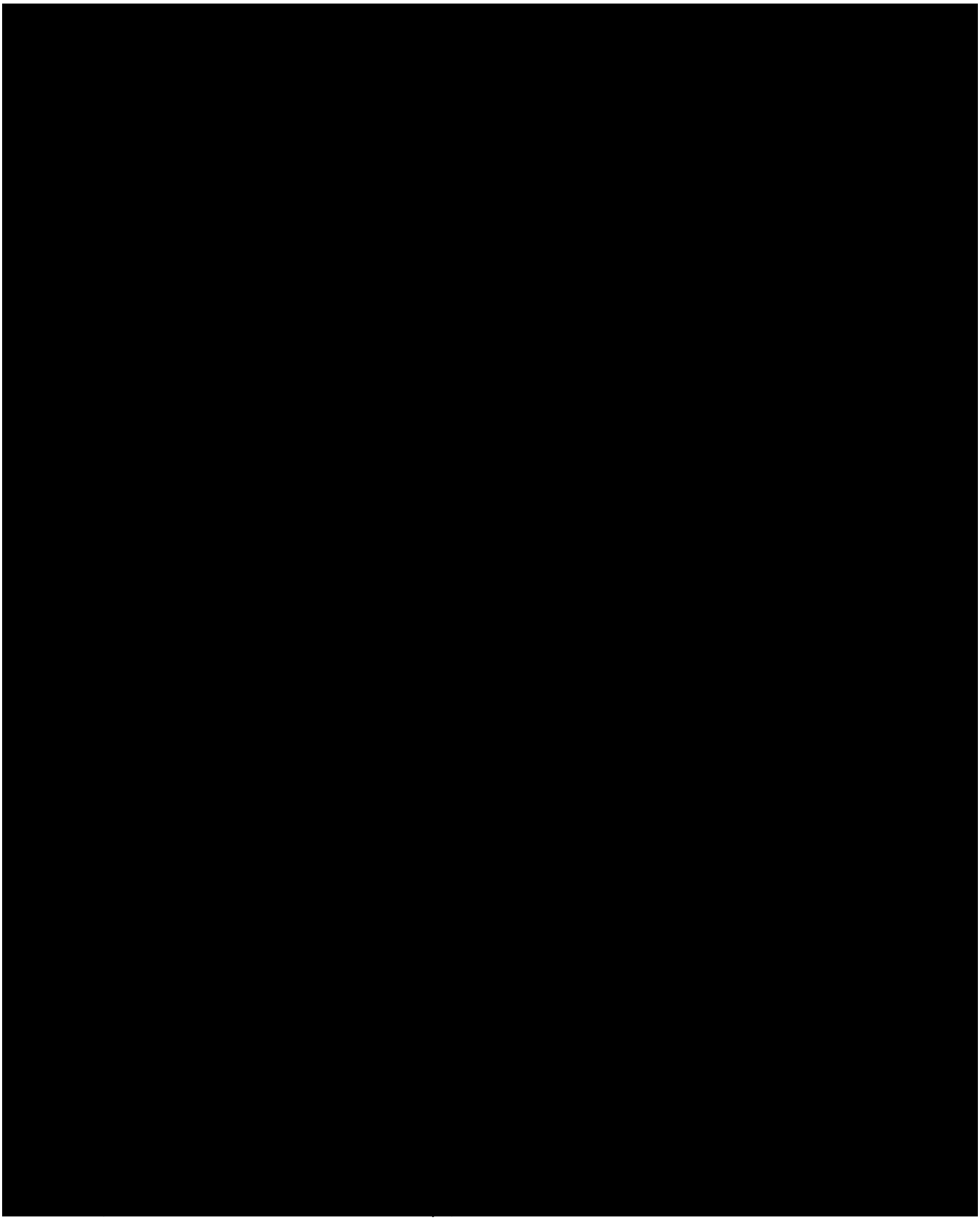


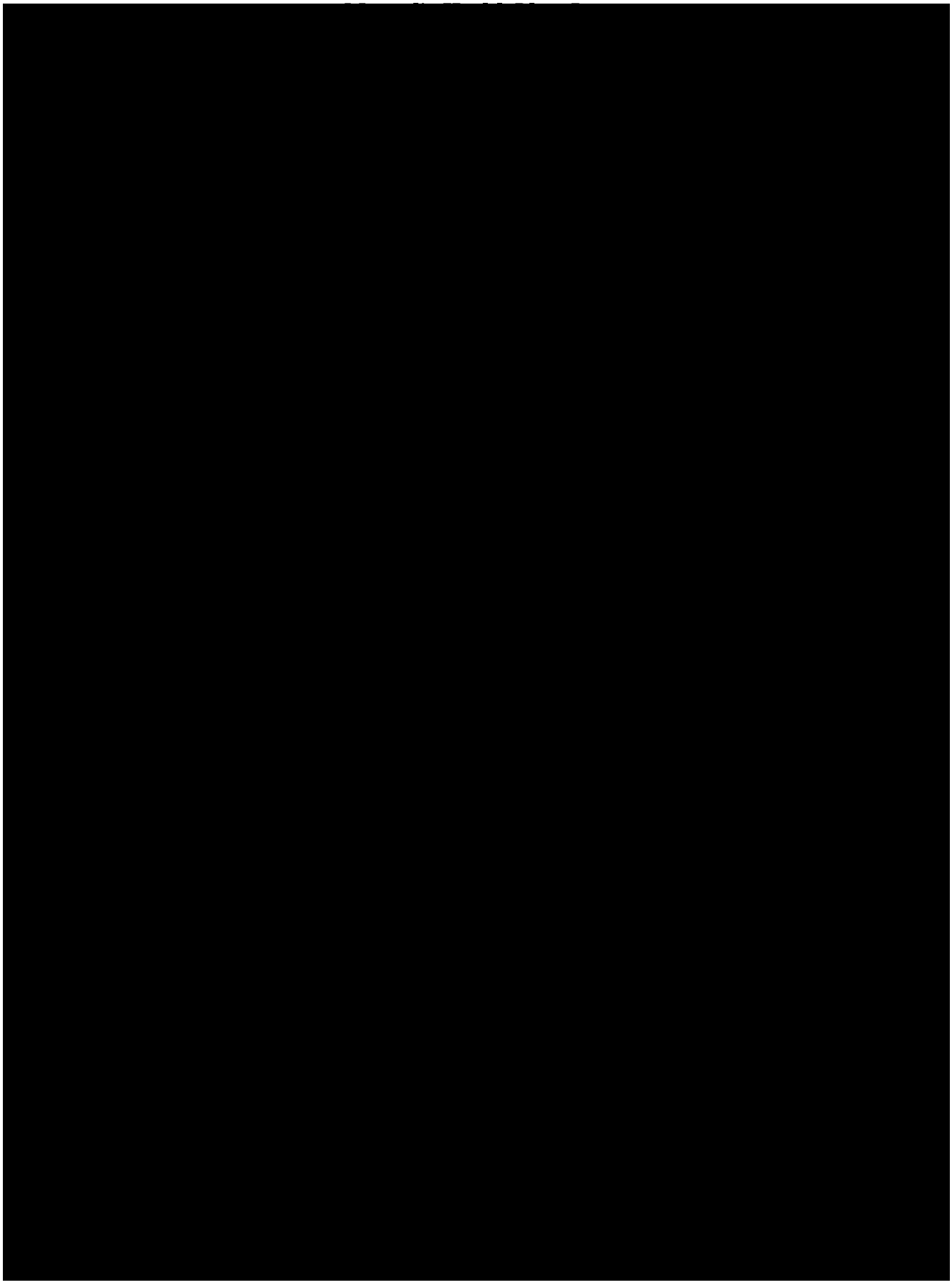


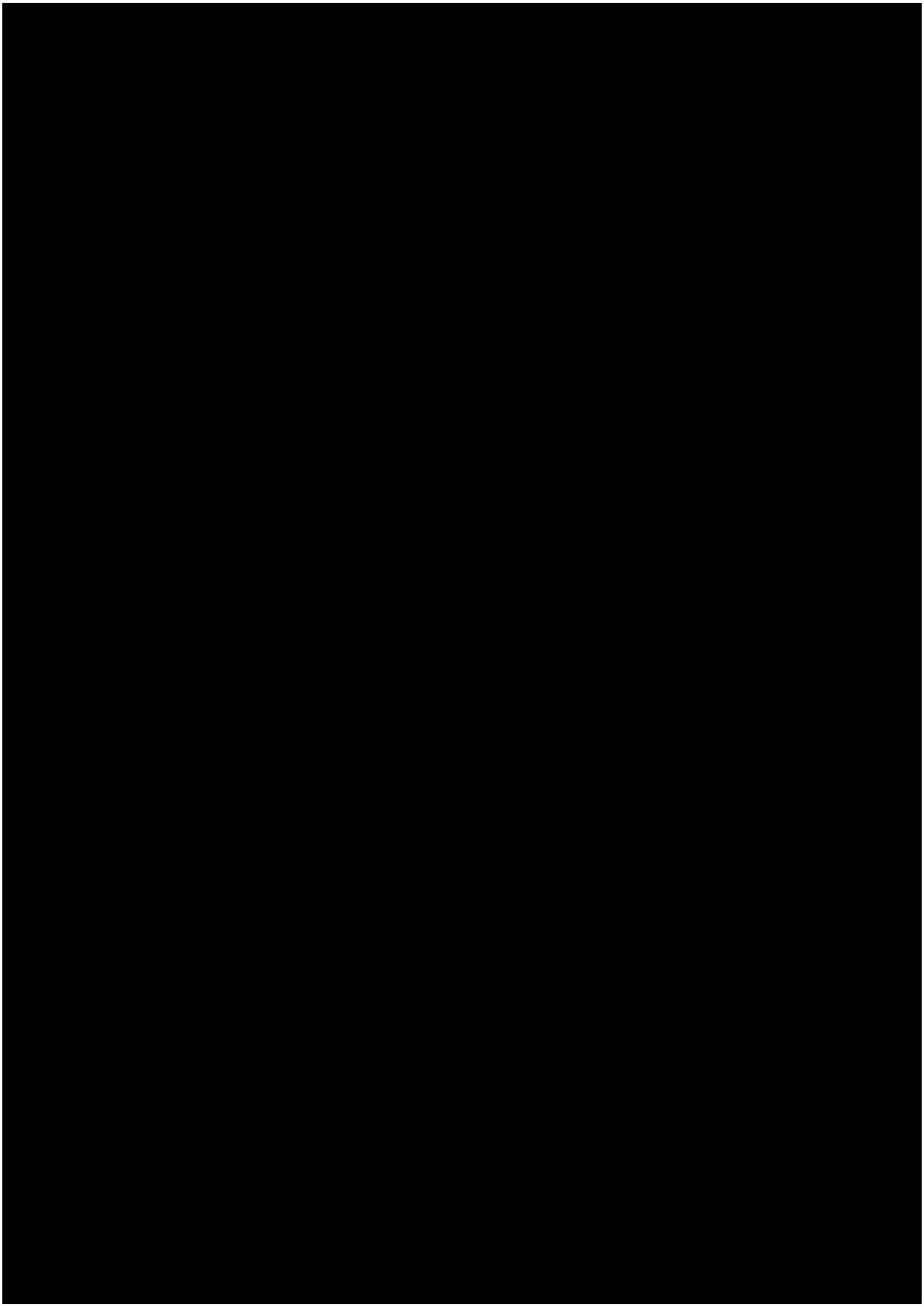


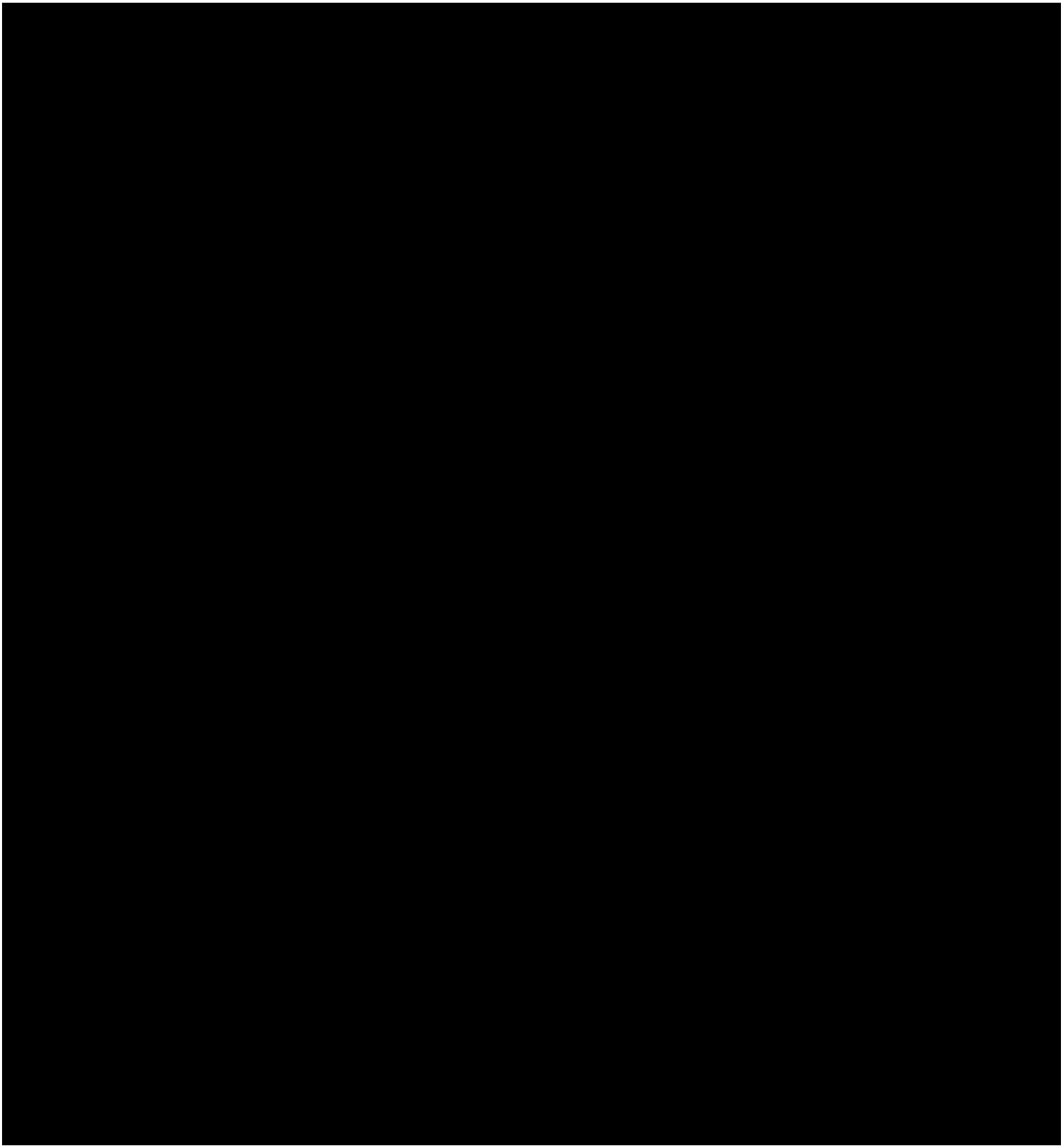




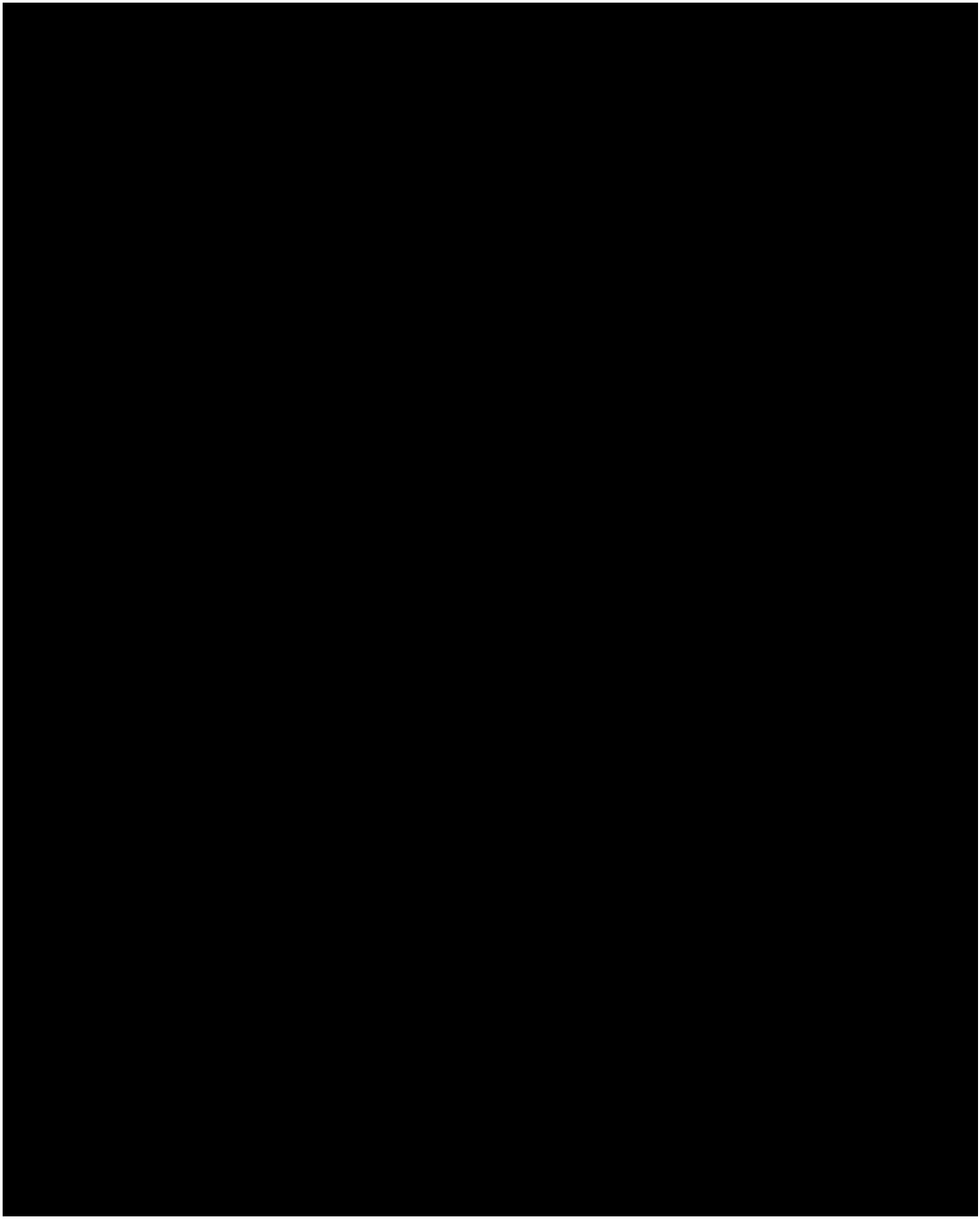








SUPPLEMENT FOR THE YEAR 2020 OF THE Magnolia Health Plan Inc.



SUPPLEMENT FOR THE YEAR 2020 OF THE Magnolia Health Plan Inc.

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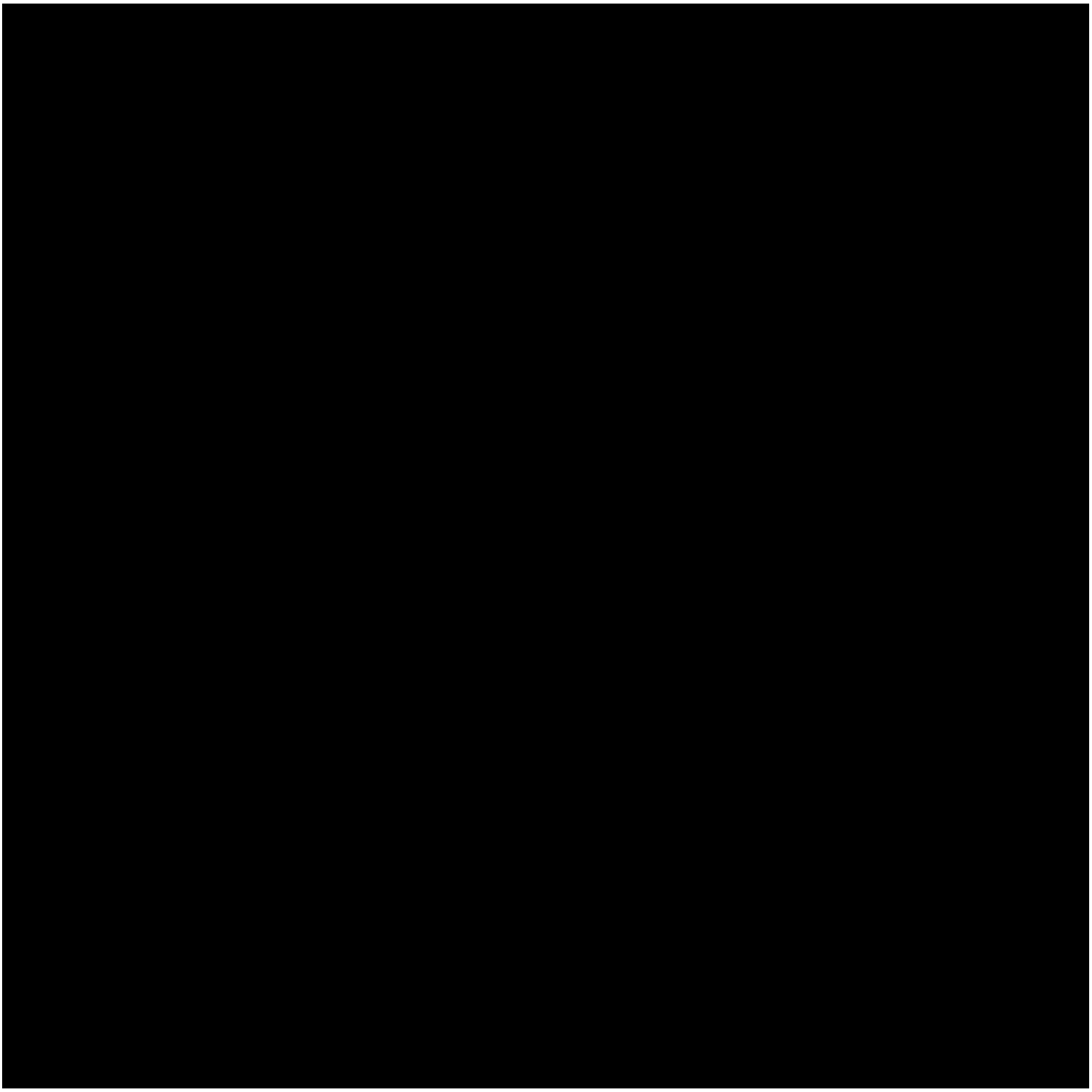

SUPPLEMENT FOR THE YEAR 2020 OF THE Magnolia Health Plan Inc.

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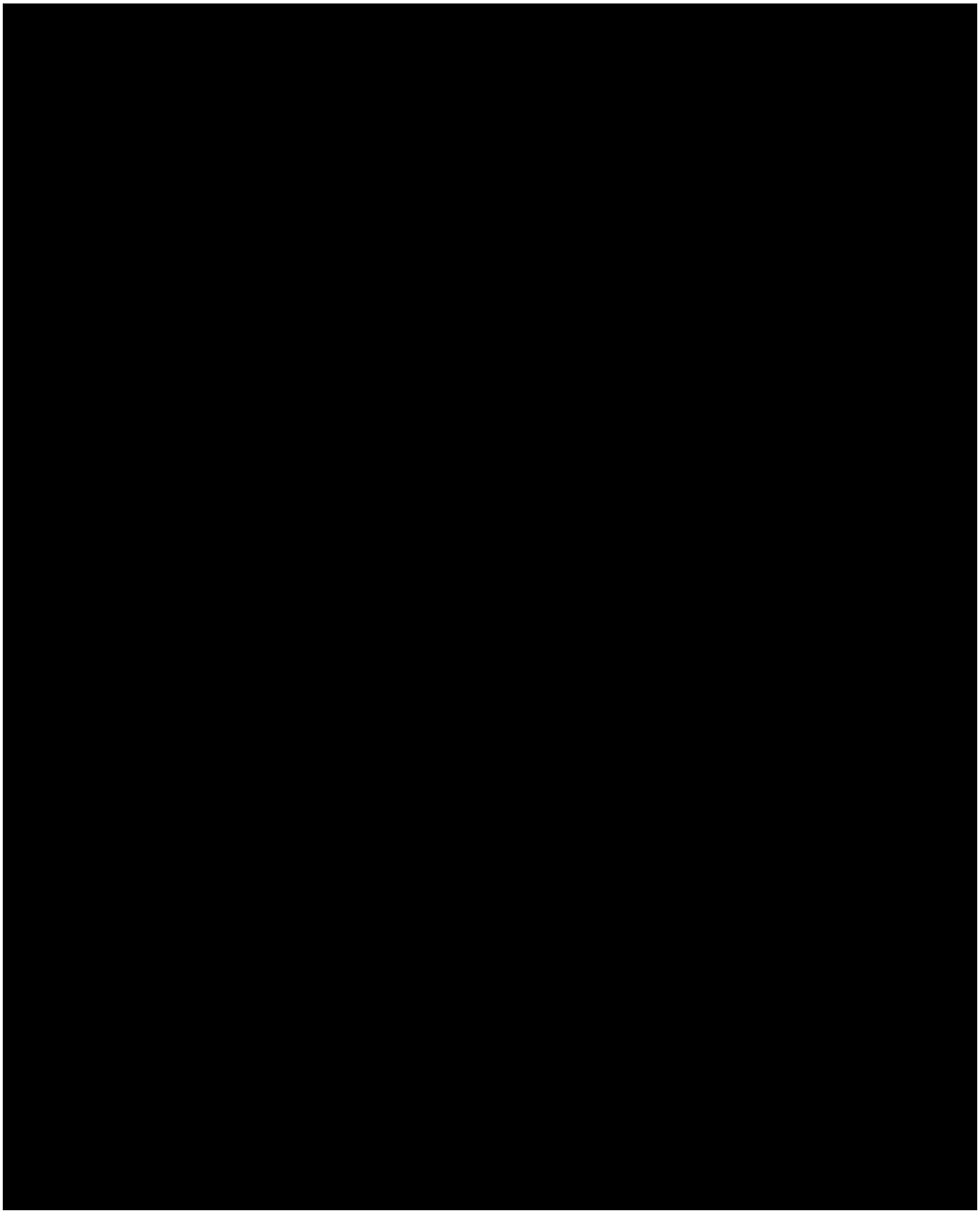
See accompanying independent auditor's report.



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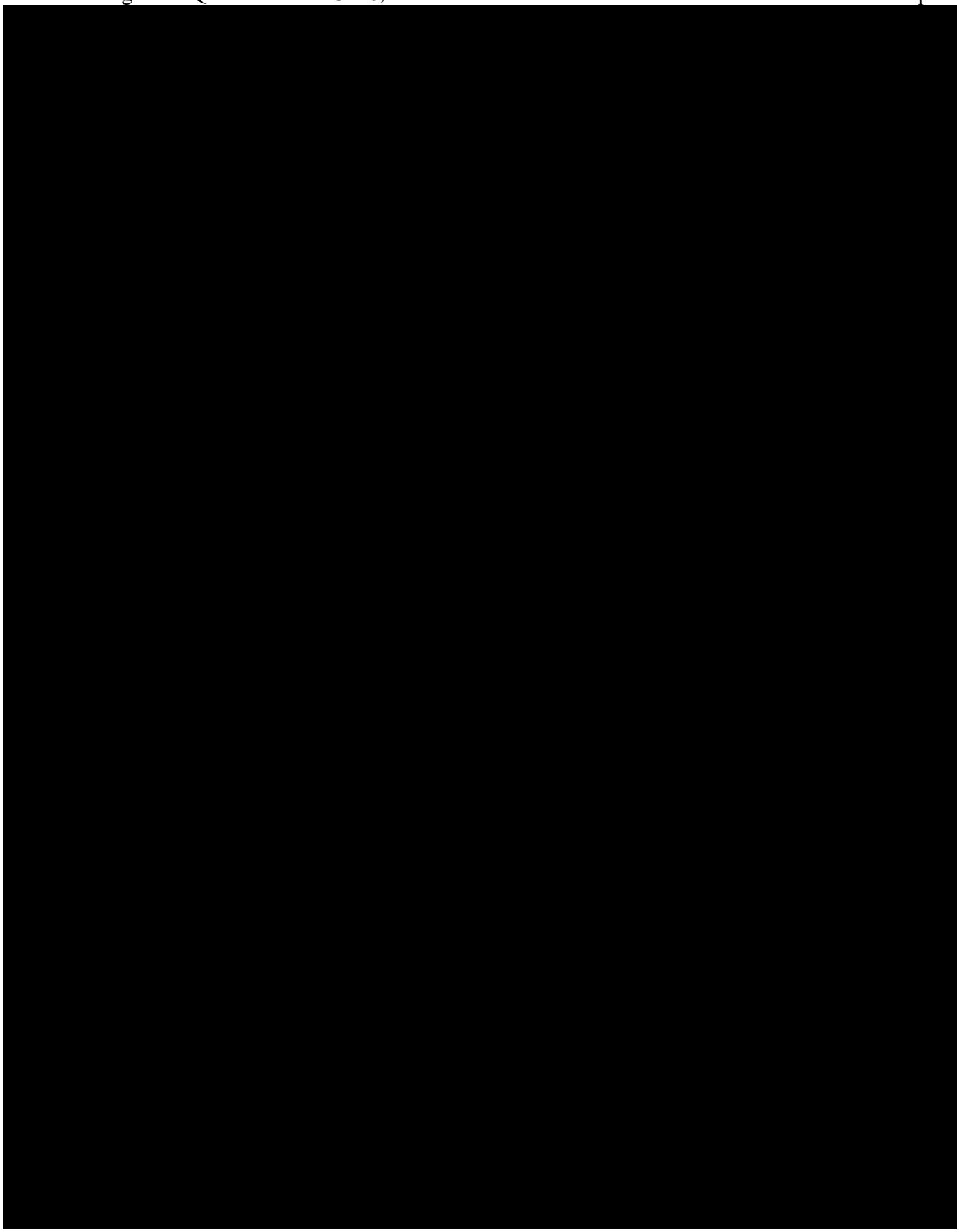

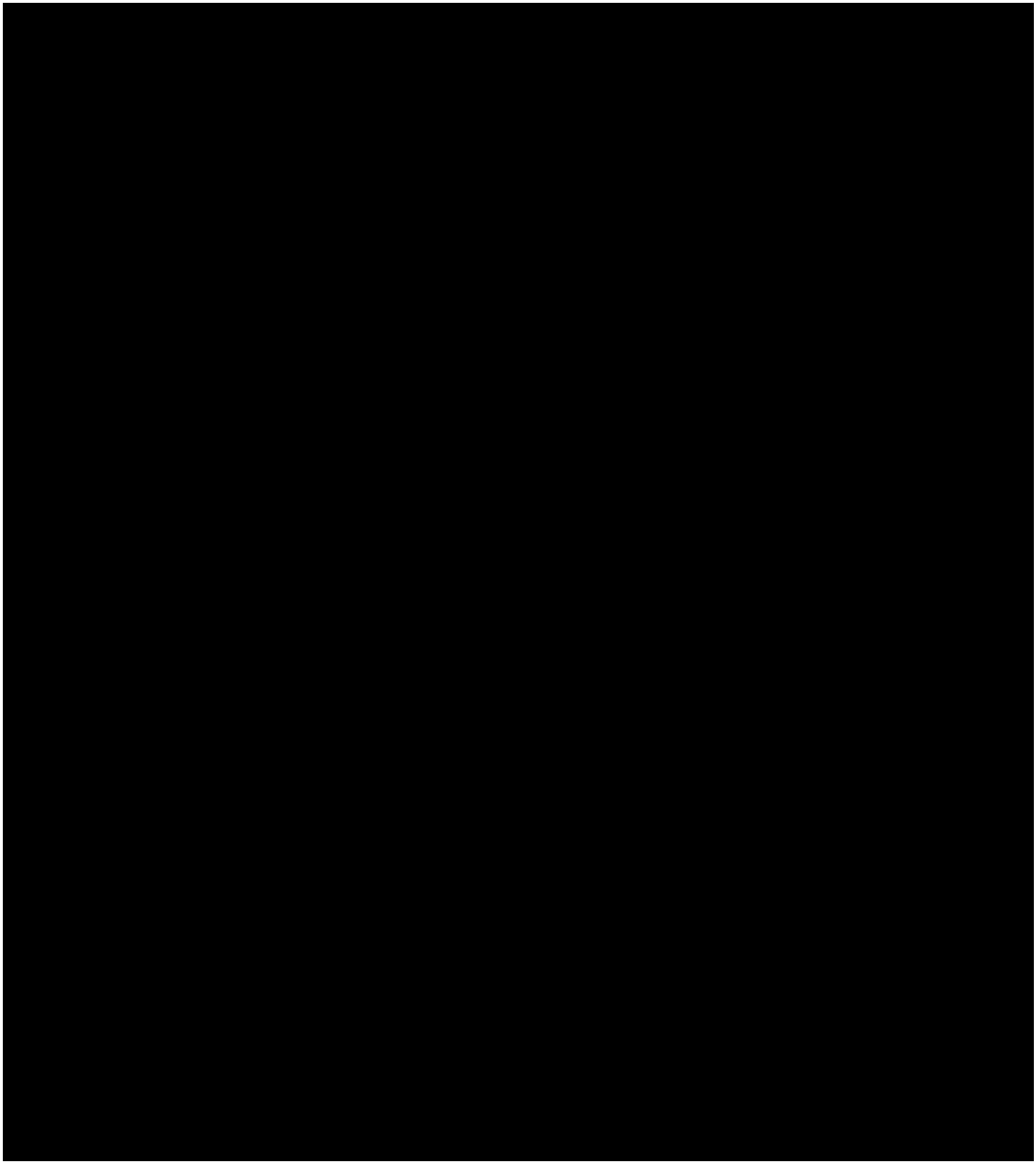

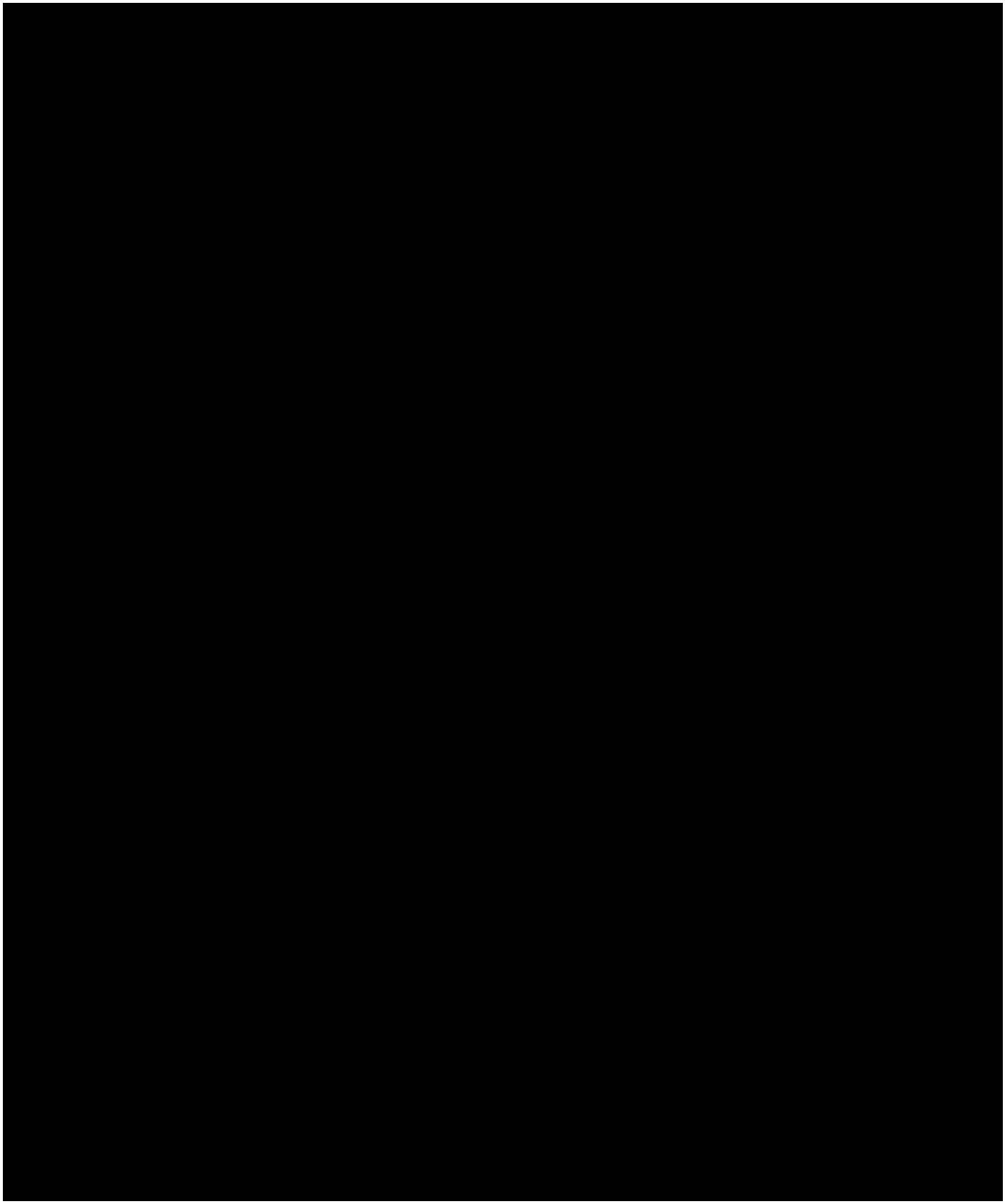

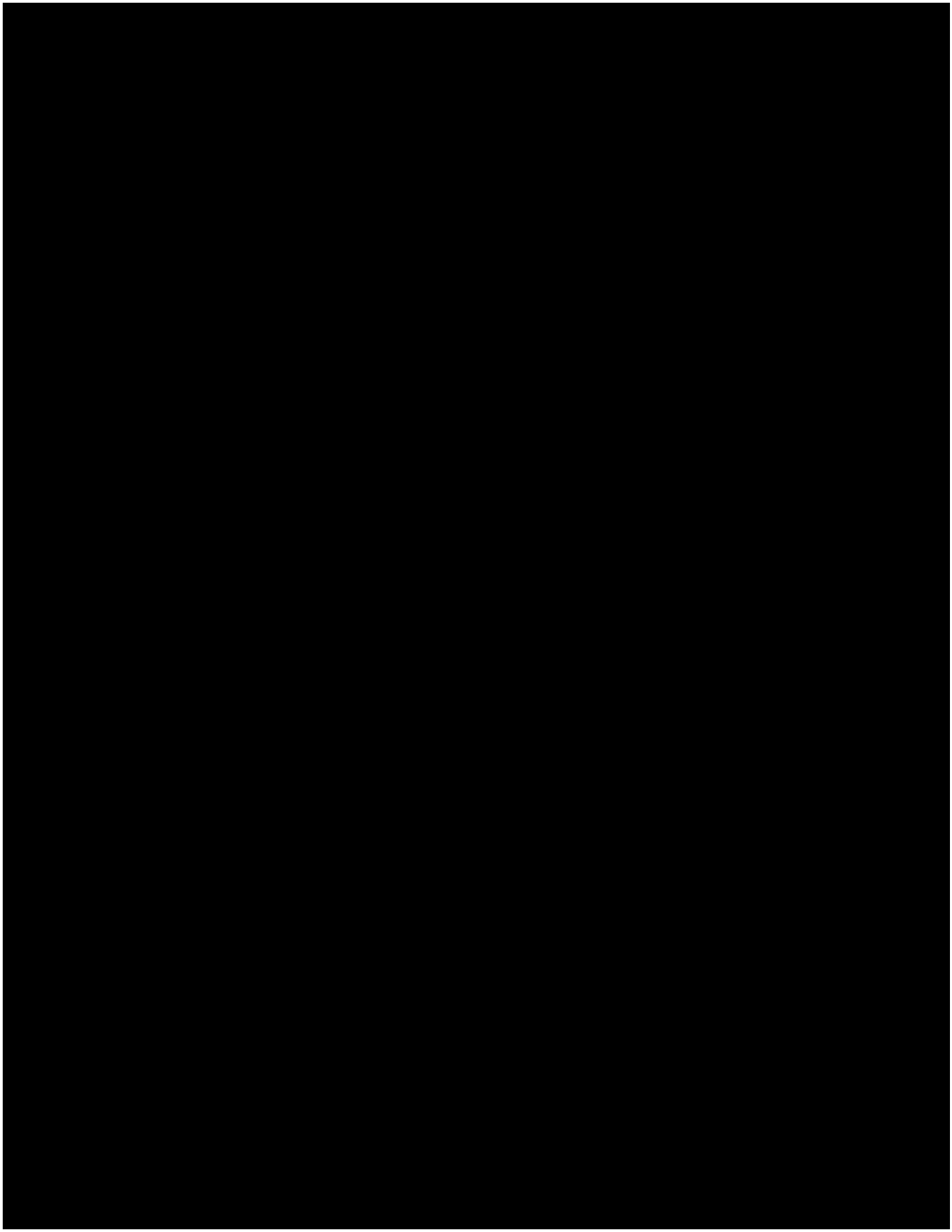

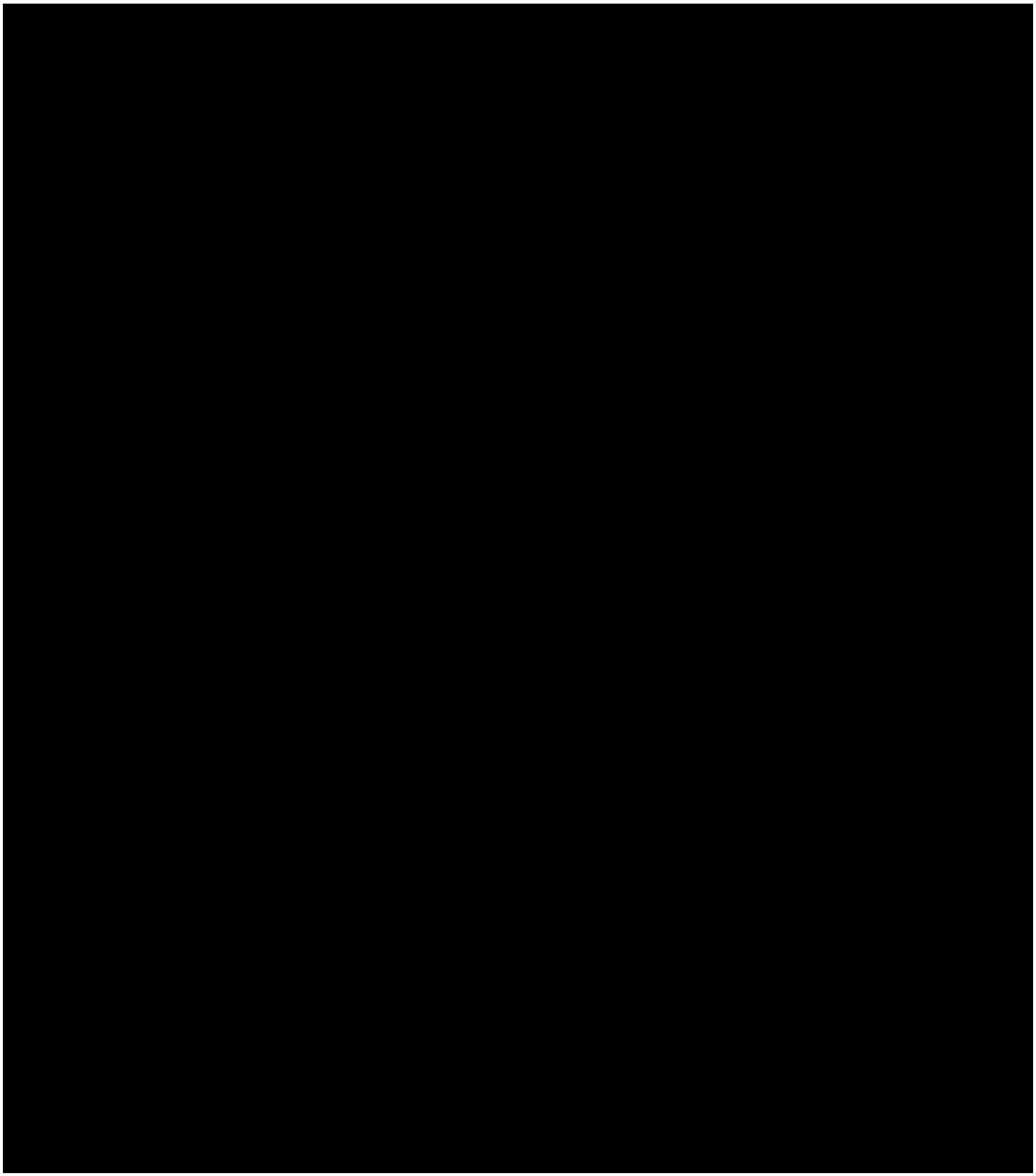

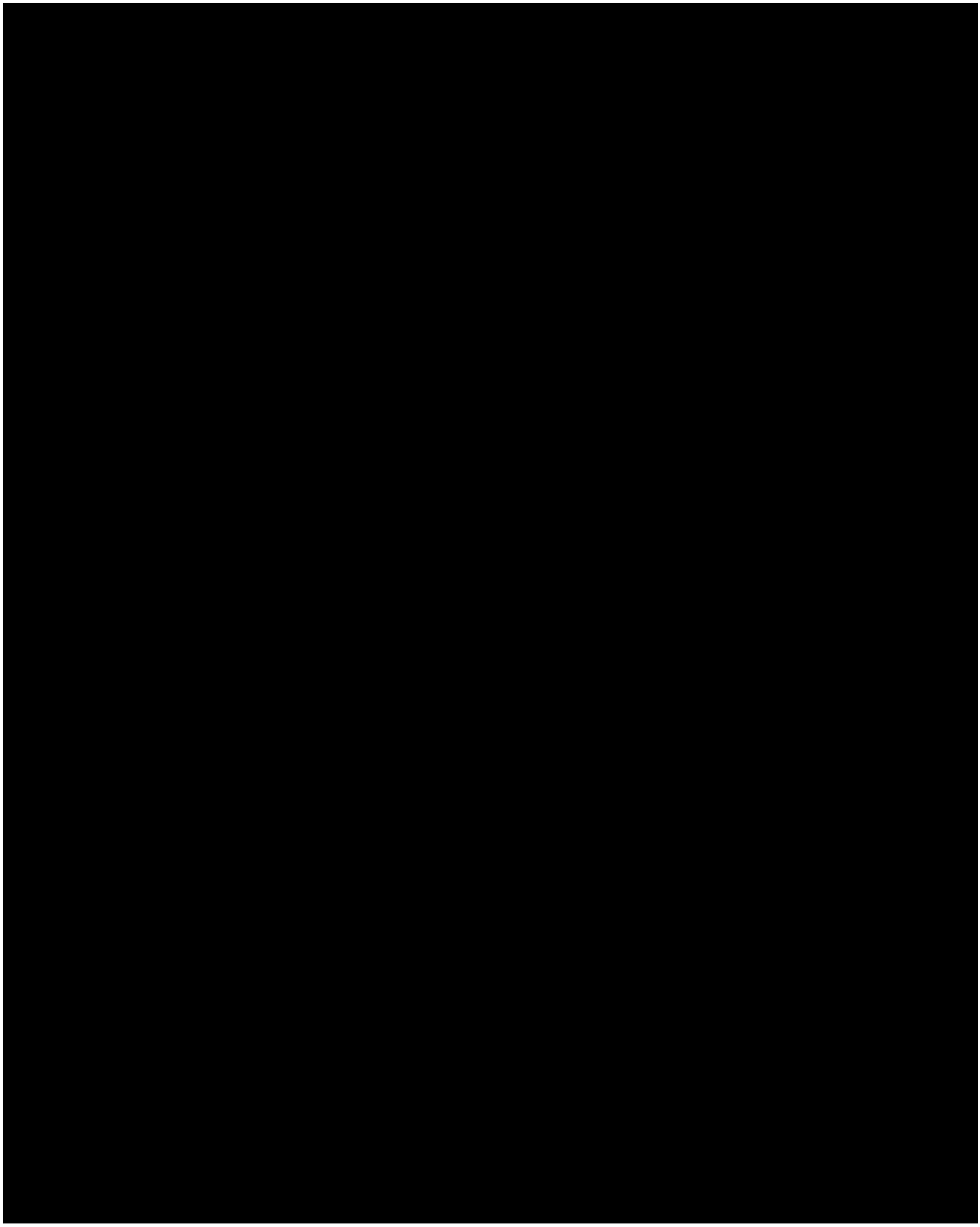

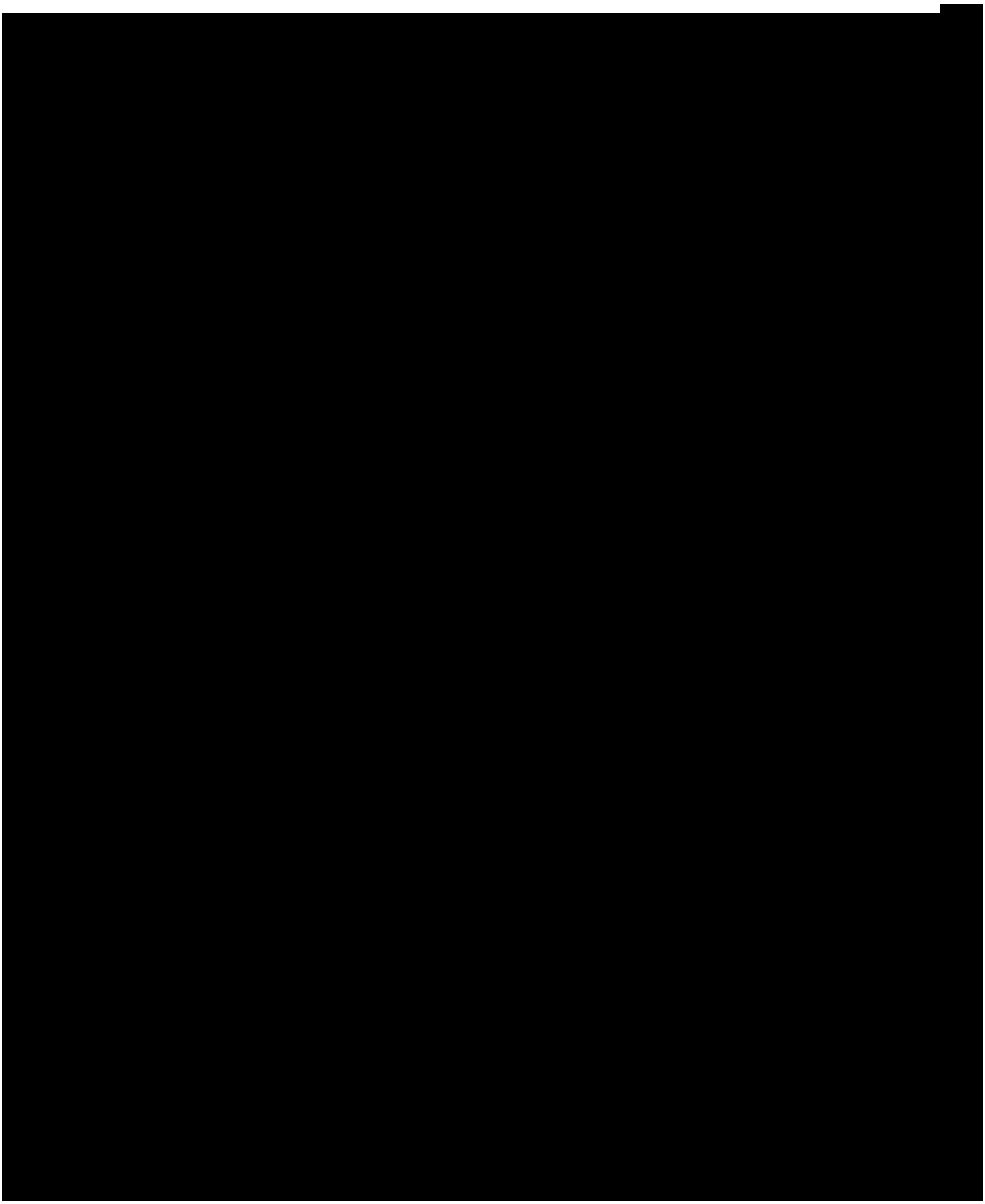

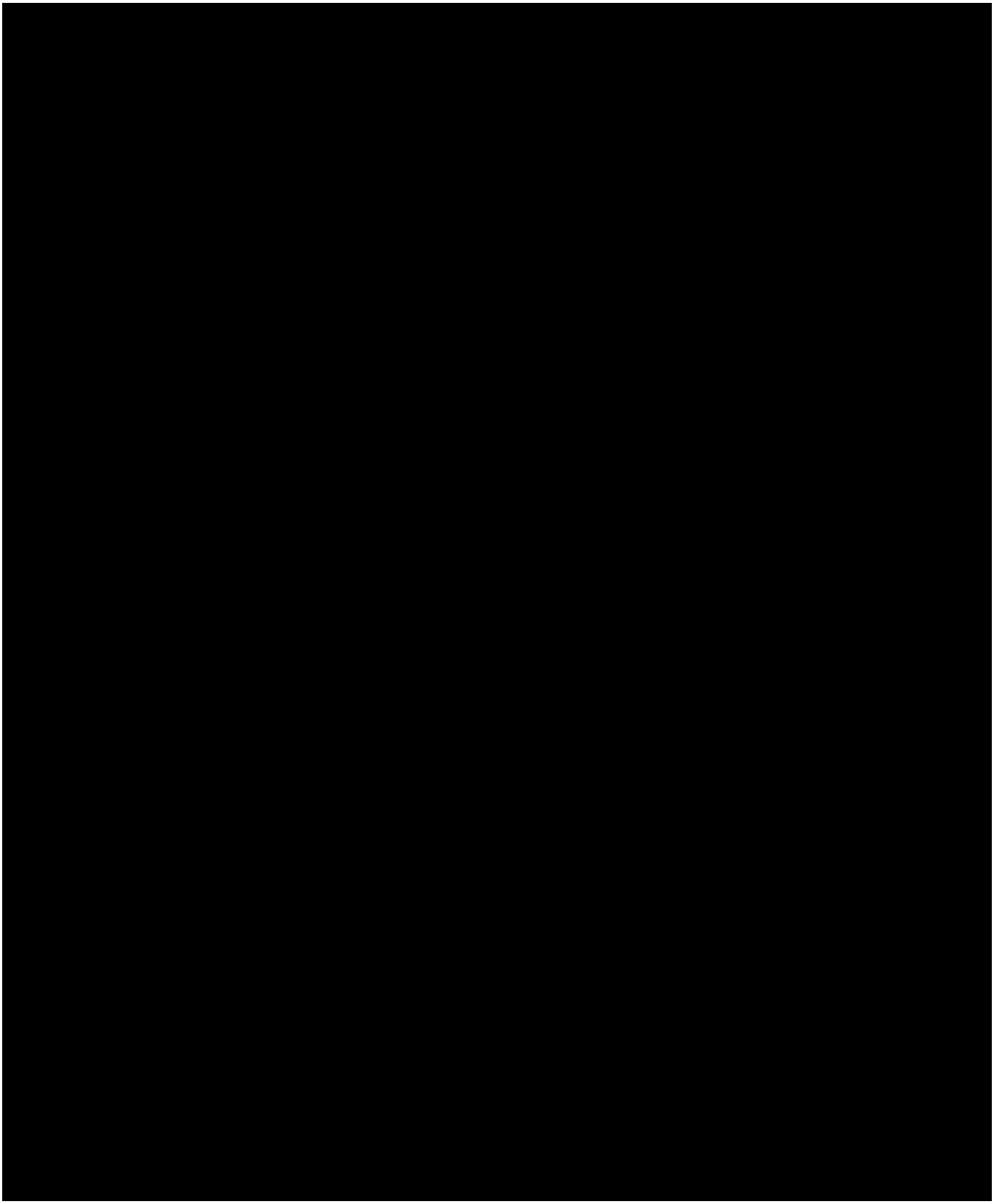

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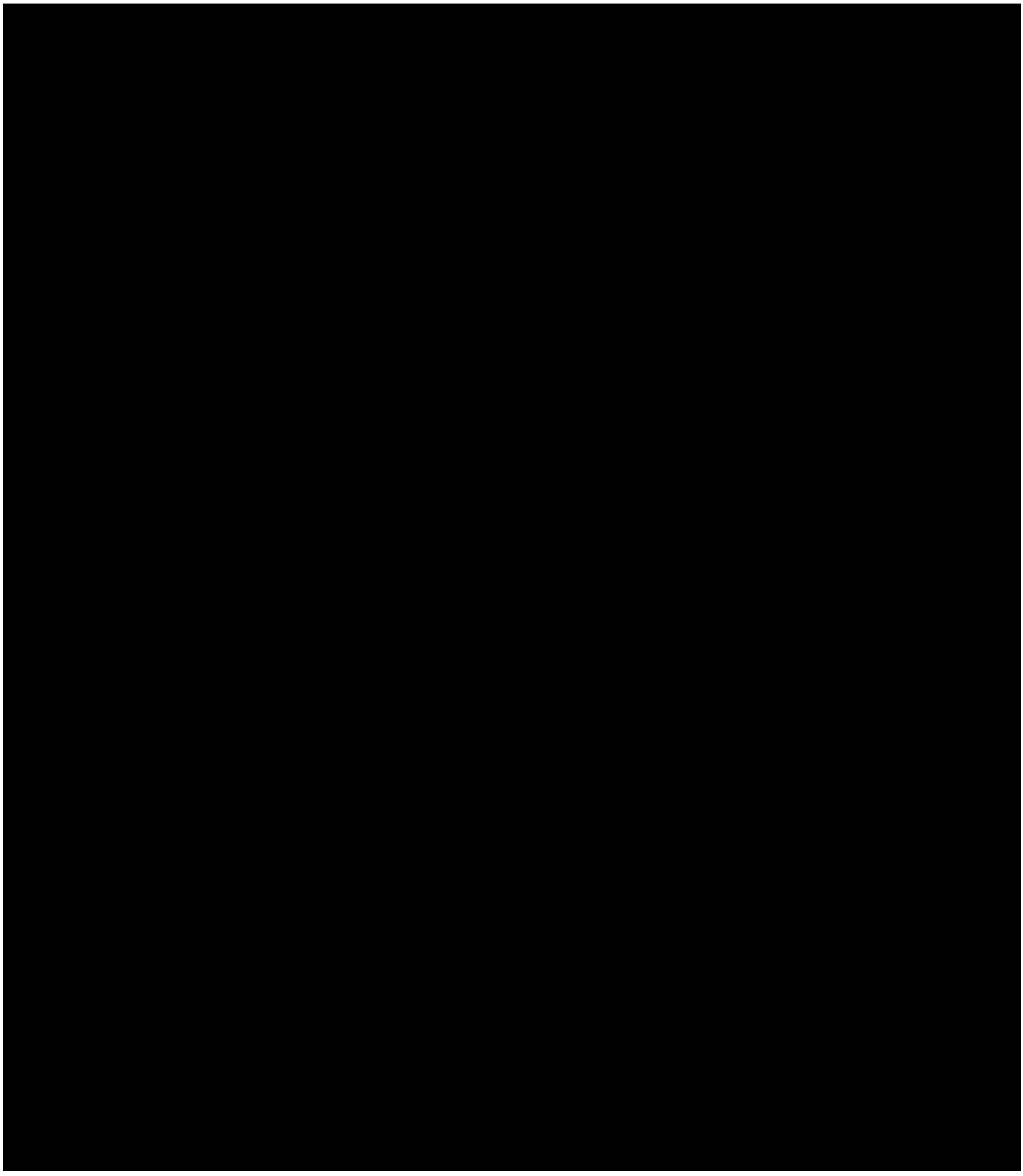

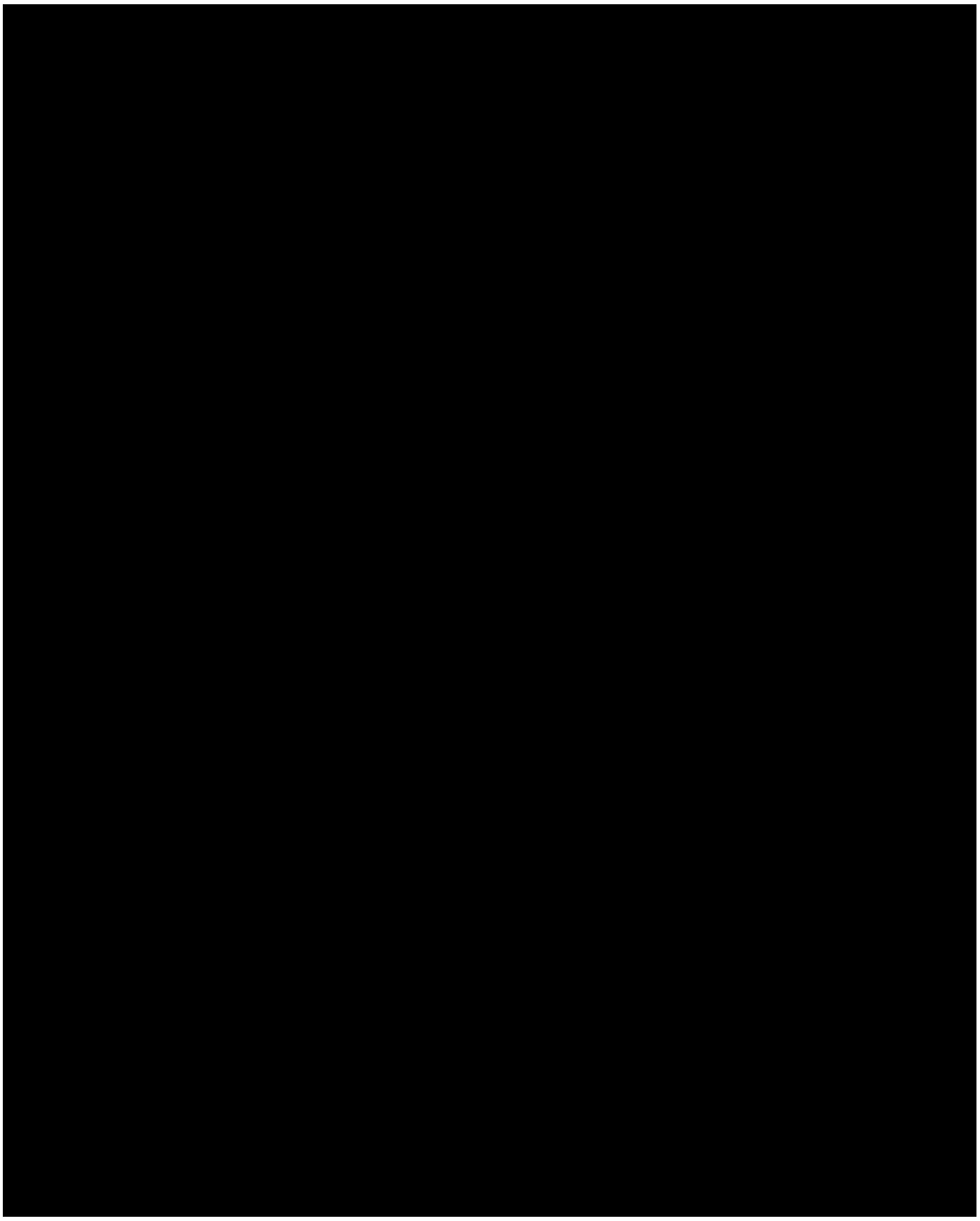

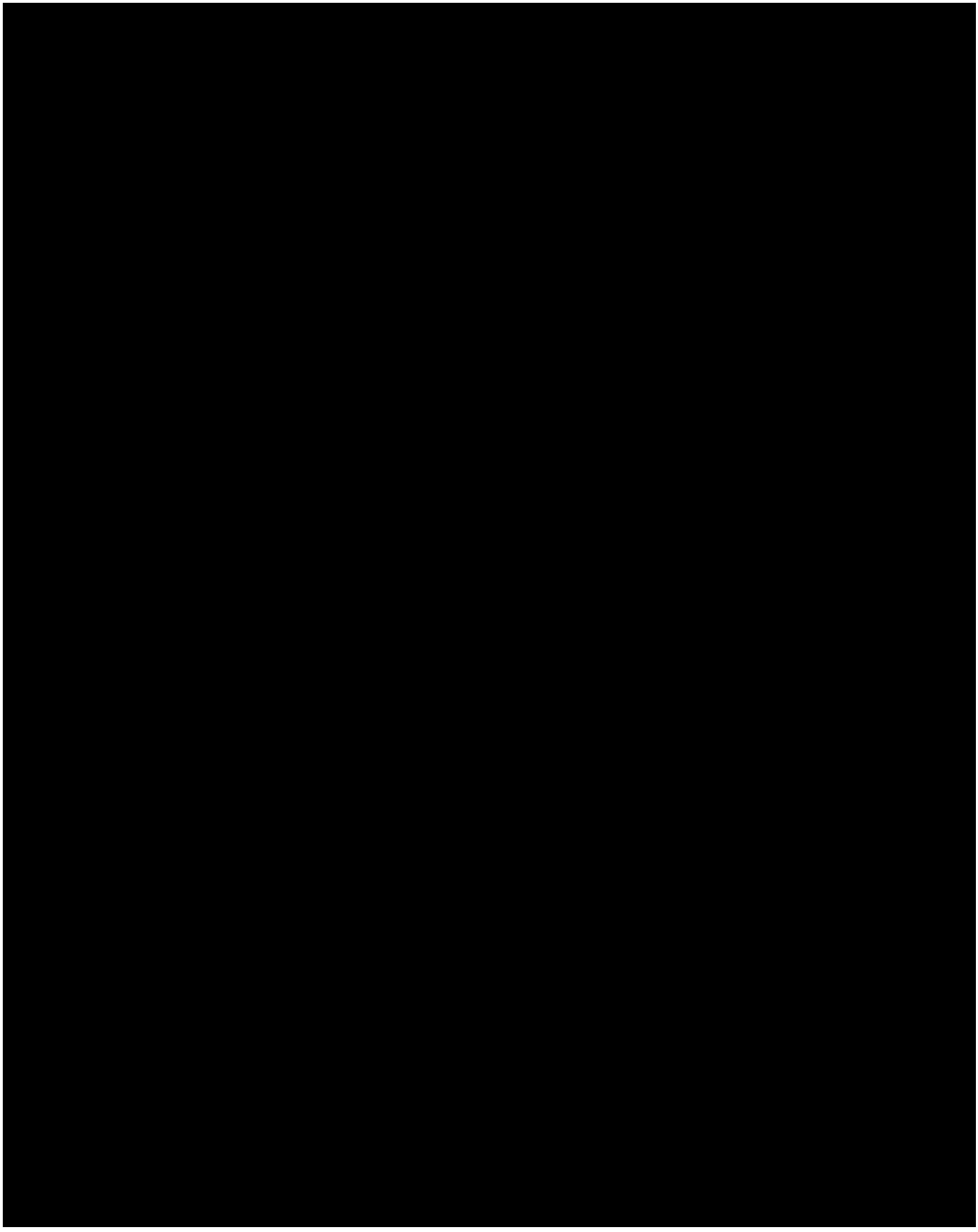

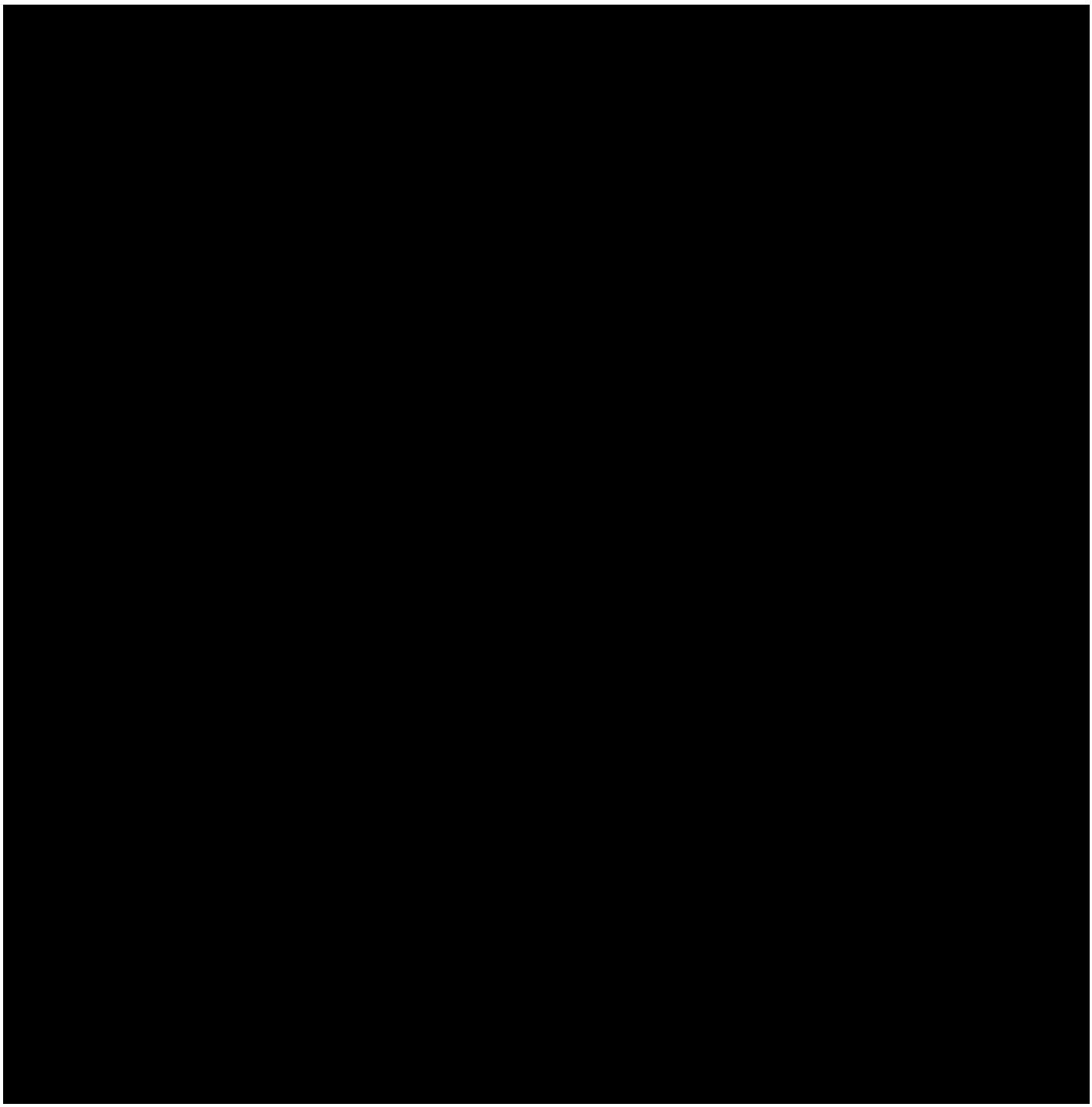

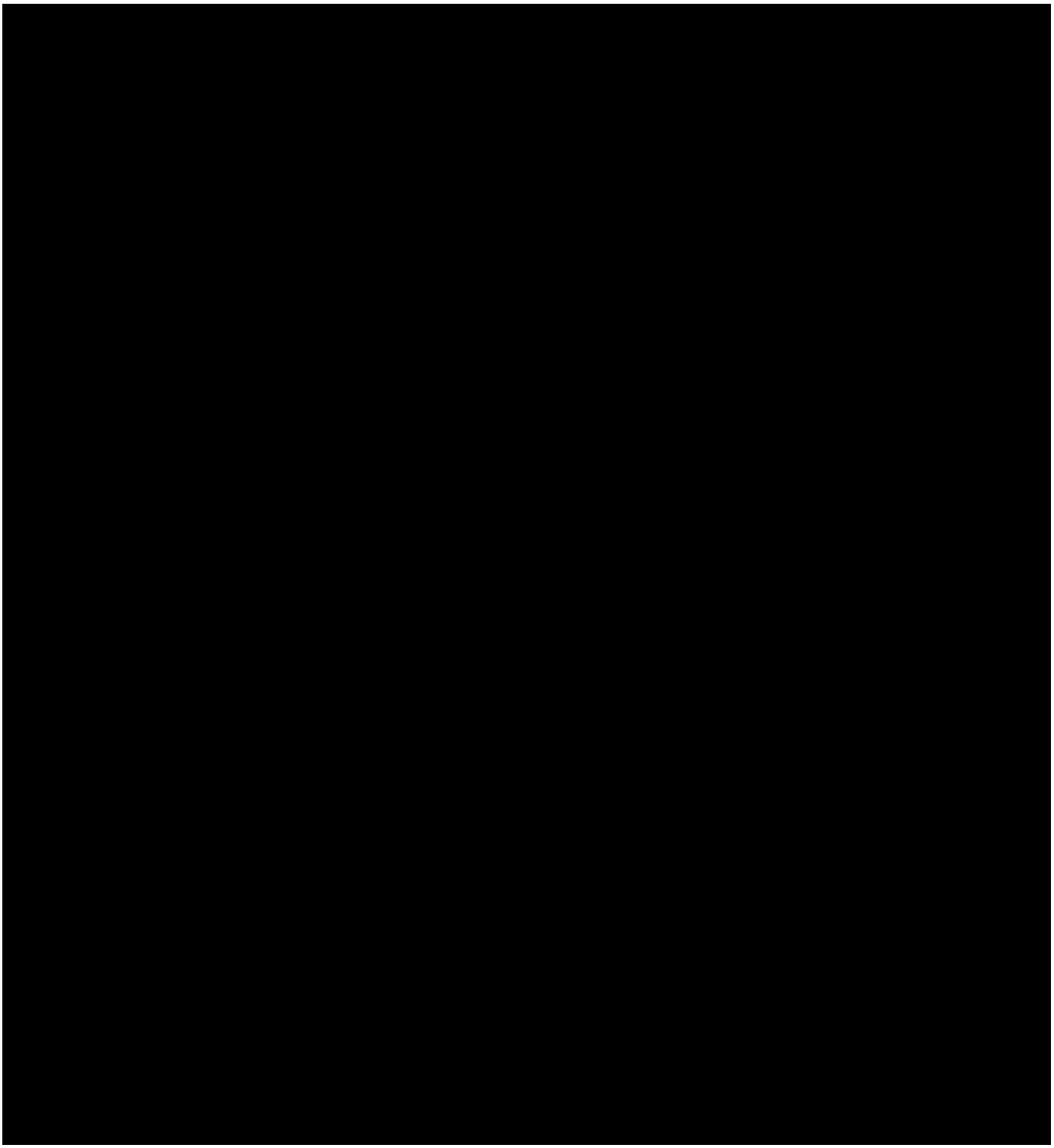

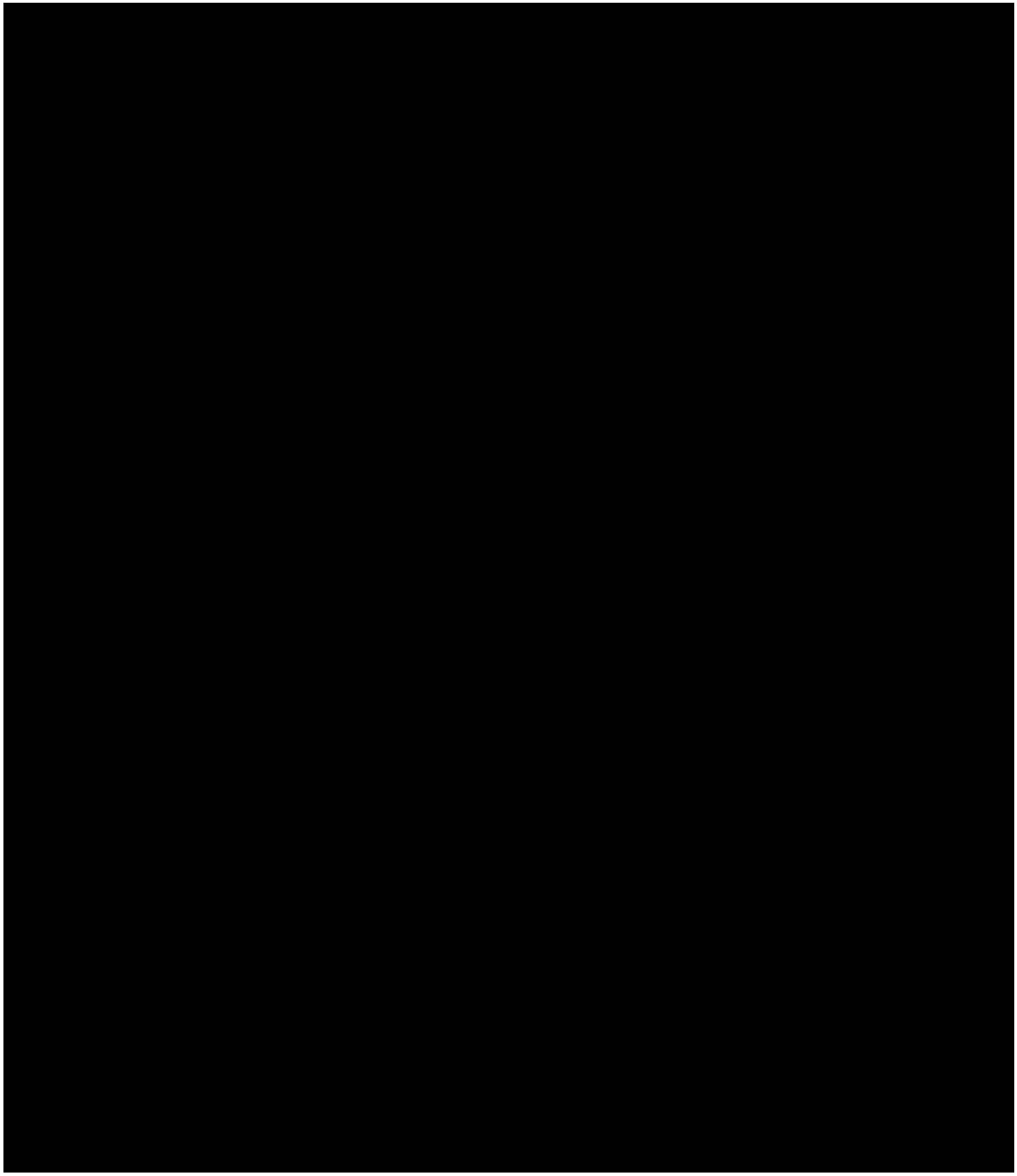

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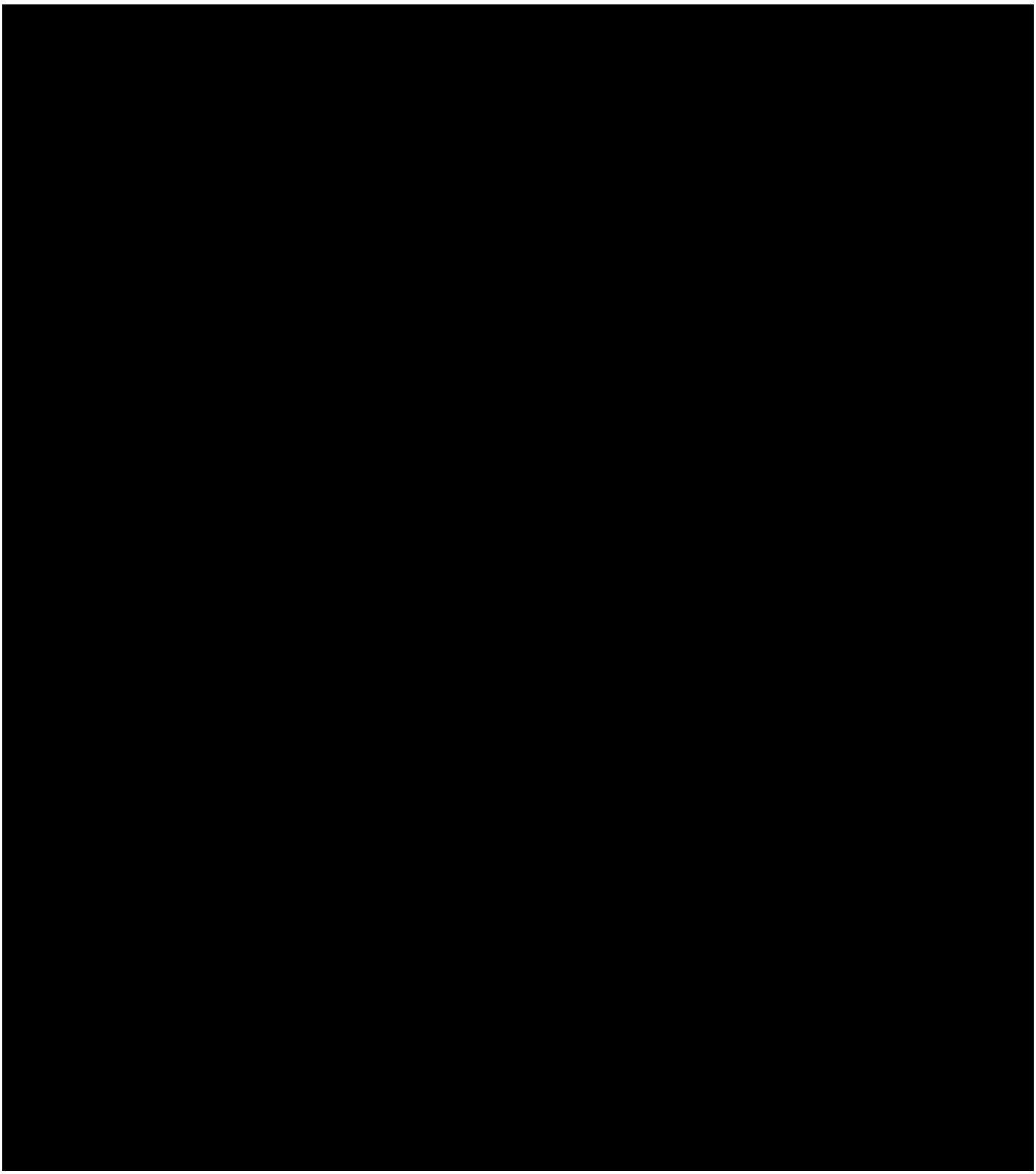
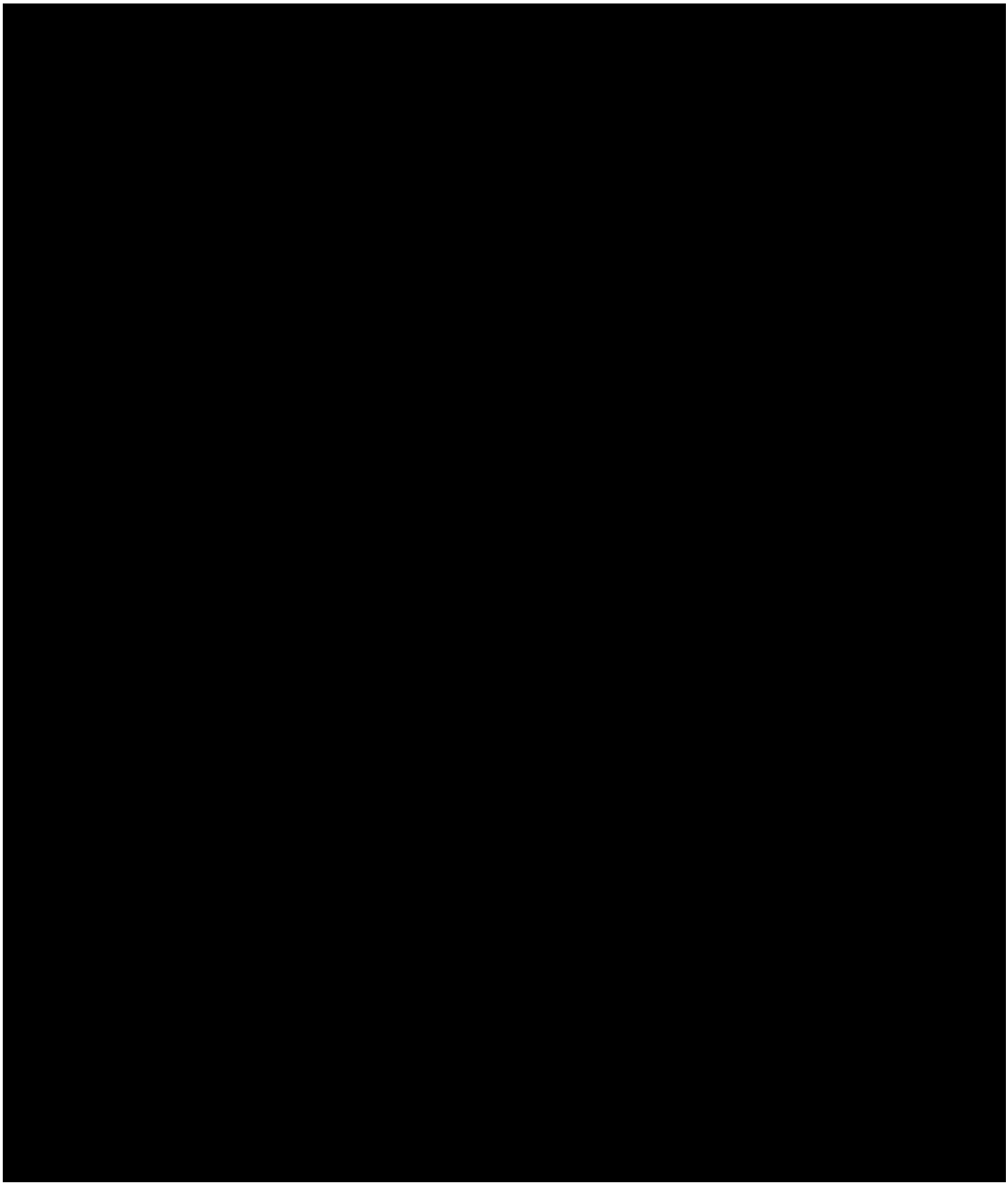
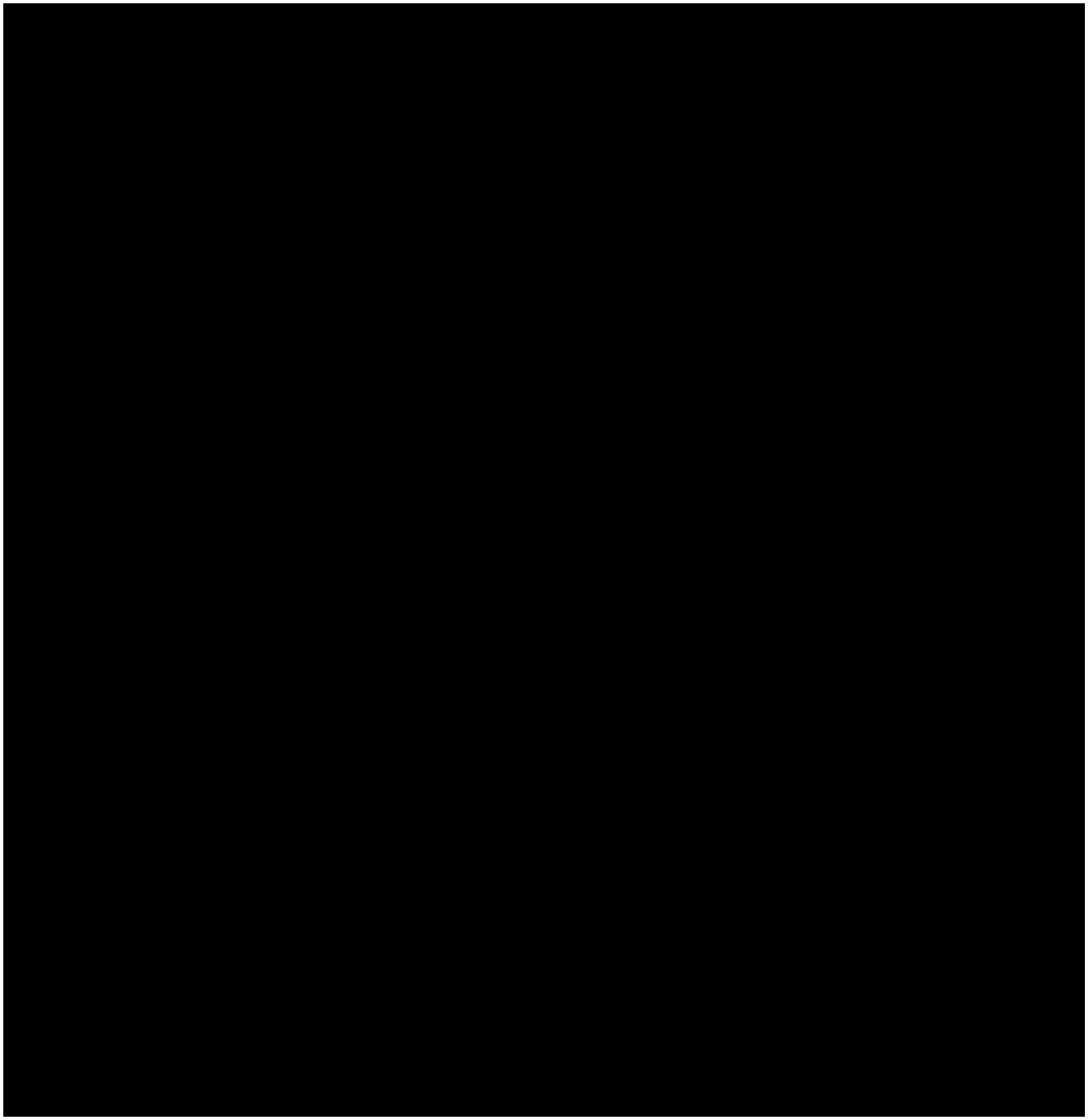
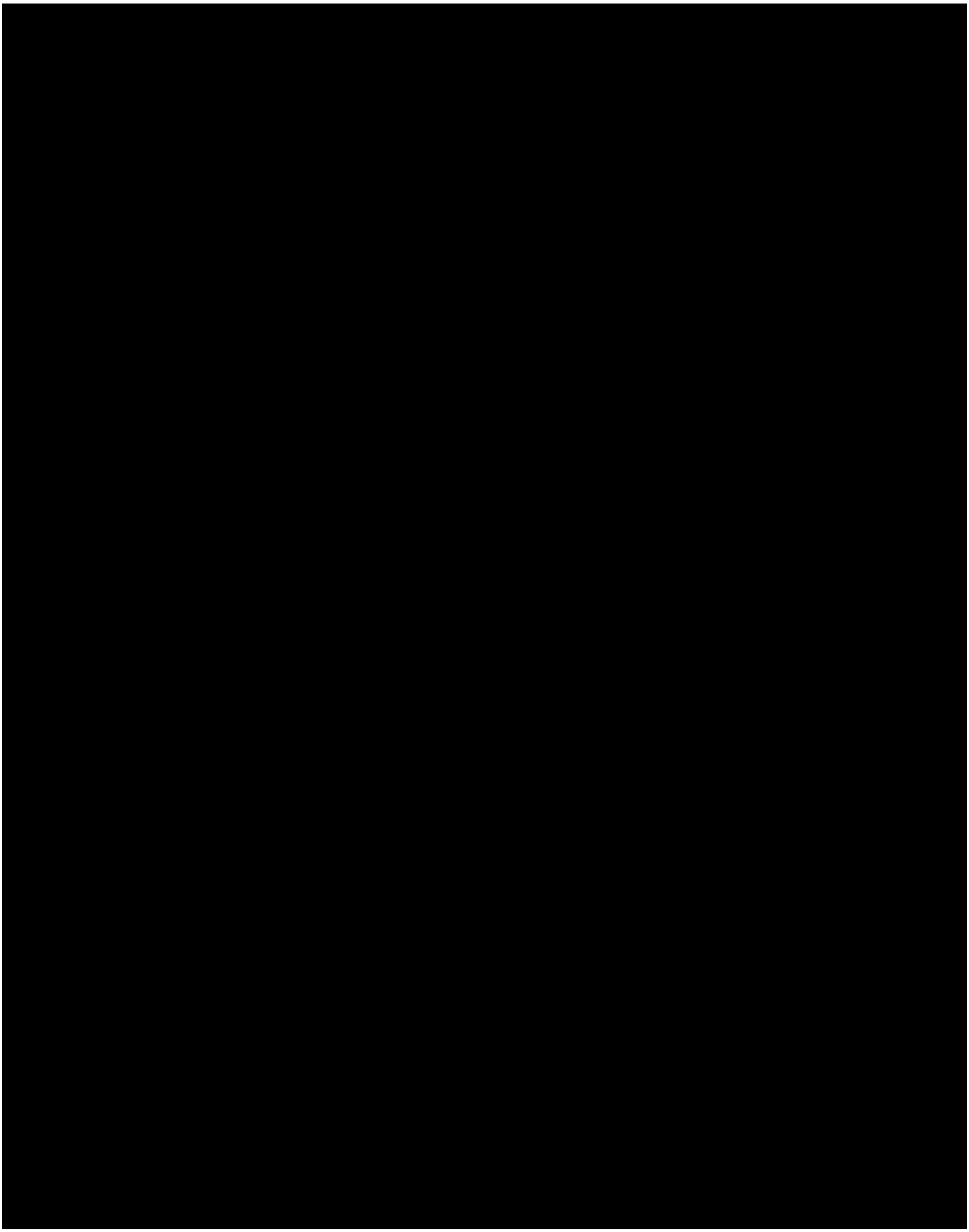








MISSISSIPPI DIVISION OF MEDICAID

Coordinated Care Procurement - 4.3.2.6 Pro Forma Finanical Template

Instructions

Balance Sheet
Please report each line item requested in the Balance Sheet on a Calendar Year Basis Enter the Plan name in B1. The plan name will flow through to the other reports. Risk-Based Capital (RBC) ratio is defined as the ratio of Total Adjusted Capital divided by Authorized Control Level RBC. RBC is calculated by applying risk factors to various assets, credits, premiums, reserves and off-balance sheet items, where the factor ishigher for those items with greater underlying risk and lower for those tiems with lower under lying risk.

Profit and Loss (P&L) Statement
Please report each line item requested in the P&L statement on a Calendar Year Basis

Cash Flow Statement
Please report each line item requested in the cash flow statement on a Calendar Year Basis

Medical Loss Ratio (MLR)
Medical Loss Ratio Rebate Calculation – MSCAN (Please report on a State Fiscal Year (SFY) basis (July 1 - June 30) **Purpose of the report:** Monitor the share of premium revenues the CCO spends on member services and quality improvement activities (MLR Rebate Calc.); calculate the MLR Pricing Percentage Calculation for each reporting period (MLR Rebate Calc.); calculate the total dollar amounts associated with the Adjusted HCQI and HIT Expenses by Reporting Categories for each reporting period (this is to track total HCQI and HIT expenditures in relation to medical expenses) [MLR Rebate Calc.]; and compare the financial impact of the Annual Medical Loss Ratio (MLR) Report to the Annual Mississippi Insurance Department Statement of Revenue and Expenses Financial Statement as filed by the CCOs (MLR Rebate Calc.). **Capitation Revenue and Tax Assessments** 1. Total YTD Capitation Revenue. Sum of total capitation payments, Line 1 2. DO NOT USE THIS LINE 3. Less: Allocation for Premium Taxes 4. Less: Other taxes and other Revenue Based Assessments: Income taxes from earnings applicable to the respective Medicaid operations in the State of Mississippi (exclusive of investment activities) for the MLR reporting year. Any changes in estimates utilized should be adjusted to actual costs in subsequent MLR reporting periods. If there is a deferred tax asset generated for the year's operations, no amount should be reported for income taxes. 5. NET Current YTD Adjusted Premium Revenue (automatically calculated): Difference of Premium Tax Component of Reported Revenue and Total YTD Capitation Revenue **MLR Medical and Administrative Expenses** 6a. Total Net Medical Expenses from Income Statement: Insert Total Net Medical Expenses from CCOs Income Statement 6b. DO NOT USE THIS LINE, Line 3 6c. DO NOT USE THIS LINE, Line 4 7. Incurred Claim Adjustment Additions. The additions total is the sum of incurred claim adjustment additions, as specified in Exhibit C of the MississippiCAN Contract. 8. Incurred Claim Adjustment Deductions. The additions total is the sum of incurred claim adjustment deductions, as specified in Exhibit C, of the MississippiCAN Contract 9. Incurred Claim Adjustment Exclusions. The additions total is the sum of incurred claim adjustment exclusions, as specified in Exhibit C, Of the MississippiCAN Contract 10. Adjusted Net Medical Expenses (automatically calculated): Sum of Total Net Medical Expenses from Income Statement and Incurred Claim Adjustment Additions minus Incurred Claim Adjustment Deductions minus Incurred Claim Adjustment Exclusions **HealthCare Quality Improvement (HCQI) and HealthCare Information Technology (HIT) Meaningful Use Expenses** 11. HCQI and HIT Administrative Expenses from Income Statement: Insert HCQI and HIT administrative expenses from Income Statement 12. Adjustments or Exclusions to HCQI/HIT Meaningful Use Expenses: Enter detailed information in Supplemental Adjustments tab in Category 4 section. This line is the sum of adjustments or exclusions, as specified in Exhibit C of the MississippiCAN Contract 13. Adjusted HCQI/HIT Expenses: Sum of HCQI and HIT Administrative Expenses from Income Statement and Adjustments or Exclusions to HCQI/HIT Meaningful Use Expenses 14. Other Non-Claims Costs: For reporting purposes only, this is not included in the numerator 15. Program Integrity Costs: Enter detailed information in the Program Integrity Cost tab. 16. Total Adjusted Current YTD MLR Expenditures (automatically calculated): Sum of Adjusted Net Medical Expenses and Adjusted HCQI/HIT Expenses 17. Reporting MLR Percentage (automatically calculated): Total Adjusted MLR Expenses divided by Total Adjusted Current YTD MLR Expenditures 18. MLR Percentage Requirement for Rebate Calculation (automatically calculated): 87.5% as consistent with the Exhibit C of the MississippiCAN Contract 19. Percentage Below 87.5% Requirement (automatically calculated): The difference between MLR Percentage Requirement for Rebate Calculation and MLR Percentage Achieved 20. Dollar Amount of Rebate Requirement (automatically calculated): Percentage Below 87.5% Requirement multiplied by Total Adjusted Current YTD MLR Expenditures **Credibility Adjustment Applied** **In alignment with MLR requirements, as defined in 42 CFR 438.8(b), the credibility adjustment is used to account for random statistical variation related to the number of enrollees in a managed care plan. The credibility adjustment categorizes managed care plans into three groups:** • Fully-credible. Managed care plans in this group, it is highly likely that the difference between the actual and target MLR is statistically significant and not due to random variation. • Partially-credible. Managed care plans in this group, it is somewhat likely that the difference between the actual and target MLR is statistically significant but such difference could. at least in part. be due to random variation. • Non-credible. Managed care plans with insufficient claims experience. measured in terms of member months. to calculate a reliable MLR. **The temulate will automatically calculate the MLR credibility adjustment required based uoon the table in the temulate provided bv CMS.** 21. MLR Member Months: Enter the sum of beneficiary count for the year to date period for each reporting period. 22. MLR Member Months (Annualized) 23. Credibility Adjustment 24. Adjustment Reporting MLR Percentage 25. MLR Percentage Requirement for Rebate Calculation 26. Percentage below 87.5% Requirement 27. Dollar Amount of Rebate Required

Denials
Enter the expected denial percentage rates for each of the three (3) categories requested for each state fiscal year. The rates should be based on your projection but taking into account what you have done historically in other markets with denials. Please include any additional information to help the rates.

Assumptions
Provide any additional detail here for assumptions used in the pro forma of the financials.

Company Name: **Magnolia Health Plan, Inc.**

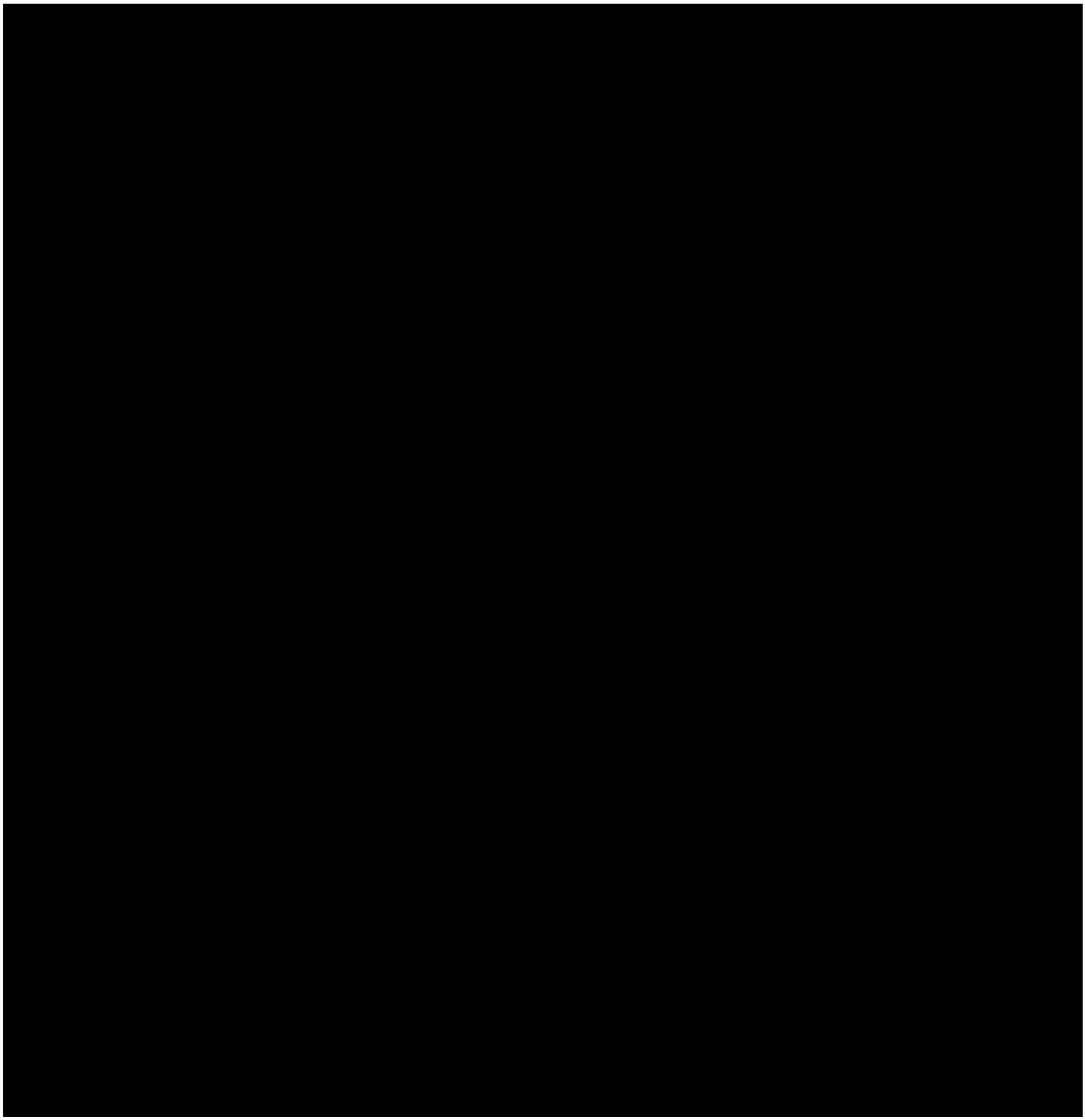
Pro Forma Statutory Balance Sheet

(In Thousands)

Company Name: **Magnolia Health Plan, Inc.**

Pro Forma Statutory Profit & Loss Statement

(In Thousands, except Member Months, in Whole numbers)

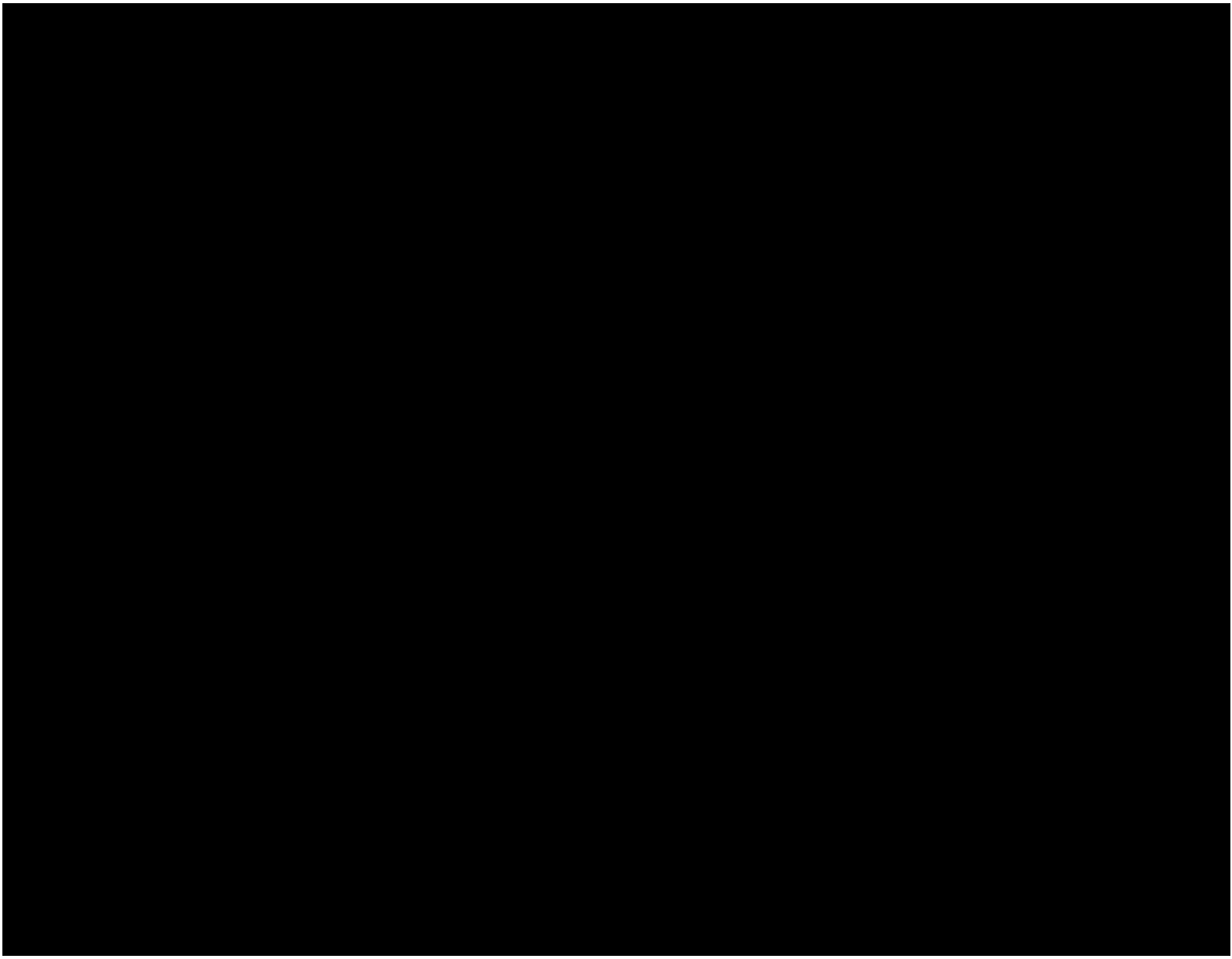


Company Name: **Magnolia Health Plan, Inc.**

Pro Forma Statutory Cash Flow Statement

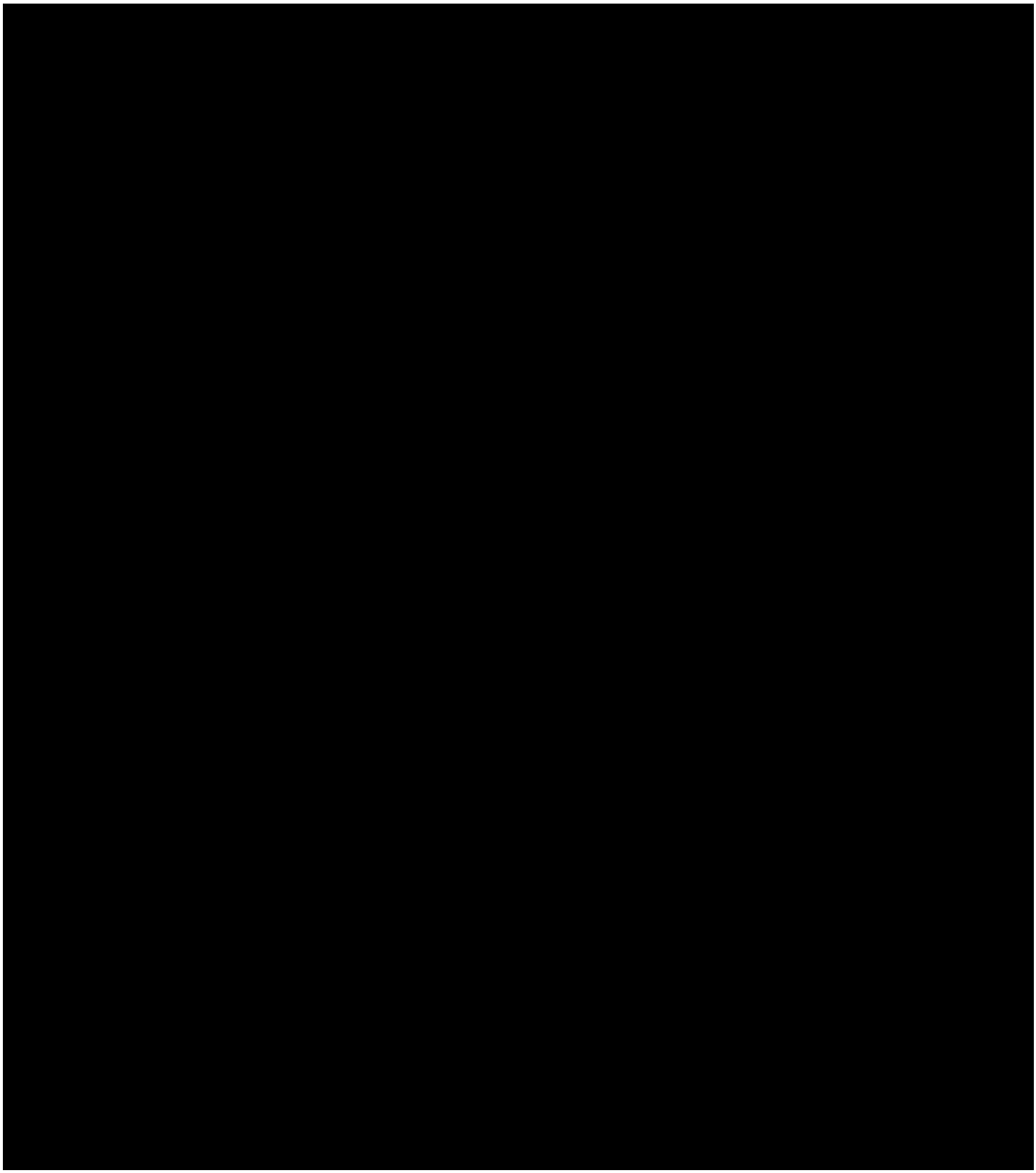
(In Thousands)

Company Name: **Magnolia Health Plan, Inc.**
Preliminary MLR Statement
(In Thousands)



Company Name: **Magnolia Health Plan, Inc.**

Denials



[END OF RESPONSE]

4.3.3 ORGANIZATION AND STAFFING

The Organization and Staffing Section shall include team organization, charts of proposed positions, number of FTEs associated with each position for key staff, and job descriptions of key management personnel and care managers listed in Section 1.13, Administration, Management, Facilities, and Resources of Appendix A, Draft Contract, as well as the Offeror's plan for hiring and management of any subcontractors the Offeror plans to execute the Contract and what economic impact the selection of the Offeror might have on the state.

Magnolia's Organization and Staffing

Magnolia Health Plan (Magnolia) has approximately 350 employees, all of whom are Mississippi residents, living and serving the Members of their communities throughout the 82 counties of the state. ***Our local approach ensures that Magnolia supplies jobs of all skill levels and brings growth and development opportunities for Mississippians statewide***. As a current Coordinated Care Organization (CCO) serving Mississippi Coordinated Access Network (MSCAN) Members since the start of the program, Magnolia staff are familiar with the local culture, geography, and health care delivery system which contributes to an unparalleled understanding of the needs of our Members. Magnolia currently serves more than 169,000 Members statewide from our office in Jackson and employees across the state. Our local approach enables us to:

- Provide accessible, high quality, and culturally sensitive health care services to our Members
- Form strong, collaborative relationships with the Provider community
- Be a responsive partner to DOM, undertaking special projects and setting the bar as a CCO
- Create flexibility in our operating model to meet the unique needs of Mississippi

Our organizational structure has clear lines of authority and an experienced Senior Leadership Team, many of whom have been in place since the inception of MSCAN. Magnolia's governing body, our local Board of Directors, sets forth policy and has overall responsibility for the organization of the plan. The plan is responsible for the administration and management of all aspects of the contract.

Our parent company, Centene Corporation (Centene), enables us to take advantage of economies of scale by providing administrative services, such as IT, Finance, and Human Resources support as well as access to national expertise through affiliate health plans. By utilizing the corporate expertise for some administrative tasks, Magnolia can focus on important Member- and Provider-facing positions, such as employing physical and behavioral health care managers to promote integration of care and numerous field positions within the care management department to provide community outreach and face-to-face visits.

4.3.3.1 ORGANIZATION

The organization charts shall show:
1. Organization and staffing during each phase as described in the RFQ;
2. Full-time, part-time, and temporary status of all employees; and
3. Indication if staff shall be wholly dedicated to the associated contract or if the staff member is shared.

For the purposes of this RFQ, "full-time" employment is considered at least forty (40) work hours per week and/or 2,080 work hours per year. Anything less is considered "part-time."

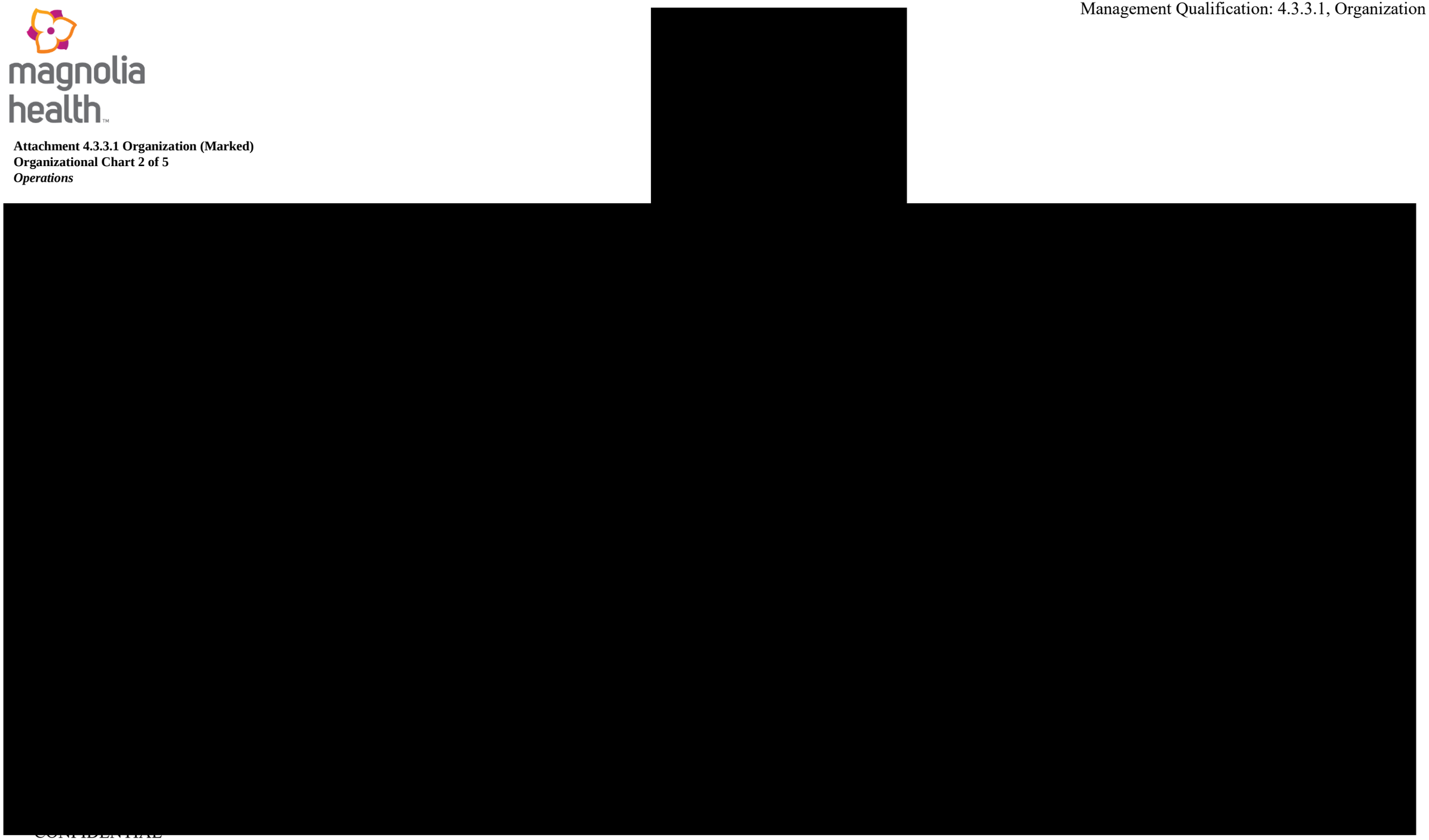
Organization Charts

As of February 2022, our organization comprises approximately 350 full-time employees (FTEs) located in Mississippi. Our organizational charts/positions will be the same through each phase of the contract, including implementation, operation, and any turnover. We have included the following organizational charts in **Attachment 4.3.3.1 Organization Charts:**

- Plan Overview
- Operations
- Population Health Management
- Quality Management
- Provider Network

Attachment 4.3.3.1 Organization (Marked)
Organizational Chart 1 of 5
Overview

Attachment 4.3.3.1 Organization (Marked)
Organizational Chart 2 of 5
Operations



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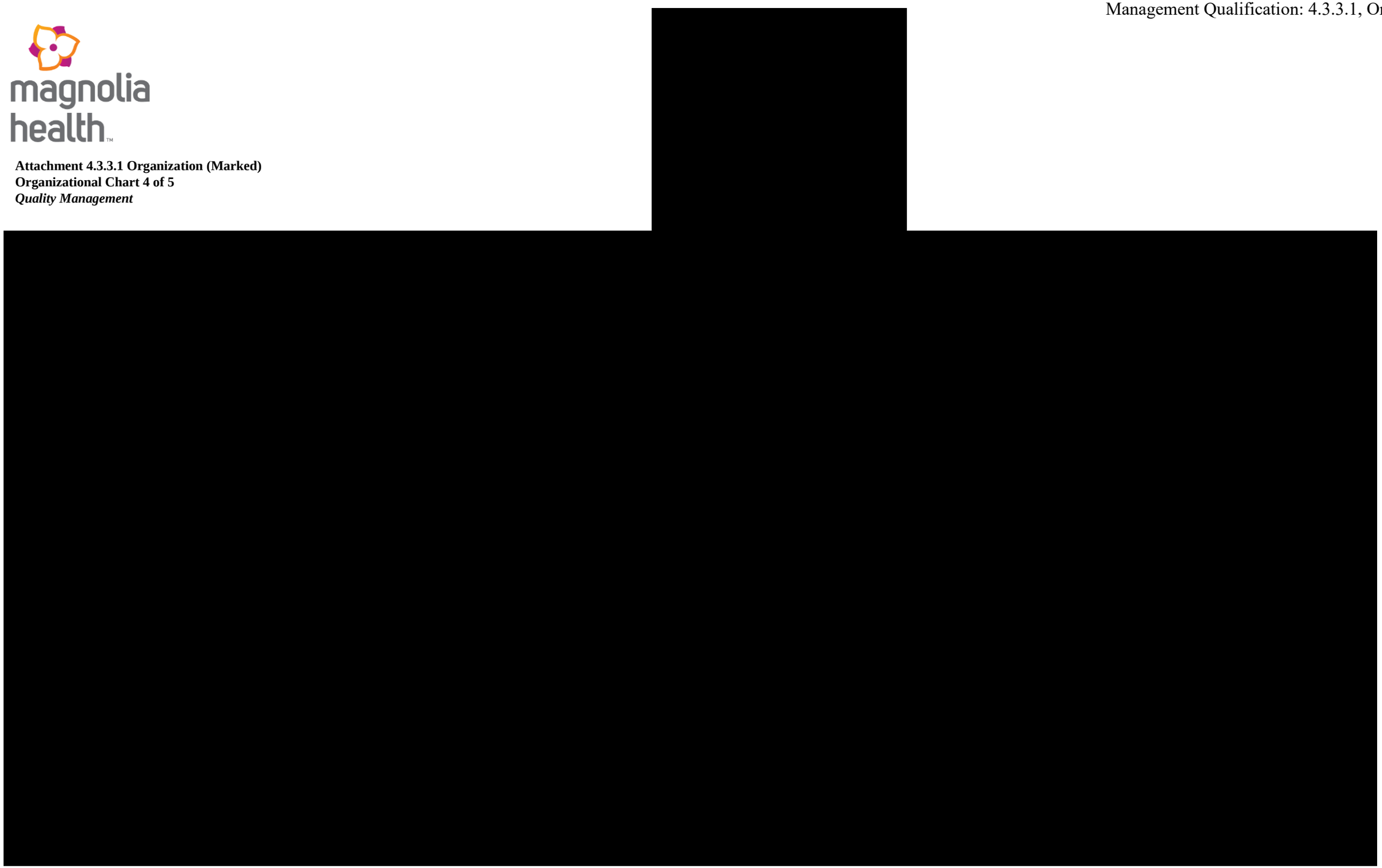
Attachment 4.3.3.1 Organization (Marked)
Organizational Chart 4 of 5
Quality Management



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Attachment 4.3.3.1 Organization (Marked)
Organizational Chart 5 of 5
Provider Network

[redacted]

[END OF RESPONSE]

4.3.3.2 JOB DESCRIPTION AND RESPONSIBILITIES OF KEY POSITIONS

The Offeror must submit detailed job descriptions for each position included in Section 1.13, Administration Management, Facilities, and Resources, Appendix A, Draft Contract.
The Offeror must use the appropriate form provided in Appendix H to respond to this request. The Offeror may not submit resumes or other information identifying current or prospective employees who are expected to fill the subject positions if the Offeror wins the contract.

Detailed job descriptions for each position included in Section 1.13, Administration, Management, Facilities, and Resources, Appendix A, Draft Contract are included in **Attachment 4.3.3.2 Appendix H Job Descriptions**. Specifically, Magnolia has outlined all Executive Positions (1.13.1.1), Administrative Positions (1.13.1.2), and Additional Staff Requirements (1.13.2), as described in Appendix A, Draft Contract. For the Additional Staff Requirements (1.13.2), Magnolia included in parentheses next to the “Title of Position” the associated Draft Contract language.

APPENDIX H: Organization and Staffing

The forms in this Appendix must be used by the Offeror to respond (either in whole or in part, depending on the instructions in the RFQ) to the following:

- 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked) – 20 points
- 4.3.3.3 Administrative Requirements (Marked) – 10 points
- 4.3.3.5 Subcontractors – 20 points
- 4.3.3.6 Economic Impact – 20 points

The Offeror must respond to all other portions of the Organization and Staffing portion of the RFQ in the manner and format stated therein. Answers should be presented in the Offeror's qualification in the order and format indicated within the RFQ.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked) – 20 points

Use the following form to provide job descriptions and responsibilities for each position included in Section 1.13, Administration Management, Facilities, and Resources, Appendix A, Draft Contract.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Key Position: Job Description
Title of Position: Chief Executive Officer (CEO)
Description of Position: Plans and directs all aspects of the company's operational policies, objectives, and initiatives.
Description of Responsibilities of Position: Develops policies and procedures for operational processes in order to ensure optimization and compliance with established standards and regulations. Represents the organization in its relationships with major customers, suppliers, competitors, commercial and investment bankers, government agencies, professional societies, and similar groups. Develops a sound short- and long-range plan for the organization. Ensures the adequacy and soundness of the organization's financial structure and reviews projections of working capital requirements. Negotiates and otherwise arranges for any outside financing that may be indicated.
Minimum Experience Required: Extensive experience in contracting and strategic planning and development. At least 5-8 years of experience in a top management position in the government or healthcare industry working on contract acquisition and operations management.
Skills Required: Excellent managerial and financial skills and the ability to take leadership over any health plan business operations area. Outstanding communication skills. Thorough understanding of management and financial/budgeting practices in all areas and phases of business operations.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in business, health care administration, public administration or related field. Master's degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Chief Operating Officer (COO) (A designee or designees who can respond to issues involving systems and reporting, Member Encounter Data, Grievances and Appeals, quality assessment, Member services, Provider services, EPSDT services management, Well-Baby and Well-Child Care assessments and immunization services, Mental Health, medical management, Care Management, and management of any other services rendered under this Contract.)
Description of Position: Plans and directs all aspects of the Business Unit's operations. Responsible for the short and long term profitability and growth of the Business Unit.
Description of Responsibilities of Position: Plans and directs all aspects of the company's operational policies, objectives, and initiatives. Develops policies and procedures for operational processes in order to ensure optimization and compliance with established standards and regulations. Represents the organization in its relationships with major customers, suppliers, competitors, commercial and investment bankers, government agencies, professional societies, and similar groups. Develops a sound short - and long- range plan for the organization. Ensures the adequacy and soundness of the organization's financial structure and reviews projections of working capital requirements. Negotiates and otherwise arranges for any outside financing that may be indicated.
Minimum Experience Required: Extensive experience in contracting and strategic planning and development. At least 5-8 years of experience in a top management position in the government or healthcare industry working on contract acquisition and operations management.
Skills Required: Excellent managerial, financial planning, and strategy planning skills. Thorough understanding of management and financial/budgeting practices in all areas and phases of health plan business operations. Outstanding leadership and communication skills. Deep understanding of advanced business planning and regulatory issues. Understanding of data analysis and performance metrics.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in business, health care administration, public administration or related field. Master's degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Chief Financial Officer (CFO)
Description of Position: Provide leadership and oversight of all aspects of finance for the Business Unit.
Description of Responsibilities of Position: Oversee all finance related activities for business unit including developing and monitoring progress against Annual Operating Plan. Responsible for financial analysis, identification of month-end financial drivers, and forecasting including headcount planning to ensure compliance with state requirements. Responsible for identifying medical cost trends and leadership of medical cost improvement initiatives. Perform financial impact analysis for new contracts and support negotiations. Review monthly performance and financial results of the business unit and provide recommendations to senior management. Responsible for the business unit's contribution to corporate. Perform duties as Chief liaison between Corporate Finance and the Business Unit. Establish financial strategic vision, objectives, policies and procedures in support of the overall strategic plan. Oversee and validate pricing models and lead initiatives to identify inefficiencies and areas of development and improvement. Direct health plan analytical needs and coordinate reporting strategy. Act as a lead for internal and external audits. Lead rate setting activity and coordinate corporate and state actuaries.
Minimum Experience Required: 10+ years in a high level finance role in the healthcare or insurance industry
Skills Required: Excellent skills in financial planning and strategy, strategic planning and vision, process improvement, forecasting, corporate finance, budget development and management, and quality management. Outstanding written and verbal communication and leadership skills. Proficient in database and accounting computer application systems.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Finance, Accounting, Economics, Business Administration. 10+ years in a high level finance role in the healthcare or insurance industry. Master's degree preferred.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** CPA preferred.
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Medical Director (Chief)
Description of Position: Direct and coordinate the medical management, quality improvement and credentialing functions for the assigned business unit based on, and in support of the strategic plan, establishing the strategic vision and attendant policies and procedures.
Description of Responsibilities of Position: Serves as clinical advisor to and educator of medical management staff making sure correct clinical judgment is applied to all medical management determinations. Oversees internal medical review guidelines to ensure clinical integrity and compliance and acts as a resource for staff members throughout the operation. Coordinates with other departments, the responses needed to address regulatory accreditation concerns pertaining to medical management issues. Performs medical review activities pertaining to utilization review, quality assurance, and medical review of complex, controversial, or experimental medical services. Facilitates the achievement of the Medical Management Program goals through an effective health services delivery system. Responsible for physician review and oversight of all potential adverse determinations including pre-certifications/prior authorizations, concurrent review and appeals/retrospective review. Responsible for HEDIS improvement and strategy. Actively participates in the auditing process of medical management processes and corrective action team projects for medical management. Achieves utilization, cost management and quality goals. Participates and advises in the development of corporate medical policies for UM, pharmacy, and new technology.
Minimum Experience Required: Medical Doctor or Doctor of Osteopathy, board certified in a specialty recognized by the American Board of Medical Specialists. Volunteer patient care required. Previous experience as Medical Director is preferred.
Skills Required: Knowledge and understanding of managed care principles, industry, Provider reimbursement, and human resource management required. Strong communication, interpersonal, and presentation skills. Experience treating or managing care for a culturally diverse population preferred.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Medical Doctor or Doctor of Osteopathy, board certified in a specialty recognized by the American Board of Medical Specialists. Master's degree in Business Administration, Public Health, Healthcare Administration or related field preferred
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Board Certification through American Board of Medical Specialists. Current state medical license without restrictions.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Perinatal Health Director
Description of Position: Oversee and be responsible for the development and implementation of Perinatal Health policy through covered services to Members.
Description of Responsibilities of Position: Oversee and be responsible for the development and implementation of Perinatal Health policy through covered services to Members. The Perinatal Health Director will also serve as a liaison between Magnolia and Providers; be available to Magnolia staff for consultation on referrals, denials, Grievances, and Appeals; review potential quality of care problems, and participate in the development and implementation of corrective action plans. The Perinatal Health Director will also serve on Quality Workgroups as required by the Division.
Minimum Experience Required: Must be an actively practicing physician with a specialty in obstetrics and gynecology in Mississippi or have been an actively practicing physician in Mississippi with a specialty in obstetrics and gynecology in the past five (5) years and be located in Mississippi.
Skills Required: Knowledge and understanding of managed care principles, industry, Provider reimbursement, and human resource management. Strong communication, interpersonal, and presentation skills. Experience treating or managing care for a culturally diverse population preferred.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Medical Doctor or Doctor of Osteopathy, board certified in obstetrics and gynecology.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Board Certification through American Board of Medical Specialties. Current state medical license without restrictions.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Behavioral Health Director
Description of Position: Assist the Chief Medical Director to direct and coordinate the medical management, quality improvement and credentialing functions for the business unit.
Description of Responsibilities of Position: Oversee and be responsible for all behavioral health activities. Implement onsite Behavior Crisis Prevention and Intervention and Stabilization Services to help prevent unnecessary institutional placement or psychiatric hospitalization. Ensure proper implementation of all behavioral health activities, including the management and coordination of behavioral health needs. Coordinate with the Medical Director, Perinatal Health Director, and other relevant staff to ensure the integration of physical and behavioral health services and supports, as applicable, , and to oversee the quality improvement initiatives regarding behavior supports and the appropriate use of psychotropic medications in each of these populations.
Minimum Experience Required: Medical Doctor or Doctor of Osteopathy, board certified preferable in a primary care specialty (Internal Medicine, Family Practice, Pediatrics or Emergency Medicine). The candidate must be an actively practicing physician. Previous experience within a managed care organization is preferred. Course work in the areas of Health Administration, Health Financing, Insurance, and/or Personnel Management is preferred. Experience treating or managing care for a culturally diverse population preferred. Board Certified Psychiatrist. 5+ years of experience in mental health and substance use disorder services. Experience directing behavioral health programs and services for special populations, including individuals with intellectual or developmental disabilities, preferred.
Skills Required: Knowledge and understanding of managed care principles, industry, Provider reimbursement, and human resource management. Strong communication, interpersonal, and presentation skills. Experience treating or managing care for a culturally diverse population preferred.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Medical Doctor or Doctor of Osteopathy, board certified preferable in a primary care specialty (Internal Medicine, Family Practice, Pediatrics or Emergency Medicine) Course work in the areas of Health Administration, Health Financing, Insurance, and/or Personnel Management is preferred.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Board certification by the American Board of Psychiatry and Neurology. Current state medical license without restrictions.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Chief Information Officer
Description of Position: Develop company wide information and technology related strategies. Maintain up to date industry knowledge of information technology trends. Apply knowledge of industry trends to enable substantial advancements in operating efficiencies, product enhancement and market position. Direct senior level managers on the execution of defined strategies.
Description of Responsibilities of Position: Develop advancements and identify emerging trends in the use of information within the Work/Life, Health and Wellness industry. Set strategic direction for acquisition or development of information technology solutions. Identify solutions to enhance operational efficiencies; extend product/service offerings and improve market position. Provide guidance on mergers and acquisitions with respect to information management; technology assessments; and technology staffing of key targets. Direct research of clients and vendor partners to identify future needs. Provide counsel as member of the executive team to align operational model with appropriate technology solutions. Analyze management needs regarding information retrieval, data control, and expanded use of computers and related equipment. Maintain professional contacts with other organizations, research institutions, and equipment manufacturers concerning computer applications and equipment.
Minimum Experience Required: 15+ years of related experience. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff.
Skills Required: Excellent analytical and problem-solving skills. Superior leadership skills. Relationship building and team development skills. Thorough understanding of health plan data management and administration.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in related field. Master’s degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Compliance Officer (Internal Title: Senior Director, Compliance)
Description of Position: Ensure regulatory compliance with state and other government agencies related to the health insurance industry, Centene Corporation, and its business subsidiaries.
Description of Responsibilities of Position: Ensure business unit and Centene Corporate are in compliance with state and federal program regulations, insurance regulations, regulatory requirements for business entities and state contract requirements. Maintain and track laws and regulations, contract documentations, amendments, and various compliance measures. Develop policies, procedures, and processes to comply with state law, federal law, contract requirements, and various standards. Oversee, administer, and implement various compliance programs, including fraud and abuse and HIPAA. Provide guidance to various departments regarding compliance issues and implementation of new compliance requirements with respect to regulatory and contract language. Conduct compliance audits, develop and implement corrective action plans, and report on achievement of action plans to senior management and Board of Directors. Develop strategic relationships with state legislative policymakers and assist with the development of state legislative public policy concerning state insurance, Managed Care Organization, Medicare and Medicaid regulations and initiatives. Identify, evaluate and analyze the impact of state legislative and regulatory issues and advise management concerning impact. Represent senior management at various committees, meetings, and seminars
Minimum Experience Required: 8+ years of compliance program management and contract experience. Extensive knowledge of state administrative code and regulations, state insurance laws and regulations including managed care regulations. Experience with state and federal government agencies, accreditation bodies, participating Provider agreements, HIPAA and Third Party Administration (TPA) laws, credentialing regulations and prompt pay laws.
Skills Required: Excellent organizational and analytical skills. Strong influencing skills and perseverance in investigating. Ability to read, analyze, and interpret technical procedures, governmental regulations, and legal documents. Excellent oral and written communication skills. Ability to write clear, concise reports, business correspondence, and procedures. Ability to effectively present and represent the plan's interests externally with regulators. Ability to effectively present information and respond to inquiries from employees, regulatory agencies, and others, as necessary. Ability to initiate administrative activities as necessary, and institute quality control procedures. Ability to meet deadlines and adjust to changes in company policies, procedures, and priorities.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Public Policy, Government Affairs, Business Administration or related field. Master's or Law degree preferred.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Master's or Law degree preferred.
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Project Manager
Description of Position: Plan, organize, monitor, and oversee complex projects utilizing cross functional teams to deliver defined requirements and meet company strategic objectives.
Description of Responsibilities of Position: Manage the full project life cycle including requirements gathering, creation of project plans and schedules, obtaining and managing resources, managing budget, and facilitating project execution, deployment and closure. Utilize corporate and industry standard project management tools and techniques to effectively manage projects. Assist with establishment and maintenance of corporate project management methodology and other department procedures. Maintain detailed project documentation including meeting minutes, action items, issues lists and risk management plans. Provide leadership and effectively communicate project status to all stakeholders, may include written executive summaries. Negotiate with project stakeholders to identify resources, resolve issues, and mitigate risks. Coordinate cross-functional meetings with various functional areas to meet overall stakeholder expectations and company's objectives. Provide functional and technical knowledge across multiple business and technical areas. Monitor the creation of all project deliverables to ensure adherence to quality standards including design documents, test plans, training materials, and operations documentation.
Minimum Experience Required: 3+ years of project management experience. Experience working with and leading diverse groups and matrix managed environments.
Skills Required: Excellent interpersonal, leadership, and problem-solving skills. Demonstrates flexibility. Proficient with MS Office applications and project management tools.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Business Administration, Healthcare Administration, related field, or equivalent experience.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** PMP or CAPM certification preferred.
Are there any continuing education requirements for this position? **[] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Provider Services Manager
Description of Position: Manage the day-to-day work function of the member and Provider services area, provide support to staff and investigate and resolve complex member and Provider issues.
Description of Responsibilities of Position: Manage the member and Provider services staff. Develop policies, procedures and performance standards for the member and Provider services departments in compliance with Federal, State and Company regulations, and in conjunction with site management and appropriate corporate staff. Drive change initiatives to address future-oriented business needs. Identify process and infrastructure needs to support change and considers broad range of internal/external factors when making decisions. Assist in development of annual budget for member and Provider services departments.
Minimum Experience Required: 3+ years of customer service experience in a call center environment. Previous experience as a lead in a functional area, managing cross-functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff.
Skills Required: Strong leadership skills, demonstrated ability to manage cross-functional teams on large scale projects.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school education or equivalent. Bachelor's degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Network/Contracting Manager [Internal Name: Senior Manager, Contracting & Network Development] (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)
Description of Position: Provide support for the management of physician, hospital and ancillary Provider recruitment in accordance with corporate, health plan and state guidelines for assigned regions.
Description of Responsibilities of Position: Implement development activities for the recruitment and contracting of Providers in Provider networks in new and prospective markets. Promote, maintain and manage team goals and objectives through effective hiring, performance management, coaching and career development. Collaborate interdepartmentally for new and existing market expansions to ensure network operations deliverables are identified and completed as defined by the state Request for Proposals (RFPs) and/or state contract. Manage and conduct effective contract negotiations and develop strategies, tactics and methods for specific network development initiatives. Manage Provider data management functions through a new RFP and/or state contract implementation with strategies that promote Provider network. Monitor operational and financial performance of contracts to guide future recruitment activities and future contract negotiations. Develop a comprehensive Provider network to meet or exceed contractual requirements. Contribute to the development and use of Provider marketing and training materials assuring compliance with all state, federal, and product guidelines in new and existing markets. Contribute to the development of contract reimbursement methodologies, reimbursement allotment, and covered benefit grid to ensure contracts and fee schedules are performing optimally.
Minimum Experience Required: 4+ years of Provider recruitment, contracting, contract analysis, or Provider relations
Skills Required: Must be knowledgeable of network development processes, contract language, principles of negotiation, credentialing and call center operations.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Health Administration, Business Administration, related field, or equivalent experience
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Member Services Manager
Description of Position: Manage the day-to-day work function of the member and Provider services area, provide support to staff and investigate and resolve complex member and Provider issues.
Description of Responsibilities of Position: Manage the member and Provider services staff. Develop policies, procedures and performance standards for the member and Provider services departments in compliance with Federal, State and Company regulations, and in conjunction with site management and appropriate corporate staff. Drive change initiatives to address future-oriented business needs. Identify process and infrastructure needs to support change and considers broad range of internal/external factors when making decisions. Assist in development of annual budget for member and Provider services departments.
Minimum Experience Required: 3+ years of customer service experience in a call center environment. Previous experience as a lead in a functional area, managing cross-functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff.
Skills Required: Strong leadership skills, demonstrated ability to manage cross-functional teams on large scale projects.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school education or equivalent. Bachelor's degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Quality Management Director
Description of Position: The Director of Clinical Quality Management is responsible for the operations of Clinical Quality Management (CQM) within the Company. The Director of CQM is also responsible for ensuring conformance to the Company's quality system in accordance with customer and company requirements.
Description of Responsibilities of Position: Develops and maintains an integrated, well-defined department to support all reporting requirements as well as other clinically appropriate performance metrics. Develops standardized reporting tools and formats for use to understand and act on performance measure results indicating strengths and opportunities for improvement. Develops and maintains strong collaborative relationships with multiple departments and with the government customer in order to maximize efficiencies and knowledge and standardized, quality, cost-effective output for HEDIS (in conjunction with the government) and other clinical metrics. Continually assesses and incorporates changing reporting needs related to Disease Management and Population Wellness programs. Effectively manages the activities of staff providing leadership and guidance. Interviews, recommends for hire, and evaluates staff, and counsels and confronts unsatisfactory performance promptly and fairly and administers corrective action. Identifies department goals and objectives, develops and communicates action plans through regular staff meetings and other communications, uses team approach to problem solving and sets clear expectations. Identifies training needs and develops and participates in staff training. Provides a challenging and supportive environment and delegates appropriately. Seeks additional training opportunities through outside sources. Analyzes work plans developed by subordinate managers and monitors the status of their work in relation to the overall schedule requirements. Develops monitoring systems and measurements and exhibits a customer service philosophy. Establishes procedures for maintaining high standards of quality, reliability, and safety. Determines and enforces -- through functional groups - quality and safety requirements in accordance with real company needs, based on current regulations and state-of-the-art product development. Organizes and promotes clinical quality improvement efforts. Evaluates, plans and develops improved techniques for the control of quality, reliability and safety. Implements and maintains the company clinical quality management system and reporting on the performance to the Board of Directors. The Quality Manager also has responsibility to act as liaison with external parties on matters relating to clinical quality management. Plans the overall use of resources on a quarterly, or longer, basis. Provides information and advice to higher-level management clinical quality improvement.
Minimum Experience Required: Five years clinical experience in an acute care setting. Four years' experience in quality management/improvement in a health care setting. Two years' work experience in a managed care environment. Five years management experience in a health care setting. Three years management experience in quality management/improvement in an HMO setting.
Skills Required: Strong leadership skills, demonstrated ability to manage cross-functional teams on large scale projects. Excellent strategic planning and process improvement skills. Broad understanding of HEDIS and how it is used to drive business growth and efficiencies. Ability to develop, execute and improve clinical programs across large or multiple business units.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Nursing or equivalent is required; Master's degree in health services administration or equivalent is desired.

Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Must have and maintain current valid and unrestricted Registered Nursing (RN) license, valid state driver's license and Certified Professional in Healthcare Quality (CPHQ).
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Care Management Director
Description of Position: Direct medical management program including utilization management, case management, quality improvement and credentialing in accordance with the mission, philosophy, and objectives of plan and in conjunction with Corporate goals and objectives.
Description of Responsibilities of Position: Develop department objectives and organize activities to achieve objectives. Evaluate and implement changes to medical service functions and performance in relation to company mission, philosophy objectives and policies. Manage budget and forecast for strategic planning and key initiatives. Coordinate with operating departments on research and implementation of best practices. Responsible for the statistical analysis of utilization data on programs. Participate in NCQA, State, and/or other accreditations of the Plan. Organize and present new concepts, programs and tools to staff and other plan departments. Develop communication plans with external Providers such as hospitals and State agencies as required to facilitate plan goals and objectives. Coordinate with Medical Director to educate and communicate expectations with Providers.
Minimum Experience Required: 7+ years of nursing, quality improvement, and management experience in a healthcare environment, preferable managed care. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff.
Skills Required: Strong leadership skills, demonstrated ability to manage cross-functional teams on large scale projects. Excellent strategic planning and process improvement skills. Broad understanding of accreditation. Ability to develop, execute and improve clinical programs across large or multiple business units. Strong understanding of health care Provider communication strategies.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Nursing, related field, or equivalent experience.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Current state's RN or LMSW license.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Population Health Director (Vice President, Population Health & Clinical Operations) (A designee or designees who can respond to issues involving systems and reporting, Member Encounter Data, Grievances and Appeals, quality assessment, Member services, Provider services, EPSDT services management, Well-Baby and Well-Child Care assessments and immunization services, Mental Health, medical management, Care Management, and management of any other services rendered under this Contract.)
Description of Position: Oversee and direct all population health functions for the assigned business unit based on, and in support of the company's strategic plan.
Description of Responsibilities of Position: Lead complex projects including affordability analyses around medical and pharmacy expense, business analysis, documentation of business requirements, and defining current/future scope of work. Create and manage clinical affordability projects with internal partners, including but not limited to pharmacy, other clinical and network affordability teams, and pilots. Create innovative solutions and process enhancements to drive financial and quality success. Lead Clinical Model development and process support for the program in all approved state regions to align with the Clinical Model and meet the requirements for the program by supporting reports , technology and core team. Identify trends between Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Member Engagement; create programs/pilots to improve engagement with strategic partners. Establish the organizations focus and direction regarding models of care that incorporate needs of all lines of business, focusing on quality and operational efficiencies across the organization. Create and measure business and clinical outcomes with respect to the provision of clinical support for practice transformation and successful transition of practice to shared savings/risk contract.
Minimum Experience Required: 8+ years of clinical experience in the Healthcare industry. Prior experience in an innovation field, long term project, or evidence of driving successful clinical practice innovative solutions.
Skills Required: Broad understanding of HEDIS and how it is used to drive business growth and efficiencies. Ability to develop, execute and improve clinical programs across large or multiple business units. Ability to identify, create and tracking clinical program opportunities for population health management. Prior experience in an innovation field, long term project, or evidence of driving successful clinical practice innovative solutions.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Medical Doctor or Master's degree in Nursing, Therapy, Pharmacy, Public Health/Administration or related field. MBA preferred. 8+ years of clinical experience in the Healthcare industry
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Medical Doctor or Master's degree in Nursing, Therapy, Pharmacy, Public Health/Administration or related field.
Are there any continuing education requirements for this position? **[X] Yes [ ] No**

If yes, list below: Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Utilization Management Coordinator
Description of Position: Perform duties to conduct and manage the day-to-day operations of the utilization management function. Communicate with staff to facilitate daily department functions.
Description of Responsibilities of Position: Review analyses of activities, costs, operations and forecast data to determine progress toward stated goals and objectives. Promote compliance with federal and state regulations and contractual agreements. Develop, implement and maintain compliance, policies and procedures regarding medical utilization management functions. Develop, implement, and maintain utilization management programs to facilitate the use of appropriate medical resources and decrease the business unit's financial exposure. Compile and review multiple reports on work function activities for statistical and financial tracking purposes to identify utilization trends and make recommendations to management. Facilitate on-going communication between utilization management staff and contracted Providers. Develop staff skills and competencies through training and experience. Available to non-clinical staff as a resource for clinical questions.
Minimum Experience Required: 3+ years utilization management and recent nursing experience in an acute care setting particularly in medical/surgical, pediatrics, or obstetrics and management experience. Thorough knowledge of utilization management and clinical nursing. Familiarity with Medicare and Medicaid managed care practices and policies, CHIP and SCHIP. Previous experience as a lead in a functional area, managing cross functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff.
Skills Required: Excellent understanding of and ability to apply clinical guidelines and best practices in utilization management. Strong cross-functional and external communication skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in related field or equivalent experience. Bachelor's degree in nursing preferred.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Current state's nursing license.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Grievance and Appeals Coordinator
Description of Position: Analyze and resolve verbal and written claims and authorization grievance/appeals from Providers and members. Resolve all State inquires related to complaints, grievances and appeals.
Description of Responsibilities of Position: Review and process member and Provider grievances and appeals within federal, state and organizational regulations and policies and procedures. Review claim grievance for reconsideration and either approve/deny based on determination level or prepare for medical review presentation. Prepare cases for medical review as necessary. Review and determine if claim grievance includes a potential quality or access issue. Collaborate with subject matter experts within the organization to obtain benefit and/or clinical opinions/interpretations of complex cases. Serve as liaison between member, Provider regulatory agencies and internal staff. Correspond with key individuals regarding grievance and appeal decisions. Act as subject matter expert regarding grievances and appeals. Lead Appeals and Grievance Committee.
Minimum Experience Required: 2+ years of claims, contracting, or related experience in a managed care environment.
Skills Required: Excellent understanding of and ability to apply regulations and requirements regarding grievances and appeals. Strong cross-functional and external communication skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in related field or equivalent experience.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Claims Administrator
Description of Position: Ensure the timely and accurate adjudication of claims. Supervise the daily activities of the Claims Administration department, including all activities from receipt of mail through claim closing processes. Review claim production reports for trends and implement process improvement initiatives.
Description of Responsibilities of Position: Supervise the claims administration department including staffing issues, training and new employee orientation. Define and execute process changes for new plan implementations. Ensure that claim staff members adhere to corporate, claim, and medical management and various applicable policy and procedures. Develop quality and production standards using proven quantitative and qualitative methods. Develop appropriate management reports used to track department operations. Develop and monitor quality checks to ensure that claims are processed accurately and in accordance with payor, State and Federal guidelines. Maintain and update departmental policy and procedure manuals. Participate in company committees as needed.
Minimum Experience Required: 4+ years of medical surgical claims processing experience, including knowledge of claims processing methodology. Previous experience as a lead in a functional area or managing cross functional teams on large scale projects.
Skills Required: Excellent understanding of and ability to apply regulations and requirements regarding claims adjudication and processing. Strong cross-functional and external communication skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Associate's degree or equivalent experience. Bachelor's degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Data and Analytics Manager (A designated person or person(s) to be responsible for data processing and the provision of accurate and timely reports and Member Encounter Data to the Division)
Description of Position: Oversee and ensure accurate, timely, and efficient reporting related to all core business functions.
Description of Responsibilities of Position: Ensure the timeliness and accuracy of internal and external state report deliverables. Manage scheduled and ad hoc reporting needs of the organization. Execute and manage the completion of large reconciliation tasks and analytical projects. Responsible for the quality and completeness of data in core systems by performing and overseeing the auditing of data. Oversee large systems and data related projects and collaborate with cross-functional departments to develop and implement improved reporting and data workflows and processes. Mentor and manage a team of data analysts of variable skill and practice levels. Lead and execute complex data related analytical projects to drive business decisions and efficiencies.
Minimum Experience Required: 4+ years of statistical analysis or data analysis experience. Medicare and Medicaid managed care experience a plus.
Skills Required: Knowledge of various data mining, reporting, and reconciliation tools and methodologies. Advanced systems and software knowledge in MS Access and Excel, SQL, Business Objects, and data warehousing. Amysis experience preferred. Experience working with diverse business groups within a matrix environment. Project management experience preferred.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Business Administration, Computer Science or IT, related field or equivalent experience
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Clinical Pharmacist (Pharmacy Director)
Description of Position: The Clinical Pharmacist processes review prior authorization requests for non-formulary medications for clinical appropriateness. This assures members receive the most effective and cost effective pharmacological therapies.
Description of Responsibilities of Position: Reviews a completed prior authorization request received from the Provider and/or reviews the pharmacy technician's recommended denial, suggested formulary alternatives, comments and attachments for appropriateness. Verifies member's ID number and date of birth. Verifies member's eligibility in the appropriate health plan eligibility system. Records carrier and group number if applicable. Checks for previous prior authorization decisions. Verifies coverage in member's prescription benefit when necessary. Verifies coverage in member's health plan benefit when necessary. Evaluates prescription claim history. Reviews chart notes and/or lab values. Identifies Provider specialty when appropriate. Applies Medical Policy Criteria to prior authorization requests. Evaluates whether request meets criteria for approval. Reviews the request using professional clinical judgment on a case by case basis. A pharmacist will review medication requests not addressed by P&T Committee criteria or guidelines, develop and draft criteria for the non-formulary medication requested. Researches and contributes drug references and clinical information to facilitate prior authorization review: directly to physicians via fax or phone encounter; or to pharmacy technicians via memo or on a personal level as an educational tool. Communicates with physicians regarding prior authorization: For a non-formulary drug; Plan benefits, exclusions; Quantity limits; Age restrictions; Formulary alternatives. Retrieves and collects data through available reporting resources (i.e. Discoverer, IT Department). Compiles data for reporting purposes: Drug utilization of non-formulary drugs; Overturned IPS recommended denials; Audit pharmacy claims greater than $200.00; Suggest addition or deletion of drugs to/from the formulary; Updating qty/days or age limit ends; Support National P&T Committee; Other tasks which may arise during the performance of any of the above mentioned duties.
Minimum Experience Required: One year prior experience in clinical pharmacy. Demonstrated success in managing professional relationships in a managed care system, medical group, hospital, or related organizations.
Skills Required: Strong clinical pharmacy background with ability to demonstrate clinical pharmacy skills and knowledge in a care setting. Strong knowledge of managed care; pharmaceutical/healthcare industry dynamics and Provider reimbursement; and Provider contracting processes and strategies. Demonstrated success in managing professional business relationships in a managed care system, medical group, hospital, or related business in health care delivery industry. Excellent verbal and written communication skills; strong business analytical skills and abilities; strong project management and coordination ability; ability to function effectively as a management team member.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's or Doctorate of Pharmacy degree.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Must have and maintain current, valid and unrestricted Pharmacist license in the state of employment and credentialed by the health plan of employment.

Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

1.13.2 Additional Staff Requirements

Key Position: Job Description
Title of Position: Senior Director, Marketing & Communications (Designated staff to be responsible for Marketing, Member communications, and/or public relations)
Description of Position: Direct and oversee marketing communications programs that effectively describe and promote the organization, with an emphasis on marketing, brand strategy, message development, and execution.
Description of Responsibilities of Position: Assist with establishing and maintaining the marketing and communications department's strategic vision, objectives, and policies & procedures. Direct marketing and communication programs for Centene and its subsidiaries. Interpret and clearly communicate relevant Centene strategic goals and tactical responses. Ensure Centene's corporate and subsidiary identities are protected at all levels of utilization. Direct the implementation of promotional ideas in various types of marketing venues. Advise Senior Management throughout the organization on marketing and communication strategies. Oversee department personnel for the marketing and communications department. Develop measurement tools for marketing communications activities. Plan and manage an annual budget and help allocate resources
Minimum Experience Required: 10+ years of marketing or related experience, including management experience. Experience working in a managed care, insurance, or healthcare environment preferred.
Skills Required: Strong leadership and motivational skills. Familiarity with essential digital, print, and other marketing tools and technologies. Excellent oral and written communication skills. Motivated to continually innovate.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Marketing, Communications or equivalent experience.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Health Equity Director (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: The Health Equity Director will provide leadership and management to define, implement, and evaluate strategies to achieve equitable access and reduce disparities in clinical care and quality outcomes. This strategy will include tracking, assessing, and improving disparities in care, and supporting the diverse cultural, language, economic, education and health status needs of those served by Magnolia.
Description of Responsibilities of Position: The Health Equity Director partners with other senior leaders to develop and drive forward the key strategies of the organization to incorporate an equity lens into all improvement strategies, including quality, patient safety and population health, to improve health outcomes and the member experience. Responsible for implementing Magnolia's Health Equity Program to reduce disparities through determining the root cause of inequities, developing targeted initiatives, implementing Culturally and Linguistically Appropriate Services (CLAS) programs, and collecting, measuring, and analyzing data to track progress in disparity reduction efforts. Provides collaboration with state, county, and local agencies to promote services that improve health outcomes, decrease health disparities, and reduce the cost of care. The Health Equity Director works to embed health equity across the organization so that health equity becomes part of the practice, process, action, innovation, and organizational performance and outcomes.
Minimum Experience Required: Minimum 10 years' experience advocating for and implementing change within a multi-cultural environment. Minimum 3 years' experience developing and implementing diversity/equity/inclusion programs. This leader should have a demonstrated understanding of cultural values and norms of various communities, particularly of communities of color, LGBTQ+, and Recovery communities. Understanding of culturally-specific resources available within the community. Effective intercultural communication skills and ability to advocate/address issues of diversity. Sensitivity and understanding of specific barriers which may lead to lack of access and engagement.
Skills Required: Strong leadership skills, demonstrated ability to manage cross-functional teams on large scale projects. Effective intercultural communication skills and ability to advocate/address issues of diversity. Sensitivity and understanding of specific barriers which may lead to lack of access and engagement. Deep understanding of the Medicaid and CHIP populations, the cultural values and norms of various communities, culturally-specific resources available within the communities, and best practices in health equity. Ability to develop, execute, and improve diversity/equity/inclusion programs across large or multiple business units.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Requires a minimum of a BA/BS in social work, psychology, business, education, or related field. Master's Degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No**

If yes, list below: N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Community Engagement Specialist (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Develop, implement, and provide oversight for Health Equity programs. Ensure the successful integration of cultural competency into operational programs. Oversee cultural competency requirements to external stakeholders and government agencies, including government relations, network Providers, and delegated entities. Lead and coordinate workforce staff development in cultural competency.
Description of Responsibilities of Position: Develop, manage, and oversee health equity programs. Collaborate with multiple functional areas on the implementation of Compliance Program goals, including member and Provider materials. Serve as the subject matter expert to key stakeholder and team on health equity and cultural competency, including developing, planning, and coordinating training. Responsible for oversight and implementation of key regulations and polices related to health equity, cultural competency, language services and health literacy including readiness assessments, monitoring and corrective actions. Monitor network adherence to the provision of culturally competent care. Lead the development and coordination of targeted health equity promotion programs including place-based and health plan level initiatives. Research and make recommendations to executive management team on population specific initiatives. Responsible for Quality Management Performance Improvement (QMPI) Committee reporting including analyzing results to determine progress against plan elements and evaluating the Plan(s) Health Equity program, including compliance with CLAS standards and state and federal regulations. Represent the Plan(s) in Community/ Stakeholder Workgroups and Forums related to Cultural Competency and health equity. Responsible for any regulatory deliverables related to health equity and CLAS.
Minimum Experience Required: 3+ years of experience focused on Health Equity, Social Determinants of Health, Community Health and/or strengthening protective factors within Medicaid populations. Managed care experience preferred. Strong verbal and written communication skills, including demonstrated ability to adapt communication style based on audience. Familiarity with CLAS standards preferred.
Skills Required: Effective intercultural communication skills and ability to advocate/address issues of diversity. Sensitivity and understanding of specific barriers which may lead to lack of access and engagement. Deep understanding of the Medicaid and CHIP populations, the cultural values and norms of various communities across Mississippi, culturally-specific resources available within the communities, and best practices in health equity. Ability to develop, execute, and improve diversity/equity/inclusion programs across large or multiple business units.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Behavioral Health, Social Work, Public Health, or equivalent experience.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No**

If yes, list below: N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Claims Liaison (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Serve as the claims payment expert for the Plan and as a liaison between the plan, claims, and various departments to effectively identify and resolve claims issues. Act as the subject matter expert for other Claims Liaisons.
Description of Responsibilities of Position: Analyze trends in claims processing issues and identify work process solutions. Lead meetings with various departments to assign claim project priorities and monitor days in step processes to ensure the projects stay on track. Assist in the writing work processes and continual auditing of the processes to ensure configuration, state mandates, benefits, etc. Review all Medicaid Bulletins for changes and updates and submit change requests (CRs) to update payment system. Audit check run and send claims to the claims department for corrections. Identify any system changes and work notify the Plan CIA Manager to ensure its implementation. Collaborate with the claims department to price pended claims correctly. Document, track and resolve all plan Providers' claims projects. Collaborate with various business units to resolve claims issues to ensure prompt and accurate claims adjudication. Identify authorization issues and trends and research for potential configuration related work process changes. Analyze trends in claims processing issues and assist in identifying and quantifying issues and reviewing work processes. Identify potential and documented eligibility issues and notify applicable departments to resolve. Research the claims on various reports to determine if appropriate to move forward with recovery due to non-covered items being allowed, etc. Travel and in-person Provider interaction required.
Minimum Experience Required: 5+ years of claims processing, Provider billing, or Provider relations experience, preferably in a managed care environment, Knowledge of Provider contracts and reimbursement interpretation preferred.
Skills Required: Customer service, data entry, data analysis for trending and tracking, and/or root cause analysis. The ability to disseminate information across a wide variety of audiences. The ability to prioritize work and successfully handle issue resolution in a timely manner.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** CPC certification preferred.
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Claims Research Specialist (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Perform duties to act as a liaison between Provider relations, Provider services, the health plan and corporate to investigate and resolve claims inquiries.
Description of Responsibilities of Position: Assist in reviewing, investigating, adjusting and resolving complex claims, claims appeals, inquiries, and inaccuracies in payment of claims. Responsible for training claims research specialists and CG&A coordinators also providing claims and authorization education to the appeals nurse. Provide training and performance of audits. Educate Provider relations, Provider services and claims liaisons regarding policies and procedures related to referrals and claims submission.
Minimum Experience Required: 4+ years of experience in claims payment processing in government programs and experience in a managed care environment. Knowledge of claims billing and processing functions, Medicaid benefits, and/or customer service.
Skills Required: Customer service, data entry, data analysis for trending and tracking, and/or root cause analysis. The ability to disseminate information across a wide variety of audiences. The ability to prioritize work and successfully handle issue resolution in a timely manner.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent. Bachelor's degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Claims Business Analyst (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Serve as the claims payment and claims configuration expert for plan and various departments to effectively identify and resolve claims issues. Act as the subject matter expert for the claims payment structure.
Description of Responsibilities of Position: Audit check run and send claims to the claims department for corrections. Collaborate with the claims department to price pended claims correctly. Identify authorization issues and trends and research for potential configuration related work process changes. Collaborate with various business units to resolve claims issues to ensure prompt and accurate claims adjudication. Document, track and resolve all plan Providers' claims projects. Research the claims on various reports to determine if appropriate to move forward with recovery. Lead meetings with various departments to assign claim project priorities and monitor days in step processes to ensure the projects stay on track. Support business initiatives through data analysis, identification of implementation barriers and user acceptance testing of new systems. Perform detailed analysis on assigned projects, recommend potential business solutions and assist with implementation. Identify and analyze user requirements, procedures, and problems to improve existing processes.
Minimum Experience Required: 3+ years of claims experience required. 0-2 years of business process analysis or data analysis experience preferred. 5+ years of claims processing, providing billing or Provider relations experience pin managed care environment preferred.
Skills Required: Skilled in data entry and data analysis. The ability to disseminate information to cross-functional teams. The ability to prioritize work and successfully handle issue resolution in a timely manner.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent experience. Bachelor's degree in related field preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Quality Specialist (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Perform quality reviews to ensure high level of customer service and/or accuracy in processing claims and transactions.
Description of Responsibilities of Position: Conduct procedural and quality reviews/audits to ensure adherence to policies and procedures and high levels of customer service, satisfaction and accuracy using applicable tools and technologies. Provide written documentation to management regarding quality review/audit results. Collaborate with various cross functional departments to identify training needs, system errors, processing errors, etc. and develop work plans and processes. Participate in continuous quality improvement initiatives and serve as a resource to others regarding quality concerns. Analyze data to ensure adjustments/changes yielded anticipated results. Assist with managing databases, policies and procedures related to assigned areas. Complete special projects as needed.
Minimum Experience Required: 4+ of combined call center/customer service and training/auditing/data analysis experience. Knowledge of insurance or healthcare products and procedures highly preferred.
Skills Required: Excellent written and verbal communication skills. Data analysis and analytical skills. Ability to collaborate with cross-functional teams.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High School Diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Lead Customer Service Representative (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Serve as a liaison between CSRs, management and other various departments. Resolve customer inquiries via telephone and written correspondence in a timely and appropriate manner.
Description of Responsibilities of Position: Investigate and resolve complex claims matters in coordination with health plan and/or corporate departments. Coordinate the day-to-day work functions, acting as a "go to" person and investigating and resolving complex issues. Initiate change requests to resolve system configuration questions impacting claims processing; review and test results. Conduct appropriate auditing processes. Reference current materials to answer escalated and complex inquiries from members and Providers regarding claims, eligibility, covered benefits and authorization status matters. Educate members and/or Providers on health plan initiatives; train and assist Providers regarding proper claims billing procedures. Provide first call resolution and "own the process" by working with appropriate internal/external resources and ensure the closure of all inquiries. Document all activities for quality and metrics reporting through the Customer Relationship Management (CRM) application. Identify trends related to member and/or Provider inquiries to respond proactively and provide feedback to management. Collaborate with other departments on cross functional tasks and projects. Maintain performance and quality standards based on established call center metrics including turn-around times.
Minimum Experience Required: 2+ years of experience in Medicare, Medicaid managed care or insurance environment preferred. 4+ years of combined customer service and call center experience. Knowledge of managed care software systems (i.e.: OMNI, ABS, CRM, Amisys, TruCare, etc.) preferred. Depending on the state, bi-lingual may be preferred.
Skills Required: Excellent customer service and written and verbal communication skills. Ability to support colleagues and collaborate with cross-functional teams.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent. Associate's degree and claims processing, billing and/or coding experience preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Customer Service Representative (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Respond to customer inquiries via telephone and written correspondence in a timely and appropriate manner.
Description of Responsibilities of Position: Reference current materials to answer escalated and complex inquiries from members and Providers regarding claims, eligibility, covered benefits and authorization status matters. Provide assistance to members and/or Providers regarding website registration and navigation. Educate members and/or Providers on health plan initiatives Provide first call resolution working with appropriate internal/external resources, and ensure closure of all inquiries. Document all activities for quality and metrics reporting through the Customer Relationship Management (CRM) application. Process written customer correspondence and provide the appropriate level of follow-up in a timely manner. Research and identify processing inaccuracies in claim payments and route to the appropriate team for claim adjustment. Identify trends related to member and/or Provider inquiries that may lead to policy or process improvements that support excellent customer service and impact quality and performance standards. Work with other departments on cross functional tasks and projects. Maintain performance and quality standards based on established call center metrics including turn-around times.
Minimum Experience Required: 1+ years of experience in Medicare, Medicaid managed care or insurance environment preferred. 2+ years of customer service experience in a call center environment. Knowledge of managed care programs and services preferred.
Skills Required: Excellent customer service and written and verbal communication skills. Ability to collaborate with cross-functional teams.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent. Associates degree and claims processing, billing and/or coding experience preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Trainer (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Responsible for developing and conducting a variety of training programs and auditing tools.
Description of Responsibilities of Position: Conduct training needs analyses to determine specific training needs for clinical staff. Identify, select, or develop appropriate training programs, including the selection or design of appropriate training aids. Evaluate effectiveness of training programs and location including cost/benefit analyses. Research, analyze, and recommend external training programs. Maintain records of training activities and employee progress. Assist with revisions to Policy and Procedure and/or work process development. Conduct auditing of work performed by clinical staff and present findings and recommendation for areas of improvement to management. Under minimal supervision responsible for all aspects of difficult projects that are broad in nature and require originality and/or ingenuity.
Minimum Experience Required: 4+ years of nursing, training or auditing experience in a managed care or healthcare setting. Amisys and CCMS experience preferred.
Skills Required: Excellent training and written and verbal communication skills. Outstanding organizational skills. Skilled in reviewing clinical work and identifying opportunities for improvement.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Associate's or Bachelor's degree in Nursing or equivalent experience.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** RN or LPN license.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Community Relations Representative (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Provide sales coverage and develop best possible market penetration for all lines of business to present to prospective members in assigned territory in accordance with company's policies and programs. Provide greater access to health insurance, by providing education, assistance and coordinating community outreach to individuals.
Description of Responsibilities of Position: Identify prospective enrollees and determine eligibility for participation in the Medicaid and/or Medicare. Attend various community events, including health fairs, HEDIS initiatives and Member Advisory Groups and other sites as designated to market products. Identify and develop relationships with new community contacts and organizations to pursue outreach engagements. Enroll consumers in Medicare product, present information on Medicaid programs, help facilitate the continuance of enrollment, and offer information with Medicaid recertification. Conduct home visits and personalized appointments as needed to complete the Medicare enrollment process or as requested by potential enrollees to explain the Medicaid product. Assist members in accessing health care, transportation needs and other services or issues as they occur and pertain to members. Keep informed and adhere to current information pertaining to marketing activity guidelines set forth by various regulatory agencies, including providing enrollees with all corresponding materials and documentation. Research and monitor competitive products and marketing practices. Submit special reports regarding the operation of the territory, acceptance or rejection of products, and competitive conditions beneficial to other Marketing initiatives.
Minimum Experience Required: 2+ years of marketing, sales or community relations or outreach experience, preferably in a managed care or Medicaid environment Bilingual is a plus.
Skills Required: Thorough understanding of diverse member backgrounds and needs. Excellent written and verbal communication skills. Ability to participate in community events and liaise with community organizations.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in marketing, sales, related field or equivalent experience.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Obtain current state's Accident and Health Insurance Agent License within 6 months of hire.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education requirements (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Community Health Services Representative (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Responsible for delivering of a range of activities for individuals who are enrolled in the health plan for Medicaid or and Medicare in order to impact individual health outcomes and provide assistance to the clinical team of nurses and social workers. Activities include, but are not limited to outreach, community education, informal guidance and member support.
Description of Responsibilities of Position: Educate, coach and support members to understand disease prevention and achieve good health outcomes, including diabetes, high blood pressure, mental health, substance use, etc. Participate in coordination and resolution of medical and non-medical needs, including appointment tracking, documentation of member information, referrals and follow up, facilitating transportation to services, etc. Participate in meetings with external providers and community organizations to build partnerships for our members to be able to leverage member care services. Provide key information to providers for improving members care based on member's home environment and communities. Conduct non-clinical general health assessments in order to refer members to appropriate services, resolve concerns on member's behalf, and gather information for medical providers and staff working within the organization. Conduct non-medical assessments such as home safety, assessment of the community/environment resources, transportation, employment, and others to be able to refer to appropriate services, resolve concerns on member's behalf, and gather information for medical providers in staff working within our organization. Coordinate and implement community events such as baby showers, health fairs, and other health education events. Conduct telephonic and in-person outreach to locate individuals and families in the community who are hard to reach. Work with other community health workers internally and externally to share best practices, strengthen education and outreach. Participate in large scale community assessments including resource mapping, community surveys, and community meetings to discuss findings and resolutions to key member concerns. Make frequent visits to individual homes and community organizations.
Minimum Experience Required: 2+ years of community health, social work, social services, community advocacy, community outreach, member services, or education, experience. Understanding of the community in designated region through shared experiences or strong desire to help people in vulnerable communities. Bilingual skills preferred.
Skills Required: Thorough understanding of diverse member backgrounds and needs. Excellent written and verbal communication skills. Ability to participate in community events and liaise with community organizations.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Valid driver's license and proof of insurance. Community Health Worker Training/Certification must be successfully completed within 15 weeks of hire date.
Are there any continuing education requirements for this position? **[X] Yes [ ] No**

If yes, list below: Continuing education requirements (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Data Analyst (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Responsible for analytic data needs of the business unit.
Description of Responsibilities of Position: Manage multiple, variable tasks and data review processes, as well as mass data entry, maintenance, and update projects. Complete data audits and evaluations within core systems. Identify and resolve complex issues, including mass change updates, reconciliation projects, and the operationalization of data from various sources. Analyze and advise management of workflow issues and data integrity problems and offer recommendations on resolution. Develop and submit internal and external status reports. Create report and data reconciliation through Access, Excel, Business Objects and other reporting tools, to include Provider data, claims data, membership data.
Minimum Experience Required: 0-2 years of statistical analysis or data analysis experience. Experience with Business Intelligence and SQL tools preferred.
Skills Required: Thorough understanding of statistical analysis and data experience. Advanced knowledge of Microsoft Applications, including Excel and Access. Experience with Business Intelligence and SQL tools preferred.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in related field or equivalent experience.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Business Analyst (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: The Business Analyst (Healthcare Analytics) supports enterprise strategy and delivery of analytic services by performing various analyses and interpretations to link business needs for assigned functions. The analyst will collaborate within and across analytic functions, with business partners, and with customers to ensure appropriate flow of information, requirements, and strategic partnerships to support delivery of leading-edge analytics that answer important business questions.
Description of Responsibilities of Position: Lead the facilitation of business initiatives through data analysis, identification of implementation barriers and user acceptance testing of various systems. Lead the identification and analysis of user requirements, procedures, and problems to improve existing processes. Resolve issues and identify opportunities for process redesign and improvement. Perform detailed analysis on multiple projects, recommend potential business solutions and ensure successful implementations, including improvements and revisions to business processes and requirements. Evaluate risks and concerns and communicate to management. Coordinate with various business units and departments for problem solving, process improvement, and other business initiatives. Identify ways to enhance performance management and operational reports. Develop, share, and incorporate organizational best practices into business applications and processes. Oversee all changes to departmental policies and procedures, including communicating and implementing the changes. Serve as a subject matter expert on assigned functions, products, or analytic domains in support of strategic objectives. Mentor junior analysts on best practices and business need fulfilment. Delegate tasks to junior analysts, providing guidance and validation where required.
Minimum Experience Required: 5+ years of experience in business process, data analysis, or requirements analysis. Healthcare, analytics delivery, project management, and/or IT experience preferred. Working knowledge of analytical tools, including R, Python, SAS, ArcGIS, QGIS, Microstrategy, Tableau, Hadoop, or related tools preferred.
Skills Required: Excellent organizational and data analysis skills. Ability to maintain close attention to detail.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in business, economics, statistics, mathematics, actuarial science, public health, health informatics, healthcare administration, finance or related field or equivalent experience. Master's degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Workforce Analyst (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Use ACD phone system to assist with maximizing the effectiveness of scheduling, systems, performance metrics, data analysis, reporting and overall operational functions for all lines of business and all locations. Evaluate staffing adjustments and re skilling of agents as necessary to provide adequate phone coverage.
Description of Responsibilities of Position: Monitor real-time call activity at various call centers and make necessary staffing adjustments. Coordinate scheduling of all offices with call center supervisory staff. Monitor agent productivity and provide feedback to call center supervisory staff. Generate reports daily, weekly, monthly, annually and ad hoc. Detail forecasts, plans, schedules and performance, both in advance and in review. Identify, evaluate and report call center issues and differentiate between workflow, technical, external or staffing. Work directly with the department head on strategic planning and new business implementation and forecasting.
Minimum Experience Required: 5+ years of customer service experience. Working knowledge of telephony systems and call center technology and vocabulary. Experience with manpower planning and scheduling. Experience with forecasting and trending. Proficiency with all MS Office applications including Excel. Call center and service level experience preferred.
Skills Required: Excellent organizational and data analysis skills. Ability to maintain close attention to detail.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Social Services Specialist (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Coordinate psychosocial services for members identified as having special needs and assisting members with utilization of medical and/or behavioral resources related to case management, disease management and discharge planning.
Description of Responsibilities of Position: Coordinate psychosocial services for members identified as having special needs and assist the members with utilization of medical resources related to case management, disease management and discharge planning. Identify special needs members through the completion of health screens and other resources. Complete Complex Needs assessments, identify psychosocial barriers for accessing services and recommend appropriate resources to overcome psychosocial barriers. Participate in case conferences to strategize and develop member specific care plans. Participate in program specific activities to develop, review, or revise new or existing medical management programs. Maintain adequate information and community resource base for assistance with psychosocial problem resolution. Maintain appropriate documentation for all contacts and interventions. Conduct community outreach activities related to special programs.
Minimum Experience Required: Social Services Specialist I: 2+ years of social service or community outreach experience. Licensure and/or certification in a related field preferred. Social Services Specialist II: 4+ years of social service or community outreach experience. Licensure and/or certification in a related field preferred.
Skills Required: Thorough understanding of social services and resources for members with special needs. Ability to conduct health screenings and needs assessment. Excellent written and verbal communication skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Social Work, Nursing, Health, Behavioral Science or related field.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Member Advocate (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Act as an advocate for the Member and a liaison between the Health Plan and Provider(s) to ensure availability and access to care. Establish a community presence, promote Member education, identify and resolve any systemic barriers that limit Members access to appropriate care.
Description of Responsibilities of Position: Receive and respond to Member complaints and formal grievances and identify potential access barriers and resolve as indicated in the grievance procedure. Investigate and resolve access and cultural sensitivity issues identified by Member Services staff, State staff, Providers, advocacy organizations and recipients. Participate in local community organizations to acquire knowledge and insight regarding the special health care needs of Members and update and revise educational materials as appropriate. Serve as primary contact for Member advocacy groups, human services agencies and the State entities. Maintain confidentiality per HIPAA guidelines.
Minimum Experience Required: 3+ years of customer service experience in a healthcare environment. Medicare and/or Medicaid experience preferred.
Skills Required: Thorough understanding of diverse member backgrounds and needs. Excellent written and verbal communication skills. Ability to participate in community events and liaise with community organizations.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Program Coordinator (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Assist in activities related to the medical and psychosocial aspects of utilization and coordinated care.
Description of Responsibilities of Position: Initiate authorization requests for output or input services in keeping with the prior authorization list. Research claims inquiry specific to the department and responsibility. Perform tasks necessary to promote member compliance such as verifying appointments, obtaining lab results. Assess and monitor inpatient census. Screen for eligibility and benefits. Identify members without a PCP and refer to Member Services. Screen members by priority for case management (CM) assessment. Perform transition of care duties to include but not limited to, contact the member's attending physician, member or medical power of attorney, other medical Providers (home health agencies, equipment vendors) for information pertaining to special needs. Coordinate services with community based organizations. Attend marketing and outreach meetings as directed to represent the plan. Produces and mails routine CM letters and program educational material. Data enter assessments and authorizations into the system. Program Coordinator II: Initiate authorization requests for output or input services in keeping with the prior authorization list. Maintain integrity of PHI. Maintain working relationships with other departments. Research claims inquiry specific to the department and responsibility. Attend ongoing training and in-services as directed. Perform tasks necessary to promote member compliance such as verifying appointments, obtaining lab results. Assess and monitor inpatient census. Screen for eligibility and benefits. Identify members without a PCP and refer to Member Services. Answers phone queues and faxes within established standards. Screen members by priority for CM assessment. Coordinates services with community based organizations. Attends marketing and outreach meetings as directed to represent the plan. Produces and mails routine CM letters and program educational material. Helps develop marketing and outreach meetings as directed to represent the health plan. Train new Program Coordinators on system and usage. Guide staff regarding benefits, authorization requirements and policy and procedure. Data enters assessments and authorizations into the system. Maintains database as directed.
Minimum Experience Required: 2-3 years managed care or physician's office experience. Thorough knowledge of customer service, utilization review or claims processing practices in a managed care environment and operation of office equipment such as a personal computer. Knowledge of medical terminology. Program Coordinator II: 3-5 years managed care or physician's office experience. Thorough knowledge of customer service, utilization review or claims processing practices in a managed care environment and operation of office equipment such as a personal computer. Knowledge of medical terminology.
Skills Required: Excellent organizational skills. Thorough understanding of customer service, utilization review, or claims processing practices. Knowledge of medical terminology. Ability to attend community events and represent the health plan.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.

Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Eligibility Specialist (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Maintain internal computer system's Medicaid managed care membership records related to the qualifications a person or dependent must meet for coverage under the State contract or agreement through thorough research and/or collaboration with the agency contracted by the state to provide information to the Company.
Description of Responsibilities of Position: Provide timely, efficient support for the eligibility load process while coordinating with Corporate IS department to resolve issues that arise during the process. Provider research to correct errors in membership and PCP (Primary Care Physician) data input within the AMISYS system. Complete monthly reconciliation process of remittance files by resolving discrepancies in report. Generate internal ad-hoc reports and analysis as needed. Eligibility Specialist II: Provide timely, efficient support for the eligibility load process and coordinate with IT to resolve issues. Research and correct errors in membership and PCP (Primary Care Physician) data input within the Amisys system. Complete monthly reconciliation of remittance files and resolve any discrepancies. Collaborate with IT and other functional departments to develop and implement new products or changes to existing products, including UAT testing. Coordinate the Provider capitation process to ensure accurate and timely payments to Providers. Participate in eligibility release planning to identify any system changes and ensure files are complete and process timely. Provide input on process improvement initiatives and update policies and procedures for eligibility and enrollment related activities. Develop training materials and train new staff on eligibility and enrollment procedures. Generate internal ad-hoc reports and analysis as needed.
Minimum Experience Required: 2+ years of experience in member enrollment, membership eligibility records, member services and data analysis. Knowledge of Medicaid managed care programs and practices, preferably for the assigned State. Experience with the Amisys system preferred. ES II: 4+ years of member enrollment, membership eligibility, member services, or data analysis experience. Knowledge of Medicaid managed care programs and practices, preferably for the assigned State. Experience with the Amisys and CRM system preferred.
Skills Required: Excellent organizational and data analysis skills. Ability to maintain close attention to detail.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Credentialing Specialist (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Assist the plan in credentialing and re credentialing Providers.
Description of Responsibilities of Position: Credential and re-credential various Providers, including physicians, healthcare delivery organizations, or pharmacies, according to applicable specifications. Maintain and update credentialing database. Assist with coordinating credentialing committee. Process, track and file credentialing applications within established standards. Respond to internal and external customer inquiries regarding credentialing status. May require the ability to travel, a valid driver's license, and car insurance (depending on business unit). Credentialing Specialist II: Credential and re-credential various Providers, including physicians, healthcare delivery organizations, or pharmacies, according to applicable specifications. Input and maintain databases for timely access to accurate and current network status and to allow for meaningful analysis of network size, scope, etc. May perform audits, including preparation and audit of credentialing documents. Act as a "go to" person for other Credentialing Specialists and provide feedback to reduce errors and improve processes. Assist with development of department policies, procedures, workflow and tools. May assist with coordinating credentialing committee. May require the ability to travel, a valid driver's license, and car insurance (depending on business unit)
Minimum Experience Required: 2+ years of credentialing or Provider data experience. Knowledge of NCQA or URAC and state credentialing requirements preferred. Credentialing Specialist II: 4+ years of credentialing and/or Provider data experience. Knowledge of NCQA or URAC and state credentialing requirements preferred.
Skills Required: Thorough understanding of local Provider landscape and credentialing policies, procedures, and regulations. Excellent written and verbal communication skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Provider Network Administrator (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Serves as the internal and external liaison for the Provider Network Management Department who maintains positive working relationships with participating physicians, participating physician groups (PPG's), hospitals and/or ancillary Providers within an assigned area. Responsible for daily administration and operation of the contractual Provider relationships including overseeing accurate and current Provider databases, providing training, education and information to Providers, coordinating regulatory filings and rollouts, and researching, analyzing and resolving complex problems dealing with contract loading, division of financial responsibility interpretation, contract rate and language interpretation, appeals, grievances and eligibility.
Description of Responsibilities of Position: Assures that contract is understood by the Provider and various divisions, and that the Provider is in compliance with contract. Monitors performance of Provider as defined or specified in the contract. Researches, analyzes and resolves within limits of authority, issues related to contract interpretation, complex claims, benefit problems, shared risk settlements, appeals and grievances, eligibility and authorization inquiries. Responds to cross-functional inquiries from other departments regarding the contract. Acts as a resource and provides support to various functional areas. Interprets policies and procedures. Provides interpretation and clarification on benefits, eligibility, reinsurance selection, access of care and operational and administrative obligations. Escalates recurring or critical issues, if unable to independently resolve, including but not limited to, quality of care issues, claims payment issues, access issues and operational/administrative issues to the appropriate department in a timely fashion. Assists with policy and procedure development interpretation and implementation within PNM and across departments. Manages Provider databases for current data and rates relating to Physician, PPG, Hospital and Ancillary information. Ensures that Provider directory information is accurate, current and accessible when needed by internal and external contacts. Facilitates and assist other departments with data base initiatives and is integral to compliance with OIG/OPM and other regulatory agency requirements. Participates in special projects, which may include assistance on negotiations, new product development, completion of contract term sheets or contract configuration on new and/or existing contracts and PSAS reviews. Assesses training needs of Provider personnel, (physician, PPGs, Hospitals, Ancillary). Develops, implements, and conducts appropriate training programs and/or orientations for Provider staff. Coordinates and facilitates annual Joint Operating Committee Meeting at the Provider sites and conducts Provider meetings as necessary. Coordinates PPG transitions and rollouts that include coordination of transition team meetings, development maintenance of work plans including PPG/Member crossover analysis for member reassignment and report generation for Transition of care identification. Also assists with development and coordination of internal and external communication. Performs other duties as assigned.
Minimum Experience Required: Three to five years progressive Provider services experience. Experience in a managed health care environment with exposure to Provider contracting, servicing benefits interpretation, and internal operations of Provider relations function required.
Skills Required: Thorough understanding of local Provider landscape. Excellent written and verbal communication skills, including training and Provider-facing customer service. Strong project management and organizational skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree In Health Services, Health Care/Hospital Administration, or a

related field, or any combination of education and/or work experience providing equivalent background required.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Provider Relations Specialist (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Perform duties to act as a liaison between Providers, the health plan and Corporate. Perform training, orientation and coaching for performance improvement within the network and assist with claim resolution.
Description of Responsibilities of Position: Serve as primary contact for Providers and act as a liaison between the Providers and the health plan. Conduct monthly face-to-face meetings with the Provider account representatives documenting discussions, issues, attendees, action items, and research claims issues on-site, where possible, and route to the appropriate party for resolution. Receive and effectively respond to external Provider related issues. Provide education on health plan's innovative contracting strategies. Initiate data entry of Provider-related demographic information changes and oversee testing and completion of change requests for the network. Investigate, resolve and communicate Provider claim issues and changes. Educate Providers regarding policies and procedures related to referrals and claims submission, web site usage, EDI solicitation and related topics. Perform Provider orientations and ongoing Provider education, including writing and updating orientation materials. Provider Relations Specialist II: Conduct initial Provider orientations as well as ongoing educational outreach. Educate Providers regarding policies and procedures related to referrals, claims submission, credentialing documentation, web site education, Electronic Health Records, Health Information Exchange, and Electronic Data Interface. Enhance account relationships by investigating, documenting and resolving Provider matters and effectively handling and responding to account changes and correspondence. Engage Providers and educate them on Patient Centered Medical Home initiatives. Perform detailed HBR (Health Benefits Ratio) analyses, Health Information data Information Set (HEDIS) analyses, and create reports for Provider Review Provider performance by both quantitative metrics and qualitative factors. Create and communicate milestone documents, dashboards and success or improvement metrics. Act as a liaison between the Provider and the health plan ensuring a coordinated effort in improving financial and quality performance. Provide information and status updates for Providers regarding incentive agreements. Conduct site visits when required. Perform other contracting duties as requested, including but not limited to recommending changes to pricing subsystems, submitting changes to Provider related database information and assisting in the completion of special projects.
Minimum Experience Required: 0-2 years of Provider relations or contracting experience. Knowledge of health care, managed care, Medicare or Medicaid. Claims billing/coding knowledge preferred. Provider Relations Specialist II: Bachelor's degree in related field or equivalent experience. 2+ years of combined managed healthcare and Provider reimbursement experience. Advanced knowledge of Microsoft Excel. Clinical or health information management (HIM) experience preferred. Claims processing and/or managed care experience preferred.
Skills Required: Thorough understanding of local Provider landscape. Excellent written and verbal communication skills, including training and customer service. Strong data entry skills.
Are there any educational requirements for this position? **[X] Yes [ ] No**

If yes, list below: Bachelor's degree in related field or equivalent experience.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Senior Contract Negotiator (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Coordinate and negotiate hospital, physician (IPAs, PPMs, individual Providers, multi-specialty groups) and ancillary service agreements that are in accordance with corporate, health plan and State guidelines.
Description of Responsibilities of Position: Oversee all negotiations for a specific plan or Provider type (large professional groups, hospitals, etc.). Assist with plan specific contracting strategy. Manage delivery of financial settlements and collections of receivables. Evaluate and monitor Providers' performance standards and financial performance of contracts. Develop contracting action plans. Coordinate with internal departments and contracted Providers to implement and maintain contract compliance.
Minimum Experience Required: 4+ years of contracting or Provider relations experience in a healthcare, managed care, or insurance related environment.
Skills Required: Thorough understanding of local Provider landscape. Excellent written and verbal communication skills, including training and customer service. Strong project management and organizational skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Healthcare Administration, Business Administration, Marketing, related field or equivalent experience.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Contract Audit Specialist (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Audit Provider information to ensure consistency in Provider setup and contract language. Ensure accurate and safe storage of all Provider contract files.
Description of Responsibilities of Position: Audit all Provider information to ensure payment accuracy as outlined in the contract. Respond to audit inquiries and work with internal team to address audit quality results and assist with making necessary changes. Ensure storage formatting compliance with internal systems. Maintain primary control of all Provider contract files and records ensuring files are secure and stored appropriately. Serve as the "gatekeeper" for all physical files including files check in and out. Create, change, edit, or terminate new and existing Provider (electronic and physical) contract files and records according to retention guidelines. Coordinate with functional teams to ensure seamless transitions of Provider contract files from credentialing, approval, scan, and storage.
Minimum Experience Required: 3+ years' experience managing large databases, Provider information systems, and performing quality data audits. Proficient in Excel and Access applications.
Skills Required: Excellent organizational and data analysis skills. Ability to maintain close attention to detail.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Contracts Coordinator (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Assist with the contract submission process and the auditing of Provider information systems (AMISYS) for consistency and best practices in Provider set up.
Description of Responsibilities of Position: Maintain spreadsheets and collect, track, prepare, compile, and distribute statistical data for daily and monthly reports. Maintain and report on the Health Plan(s) compliance with contract submission rules and exception requests and communicate to Manager on a monthly basis. Support the contract submission process to ensure confirmation with Corporate standards by the Health Plan(s), provide support to the Contract Case Conferences and ensure that appropriate internal controls are established to account for and secure hardcopy or scanned images of contracts. Maintain and update on a routine basis the contract organization's databases. Produce reports, as requested. Coordinate the Corporate-wide data verification process for contracted Providers. Update contract organization's databases, as necessary. Interface with the credentialing staff to ensure all Health Plan data systems are congruent.
Minimum Experience Required: 2+ years of experience managing large databases and Provider information systems. Healthcare industry experience preferred. Auditing experience preferred.
Skills Required: Excellent organizational and data analysis skills. Ability to maintain close attention to detail.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Vice President, Government Relations and Communications (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Responsible for establishing and maintaining executive level relationships with government officials to impact positive outcomes for health plan and members served. Lead market-level marketing and communication efforts internally and externally. Work with health benefit exchange and other internal and external parties for Ambetter product market position.
Description of Responsibilities of Position: Serve as the expert on local, state and national health policy that positively impacts the local outcomes for Centene. Serve as external-facing executive for health plan, legislative and government and regulatory officials. Facilitate corporate communications and marketing framework with local health plan. Oversee regulatory communications and oversight with state agencies (Health Care Authority & Office of Insurance Commissioner) and health plan. Manage and develop content for internal and external Provider, member, and employee communication / marketing. Work with Regulatory Operations for exchange filings. Work with Ambetter team on Benefit design and local marketing plans.
Minimum Experience Required: 10+ years of Health plan, government relations, marketing or communications experience.
Skills Required: Excellent verbal and written communication skills. Outstanding interpersonal and negotiation skills. Strong government contacts at local, state, and federal levels. Strong analytical and problem-solving skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in business, government, marketing. communications or related field.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Manager, Compliance and Reporting (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Design and implement programs, policies, and practices to ensure State and Federal program contract compliance, as well as compliance with federal and state legal and regulatory requirements.
Description of Responsibilities of Position: Manage the compliance/reporting staff. Oversee the day-to-day health plan policies and procedures to ensure federal and state regulatory compliance. Validate state and federal deliverable reports for accuracy and ensure timeliness of submission. Review and analysis of health plan deliverables and data to identify trends in performance and opportunities for improvement. Ensure timely, accurate and appropriate submission of all State filings related to health plan licensure. Act as a resource to staff in all health plan departments related to contract and reporting requirements and regulatory compliance. Act as a liaison with State and/or federal agency staff in response to inquiries and requests for information. Interact with Corporate compliance staff and serve as primary health plan liaison with the Corporate Special Investigations Unit related to fraud and abuse. Conduct oversight audits of health plan procedures and processes to ensure compliance with contractual and regulatory requirements. Coordinate with Marketing Manager and Delegation Oversight Manager for applicable activities and initiatives. Conduct/manage training programs for all health plan staff as required by contract and applicable regulatory requirements.
Minimum Experience Required: 4+ years of compliance/regulatory experience in a health care and/or managed care setting/organization. Previous experience as a lead in a functional area, managing cross functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff.
Skills Required: Excellent organizational and analytical skills. Ability to read, analyze, and interpret technical procedures, governmental regulations, and legal documents. Excellent oral and written communication skills. Ability to write clear, concise reports, business correspondence, and procedures. Ability to effectively present information and respond to inquiries from employees, regulatory agencies, and others, as necessary. Ability to initiate administrative activities as necessary, and institute quality control procedures. Ability to meet deadlines and adjust to changes in company policies, procedures, and priorities.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in related field.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Child Health Coordinator (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Conduct outreach (via telephone and mail) to encourage enrollees to access preventive care; assist with making appointments and arrangements as necessary.
Description of Responsibilities of Position: Communicate the importance of regular preventive healthcare for the enrollee population. Monitor the services for those enrollees who are currently seeking preventive care on a regular basis. Responsible for outreach mailing as required. Maintain initial and continuing outreach on a daily basis to targeted enrollees and assist in providing transportation to and from the appointment. Identify enrollees for purposes of Wellcheck. Responsible, with input from appropriate staff, for development of Health/Preventive Care Outreach materials. Responsible for investigating and documenting any mention of other insurance while outreaching enrollees. Provide copies of all information. Responsible for complete, clear and concise documentation of all services and outreach efforts. Participate on committees to improve member health outcomes.
Minimum Experience Required: 1+ years of customer service experience.
Skills Required: Thorough understanding of diverse member backgrounds and needs. Excellent written and verbal communication skills. Strong organizational skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Senior Executive Assistant (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: Relieves the executive of administrative type functions in order to increase the time the executive has available for senior level responsibilities.
Description of Responsibilities of Position: Communicates and interprets administrative and operating policies and procedures. Assists in the preparation and coordination of records, statistics, and reports regarding operations, etc. Gathers information for board meetings, programs, events or conferences by arranging facilities and caterers, issuing information or invitations, coordinating speakers, preparing materials and assisting with controlling event budget. Handle a wide variety of situations and conflicts involving the clerical and administrative function of the office. Responsible for confidential and time sensitive material. Prepare routine and advanced correspondence including letters, memoranda, and reports.
Minimum Experience Required: 5+ years of related experience with knowledge of positions concepts, practices and procedures. 2+ years of experience as an Executive Assistant preferred.
Skills Required: Excellent organizational and data analysis skills. Ability to maintain close attention to detail. Strong verbal and written communication skills. Ability to communicate professionally with internal and external leaders.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Concurrent Review Nurse (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Promote the quality and cost effectiveness of medical care by applying clinical acumen and the appropriate application of policies and guidelines to emergent/urgent and continued stay reviews.
Description of Responsibilities of Position: Perform onsite review of emergent/urgent and continued stay requests for appropriate care and setting, following guidelines and policies, and approve services or forward requests to the appropriate Physician or Medical Director with recommendations for other determinations. Complete medical necessity and level of care reviews for requested services using clinical judgment and refer to Medical Directors for review depending on case findings. Collaborate with various staff within Provider networks and discharge planning team electronically, telephonically, or onsite to coordinate member care. Conduct discharge planning. Educate Providers on utilization and medical management processes. Provide clinical knowledge and act as a clinical resource to non-clinical team staff. Enter and maintain pertinent clinical information in various medical management systems. Level II: Perform onsite review of emergent/urgent and continued stay requests for appropriate care and setting, following guidelines and policies, and approve services or forward requests to the appropriate Physician or Medical Director with recommendations for other determinations. Complete medical necessity and level of care reviews for requested services using clinical judgment and refer to Medical Directors for review depending on case findings. Collaborate with various staff within Provider networks and discharge planning team electronically, telephonically, or onsite to coordinate member care. Conduct discharge planning. Educate Providers on utilization and medical management processes. Provide clinical knowledge and act as a clinical resource to non-clinical team staff. Enter and maintain pertinent clinical information in various medical management systems. Direct care to participating network Providers. Participate in utilization management committees and work on special projects related to utilization management as needed.
Minimum Experience Required: 2+ years of clinical nursing experience. Acute care experience preferred Knowledge of healthcare and managed care preferred. Level II: 2+ years of clinical nursing experience and 1+ years of utilization management experience in a managed care setting. Acute care experience preferred. Knowledge of utilization management principles and healthcare managed care. Experience with medical decision support tools (i.e., Interqual, NCCN) and government sponsored managed care programs.
Skills Required: Thorough understanding of utilization management principles and managed care. Ability to use medical decision support tools and associated systems. Ability to apply clinical knowledge and guidance to Providers and clinical staff. Strong verbal and written communication skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Graduate from an Accredited School of Nursing. Bachelor's degree in Nursing preferred.
Are there any professional licenses or certifications required for this position?

[X] Yes [ ] No **If yes, list below:** Current state's LPN/LVN or RN license.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Prior Authorization Nurse (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Promote the quality and cost effectiveness of medical care by applying clinical acumen and the appropriate application of policies and guidelines to prior authorization requests.
Description of Responsibilities of Position: Perform telephonic review of prior authorization requests for appropriate care and setting, following guidelines and policies, and approve services or forward requests to the appropriate Physician or Medical Director with recommendations for other determinations. Complete medical necessity and level of care reviews for requested services using clinical judgment and refer to Medical Directors for review depending on case findings. Collaborate with various staff within Provider networks and case management team electronically or telephonically to coordinate member care. Educate Providers on utilization and medical management processes. Provide clinical knowledge and act as a clinical resource to non-clinical team staff. Enter and maintain pertinent clinical information in various medical management systems.
Minimum Experience Required: 2+ years of clinical nursing experience. Knowledge of healthcare and managed care preferred.
Skills Required: Thorough understanding of utilization management principles and managed care. Ability to use medical decision support tools and associated systems. Ability to apply clinical knowledge and guidance to Providers and clinical staff. Strong verbal and written communication skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Graduate from an Accredited School of Nursing. Bachelor's degree in Nursing preferred.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Current state's LPN/LVN or RN license.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Referral Specialist (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Assist in monitoring utilization of medical services to assure cost effective use of medical resources through processing prior authorizations.
Description of Responsibilities of Position: Initiate authorization requests for outpatient and inpatient services in accordance with the prior authorization list. Route to appropriate staff when needed. Verify eligibility and benefits. Answer phone queues and process faxes within established standards. Data enters authorizations into the system.
Minimum Experience Required: 2+ years of customer service experience. Knowledge of medical terminology preferred.
Skills Required: Thorough understanding of utilization management principles and managed care. Excellent customer service and data entry skills. Strong verbal and written communication skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Supervisor, Utilization Management (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Supervise the daily operations of the utilization management (UM) department.
Description of Responsibilities of Position: Supervise the daily operations of the UM staff. Ensure appropriate usage of resources in order to facilitate the UM process. Ensure compliance within applicable state program guidelines. Evaluate compliance policies and procedures and analyze/recommend enhancements. Assist with ensuring consistent data collection from UM staff that is used to assist the company in achieving corporate goals, to improve monitoring and reporting in order to meet external requirements. Identify opportunities for process improvements necessary to facilitate department functions. Educate staff as necessary to ensure consistent performance and adhere to standards. Assist UM Manager and Director with coordinating and facilitating system processes with Providers, partners, vendors, and subcontractors as necessary. Supervise the Transition of Care staff and provide face to face contact with inpatient members at assigned hospitals.
Minimum Experience Required: 3+ years of utilization management/quality improvement experience. Working knowledge and understanding of basic utilization management and quality improvement concepts. Previous experience as a lead in a functional area or managing cross functional teams on large scale projects.
Skills Required: Thorough understanding of utilization management principles and managed care. Strong verbal and written communication skills. Excellent managerial and leadership skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Nursing degree, state registered nursing license, and advanced degree preferred.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Current Mississippi RN license
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Supervisor, Medical Management (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Supervise the day to day operations of the medical management, utilization and case management functions
Description of Responsibilities of Position: Oversee changes to medical service functions and performance in relation to company mission, philosophy objectives and policies, as directed. Assist senior management with budgets and forecast for strategic planning and key initiatives. Balance current future needs effectively. Ensure compliance with established onsite and concurrent review, case management, referral, pre-authorization policies, procedures, and processes. Assure that Medical Services functions and responsibilities are coordinated with other operating departments of the Plan and Corporate. Assist senior management with statistical analysis of utilization data. Participates in NCQA accreditation of the Plan. Participate in case review with Medical Directors and act as resource for appeals function.
Minimum Experience Required: 3+ years nursing experience. 1+ year quality improvement, case/utilization management in a healthcare environment, preferably managed care. Previous experience as a lead in a functional area or managing cross functional teams on large scale projects.
Skills Required: Thorough understanding of utilization management principles and managed care. Strong verbal and written communication skills. Excellent managerial and leadership skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Nursing degree, state registered nursing license, and advanced degree preferred.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Current Mississippi RN license
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Supervisor, Referral Services (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Supervise the day to day operations of the utilization and case management areas
Description of Responsibilities of Position: Supervise day to day activities of the Referral Services department including workflow, training, hiring, etc. Assist Providers, members and/or internal customers with cases pertaining to referral questions, issues and authorizations. Reconcile pended claim issues in a timely manner per health plan/department procedure. Review and process denial letters, maintain logs, and coordinate decisions to external or internal. personnel per plan procedures. Receive and review incoming phone and case management log reports and determine course of action. Work with analysts and programmers in adapting and testing programs and procedures to adhere to our standard operating procedures.
Minimum Experience Required: 3+ years of prior authorization, physician's office, customer service, claims processing or Provider relations experience preferably in a managed care setting. Previous experience as a lead in a functional area or managing cross functional teams on large scale projects.
Skills Required: Thorough understanding of utilization management principles and managed care. Strong verbal and written communication skills. Excellent managerial and leadership skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** High school diploma or equivalent.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Supervisor, Pharmacy Specialist (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Perform duties to implement a pharmacy benefit management program. Aid the Director of Pharmacy in formulating and administering related organizational policies and procedures including quality, compliance and pharmacy utilization management.
Description of Responsibilities of Position: Supervise, plan, direct and implement in-house pharmacy activities of the subordinate pharmacy coordinators. Receive and respond to Provider and pharmacy calls regarding the prior Authorization/formulary process. Perform review of pharmacy and override process in compliance with pharmaceutical related company and State guidelines. Track and trend overrides, audit prior authorizations, analyze cost and determine utilization patterns. Conduct statistical analysis of data, prepare reports and records on data and the assigned work function activities for management and corporate. Resolve complaints/grievances related to the pharmacy network in conjunction with the Pharmacy Benefit Manager (PBM) and Plan Pharmacist. Assist Provider Relations staff and other departments with educating Providers and others on the health plan's pharmacy process. Collaborate with Quality Improvement (QI) Manager for various meeting preparation and transcription of minutes. Assist Case Managers with members' inquiries related to the formulary process.
Minimum Experience Required: 3+ years of related pharmacy experience. Working knowledge of pharmaceutical care and pharmacy benefit management practices as well management experience. Previous experience as a lead in a functional area or managing cross functional teams on large scale projects. Medicare and/or Medicaid experience preferred.
Skills Required: Strong clinical pharmacy background with ability to demonstrate clinical pharmacy skills and knowledge in a care setting. Strong knowledge of managed care; pharmaceutical/ healthcare industry dynamics and Provider reimbursement; and Provider contracting processes and strategies. Demonstrated success in managing professional business relationships in a managed care system, medical group, hospital, or related business in health care delivery industry. Excellent verbal and written communication skill.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in related field or equivalent experience.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Quality Practice Advisor (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Establishes and fosters a healthy working relationship between large physician practices, IPAs and the health plan. Educates Providers and supports Provider practice sites regarding NCQA HEDIS measures and risk adjustment. Assists in resolving deficiencies impacting plan compliance to meet State and Federal standards for HEDIS and documentation standards. Acts as a resource for the health plan peers on HEDIS measures, appropriate medical record documentation and appropriate coding. Supports the development and implementation of quality improvement interventions and audits in relation to plan Providers.
Description of Responsibilities of Position: Delivers, advises and educates Provider practices and IPAs in appropriate HEDIS measures, medical record documentation guidelines and HEDIS ICD-9/10 CPT coding in accordance with state, federal, and NCQA requirements. Collects, summarizes, trends, and delivers Provider quality and risk adjustment performance data to identify and strategize/coach on opportunities for Provider improvement and gap closure. Collaborates with Provider Relations and other Provider facing teams to improve Provider performance in areas of Quality, Risk Adjustment and Operations (claims and encounters). Identifies specific practice needs where Centene can provide support. Develops, enhances and maintains Provider clinical relationship across product lines.
Minimum Experience Required: 3+ years of experience in HEDIS record collection and risk adjustment (coding)
Skills Required: Thorough understanding of healthcare quality measures and best practices. Excellent written and verbal communication skills, including training and Provider-facing customer service. Strong project management and organizational skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in related field or equivalent experience.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Quality Improvement Specialist (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Support the data management and quality improvement initiatives for assigned functional areas.
Description of Responsibilities of Position: Assist with the development and coordination of all core health services data reports. Support the development of quality improvement performance audit function processes and tools. Assist in designing, running, managing, and data review process for assuring accuracy and integrity of health services data reports to meet regulatory and operational requirements. Report outcomes and quality monitoring results to management. Assist with managing databases, policies and procedures related to assigned areas. Assist with related activities for various committees and meetings for assigned areas.
Minimum Experience Required: 2+ years of data management, including reporting, project management or quality improvement experience.
Skills Required: Thorough understanding of healthcare quality measures and best practices. Strong data analysis and organizational skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Associate's degree in related area or equivalent experience.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** N/A
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Quality Improvement Coordinator (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Conduct review of delegated entities for compliance with quality, service performance and utilization, credentialing reviews and medical record audits. Perform community activities related to clinical initiatives such as health fairs and communicate with agencies and Providers.
Description of Responsibilities of Position: Perform quality on site reviews of delegated entities, physician office/clinics, resolve quality issues, generate written summary of findings and follow up as directed by the Medical Director and/or Credentialing and Quality Improvement Committee (QIC). Document, investigate and resolve formal and informal complaints, risk management and sentinel events related to quality of care issues. Audit medical records, review administrative claims and analyze data and interventions for quality improvement studies and activities. Function as the primary liaison between community resources/agencies and the company related to clinical initiatives and technical guidance. Schedule and chair meetings with delegated entities in accordance with their contract. Gather data and compile various utilization and quality improvement reports. Develop and implement Corrective Action Plans. Recommend changes/enhancements to the Quality Improvement policies and procedures. Identify best practices, research new processes and recommend program enhancements. Coordinate QIC activities and monthly meetings. Oversee the enforcement of contract terms regarding data submission for delegated entities. Participate in the development of reporting and data outcome reports.
Minimum Experience Required: 3+ years of clinical, quality improvement or healthcare experience. 2+ years of experience in quality function in a healthcare setting.
Skills Required: Thorough understanding of healthcare quality measures and best practices. Excellent written and verbal communication skills, including interactions with Providers. Ability to pay close attention to detail.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Nursing preferred.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** LPN, LVN, RN, PA, or LCSW license preferred. CPHQ (Certified Professional in Healthcare Quality) preferred.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Specialty Therapy Advisor (Sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' Care Management needs at all times)
Description of Position: Perform utilization review of authorization requests regarding specialty therapy services for members, including speech language, occupational, and physical therapy across the identified regions and products. Assist with training and network management support for therapy providers.
Description of Responsibilities of Position: Perform detailed review of therapy service requests based on evidenced based practice, documentation standards as indicated by the national therapy associations, and organizational policies. Refer members to case management as appropriate based on service request assessment. Provide clinical recommendations for any adverse therapy determination. Provide clinical expertise based on shared practice standards regarding sub-specialty therapy practice to peers. Provide support for specialty therapy providers, including assistance with clinical trainings, consultation and guidance on matters related to therapy authorization and provision. Provide clinical expertise to multi-functional areas within organization to support provider relations and operations.
Minimum Experience Required: 3+ years of experience providing therapy services in healthcare or home health settings. Pediatric clinical experience preferred.
Skills Required: Excellent understanding of and ability to apply clinical guidelines and best practices in utilization management for specialty therapy services. Strong cross-functional and external communication skills.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Master's degree in area of specialty therapy or equivalent experience.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Current state license in Physical Therapy, Occupational Therapy or Speech-Language Therapy. Speech-Language Therapist must have an active Certificate of Clinical Competence from the American Speech-Language-Hearing Association.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Care Manager (All Care Managers)
Description of Position: Perform care management duties to assess, plan and coordinate all aspects of medical and supporting services across the continuum of care for select members to promote quality, cost effective care.
Description of Responsibilities of Position: Assess the member's current health status, resource utilization, past and present treatment plan and services, prognosis, short and long term goals, treatment and Provider options. Utilize assessment skills and discretionary judgment to develop plan of care based upon assessment with specific objectives, goals and interventions designed to meet member's needs and promote desired outcomes. Coordinate services between Primary Care Physician (PCP), specialists, medical Providers, and non-medical staff as necessary to meet the complete medical socio economic needs of clients. Provide patient and Provider education. Facilitate member access to community based services. Monitor referrals made to community based organizations, medical care and other services to support the members' overall care management plan. Actively participate in integrated team care management rounds. Identify related risk management quality concerns and report these scenarios to the appropriate resources. Enter and maintain assessments, authorizations, and pertinent clinical information into various medical management systems. Direct care to participating network Providers. Perform duties independently, demonstrating advanced understanding of complex care management principles. Participate in case management committees and work on special projects related to case management as needed.
Minimum Experience Required: Care Manager II: 2+ years of clinical nursing experience in an acute care setting and 1+ years of case management experience in a managed care setting. Care Manager I: 2+ years of clinical nursing experience in an acute care setting. Knowledge of healthcare and managed care preferred.
Skills Required: Knowledge of utilization management principles and healthcare managed care. Experience with medical decision support tools (i.e., Interqual, NCCN) and government sponsored managed care programs. Excellent interpersonal communication skills and experience working with individuals with diverse backgrounds.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Graduate from an Accredited School of Nursing. Bachelor's degree in Nursing preferred.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Current Mississippi RN license.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Care Manager (Social Work) (All Care Managers)
Description of Position: Perform care management duties to assess, plan and coordinate all aspects of medical and supporting services across the continuum of care for select members to promote quality, cost effective care.
Description of Responsibilities of Position: Assess the member's current health status, resource utilization, past and present treatment plan and services, prognosis, short and long term goals, treatment and Provider options. Utilize assessment skills and discretionary judgment to develop plan of care based upon assessment with specific objectives, goals and interventions designed to meet member's needs and promote desired outcomes. Coordinate services between Primary Care Physician (PCP), specialists, medical Providers, and non-medical staff as necessary to meet the complete medical socio economic needs of clients. Provide patient and Provider education. Facilitate member access to community based services. Monitor referrals made to community based organizations, medical care and other services to support the members' overall care management plan. Actively participate in integrated team care management rounds. Identify related risk management quality concerns and report these scenarios to the appropriate resources. Enter and maintain assessments, authorizations, and pertinent clinical information into various medical management systems. Direct care to participating network Providers. Perform duties independently, demonstrating advanced understanding of complex care management principles. Participate in case management committees and work on special projects related to case management as needed.
Minimum Experience Required: Care Manager I (Social Work): 2+ years of social work experience in an acute care or community setting. Knowledge of government sponsored managed care programs preferred. Care Manager II (Social Work): 2+ years of social work experience in an acute care or community setting and 1+ years of case management experience in a managed care setting. Experience government sponsored managed care programs.
Skills Required: Knowledge of utilization management principles and healthcare managed care. Experience with medical decision support tools (i.e., Interqual, NCCN) and government sponsored managed care programs. Excellent interpersonal communication skills and experience working with individuals with diverse backgrounds.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Social Work.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Care Manager I (Social Work): MS unrestricted license as Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Marriage & Family Therapist (LMFT) or Registered Nurse (RN) License. Master's degree required with Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage & Family Therapist (LMFT). Valid MS Driver's License Required.

Care Manager II (Social Work): Current state's LMSW or LCSW license.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Vice President, Quality Improvement (A designee or designees who can respond to issues involving systems and reporting, Member Encounter Data, Grievances and Appeals, quality assessment, Member services, Provider services, EPSDT services management, Well-Baby and Well-Child Care assessments and immunization services, Mental Health, medical management, Care Management, and management of any other services rendered under this Contract.)
Description of Position: Oversee all related activities for the Quality Improvement functions. Lead and direct process improvement activities for more efficient and streamlined workflow. Oversee the business processes related to risk adjustment and quality improvement for assigned products and plans.
Description of Responsibilities of Position: Responsible for all activities related to National Committee for Quality Assurance (NCQA) Accreditation and/or Healthcare Effectiveness Data and Information Set (HEDIS) performance ensuring highest level of accreditation. Manage all aspects of HEDIS improvement activities, including outreach, incentives, data integrity and chart review. Review and implement new technological tools and processes and foster team concept with internal and external constituencies. Present results of improvement efforts and ongoing performance measures and recommend actions plans to senior management. Research and incorporate quality improvement best practices into operations. Organize and control activities, methods, and procedures to achieve business objectives. Formulate and establish policies, operating procedures, and goals in compliance with internal and external guidelines. Manage and ensure compliance of EPSDT program as well as compliance and turnaround time of grievances and appeals.
Minimum Experience Required: 10+ years of healthcare operations experience, including quality improvement and NCQA accreditation experience. Experience managing acquisition and integration of external data sources. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff. Familiarity with running Risk Adjustment prospective and retrospective programs preferred
Skills Required: Outstanding leadership and communication skills. Thorough understanding of healthcare quality measures and best practices. Excellent written and verbal communication skills. Ability to pay close attention to detail. Ability to run Risk Adjustment prospective and retrospective programs preferred
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Bachelor's degree in Nursing or related clinical field or equivalent experience. Master's' degree preferred.
Are there any professional licenses or certifications required for this position? **[ ] Yes [X] No** **If yes, list below:** RN license and Certified Professional in Health Care Quality preferred.
Are there any continuing education requirements for this position? **[ ] Yes [X] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: PCMH Director (Sufficient support staff to conduct daily business in an orderly manner)
Description of Position: The PCMH Program Director is responsible for leading and overseeing all aspects of Patient-Centered Medical Home (PCMH) program for Magnolia's PCMH network in Mississippi. As part of the Provider Network Management Team, the PCMH Program Director works cross-functionally to effectively engage PCMH Primary Care Providers to improve overall population health and stability and decrease the healthcare cost curve. The PCMH Program Director ensures that PCMH-enrolled practitioners become active participants in managing their patient population through risk stratification, appropriate planning, and allocation of resources to meet the patient's needs.
Description of Responsibilities of Position: Responsible for building relationships with network providers and championing the PCMH Model in all PCP and PCMH practices. Builds a solid professional relationship with all assigned PCMH offices and is proficient and knowledgeable about the PCMH model. Communicates regularly with the Provider Practice Senior Leadership on the operational issues/concerns and barriers identified from their field work with PCMH practices. Recruits and assists qualified, ready, network providers in transforming to a PCMH model of care. Ensures that PCMH practices maintain external recognition from an accrediting body that attests to their capacity to fully execute the PCMH model. Evaluates the performance of PCMH practices in the Network and creates corrective action plans with PCMH practices that are failing to meet functionality or achieve mutually agreed upon goals and objectives. Collaborates with statewide efforts for the advancement of the PCMH model, including CHCAMS, DOM, and others. Develops educational conferences, workshops, and engagement materials for the PMCH program aimed at PCMH Providers. Develops materials to assist in the members understanding of PCMH and their rights and responsibilities as members of a PCMH. Works with others at Magnolia and statewide stakeholders to design PMCH programming to close health equity gaps and address SDOH. Develops and revises Magnolia's PCMH program and its implementation. Contributes to VBP strategies and contracting as it relates to PCMH practices. Translates the concepts of VBP and Total Care and Cost Improvement concepts with PCMH practices in the network. Contributes to Magnolia's population health management and subsequent bending of healthcare cost curve through engagement with PMCH practices.
Minimum Experience Required: Minimum 5+ years of related experience working in a PMCH or Patient Care Collaborative or in Case Management or Disease Management.
Skills Required: Must be knowledgeable of the PCMH model. Thorough understanding of local Provider landscape in Mississippi. Excellent written and verbal communication skills, including provider training and customer service.
Are there any educational requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Graduate level degree in a health care discipline or equivalent work experience.
Are there any professional licenses or certifications required for this position? **[X] Yes [ ] No** **If yes, list below:** Current Registered Nurse license.
Are there any continuing education requirements for this position? **[X] Yes [ ] No** **If yes, list below:** Continuing education units (CEUs) as required by license.
Any additional information relevant to this position: N/A

[END OF RESPONSE]

4.3.3.3 ADMINISTRATIVE REQUIREMENTS

The Offeror will verify and answer the following:
1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.
2. In a narrative no longer than two (2) pages, the Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives.
The Offeror must complete the appropriate attestation in Appendix H as its response to Question 1.

Please see **Attachment 4.3.3.3 Appendix H** for a signed attestation regarding Magnolia's Administrative Office location within 15 miles of DOM's Central Office.

Maintaining Administrative Records and Data

Magnolia maintains detailed records evidencing the administrative costs and expenses incurred pursuant to:

- The contract between Magnolia and DOM
- Member enrollment status
- Provision of covered services
- Complaints
- All relevant medical information relating to Members, for the purpose of audit and evaluation by DOM and other Federal or State agencies

In accordance with our established policy on Records Management, administrative records and data are maintained for the purpose of audit and evaluation by DOM and other federal and/or state agencies. All records, including training records, pertaining to the contract between Magnolia and DOM, are maintained and available for review by authorized Federal and/or State agencies during the entire term of the contract, and for a period of 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 other legal action is in process, such records are kept for a period of 10 years or until all issues are finally resolved, whichever is later. All records pertaining to the Contract must be readily retrievable within three business days for review at the request of DOM and its authorized representatives at no cost to DOM or its authorized representatives.

All records are maintained at Magnolia's central office in Mississippi during the entire term of the contract. Our policy establishes that should Magnolia close its central office at any time during the period of time for which records must be kept in Mississippi, such records will be kept at a site and location designated by Magnolia and approved by DOM. Records are retained only as long as required for Magnolia's business operations or archival purposes, or to satisfy specific requirements including, but not limited to, accounting, audit, legal, and tax requirements, after which time the records must be promptly destroyed.

Process and Timeframe for Retrieving Records

Through our more than 11 years working with DOM to serve Mississippians, Magnolia has established reliable processes to retrieve records requested by DOM or other State external review representatives in a timely manner.

Acknowledging Receipt. Magnolia acknowledges receipt of DOM's (or other State or external review representatives') written, electronic, or oral requests for assistance no later than one business day from receipt. We immediately, without unreasonable delay, acknowledge urgent requests and give such requests priority. If the request is received from DOM or other State or external review representative in writing or electronically, Magnolia will acknowledge receipt in the same manner the request was received, either in writing or electronically. If the request was received orally, Magnolia will acknowledge receipt of the request orally and immediately follow up with a written or electronic acknowledgment.

Completing Requests. Magnolia uses a dedicated tracker to manage all issues and requests from DOM or other State or external review representative, including requests for records. Once we receive the request, the Lead Compliance Coordinator enters the information into the tracker, acknowledges receipt in accordance with the process above, and sends the request to the appropriate business owner(s) to review and process. Information captured includes:

- Date the request was received
- Requestor (who sent the email)
- Description, including any questions, action items, and details from associated attachments
- Type of state issue (Member or Provider)
- Responsible party: the individual who is responsible for completing the request
- Internal date: date that deliverable is due to Compliance
- Date response received from business owner
- The response and associated attachments
- Due date: date the deliverable is due to the requestor
- Submission date: when was the deliverable sent to the requestor
- Submitted by: individual who submitted the deliverable to the requestor
- Disposition: Open, Pending, or Closed

We complete requests within five business days of receipt, unless otherwise specified by DOM. The Lead Compliance Coordinator or designated backup reviews our internal tracker daily to ensure all records are submitted in a timely and compliant manner. Our completed requests include a detailed completion summary of our action and resolution, within the specifications requested by DOM.

4.3.3.3 Administrative Requirements (Marked) – 5 points

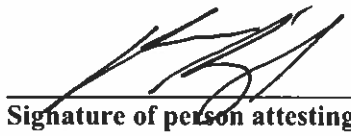
Offeror attests to the following:

1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid's Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.

Magnolia Health Plan, Inc.
Name of Offeror

Aaron Sisk
Printed name of person attesting for Offeror

President and CEO
Title of person attesting for Offeror


Signature of person attesting for Offeror

2/24/2022
Date

[END OF RESPONSE]

4.3.3.4 STAFFING

The Offeror will describe the following:
1. Describe the entity's staffing ratios per enrolled Member, including the number of Member services call center employees and nurse advice line employees, as well as supervisor to staff ratios. Describe the job qualifications for Member services call center employees, as well as training and education that the Offeror will provide to these employees.

Member Services Staff

Magnolia provides a best-in-class Member Services team, ensuring our qualified staff can quickly, accurately, and compassionately respond to requests, questions, and concerns from our Members and their families. The table below provides staffing information for our Member Services Call Center staff and Nurse Advice Line partner, as of January 2022:

Magnolia Member Services: Fast Facts	
Member Services Call Center Staff Ratio to Enrolled Members	[redacted]
Nurse Advice Line Staff Ratio to Enrolled Members	[redacted]
Number of Member Services Call Center Staff	[redacted]
Number of Nurse Advice Line Staff	[redacted]
Member Services Supervisor to Staff Ratio	[redacted]
Member Services Calls Received in 2021	[redacted]

Member Services Job Qualifications

Role	Job Qualifications
Member Services Manager	3+ years of customer service experience in a call center environment. Previous experience as a lead in a functional area, managing cross-functional teams on large scale projects or supervisory experience including hiring, training, assigning work, and managing the performance of staff. High school education or equivalent. Bachelor's degree preferred.
Lead Customer Service Representative	2+ years of experience in Medicare, Medicaid managed care, or insurance environment preferred. 4+ years of combined customer service and call center experience. Knowledge of managed care software systems preferred. High school diploma or equivalent. Associate's degree and claims processing, billing, and/or coding experience preferred.
Customer Service Representative I	1+ years of call center customer service experience, or 2+ years of customer service experience, preferably in a healthcare or insurance environment. High school diploma or equivalent.
Customer Service Representative II	1+years of experience in Medicare, Medicaid managed care or insurance environment preferred. 2+ years of customer service experience in a call center environment. Knowledge of managed care programs and services preferred. High school diploma or equivalent. Associates degree and claims processing, billing and/or coding experience preferred.

Nurse Advice Line Job Qualifications

Role	Job Qualifications
Director, Call Center Operations	Current state's RN license. Bachelor's degree in Nursing, related field, or equivalent experience. 7+ years of combined clinical and call center management experience. Experience in behavioral health and Medicaid managed care preferred. Master's degree preferred.
Telehealth Registered Nurse	A graduate certificate from an accredited nursing program. Current RN license in the state of residence. 3+ years combined experience in pediatric obstetrics, home health, community health, school nursing, or emergency nursing. Five years experience is strongly preferred. Strong computer skills including experience with Microsoft office or data entry systems. Must possess and demonstrate strong abilities in data entry, typing, call documentation, and customer service skills including active listening. Telephonic triage or managed care setting experience preferred. Bilingual in Spanish is highly preferred.
Supervisor, Call Center Operations (Clinical)	Associate's degree in Nursing. Bachelor's degree preferred. Active unrestricted RN license. Bilingual in Spanish or another language preferred. 3+ years of direct care clinical experience in healthcare-related field and/or call center environment. Strong computer skills, including experience with Microsoft office and/or data entry systems. Previous experience as a lead in a functional area or managing cross-functional teams on large scale projects.
Supervisor, Call center Operations (Non-Clinical)	Bachelor's degree in Social Work, Behavioral Health, or in a related field or equivalent experience. Bilingual in Spanish or another language preferred. 5+ years of related experience in healthcare, managed care, business administration, or call center management. Strong computer skills, including experience with Microsoft office applications and/or data entry systems. Previous experience as a lead in a functional area or managing cross functional teams on large scale projects.
Customer Care	High school diploma or equivalent. 2+ years of customer service experience, preferably in a healthcare call center

Professional	environment. Experience with Microsoft Office applications and data entry systems. Experience with data entry and call documentation. Strong verbal and written communication skills. Bilingual in Spanish preferred.
Manager, Call Center Operations	Must have one of the following: RN, Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Psychologist, or Licensed Independent Substance Abuse Counselor. 5+ years of relevant clinical and administrative experience. Previous experience as a lead in a functional area, managing cross functional teams on large scale projects or supervisory experience including hiring, training, assigning work, and managing the performance of staff. Call Center experience preferred.
Lead, Call Center Operations	Associate's degree in related field or equivalent experience. Bachelor's degree preferred. 4+ years of customer service or health care related experience. Experience with multiple system applications, including call center and/or health care databases. Experience in health care setting and knowledge of medical terminology preferred. Call center and lead/supervisory experience preferred.

Member Services Training and Education. Magnolia has established a robust training and education program for our Member Services staff. Member Customer Service Representatives (CSRs) are empowered to engage Members in their healthcare during every call, thereby improving health literacy and promoting personal responsibility.

Upon hire, Magnolia's Member Services Call Center staff received a two-week interactive training that details how to respond and answer Member inquiries. Trainings are provided via face-to-face interactions, educational newsletters, as well as Training Updates sent via email for *"Late Breaking News"* articles; Provider Bulletins; State Plan Amendments, and Administrative Code Filings. Training topics include but are not limited to:

- **Fundamentals.** Customer service tools, including active listening and use of the language services line; conflict resolution; review of internal departments and warm transfers, including interfacing with Care Management staff; arranging interpretation and communication support services; ethics and confidentiality of Member information, including HIPAA; claims and prior authorizations; web tools and mobile apps; emergency management protocols; and other topics.
- **Program information.** Including differences between MSCAN and CHIP benefits and services; appropriate service utilization; review of benefits, including self-direction; Member materials and education; functions of Care Management and other clinical programs and how Members can self-refer; Member Rights and Responsibilities; reporting Fraud, Waste, and Abuse; and other topics.
- **Job functions.** Warm transfer protocols and escalating urgent or emergent medical or BH crisis calls; functions of the NAL and BH/SUD lines; helping Members select PCPs; how to explain the prior authorization process; impacts of health literacy on health inequities and Member CSRs' role in helping Members understand how to access care and practice self-care; using DOM approved interactive scripts during Member calls; and how to document a caller's satisfaction at call conclusion.
- **Cultural Competency.** Upon hire and at least quarterly, we require all Member CSRs to complete training based on the Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) as developed by the United States Department of Health and Human Services, Office of Minority Health. Magnolia's training also includes disability sensitivity training, the use of People-First Language, Americans with Disabilities Act, Poverty Simulation, Disability Sensitivity, Adverse Childhood Experiences, and Person-Centered Thinking. In addition, we provide Unconscious Bias and health equity training. Annually, we host trainings provided by Mississippi disability advocacy groups to provide staff with locally-focused disability sensitivity training.
- **Care Management (CM) Training.** Our call center training includes an in-depth review of all CM programs and functions, including how Members can access and self-refer for CM services, such as our Maternity Health or Diabetes Management Programs, and how Providers can refer Members for those services using CM referrals forms located on the Provider Portal.
- **SDOH Mini-Screening Training.** We will train Member CSRs to conduct SDOH Mini-Screenings to identify Members with barriers and to search our Community Resource Support Database to provide access to community support services. For more complex SDOH, Member CSRs will refer Members to our Social Services Specialists to remove these barriers.

Magnolia's dedicated staff are prepared to serve our diverse Membership, including Members who require

behavioral health services or for whom English is not their primary language, in a culturally responsive manner. Our ISO-certified, award-winning telephonic language subcontractor, Voiance, provides interpretation services through trained professionals in over 200 languages. Voiance provides language interpretation service to Members during all "live" operating hours.

We train Member CSRs using Choose Tomorrow and Mental Health First Aid training curricula so that they can quickly identify triggers indicating a Behavioral Health Crisis Call or other urgent or emergent situation. CSRs listen for triggers such as key emergency words and phrases, Member voice volume and tone, and other indicators of stress. As needed, any Member Services staff member can warm transfer Members to outside entities as needed, such as 911 and Provider offices. For calls that need require Care Manager support, Member Services staff can send messages to Care Managers through our Customer Relationship Management system or email them with any details needed to best assist the Member before staff completes a warm transfer.

To ensure Member Services CSRs are ready to serve Magnolia Members, trainers monitor and provide feedback to staff on Member calls they must handle during training. To test their knowledge, new Member Services staff must pass a final exam upon completion of training. Magnolia trainers monitor quality scores of new hires on a monthly basis for at least 90 days post training and work with the new hires to address any opportunities for improvement. Once new team Members begin handling Member calls, Magnolia's Quality team completes documented side-by-sides during live calls and provides feedback to enable continuous quality improvement. Member Services Call Center staff are required to maintain a passing score of 90%.

In accordance with Section 5.1.5 of Appendix A, Draft Contract, we provide ongoing training to update staff on new program developments and requirements, including system updates, process changes, "*Late Breaking News"* articles, State Plan Amendments, Administrative Code Filings, the Provider Billing Handbook, and MississippiCAN and CHIP requirements. Through this ongoing training, we ensure that staff receives training at least quarterly. We will deploy a new tool, Q Mindshare, to enhance ongoing training, improve CSR engagement, and check for understanding of new announcements and developments.

We will continue to submit all trainings to DOM through quarterly reports that detail the trainings conducted, topics covered, and the number and positions of staff completing the trainings.

2. Describe the entity's staffing ratios per enrolled Provider, including the number of Provider services call center employees, as well as supervisor to staff ratios. Describe the job qualifications for Provider services call center employees, as well as training and education that the Offeror will provide to these employees.

Provider Services Call Center Staff

Magnolia offers a Provider Services Call Center team that is well informed and fully qualified to ensure Providers receive prompt, accurate, and informative responses to their inquiries.

The table below provides staffing information for our Provider Services Call Center staff as of January 2022:

Magnolia Provider Services: Fast Facts	
Provider Services Call Center Staff Ratio to Contracted Providers	[redacted]
Number of Provider Services Call Center Employees	[redacted]
Provider Services Supervisor to Staff Ratio	[redacted]
Provider Services Calls Received in 2021	[redacted]

Provider Services Call Center Job Qualifications

Role	Job Qualifications
Provider Services Manager	3+ years of customer service experience in a call center environment. Previous experience as a lead in a functional area, managing cross functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff. High school education or equivalent. Bachelor's degree preferred.
Lead Provider Customer Service Representative	2+ years of experience in Medicare, Medicaid managed care or insurance environment preferred. 4+ years of combined customer service and call center experience. Knowledge of managed care software systems preferred. High school diploma or equivalent. Associate's degree and claims processing, billing and/or coding experience preferred.
Provider Customer	1+ years of call center customer service experience, or 2+ years of customer service experience, preferably in a

Service Representative I	healthcare or insurance environment. High school diploma or equivalent.
Provider Customer Service Representative II	1+years of experience in Medicare, Medicaid managed care or insurance environment preferred. 2+ years of customer service experience in a call center environment. Knowledge of managed care programs and services preferred. High school diploma or equivalent. Associates degree and claims processing, billing and/or coding experience preferred.

Provider Services Training and Education. Magnolia's highly trained Provider Services Call Center staff are committed to exceeding our customers' expectations. Our Provider Services Call Center is based in Mississippi, and we handle 100% of our calls with Mississippi-based staff.

All newly hired Provider Services Call Center staff will receive training from and will shadow our Mississippi-based Customer Services Trainer. All Mississippi Provider CSRs will undergo new hire training that includes:

- **Fundamentals** include active listening, use of the language line, conflict resolution, review of internal departments and warm transfers, including interfacing with care management staff, arranging interpretation and communication support services, claims and prior authorizations, online tools and mobile applications, subcontractor roles, and responsibilities, and emergency management protocols
- **Program Information** including Medicaid 101, MSCAN and CHIP, Provider Billing Handbook, accessing appropriate services, review of benefits, Provider materials, and education, an overview of our Provider Engagement Model, how to refer Providers to the Fraud, Waste, and Abuse Hotline, and how Providers can refer Members for care management and other clinical programs
- **Job Functions** include assisting Providers with Member eligibility status, prior authorization and referral procedures, claims payment, out-of-network services coordination, disputes and grievances, and use of the Provider Portal. CSRs will be trained on when they need to escalate a Provider concern to the correct department via the CRM system.
- **Cultural Competency** based on our Cultural Competency Plan, the Culturally and Linguistically Appropriate Services (CLAS) Standards as developed by the United States Department of Health and Human Services (HHS), Office of Minority Health, and training materials from Mississippi agencies and organizations such as the Mississippi Department of Health and the University of Southern Mississippi. Our cultural competency training program will address both statewide and regional cultural sensitivity considerations through the following topics:
  - Cultural Competency Defined
  - Health Literacy Defined
  - Limited English Proficiency
  - Becoming Culturally Competent
  - Cultural Diversity in Mississippi
  - Translation and Interpretation Services
  - Disability Sensitivity and Awareness
  - Disability Etiquette
  - Cultural Competency Compliance
  - Cultural Competency Resources

Ongoing training topics will be held on at least a quarterly basis and will include refreshers on excellent customer service, critical thinking skills, effective communication, conflict resolution, managing emotions, empathy, self-awareness, and global mindset. Training will include subjects identified as trends through call quality audits, escalated calls, and team lead assistance calls. Additionally, we will conduct regular training huddles to communicate "Late Breaking News"; Provider Bulletins; updates related to State Plan or CHIP State Health Plan Amendments or Administrative Code filings; system enhancements; benefit, billing, and claims-related updates; and changes to work processes or call scripts. In addition to team huddles, our Call Center Learning Software will allow us to send role-specific updates to PSCC staff and verify understanding of those updates through knowledge checks. We will continue to submit quarterly reports to DOM detailing the Provider Services Call Center staff trainings conducted, topics covered, and the number and positions of staff completing the trainings.

To ensure Provider CSRs are ready to serve Magnolia Providers, trainers monitor and provide feedback to staff on Provider calls they must handle during training. To test their knowledge, new Provider CSRs must pass a final exam upon completion of training. Magnolia trainers monitor quality scores of new hires on a monthly basis for at least 90 days post-training and work with the new hires to address any opportunities for improvement. Once new team Members begin handling Provider calls, Magnolia's Quality team completes documented side-by-sides during live calls and provides feedback to enable continuous quality improvement. Provider CSRs are required to maintain a passing score of 90%.

3. Describe staff who will be assigned to the quality management program and their qualifications.

Quality Management and Improvement Staff

Magnolia's talented Quality Management and Improvement staff are well trained and versed in the most up-to-date quality standards, requirements, and best practices in Medicaid and CHIP. Our team is comprised of the following:

Magnolia Quality Management Team Member	Qualifications and Experience
Chief Medical Director	Medical Doctor or Doctor of Osteopathy, board-certified in a specialty recognized by the American Board of Medical Specialists. Volunteer patient care required. Previous experience as Medical Director is preferred.
Vice President of Quality	Bachelor's degree in Nursing or related clinical field or equivalent experience. Master's' degree preferred. 10+ years of healthcare operations experience, including quality improvement and NCQA accreditation experience. Experience managing acquisition and integration of external data sources. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff. RN license and Certified Professional in Health Care Quality preferred.
Director of Quality Improvement	Five years clinical experience in an acute care setting; Seven plus years experience in quality management/improvement in a health care setting; two years work experience in a managed care environment; three years management experience in quality management/ improvement in a health plan setting. Bachelor's degree in Nursing, related clinical degree or equivalent experience. Master's preferred. Current state's RN license preferred. Certified Professional in Health Care Quality preferred.
Senior Manager, Quality Improvement	Bachelor's degree in related field or equivalent experience. 3+ years clinical, quality management or healthcare related experience and one year of recent quality improvement and supervisory experience in a healthcare environment, preferably managed care. Current state registered nursing license preferred. Certified Professional in Healthcare or other licensed clinical experience preferred.
Manager, Quality Improvement, Accreditation	Bachelor's degree in health related field. 4+ years of quality improvement. Supervisory experience in a healthcare environment preferred. Nursing background preferred., preferred with significant exposure to accreditation processes and/or delegation oversight. Prior NCQA Health Plan Accreditation Project Management experience was highly desirable. Strong project management, analytical, written, and verbal communication skills. Proficiency in Microsoft applications. Certified Professional in Healthcare or quality improvement certification preferred.
Manager, Quality Improvement, HEDIS	Bachelor's degree in related field or equivalent experience. 3+ years clinical, quality management or health care related experience and 1 year of recent quality improvement and supervisory experience in a healthcare environment, preferably managed care. Current state registered nursing license preferred. Certified Professional in Healthcare or other licensed clinical experience preferred.
Quality Improvement Coordinators	3+ years of clinical, quality improvement or health care experience. 2+ years of experience in quality function in a healthcare setting. Bachelor's degree in Nursing preferred. LPN, LVN, RN, PA, or LCSW license preferred. CPHQ (Certified Professional in Healthcare Quality) preferred.
Quality Improvement Specialists	2+ years of data management, including reporting, project management or quality improvement experience. Associate's degree in related area or equivalent experience.
Child Health Coordinator	1+ years of customer service experience. Thorough understanding of diverse Member backgrounds and needs. Excellent written and verbal communication skills. Strong organizational skills. High school diploma or equivalent.
Quality Practice Advisor	Bachelor's degree or equivalent required. 3+ years of experience in HEDIS record collection. One of the following required: CCS, LPN, LCSW, LMHC, LMSW, LMFT, LVN, RN, APRN, HCQM, CHP, CPHQ.
Business Analyst /Healthcare Analyst	Experience with HEDIS, NCQA, Medicare Star Rating System, QRS, or other quality measures preferred; Quality auditing or analysis of call center performance preferred; Experience with data mining, population health, and statistical modeling preferred. Bachelor's degree in business, economics, statistics, mathematics, actuarial science, public health, health informatics, healthcare administration, finance or related field or equivalent experience. 2+ years of experience.

Quality Management Committee (QMC). Magnolia's QMC is comprised of 28 voting members who bring a wide range of experience and are fully committed to improving the delivery and quality of services to MSCAN and CHIP Members.

In accordance with Section 8.13 of Appendix A, Draft Contract, the QIC includes all required positions and representatives. The QIC includes five external Providers who bring expertise in Pediatrics, Family Medicine, Psychiatry, and Nursing; Magnolia's Medical Director; representatives from clinical and non-clinical areas of

the health plan; and a senior executive who is responsible for program implementation.

4. Describe the role of the Care Manager and Care Management Team. Describe the minimum level of education, training, and experience required for care managers. Describe the entity's approach to ensure that care managers are culturally competent and understand the unique needs of Members, including how a Member's initial risk level and needs may factor into care manager assignment. A ratio of care managers to Members is described in Appendix A: Draft Contract: Section 7: Care Management. Describe the Offeror's ability to reach this ratio. Also provide an overview of the training and education the Offeror will provide to Care Managers.

Magnolia's Care Management Team

All of Magnolia's Care Management (CM) staff will be locally based in Mississippi. Our CCO CM staffing model is based on a high-touch approach and includes regionally located CM teams available to provide face-to-face support and coordination with other entities, Providers, and systems of care involved in the care of MSCAN and CHIP individuals and families. Our CCO CM Teams will include local, boots-on-the-ground staff comprised of Clinical Care Managers, Program Coordinators, Program Specialists, Community Health Workers (CHWs) in addition to Directors, Managers, and Supervisors. We will submit our CM hiring and development plan as part of our Care Management System proposal within 60 calendar days of contract award. Roles and minimum education, training, and experience for CM positions are outlined in the table below:

Magnolia CM Team Member	Role	Minimum Education, Training, and Experience
Care Manager (RN)	The Care Manager is a driver within Magnolia's Population Health Management approach. The Care Manager works to support the whole Member, including medical, behavioral health, and SDOH needs. The Care Manager empowers, engages, and encourages our Members through education, phone calls, attending physician visits, and other forms of engagement.	Licensed nurse, CCM preferred. 2+ years of CM experience and recent nursing experience in an acute care setting, particularly in medical/surgical, pediatrics, or obstetrics. 2+ years of related experience in a managed care environment. At least one Care Manager is specially trained on serving the Native American community.
Care Manager (Social Work)	The Behavioral Health Care Manager is a driver within Magnolia's Population Health Management approach. The Care Manager works to support the whole Member, with a focus on behavioral health needs. The Care Manager empowers, engages, and encourages our Members through education, phone calls, attending physician visits, and other forms of engagement.	Master's degree in BH and an unrestricted license as an LCSW, LMFT or LPC, or a PhD, PsyD or RN with experience in psychiatric, substance use disorder, and/or medical health care settings. Knowledge of utilization review procedures and familiarity with BH community resources. 3-5 years of CM and or Utilization Management (UM) experience.
Social Service Specialist (SSS)	Social Service Specialists are focused on managing the Social Determinants of Health with our Members. SSS works in tandem with our CMs in order to manage the whole Member and to meet Members where they are.	Bachelor's degree in social work, nursing, health, behavioral science, or equivalent experience. 2+ years of community experience in directly managing and integrating the social/ community needs of Members. Experience in a managed care environment is preferred.
Community Health Worker (CHW)	CHWs are our boots-on-the-ground team that works across Mississippi to locate and engage difficult-to-reach Members. CHWs are all certified in community health. They deliver education and resources in the community such as NICU Kits, Sickle Cell Kits, scales to congestive heart failure Members, and food when there is an urgency. This team also leads the Baby Shower Events, Adopt a School Events, and more.	High school diploma or equivalent. 2+ years of social services, community outreach, or education experience. Bilingual ability or Certified Peer a plus.
Program Coordinator (PC)	Program Coordinators, who are dedicated to the phone queue, are the frontline for taking Member calls with any type of medical or behavioral issues and SDOH. PCs are cross-trained to support Care Managers, SSS, and CCRs. PCs assist in scheduling transportation, finding the Member medical homes, and setting appointments. PCs conduct outreach campaigns for HEDIS and vaccination programs and so much more.	High school diploma or equivalent; 2-3 years managed care or physician's office experience. Customer service, utilization review or claims processing experience in a managed care environment and operation of office equipment such as a personal computer.
Health Coach	Provide telephonic disease management services to individuals with behavioral health issues, including stress and depression. Services may include educating Members, coaching and coordinating care.	Licensed clinical staff (respiratory therapist, certified diabetes educator, registered dietician, exercise physiologist) with at least one year of experience in a clinical setting for DM programs. For tobacco cessation, Health Coaches are certified through a program based

Magnolia CM Team Member	Role	Minimum Education, Training, and Experience
		on the University of Arizona's tobacco cessation certification program.

Care Manager Recruitment

Magnolia's organizational philosophy is centered on hiring and staffing local, qualified Care Managers with experience serving populations similar to individuals eligible for MSCAN and CHIP. Our Care Manager job descriptions include a summary of the role, responsibilities, and required education, experience, and desired skills for the position we are recruiting for to assist us with finding qualified CM staff candidates. As part of our hiring process, our Talent Acquisition team screens all potential candidates against job qualifications and position requirements to ensure we have qualified candidates for consideration. We are intentional in our recruitment and hiring practices, and our diversity and inclusion policies will be followed by all hiring managers within the organization. Our approach for the recruitment and hiring of local CM staff includes:

- **Promote from within Magnolia**. We leverage word of mouth and our employees as a recruitment strategy. We find this to be an impactful recruitment strategy since internal staff have a good understanding of the roles and responsibilities of the position and individuals who may be a good fit for the job. Recognizing the value of this recruitment strategy, we will offer referral bonus programs for our employees.
- **Post Job Openings Online**. Magnolia recruits candidates through multiple channels, including posting job openings on our website and at other sites such as LinkedIn and the Mississippi Board of Nursing.
- **Professional Organizations and Colleges and Universities**. Magnolia leverages professional clinical organizations such as the Mississippi Nurses Association and local colleges and universities, such as Hinds Community College, Jackson State University, and Mississippi College, to recruit CM staff. We regularly attend college job fairs to recruit CM staff.

Retention Strategies

To address and prevent turnover, Magnolia employs a comprehensive retention strategy based on best practices to retain knowledgeable and experienced CM staff, including:

- **Initial Interview.** Testing of probable candidates for basic computer skills, critical thinking, ethics, empathy, and commitment to our mission, making a difference in our Members' lives.
- **Career Pathway.** Identified career goals CM staff wishes to achieve, with pathway development in collaboration with CM staff and leadership.
- **Flexible Schedules.** Care Managers can work a flexible schedule. For example, to successfully reach Members after normal business hours, we will allow a later start time for some of our CM staff. For nearly the past two years, our workforce has demonstrated resilience, courage, and leadership as we've navigated the pandemic. This situation has challenged us to think and work differently, enabling us to test innovative ways to work and collaborate. Care Managers, like all our employees, are empowered to work with their leaders to do their best work in the way they work best. This may include flexible start and end times and fully remote or hybrid working arrangements in order to most efficiently meet Members right where they are in our Mississippi communities.
- **Tuition and License Reimbursements.** After one complete year of regular full-time employment, employees in good standing will be eligible for tuition reimbursement, as well as other specified costs, such as textbooks and lab fees. All clinical staff are reimbursed for their professional license renewals.
- **Continuing Education Support.** Clinical staff is encouraged and supported in obtaining certifications, including training courses, certification exams, and tuition reimbursement. For example, we financially support ongoing professional development and help prepare our staff by teaching classes and reimbursing our Care Managers to take the Certified Care Manager (CCM) exam to obtain their CCM credential. Additionally, we will work with the Mississippi Department of Health (DOH) Lead Screening Council to certify our CHWs on lead screening so we can provide evaluations and assessments for our Members. Similarly, as part of our commitment to professional and career path development, we will also work with the Mississippi DOH Kids First program to certify our CHWs in car seat safety and installation. We will

financially support our CHWs to participate in the three-day training and certification.

- **Continuing Education Units (CEUs).** We offer CEUs and training opportunities for our clinical CM staff at no cost through our parent company's established program. The program is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) and provides continuing interprofessional education through research-informed educational activities, equipping Providers to deliver current therapies and better health outcomes. As part of the program, our CM staff may participate in interprofessional educational activities through a series of monthly clinical rounds that include obstetrical rounds, sickle cell disease rounds, diabetes rounds, NICU rounds, and SUD in pregnancy rounds designed to educate Care Managers on current care management and clinical best practices for a variety of chronic disease topics.
- **Culture of Transparency.** We provide a culture of transparency supported by our Leadership Team that for example, will include a comment and suggestion box that promotes a positive work environment.
- **Culture of Connection**. Our culture of connection ensures CM staff have a connection to the community and populations they are serving, which impacts employee satisfaction.

Ensuring a Culturally Competent and Responsive Care Management Team. Magnolia's culture includes linguistic, socio-economic, and disability-related needs plus beliefs, expectations, assumptions, and preferences due to race/ethnicity, race, religion, or cultural background and we are committed to ensuring all of our CM staff are culturally competent and aware of implicit bias.

Comprehensive Training. Magnolia trains all CM staff using a comprehensive curriculum that includes assessment of cultural considerations and how to incorporate them into care planning. We have a Diversity and Inclusion Committee, and we require all staff to take Cultural Sensitivity Training. We work with and engage our Provider partners and experts from the community, such as the Mississippi Coalition for Citizens with Disabilities, the National Alliance of Mental Illness, and the Ryan White Center for HIV/AIDS to ensure our training is comprehensive and effective. All CM staff are also trained in Person-Centered Thinking training. Additionally, to meet the needs of our Members that speak a language other than English, all CM staff are trained on the use of our language assistance line and in-person interpreter services.

Use of Evidence-Based Practices. CM staff trained in cultural sensitivity and unconscious bias use evidence-based practices such as Motivational Interviewing (MI), Trauma-Informed Care (TIC), Person-Centered Care Planning, and the Strengths-Based Model to engage with Members. CM staff meet Members and families where they are by embedding staff in the community and targeting information and interventions to the Member's willingness to engage, level of health literacy, degree of trauma, disparities endured, and cultural preferences.

Hiring from and Contracting within Local Communities. Magnolia's hiring practices are inclusive and non-discriminatory, including recruiting and retaining a diverse workforce that attracts individuals from diverse cultural backgrounds, who speak prevalent languages, and with relevant life experiences. This includes bilingual staff and staff with direct experience serving pregnant women and children, individuals with disabilities, behavioral health and substance use disorders, children, youth, and young adults involved in the child welfare system, and medically and socially complex individuals.

Measure Up, Top 20 Fortune 500 Companies for Diversity and Inclusion. Magnolia's parent company, Centene Corporation, ranked 2nd among the Top 20 companies with the best diversity and inclusion overall on Fortune magazine's 2021 ranking of the most progressive companies in diversity and inclusion. Companies are ranked based on how they address 14 key measures, including the percentage of minorities on the board, the percentage of employees that are women, and the percentage of employees with disabilities, among others.

Care Manager Assignment. A defining element of Magnolia's person-centered CM program is one Care Manager working with a Member for all needs – physical health, behavioral health (BH), social support services, and coordination of covered services. The Care Manager is the Member's primary point of contact and performs screenings and assessments, develops and monitors care plans, provides educational resources, provides warm hand-offs and closed-loop referrals, and makes appropriate care and service connections.

Depending on the Member's primary diagnoses, the Member will either be assigned to a registered nurse for physical health diagnoses or a licensed BH clinician for BH diagnosis. Should a Member have co-morbid physical and BH conditions, the appropriate Care Manager is assigned based on the prevalent needs and preferences of the Member. Additionally, all Foster Care children and youth will be assigned to a Care Manager dedicated to foster care. As part of our ongoing training program, CM staff are crossed trained on physical health, behavioral health, social determinants of health (SDOH), and health equity. Each Care Manager is supported by our CCO Collaborative Care Team representing all Member needs, including SDOH. In addition to the primary Care Manager, Collaborative Care Teams may be comprised of nurses, licensed BH clinicians, Medical Directors, Social Services Specialists, Program Coordinators, Health Coaches, and CHWs.

Ensuring Sufficient Care Management Staff. In alignment with our Member-centered approach of the Member having the right level of care at the right time for the right reason, Magnolia's Care Management Team is a wholly integrated team. Our skilled Population Health Management Team, all of whom support Care Management activities, includes Care Manager Nurses, a Behavioral Health Specialist, Social Workers, Program Coordinators, Community Health Workers, Disease Management Healthy Choice Nurses/Coaches, a Referral Specialist, UM Nurses, Concurrent Review Nurses, and Quality Review/Quality Health Check nurses. At any time, Magnolia typically serves between 3,000 and 4,000 Members who receive Care Management services. Our team of 120 Care Management staff enables us to ***exceed the 40:1 ratio***. As our membership evolves and grows over time, we regularly monitor staffing levels and ratios to ensure we continue to meet Member needs and comply with all DOM requirements.

Care Management Team Training and Education

Magnolia's approach to CM Department staff education and training is rooted in our expertise gained over the past ten years deploying CM training across 30 state Medicaid managed care programs. We design our training with the goal of providing optimal service and outcomes for Medicaid and CHIP populations. We specifically hire Care Managers who have a passion for serving vulnerable populations. Our goal is to train Care Managers who are then able to improve the Member's health status and enhance coordination of care to address the Member's broader social environment and stability.

CM Staff Training Topics and Curriculum

Our dedicated health plan Clinical Trainer, coupled with our parent company's nationwide training team, comprised of master's level prepared staff, have developed a comprehensive training curriculum for our Care Managers. CM training topics include:

- CM program and Care Manager responsibilities
- CM information systems, documentation, processes, workflows
- Covered benefits and services
- Disease Management
- SDOH and Health Equity Improvement Model
- Transitions of Care
- Motivational Interviewing
- Informed consent
- Abuse, Neglect, and Exploitation
- Social isolation and loneliness
- Trauma-Informed Care
- Suicide Prevention and Crisis Training
- Person-centered service planning
- Cultural competency
- Motivational Interviewing
- Mental Health First Aid
- Foster care stakeholders
- Zero Suicide and Counseling on Access to Lethal Means (CALM)
- Co-management of PH and BH conditions
- Poverty Training
- Managed Care 101
- Fraud, Waste, and Abuse

Care Manager Staff and Department Training

Magnolia employs best-practice adult learning principles and use varied training modalities to support diverse learning styles. Training modalities include in-person training, self-directed digital training, virtual instructor-led training, and training delivered by peers. We have designed innovative ongoing trainings based on micro-learning research, which delivers the curriculum in manageable "bite-size" pieces for those with limited time to complete longer education.

Onboarding. Magnolia provides four weeks of classroom training, which begins with new employee orientation, CM tools, best practice engagement techniques (e.g., motivational interviewing, recovery and resiliency model), and MSCAN and CHIP program information. Following classroom training, new CM staff participate in a minimum of four weeks of shadowing and mentoring with seasoned staff. New staff will be closely monitored and coached during this on-the-job training. Shadowing includes both observations of and supervised practice with the completion of health screenings and assessments.

Continuing Education and Ongoing Training. Continuing education and ongoing training ensure Magnolia CM staff continue to hone skills and keep abreast of new approaches, best practices, and policy developments both in Mississippi and nationally. We provide ongoing training at least quarterly. CM staff also receive annual Person-Centered Thinking and Trauma-Informed Care training.

Evaluating Training Competencies. All trainings include competency measurement assessments. Our initial curriculum contains knowledge transfer checks, including embedded quizzes, practice interviews with corrective instruction, formal testing, and critique of care plans and motivational interviewing skills.

Following the initial training, Magnolia monitors the ability of CM staff to integrate post-training knowledge into their practice through our preceptorship program and routine audits for the first 90 days. If post-learning assessments suggest gaps in knowledge transfer, the individual will be retrained and offered coaching. Once the individual has successfully demonstrated competence, CM Supervisors will monitor individual performance by conducting monthly quality performance audits, which will measure the performance related to the workflow process, timeliness, appropriateness of care plans, and contacts with children and their caregivers.

To ensure that all CM staff stay current on training requirements, our CM and Human Resources Departments maintain documentation of orientation, training dates, attendance, and post-learning assessments for CM staff. If an individual fails to successfully complete required ongoing training, the Clinical Trainer electronically notifies the individual and his or her Supervisor to perform follow-up and completion. Supervisors will monitor knowledge transfer via coursework quizzes, monthly audits, and review of care plans. Our online training courses track, trend, and report to supervisors/trainers on each individual's learning activities.

5. Describe the entity's process to work towards managed care organization (MCO) accreditation status from the NCQA. Include whether the entity has successfully received accreditation for other state managed care programs, met required time frames to achieve accreditation, and any unsuccessful attempts.

NCQA Accreditation

As part of our commitment to quality, Magnolia is proud to be an NCQA-accredited CCO. We have maintained active NCQA accreditation continuously since 2013 and expect to receive a renewal in 2022. Magnolia has never had any unsuccessful accreditation attempts or corrective action plans. We have met all NCQA-required timeframes to achieve and maintain accreditation. Additionally, Magnolia has applied for Multicultural Healthcare Distinction, which will be transitioning to the new Health Equity Accreditation in July 2022. We look forward to receiving this new distinction, which includes all of the requirements of Multicultural Healthcare Distinction in addition to specific health equity requirements, later this year.

Magnolia's Quality Improvement team, described in Section 4.3.3.4.3 above, ensures we are prepared for quality surveys at all times. Magnolia ensures we have adequate health plan staff to meet all NCQA requirements and achieve our quality goals. Our Quality Improvement team is supported by and works in conjunction with our parent company, Centene Corporation's, Corporate Accreditation Team, ensuring we apply new and evolving best practices in our quality management and improvement efforts.

In accordance with Section 8.2 of Appendix A, Draft Contract, Magnolia posts our accreditation status on our public website and provides accreditation documents to DOM annually. Magnolia has authorized NCQA to provide DOM with all required elements pertaining to Magnolia's most recent NCQA review.

Accreditation Efforts in Other States

Beginning with Health Plan Accreditation and HEDIS reporting year 2020, NCQA determined that Health Plan Ratings and Accreditation would align to improve consistency and simplify scoring methodology. As a result of this change, NCQA eliminated Excellent and Commendable status levels and uses the Health Plan Ratings to

distinguish quality between plans. Magnolia, Centene, affiliates, or subsidiaries have never had accreditation status for any product line adjusted down, suspended, revoked, or denied. The table below describes the accreditation status for all affiliate plans and subsidiaries of Magnolia's parent company, Centene Corporation:

Health Plan Name	Status and Last Update	Insurance & Product Type	State
Ambetter of Magnolia Inc.	Accredited: 01/08/2020	Exchange	Mississippi
Harmony Health Plan, Inc. (Mississippi)	Accredited: 06/11/2019	Medicare	Mississippi
Health Net of Arizona, Inc. d/b/a Arizona Complete Health	Accredited: 05/09/2019	Exchange	Arizona
Celtic Insurance Company d/b/a Arkansas Health & Wellness Health Insurance	Accredited: 10/22/2021	Exchange	Arkansas
Harmony Health Plan, Inc. (Arkansas)	Accredited: 06/11/2019	Medicare	Arkansas
QCA Health Plan, Inc.	Accredited: 10/22/2021	Exchange	Arkansas
QualChoice Life and Health Insurance Company, Inc.	Accredited: 10/22/2021	Exchange	Arkansas
QCA Health Plan, Inc.	Accredited (with CAP): 10/22/2021	Commercial	Arkansas
California Health & Wellness, Inc.	Accredited: 05/09/2019	Medicaid	California
Health Net of California, Inc.	Accredited: 05/09/2019	Medicaid	California
Health Net of California, Inc.	Accredited: 05/09/2019	Exchange	California
Health Net of California, Inc.	Accredited: 05/09/2019	Medicare	California
Health Net of California, Inc.	Accredited: 05/09/2019	Commercial	California
Health Net Life Insurance Company-California	Accredited: 05/09/2019	Exchange - PPO	California
Health Net Life Insurance Company-California	Accredited: 05/09/2019	Exchange - EPO	California
Health Net Life Insurance Company-California	Accredited: 05/09/2019	Commercial	California
WellCare of California, Inc.	Accredited: 05/16/2019	Medicare	California
WellCare of Connecticut, Inc.	Accredited: 06/11/2019	Medicare	Connecticut
Celtic Insurance Company (FL)	Accredited: 02/08/2019	Exchange	Florida
Sunshine State Health Plan, Inc.	Health Plan: Accredited LTSS: Distinction 02/08/2019	Medicaid	Florida
Centene Venture Company Florida d/b/a Ascension Complete Joint Venture	Interim: 01/21/2021	Medicare	Florida
Peach State Health Plan, Inc.	Accredited: 05/22/2020	Medicaid	Georgia
Ambetter from Peach State Health Plan	Accredited: 05/22/2020	Exchange	Georgia
WellCare of Georgia, Inc.	Accredited: 09/18/2020	Medicare	Georgia
WellCare of Georgia, Inc.	Accredited: 09/18/2020	Medicare	Georgia
WellCare Health Insurance of Arizona, Inc. d/b/a Ohana Health Plan	Accredited: 02/11/2021	Medicaid	Hawaii
WellCare Health Insurance of Arizona, Inc. d/b/a Ohana Health Plan	Accredited: 02/11/2021	Medicare	Hawaii
Meridian Health Plan of Illinois, Inc.	Accredited: 02/11/2020	Medicaid	Illinois
Celtic Insurance Company (IL)	Accredited: 07/01/2020	Exchange	Illinois
Harmony Health Plan, Inc. (Illinois)	Accredited: 06/11/2019	Medicare	Illinois
Coordinated Care Corporation, d/b/a Managed Health Services (MHS-IN)	Accredited: 10/14/2019	Medicaid	Indiana
Celtic Insurance Company (IN)	Accredited: 10/14/2019	Exchange	Indiana
Iowa Total Care, Inc.	Health Plan: Accredited LTSS Distinction 09/07/2021	Medicaid	Iowa
Sunflower State Health Plan, Inc.	Health Plan: Accredited LTSS Distinction 04/13/2020	Medicaid	Kansas
Sunflower State Health Plan, Inc.	Accredited: 04/13/2020	Exchange	Kansas
WellCare Health Insurance Company of Kentucky, Inc.	Accredited: 09/18/2020	Medicaid	Kentucky
WellCare Health Insurance Company of Kentucky, Inc.	Accredited: 09/18/2020	Medicare	Kentucky
Louisiana Healthcare Connections, Inc.	Accredited: 05/27/2020	Medicaid	Louisiana

Health Plan Name	Status and Last Update	Insurance & Product Type	State
WellCare Health Insurance of Arizona, Inc. (Louisiana)	Accredited: 06/11/2019	Medicare	Louisiana
WellCare of Massachusetts	Interim: 12/17/2021	Medicare	Massachusetts
Meridian Health Plan of Michigan, Inc.	Accredited: 12/24/2019	Exchange	Michigan
Meridian Health Plan of Michigan, Inc.	Accredited: 12/24/2019	Medicaid	Michigan
Home State Health Plan, Inc.	Accredited: 08/03/2020	Medicaid	Missouri
Celtic Insurance Company (MO)	Accredited: 03/03/2020	Exchange	Missouri
Nebraska Total Care, Inc.	Accredited: 03/12/2019	Medicaid	Nebraska
SilverSummit Healthplan, Inc.	Accredited: 01/30/2020	Exchange	Nevada
SilverSummit Healthplan, Inc.	Accredited: 01/30/2020	Medicaid	Nevada
Granite State Health Plan d/b/a NH Healthy Families	Health Plan: Accredited MED: Deemed 08/20/2021	Medicaid	New Hampshire
Celtic Insurance Company (NH)	Accredited: 08/20/2021	Exchange	New Hampshire
WellCare Health Plans of New Jersey, Inc.	Accredited: 09/15/2021	Medicare	New Jersey
WellCare Health Plans of New Jersey, Inc.	Accredited: 09/15/2021	Medicaid	New Jersey
Western Sky Community Care, Inc.	Accredited: 03/26/2021	Medicaid	New Mexico
WellCare of New York, Inc.	Accredited: 11/17/2019	Medicare	New York
New York Quality Healthcare Corporation, d/b/a Fidelis Care	Accredited: 11/22/2021	Medicaid	New York
New York Quality Healthcare Corporation, d/b/a Fidelis Care	Accredited: 11/22/2021	Exchange	New York
New York Quality Healthcare Corporation, d/b/a Fidelis Care	Accredited: 11/22/2021	Medicare	New York
Ambetter of North Carolina, Inc.	Accredited: 01/04/2021	Exchange	North Carolina
Buckeye Community Health Plan, Inc d/b/a Buckeye Health Plan	Accredited: 03/18/2019	Exchange	Ohio
Buckeye Community Health Plan, Inc d/b/a Buckeye Health Plan	Health Plan: Accredited LTSS: Distinction 03/18/2019	Medicaid	Ohio
Trillium Community Health Plan, Inc.	Accreditation Survey submitted 10/19/2021. Final results pending	Medicaid	Oregon
PA Health & Wellness, Inc.	Health Plan: Accredited LTSS Distinction 11/19/2019	Medicaid	Pennsylvania
PA Health & Wellness	Accredited: 12/29/2020	Exchange	Pennsylvania
Absolute Total Care, Inc.	Accredited: 12/16/2021	Exchange	South Carolina
Absolute Total Care Inc.	Accredited: 08/28/2019	Medicaid	South Carolina
Harmony Health Plan, Inc. (South Carolina)	Accredited: 06/11/2019	Medicare	South Carolina
Celtic Insurance Company (TN)	Accredited: 01/04/2021	Exchange	Tennessee
Harmony Health Plan, Inc. (Tennessee)	Accredited: 06/11/2019	Medicare	Tennessee
Superior HealthPlan, Inc.	Health Plan: Accredited LTSS Distinction 02/18/2021	Medicaid	Texas
Celtic Insurance Company (TX)	Accredited: 02/18/2021	Exchange	Texas
WellCare of Texas, Inc.	Accredited: 06/11/2019	Medicare	Texas
Coordinated Care Corporation	Accredited: 05/06/2020	Exchange	Washington
Coordinated Care of Washington, Inc.	Accredited: 05/06/2020	Medicaid	Washington
Managed Health Services Insurance Corp.	Accredited: 09/06/2019	Medicaid	Wisconsin
Subsidiary Companies			
Cenpatico Behavioral Health, LLC d/b/a Centene Advanced Behavioral Health	Accredited Utilization Management: 11/25/2019	All	National
Envolve Benefit Options d/b/a Envolve Dental, Inc.	Accredited NCQA Utilization Management and Credentialing: 02/09/2021	All	National
Envolve Benefit Options d/b/a Envolve Vision, Inc.	Accredited NCQA Utilization Management and Credentialing: 10/13/2021	All	National

6. Describe staff who will be responsible for the entity's Fraud, Waste and Abuse program and their qualifications.

Magnolia's Fraud, Waste, and Abuse Staff

Our Compliance Manager resides in Mississippi and oversees activities related to the prevention, detection, and remediation of Provider and Member Fraud, Waste, and Abuse (FWA) with support from our parent company, Centene Corporation's Special Investigations Unit (SIU) Manager and Investigators. Our Compliance Manager is available to communicate with the State Program Integrity (PI) Unit staff to resolve issues. In addition, Compliance resources are available to meet in person on a regular basis to provide information and updates on cases to the PI Unit. Reporting to our Compliance Manager, we maintain at least one full-time equivalent (FTE) dedicated solely to Magnolia FWA investigations, located in Mississippi. The SIU Investigator receives support as needed from clinical/data/business analysts, local health plan staff, Magnolia management, and leaders and general counsel from our parent company.

Training and Qualifications. Per the Fraud, Waste, and Abuse Plan, SIU staff are responsible for attending 20 hours of training per year through FWA seminars or in-house trainings. Annual Ethics and Compliance training is mandatory. The lessons learned, best practices, and real-world examples continuously improve our skillset. Our Compliance Program includes annual review and distribution of a mandatory compliance plan, written standards of conduct and written policies and procedures that articulate our commitment to comply with all applicable Federal and State regulations, sub-regulatory guidance, contractual commitments, and standards. These documents also address specific areas of potential fraud, waste, and abuse. Our Program Integrity Unit (PIU) is comprised of our Compliance Officer (Senior Director of Compliance), PI Manager (Compliance Manager), Compliance Committee, Manager of Claims Configuration and Business Analysis, and Special Investigations Unit (SIU). The PIU team uses their experience in health care claims review, data analysis, professional medical coding, and law enforcement to identify, review, recover, and report improper payments, including FWA activities, on an ongoing basis.

Role	Job Description	Job Qualifications
Compliance Officer	Ensures regulatory compliance with state and other government agencies related to the health insurance industry, Centene Corporation, and business subsidiaries. Maintains and tracks laws and regulations, contract documentation, amendments, and various compliance measures. Develops policies, procedures, and processes to comply with state law, federal law, contract requirements, and various standards. Oversees, administers, and implements various compliance programs, including fraud and abuse and HIPAA. Provides guidance to various departments regarding compliance issues and implementation of new compliance requirements with respect to regulatory and contract language. Conducts compliance audits, develops and implements corrective action plans, and reports on achievement [redacted]es, evaluates, and analyzes the impact of state legislative and regulatory issues and advises management concerning impact.	8+ years of compliance program management and contract experience. Extensive knowledge of state administrative code and regulations, state insurance laws and regulations, including managed care regulations. Experience with state and federal government agencies, accreditation bodies, participating Provider agreements, HIPAA and Third Party Administration laws, credentialing regulations, and prompt pay laws. Bachelor's degree in Public Policy, Government Affairs, Business Administration, or related field. Master's or Law degree preferred.
Program Integrity Manager (Manager, Compliance and Reporting)	Safeguards against the potential for fraud, waste and abuse and coordinates with, the Special Investigations Unit and state agencies to promptly investigate reports of suspected fraud and abuse by employees, subcontractors, Providers, and others with whom the health plan does business. Serves as the health plan's primary fraud, waste and abuse subject matter expert. Coordinates audit documentation develops internal and state required reports and internal policies and procedures. Arranges, conducts, and attends the health plan's fraud, waste and abuse work groups and participate in other various committees. Acts as the primary liaison with the State to ensure assure coordination efforts with state agencies concerning program integrity issues	Bachelor's degree in Business, Healthcare, Criminal Justice, related field, or equivalent experience. 4+ years of combined medical claim investigation, financial impact analysis, business analysis, compliance or fraud, and abuse experience. Thorough knowledge of medical terminology. Previous experience in managed care environment and as a lead or supervisor of staff, including hiring, training, assigning work, and managing performance preferred. Knowledge of Microsoft Excel, medical coding, claims processing, and data mining preferred.
SIU Manager	Supervise the Special Investigation Unit staff to ensure accurate, timely, and efficient reporting related to SIU business functions. Responsible for ensuring all investigative timelines and processes are compliant with internal company and state guidelines. Review preliminary waste, abuse,	Bachelor's degree in Business, Healthcare, Criminal Justice, related field, or equivalent experience. 3+ years of medical claim or fraud investigation experience. Knowledge

	and fraud reports completed by special investigation unit investigators. Provide final reports, summaries, and recommendations to health plans and external regulators. Review reports and analysis prepared by special investigation unit analysts to validate data integrity and evaluate if investigation is warranted. Monitor cases in case tracking system (HCFS) to ensure investigations are progressing accurately, timely and in compliance with state guidelines. Recommend changes to the investigative process as needed. Develop new investigative leads by analyzing data trends and developing new reports and queries to identify instances of potential fraud, waste, and abuse. Evaluate cases and recommend changes to investigative policies and procedures to enhance Member outcomes by addressing patient safety concerns and enhancing return on investment. Assist with collection and review of information for state investigators including data requests or any investigative materials associated with subpoenas from law enforcement agencies or state regulators. Oversee, train, and mentor special investigation unit investigators and analysts.	of Excel, medical coding, claims processing, and data mining preferred. Previous experience as a lead in a functional area or managing cross functional teams on large scale projects preferred. Medical records or coding license preferred.
SIU Investigator	Position conducts comprehensive reviews of medical records and documents supporting claims for Providers, suppliers, and pharmacies to include but not limited to physicians, inpatient, outpatient, ancillary, behavioral health care, laboratory, etc. Provides investigative support to the Special Investigations Unit (SIU) related to coding and billing issues and identifies potential overpayments and suspected health care fraud and abuse. Verifies authorization for services and written documentation of services provided against claim information, ensures the appropriateness and accuracy of diagnosis and procedure codes supporting such claims, coordinate medical necessity and appropriate level of care determinations with Medical Directors, and validates services against CMS and State-specific coverage, limitations and exclusion guidelines. Coordinates with internal and external resources to determine appropriateness of codes found in administrative, medical, claim and financial records, develops reports of findings and recommendations, communicates complex results of audit findings in meetings and/or judicial hearings, and assists SIU investigators during interviews, discussions and negotiations with Providers, suppliers, and pharmacies.	High School or GED required. Bachelor's Degree in a related field preferred. Required experience: 3+ years of experience in healthcare coding directly related to determining appropriate diagnosis, procedure and other codes used in billing for services, utilization management, medical record auditing, or health care quality improvement. Preferred experience: Other work in the government sector of the managed health care industry. A license in one of the following is required: Certified Coding Specialist (CCS), Certified Coding Specialist Provider-based (CCS-P), Certified Professional Coder (CPC or CPC-H), or equivalent certification. Preferred: Certified Professional Medical Auditor (CPMA), Licensed Practical Nurse (LPN).
Claims Business Analyst	Serves as the claims payment and claims configuration expert for plan and various departments to effectively identify and resolve claims issues. Acts as the subject matter expert for the claims payment structure. Collaborates with the claims department to price pended claims correctly. Identifies authorization issues and trends and research for potential configuration-related work process changes. Collaborates with various business units to resolve claims issues to ensure prompt and accurate claims adjudication. Documents, tracks and resolves all plan Providers' claims projects. Researches the claims on various reports to determine if appropriate to move forward with recovery. Leads meetings with various departments to assign claim project priorities and monitor days in step processes to ensure the projects stay on track. Supports business initiatives through data analysis, identification of implementation barriers and user acceptance testing of new systems. Performs detailed analysis on assigned projects, recommends potential business solutions, and assists with implementation. Identifies and analyzes user requirements, procedures, and problems to improve existing processes.	3+ years of claims experience required. 0-2 years of business process analysis or data analysis experience preferred. 5+ years of claims processing, providing billing or Provider relations experience pin managed care environment preferred. High school diploma or equivalent experience. Bachelor's degree in related field preferred.

Compliance Committee. Magnolia's Compliance Committee, which reports directly to the Board of Directors, consists of a cross-functional team that is responsible for providing Magnolia with feedback and making recommendations regarding health plan compliance issues. The Committee is chaired by the Compliance Officer and meets at least quarterly. Other Compliance Committee members include the CEO, VP of Population Health and Clinical Operations, VP of Quality Improvement, Director of Contracting, Director of Member Services, Director of Provider Services, CFO, COO, and the Director of Human Resources. The Committee's key responsibilities include:

- Analyze the organization's environment, the legal requirements with which it must comply, and specific risk areas.
- Assess existing policies and procedures that address these areas for possible incorporation into the

compliance program.

- Work with appropriate departments to develop standards of conduct and policies and procedures to promote compliance with the company's program.
- Recommend and monitor, in conjunction with relevant departments, the development of internal systems and controls to carry out the organization's standards, policies, and procedures as part of its daily operations.
- Assist the Compliance Officer in monitoring, reviewing, and assessing the effectiveness of the Compliance Program and timeliness of reporting
- Determine the appropriate strategy/approach to promote compliance with the program and detect potential violations, such as through the Ethics and Compliance or BEAF Hotlines and other fraud and abuse reporting mechanisms.
- Maintain a system to solicit, evaluate and respond to complaints and problems, including being involved in reports made to Centene's Ethics & Compliance and BEAF Hotlines to provide Magnolia with feedback regarding its performance from a community-based perspective.

7. Describe how staff will respond to requests from the Division regarding complaints, ad hoc reports, etc., as required in Section 1.10, Responsiveness to the Division, of Appendix A, Draft Contract.

Responsiveness to the Division of Medicaid (DOM)

Magnolia adheres to our established policy and procedure to ensure a timely and accurate response to DOM requests regarding complaints, ad hoc reports, data, statements, accounting, claims, and other documentation. Under the supervision of the Compliance Officer (Senior Director of Compliance):

- Our Lead Compliance Coordinator is responsible for receiving all requests, entering them into our internal system, and tracking the response to completion. Our Compliance Officer and Compliance Specialist are available to provide support and backup in the event the Lead Compliance Coordinator is unavailable.
- Magnolia's Compliance Specialist receives all HIPAA-related incidents and works with business owners across the health plan to notify and respond to DOM accordingly.
- Our Manager of Compliance and Reporting is responsible for receiving, processing, and tracking all reporting requests from DOM, including working closely with business owners across the health plan as appropriate to ensure timely completion.

Acknowledging Receipt. Magnolia acknowledges receipt of DOM's written, electronic, or oral requests for assistance no later than one business day from receipt. We immediately, without unreasonable delay, acknowledge DOMs urgent requests and give such requests priority. If the request is received from DOM in writing or electronically, Magnolia will acknowledge receipt in the same manner the request was received, either in writing or electronically. If the request was received from DOM orally, Magnolia would acknowledge receipt of the request orally and immediately follow-up with a written or electronic acknowledgment.

Completing Requests. Magnolia uses a dedicated tracker to manage all DOM issues and requests. Once we receive the request, the Lead Compliance Coordinator enters the information into the tracker, acknowledges receipt in accordance with the process above, and sends the request to the appropriate business owner(s) to review and process. Information captured includes:

- Date the request was received
- Requestor (who sent the email)
- Description, including any questions, action items, and details from associated attachments
- Type of state issue (Member or Provider)
- Responsible party: the individual who is responsible for completing the request
- Internal date: the date that deliverable is due to Compliance
- Date response received from business owner
- The response and associated attachments
- Due date: date the deliverable is due to the requestor
- Submission date: when was the deliverable sent to the requestor
- Submitted by: individual who submitted the deliverable to the requestor
- Disposition: Open, Pending, or Closed

We complete requests within five business days of receipt, unless otherwise specified by DOM. The Lead Compliance Coordinator or designated backup reviews our internal tracker daily to ensure all responses are submitted in a timely and compliant manner. Our completed requests include a detailed completion summary of our action and resolution within the specifications requested by DOM.

8. Describe staff who will be responsible for subrogation and Third Party Liability activities, including staffing levels and qualifications.

Staff Responsible for Subrogation and Third Party Liability Activities

Under the oversight of our COO, we successfully conduct TPL and subrogation activities according to DOM's standards and continually improve our TPL program through collaborative and innovative approaches. Bringing Mississippi-specific experience and Provider feedback, we collaborate with our parent company's Coordination of Benefits (COB) Center of Excellence to develop and implement innovative TPL approaches that help contain health care costs and reduce administrative burden. The COB Center of Excellence is comprised of Medicaid cost avoidance and payment integrity specialists to ensure the effectiveness and continual improvement of our

TPL program. Specific Magnolia staff responsibilities and qualifications are listed in the table below:

Job Title and Levels	Role Description	Qualifications
[redacted]	Support TPL-related business initiatives through data analysis, identification of implementation barriers and user acceptance testing of various systems. Identify and analyze user requirements, procedures, and problems to improve existing processes. Perform detailed analysis on multiple projects, recommend potential business solutions and ensure successful implementations. Identify ways to enhance performance management and operational reports related to new business implementation processes. Coordinate with various business units and departments in the development and delivery of training programs around TPL and subrogation. Develop, share, and incorporate organizational best practices into business applications. Diagnose problems and identify opportunities for process redesign and improvement. Formulate and update departmental policies and procedures. Serve as the subject matter expert on TPL and subrogation to ensure operational performance.	Bachelor's degree in related field or equivalent experience. 4+ years of business process analysis, preferably in healthcare (i.e., documenting business process, gathering requirements) or claims payment/analysis experience. Advanced knowledge of Microsoft Applications, including Excel and Access preferred. Experience in benefits, pricing, contracting or claims and knowledge of Provider reimbursement methodologies. Knowledge of managed care information or claims payment systems preferred. Previous structured testing experience preferred.
[redacted]	Serve as the claims payment and claims configuration expert for plan and various departments to effectively identify and resolve claims issues. Act as the subject matter expert for the claims payment structure. Audit check run and send claims to the claims department for corrections. Collaborate with the claims department to price pended claims correctly. Identify authorization issues and trends and research for potential configuration related work process changes. Collaborate with various business units to resolve claims issues to ensure prompt and accurate claims adjudication. Document, track and resolve all plan Providers' claims projects. Research the claims on various reports to determine if appropriate to move forward with recovery. Lead meetings with various departments to assign claim project priorities and monitor days in step processes to ensure the projects stay on track. Support business initiatives through data analysis, identification of implementation barriers and user acceptance testing of new systems. Perform detailed analysis on assigned projects, recommend potential business solutions and assist with implementation. Identify and analyze user requirements, procedures, and problems to improve existing processes.	High school diploma or equivalent experience. Bachelor's degree in related field preferred. 3+ years of claims experience required. 0-2 years of business process analysis or data analysis experience preferred. 5+ years of claims processing, providing billing or Provider relations experience pin managed care environment preferred.
[redacted]	Ensure regulatory compliance with state and other government agencies related to the health insurance industry, Centene Corporation, and its business subsidiaries. Every month, our Compliance Officer sends the Third Party Casualty, Third Party Leads and Cost Avoidance, Third Party Subrogation, and TPL Recoveries files securely to DOM.	8+ years of compliance program management and contract experience. Extensive knowledge of state administrative code and regulations, state insurance laws and regulations including managed care regulations. Experience with state and federal government agencies, accreditation bodies, participating Provider agreements, HIPAA and Third Party Administration laws, credentialing regulations and prompt pay laws. Bachelor's degree in Public Policy, Government Affairs, Business Administration, or related field. Master's or Law degree preferred.

9. Describe staff who will be responsible for the entity's encounter reconciliation policies and process, including staffing levels and qualifications.

Magnolia's Encounter Reconciliation Team

Magnolia has developed a rigorous process to ensure the encounter data we collect from Providers and submit to DOM for MSCAN a[redacted]e organized our systems, processes, and staff around an end-to-end view of encounter data production: from the Provider's claim submission on the front-end to our submission of corresponding encounter record data to DOM via our Encounter Data System (EDS), with the capacity to monitor encounter production at every step. Our local team will be led by our COO, who will oversee our encounter completeness monitoring program in conjunction with our finance, compliance, data analytics, Provider relations, claims, and encounter staff to ensure successful encounter submission and performance. This team will have an in-depth understanding of State-specific claims processing rules and will work closely with our local Provider Relations

team to support Provider communication and education. We will also be supported by a centralized Encounter Business Operations team (EBO) which was strategically built to include resources with expertise in all aspects of the claims and encounters life cycle and capitalizes on that knowledge to ensure compliance with all contractual measures. The EBO uses a coordinated team approach with local claims staff, enterprise support teams, and subcontractors. Under our direction, the EBO documents and implements encounter business requirements, monitors file processing, and delivery, and analyzes encounter holds and rejects. This proven approach ensures encounter processes and performance requirements are consistently met. Specific staff members supporting encounter reconciliation policies and procedures are outlined in the table below:

Job Title	Role Description	Qualifications
[redacted]	Manage department staff including hiring, performance management and career development to ensure alignment with defined goals. Oversee the architecture, design, coding, testing and implementation of changes for claims pricing, benefits and payments within the core claims payment system. Manage all new configuration requests and changes to existing configuration ensuring accuracy and timely. Develop tools, processes, and methodologies to streamline and enhance production of change requests. Participate in planning, managing, analyzing, designing and implementing various configuration projects. Collaborate with business unit leaders and claims department to understand requirements and ensure configuration changes meet business needs.	Bachelor's degree in Computer Science, MIS, related field or equivalent experience. 5+ years of related IT or systems/application configuration experience, including systems design, coding, and testing.
[redacted]	Serve as a liaison between the plan, claims, Providers and various departments to effectively identify and resolve claims issue. Analyze trends in claims processing issues and identify work process solutions. Lead meetings with various departments to assign claim project priorities and monitor days in step processes to ensure the projects stay on track. Assist in the writing work processes and continual auditing of the processes to ensure configuration, state mandates, benefits, etc. Review all Medicaid Bulletins for changes and updates and submit change requests (CRs) to update payment system. Audit check run and send claims to the claims department for corrections. Identify any system changes and work notify the Plan CIA Manager to ensure its implementation. Collaborate with the claims department to price pended claims correctly. Document, track and resolve all plan Providers' claims projects. Collaborate with various business units to resolve claims issues to ensure prompt and accurate claims adjudication. Identify authorization issues and trends and research for potential configuration related work process changes. Analyze trends in claims processing issues and assist in identifying and quantifying issues and reviewing work processes. Identify potential and documented eligibility issues and notify applicable departments to resolve. Research claims on various reports to determine if appropriate to move forward with recovery due to non-covered items being allowed, etc.	3+ years of claims processing, Provider billing, or Provider relations experience, preferably in a managed care environment. High school diploma or equivalent required.
[redacted]	Oversee preparation of accurate and timely financial reports. Oversee the financial and business analyses based on information from various sources and financial reports. Interpret financial reports for management team. Review and evaluate analyses and recommend appropriate actions to senior management. Prepare budget and forecast and analyze financial results related to expectations. Manage the month end, quarter end, and year end closing process and oversee the completion of financial statements and supporting analysis. Monitor legislative and political developments affecting the business unit from a financial perspective. May oversee the Capitation payments and premium billing process.	Bachelor's degree in Accounting, Finance, or equivalent experience. 5+ years of accounting, financial analysis or finance related experience. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff. Experience in public accounting, operations, financial analysis, information systems and health care or insurance preferred. CPA preferred.
[redacted]	Provide leadership and oversight of all aspects of finance for the Business Unit. Oversee all finance related activities for business unit including developing and monitoring progress against Annual Operating Plan. Responsible for financial analysis, identification of month end financial drivers, and forecasting including headcount planning to ensure compliance with state requirements. Responsible for identifying medical cost trends and leadership of medical cost improvement initiatives. Perform financial impact analysis for new contracts and support negotiations. Review monthly performance and financial results of the business unit and provide recommendations to senior management.	Bachelor's degree in Finance, Accounting, Economics, Business Administration or equivalent experience. Master's degree preferred. 8+ years in a high level finance role in the healthcare or insurance industry. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff. CPA preferred.

	Responsible for the business unit's contribution to corporate. Perform duties as Chief liaison between Corporate Finance and the Business Unit. Establish financial strategic vision, objectives, policies and procedures in support of the overall strategic plan. Oversee and validate pricing models and lead initiatives to identify inefficiencies and areas of development and improvement. Direct health plan analytical needs and coordinate reporting strategy. May lead rate setting activity and coordinate corporate and state actuaries.	
[redacted]	Provide leadership and oversight of all aspects of finance for the Business Unit. Oversee all finance related activities for business unit including developing and monitoring progress against Annual Operating Plan. Responsible for financial analysis, identification of month-end financial drivers, and forecasting including headcount planning to ensure compliance with state requirements. Responsible for identifying medical cost trends and leadership of medical cost improvement initiatives. Perform financial impact analysis for new contracts and support negotiations. Review monthly performance and financial results of the business unit and provide recommendations to senior management. Responsible for the business unit's contribution to corporate. Perform duties as Chief liaison between Corporate Finance and the Business Unit. Establish financial strategic vision, objectives, policies and procedures in support of the overall strategic plan. Oversee and validate pricing models and lead initiatives to identify inefficiencies and areas of development and improvement. Direct health plan analytical needs and coordinate reporting strategy. Act as a lead for internal and external audits. Lead rate setting activity and coordinate corporate and state actuaries.	10+ years in a high level finance role in the healthcare or insurance industry. Bachelor's degree in Finance, Accounting, Economics, Business Administration. 10+ years in a high level finance role in the healthcare or insurance industry. Master's degree preferred. CPA preferred.
[redacted]	Support analytical data needs for assigned business unit. Handle complex data requests and acts as a "go to" person for other Data Analysts. Initiate and manage company wide data processes improvements. Manage cross functional activities related to large-scale analytic projects to deliver on schedule, within budget and with superior quality. Develop and lead activities to accomplish overall strategic department goals and lead the communication of these goals to stakeholders at all levels of the organization. Collaborate with health plan leadership to understand their data analysis needs, explain trends in data and actively drive further research and/or operational changes to assist in controlling medical costs and delivery of quality healthcare to Members. Participate in cross health plan initiatives and capabilities, including data analysis support. Manage development efforts with technical team liaisons, including business requirements gathering and documentation, testing, delivery and user adoption, and effectively communicate deliverable expectations to the health plan. Manage system/tool implementation and design as needed.	Bachelor's degree in data related field. 8+ years of data analysis experience, preferably in healthcare. Advanced SQL and Microsoft Access skills, relational database knowledge, and various data reporting tool experience preferred. Knowledge of statistics and application of high level mathematical models in medical and pharmacy claims data preferred. Understanding of health insurance business, claims payment procedures, strategies and trends in health care government programs preferred. Master's degree and supervisory experience preferred.
[redacted]	Safeguards against the potential for fraud, waste and abuse and coordinate with, the Special Investigations Unit and state agencies to promptly investigate reports of suspected fraud and abuse by employees, subcontractors, Providers, and others with whom the health plan does business. Serves as the health plan's primary fraud, waste and abuse subject matter expert. Coordinates audit documentation, develops internal and state required reports and internal policies and procedures. Arranges, conducts, and attends the health plan's fraud, waste and abuse work groups and participate in other various committees. Acts as the primary liaison with the State to ensure assure coordination efforts with state agencies concerning program integrity issues	Bachelor's degree in Business, Healthcare, Criminal Justice, related field, or equivalent experience. 4+ years of combined medical claim investigation, financial impact analysis, business analysis, compliance or fraud and abuse experience. Thorough knowledge of medical terminology. Previous experience in managed care environment and as a lead or supervisor of staff, including hiring, training, assigning work and managing performance preferred. Knowledge of Microsoft Excel, medical coding, claims processing, and data mining preferred.
[redacted]	Serve as the claims payment and claims configuration expert for plan and various departments to effectively identify and resolve claims issues. Act as the subject matter expert for the claims payment structure. Audit check run and send claims to the claims department for corrections. Collaborate with the claims department to price pended claims correctly. Identify authorization issues and trends and research for potential configuration related work process changes. Collaborate with various business units to resolve claims issues to ensure prompt and accurate	High school diploma or equivalent experience. Bachelor's degree in related field preferred. 3+ years of claims experience required. 0-2 years of business process analysis or data analysis experience preferred. 5+ years of claims processing, providing billing or Provider relations experience pin managed care

	claims adjudication. Document, track and resolve all plan Providers' claims projects. Research the claims on various reports to determine if appropriate to move forward with recovery. Lead meetings with various departments to assign claim project priorities and monitor days in step processes to ensure the projects stay on track. Support business initiatives through data analysis, identification of implementation barriers and user acceptance testing of new systems. Perform detailed analysis on assigned projects, recommend potential business solutions and assist with implementation. Identify and analyze user requirements, procedures, and problems to improve existing processes.	environment preferred.
[redacted]	Manage and coordinate staff engaged in business and strategic analysis. Oversee geographically distributed cross-functional team to analyze business process to link them to business application technology solutions. Oversee the analysis of business processes and development of functional requirements and appropriately document and communicate captured information for validation and re-usability. Collaborate with IT to design and maintain changes to encounter systems, including ensuring system build content meets contractual requirements. Evaluate programming techniques, training needs, and select and implement various trainings. Advise and consult with plans and user departments, identifying problem areas, and determine and recommend procedural changes. Serve as the primary liaison for business unit operations and corporate IT, claims and encounter counterparts to ensure systems, processes and tools meet business requirements. Create and maintain re-usable policies, procedures and formats suitable to the new business technology development activities of the organization.	Bachelor's degree in Healthcare Administration, IT or related field or equivalent experience. 5+ years of claims payment or encounters administration experience. Medicaid and/or Medicare experience preferred.

10. Describe staff who will be wholly dedicated to the associated Contract and those staff Members that are shared.

All Magnolia staff required to be dedicated to the MSCAN and CHIP CCO Contract will be wholly dedicated. These positions include:

- Provider Services Manager
- Network/Contracting Manager
- Member Services Manager
- Quality Management Director
- Care Management Director
- Population Health Director
- Grievance & Appeals Coordinators
- Claims Administrator
- Data and Analytics Manager
- Clinical Pharmacist

In addition, the following staff, at a minimum, will be wholly dedicated to the CCO Contract:

- Member Customer Service Representatives
- Provider Customer Service Representatives
- Health Equity Director
- Community Engagement Specialists
- Care Managers (RN and Social Work)
- Social Services Specialists
- Case Management Supervisors
- Community Health Service Supervisor
- Community Health Service Representatives
- Manager of Case Manager
- Clinical Manager
- Clinical Provider Trainer
- Program Coordination Supervisor
- Program Coordinators
- Administrative Assistant
- Clinical Trainers
- Data Analysts
- Eligibility Specialists
- Credentialing Specialists
- Concurrent Review Nurse
- Prior Authorization Nurses
- Senior Prior Authorization Nurse
- Utilization Management Manager
- Supervisor of Referral Services
- Supervisor of Utilization Management
- Concurrent Review Nurses
- Referral Specialists
- Denial Coordinators
- Prior Authorization Nurses
- PCMH Director

[END OF RESPONSE]

4.3.3.5 SUBCONTRACTORS

The Offeror must provide a narrative explanation no longer than three (3) pages giving an overview of its overall philosophy for subcontractor hiring and management. Additionally, the Offeror must use the forms provided in Appendix H to describe Subcontractors the Offeror expects to utilize for this Contract. If a subcontractor has provided services for the Offeror for a managed care contract in the past three (3) years, use the appropriate form in Appendix H to detail those services.

Please see **Attachment 4.3.3.5 Appendix H** for completed Subcontractor forms.

Subcontractor Hiring

Magnolia selects major subcontractors with ***proven experience to support our delivery of high quality, person-centered health care services*** for our Mississippi MSCAN and CHIP Enrollees. Our organization believes that our subcontractors are a valuable extension of our coordinated care system. Magnolia carefully selected partners with proven experience to support the delivery of high-quality, person-centered health care services. Selecting partners that will maintain our high standards provides continuity across all systems of care. We will leverage our corporate and affiliate experience to build an extensive and compliant Subcontractor (Vendor) Management Program. We are fully committed to maintaining a close partnership with DOM related to Subcontractor oversight and will seek DOM approval of all Subcontractors. We acknowledge that as the Contractor, we maintain sole accountability and responsibility for the performance and oversight of all Subcontractors performing tasks under this contract and have designed our program to fulfill this obligation. Affiliate Subcontractors are subject to the same oversight program with the same high level of oversight as non-affiliate Subcontractors.

Organizational Infrastructure that Supports Subcontractor Management

Within the Compliance Department, ***we will have staff dedicated solely to vendor oversight*** and will take a collaborative approach to Subcontractor management. For each Subcontractor, we will designate an individual from our senior leadership team as our internal lead to monitor Subcontractor performance and report issues to Compliance. In tandem, we require each Subcontractor to designate an appropriate senior staff person as their leader. In addition, with support from our corporate entity's Compliance Department, our Compliance Department will be highly engaged to ensure that all Subcontractors are performing at the highest levels.

Joint Oversight Committee (JOC). We will host quarterly JOC Meetings with each Subcontractor that include a focused review of performance dashboards and reports, complaints and grievances, quality initiatives, and pertinent regulatory updates. Minutes from each meeting will be recorded, approved, and stored for follow-up within our Compliance Management System. Led by Compliance, JOC meetings will include representation from the Subcontractor and other Plan staff related to the Subcontractor's delegated functions, including, but not limited to, leadership and staff from Operations, Care Management (CM), Utilization Management (UM), Quality Management (QM), and/or Network. We have found cross-functional representation at the JOC to be helpful, resulting in faster and more effective solutions to identified issues. More frequent JOC meetings may be held as necessary.

Committee and Operational Meetings. The Compliance Officer or designee will chair and conduct committee and operational meetings to support Subcontractor oversight. This includes, at a minimum, JOC meetings and a quarterly Compliance Committee where internal business leads review vendor performance. In addition, our cross-departmental Performance Improvement Team (PIT), chaired by the Chief Medical Director, will meet monthly and monitor all health plan performance metrics. The PIT reports to the Quality Management Committee (QMC), which the Chief Medical Director also chairs, and reviews Subcontractor quality program documentation and/or corrective action plans (CAPs), if applicable.

Technology Infrastructure. We will use a Compliance Management System that supports our contractual and regulatory oversight capabilities, manages our compliance with State contract requirements, and tracks all compliance activities. Our system can accept required and ad hoc reports from Subcontractors via secure file transfer protocols. This system stores contract requirements, documents to demonstrate compliance, and related policies and procedures. Any contract compliance issue identified with a Subcontractor will be tracked within the Compliance Management System along with progress on any identified issues.

Subcontractor Management

Our team will continuously monitor Subcontractors to ensure the appropriate utilization of health care services through a multi-pronged process, including annual delegation audits involving authorization file review, weekly monitoring reports, and quarterly JOC meetings. On an ongoing basis, in direct coordination with CM and UM, Compliance will monitor each Subcontractor's utilization reports and immediately follow up with the Subcontractor regarding concerns or questions, thereby initiating the appropriate monitoring and follow-up activities necessary to address the concern or question. Data and identified issues that require additional insight will be forwarded to the PIT. The PIT analyzes utilization performance measures monthly, addresses any immediate issues, and forwards recommendations to the QMC. The Utilization Management Committee (UMC), consisting of stakeholders from each business area, meets quarterly to review utilization performance measures to identify trends of over/underutilization of services and make recommendations to the QMC accordingly. The QMC will annually review and approve the Subcontractor's UM Program Description, Work Plan, and Annual Program Evaluation and, on a quarterly basis, review JOC, PIT, and UMC recommendations and take action if indicated. Finally, depending on each Subcontractor's delegated functions, other staff may review utilization information and make recommendations. As noted, any issues or concerns will be addressed with the Subcontractor for appropriate clarification, follow-up, and resolution. Substantive issues will be addressed through the CAP process, with QM and QMC input and oversight. Additionally, we will follow our Fraud and Abuse Compliance Plan, which addresses Subcontractor service patterns monitoring procedures and verification of whether services reimbursed were actually furnished to Members to ensure appropriate health care services utilization. In addition, our pre-delegation and annual audits use standardized Audit Tools that will be tailored to Mississippi to assess Subcontractor compliance with Offeror, State, Federal, and DOM requirements, as well as NCQA guidelines.

Additional Oversight Activities. Other ongoing Subcontractor monitoring processes, depending on each entity's delegated function(s), include activities such as analyzing and approving Subcontractor network listings and changes; analyzing Call Center, utilization (specific to each delegated function), and claims metrics; verification of monthly monitoring for Provider exclusions and reinstatements and (re)credentialing; conducting/tracking investigations resulting from grievances, quality of care complaints, or fraud issues and compliance review and follow up on feedback from Advisory Committee meetings.

Subcontractor Monitoring

In addition to formal audits and reviews, we will monitor Subcontractor performance on an ongoing basis. We will develop and implement written Subcontractor monitoring plans for each vendor. These plans will clearly define the type and frequency of reporting and monitoring for each Subcontractor, establish specific performance metrics, and evaluate performance against identified metrics. In addition, as a standard practice, we will conduct pre- and annual-delegation audits of all Subcontractors. To ensure a comprehensive audit, we will use a standardized Delegation Review Tool customized for Mississippi to review Subcontractor performance related to specific areas, such as policies and procedures, Member files, reports, marketing material, compliance program, and clinical guidelines, as applicable.

We contractually require Subcontractors to submit monthly, quarterly, and annual (as well as ad hoc, when necessary) reports. Upon contracting, we will provide each Subcontractor with a robust reporting manual that describes all reporting requirements, including required data/information, reporting frequency, and report submission process. Operations, Network, UM, CM, and QM staff will review and use Subcontractor reports in the daily administration of Plan responsibilities and the ongoing monitoring of delegated functions. Required reports depend on each Subcontractor's delegated functions and address areas such as all data submission requirements will be contained in our written agreements with each Subcontractor, as well as within each Subcontractor's monitoring plan. On an ongoing basis, Compliance will monitor and verify receipt of required data within the specified, required timeframes.

Encounter Data. As relevant, each Subcontractor's performance measures include encounter file delivery by specified dates each month. Each Subcontractor is required to submit a Monthly Management Report to us, which includes encounter-related analyses related to the services for which they are subcontracted, including,

but not limited to Utilization Statistics and Trends, Medical Claims Processing Statistics and Trends, Call Center Statistics and Trends, Provider Network Statistics, Prior Authorizations, and Encounter Data Acceptance Rate.

As part of our data completeness monitoring program, we will evaluate Subcontractor compliance with encounter reporting requirements and take appropriate corrective action as needed. To support timely and accurate encounter data submission, we will meet with each Subcontractor on a biweekly basis to go over any encounter issues and results. DOM is invited to participate in these calls. In addition, our parent company provides us with encounter submission technology support and error review and resolution services. Subcontractors submit encounters to our centralized Encounter Business Operations (EBO) team to monitor and support each Subcontractor's encounter data submission schedule and delivery date on an ongoing basis.

Managing Grievances

We will educate all Subcontractors regarding our Member and Provider Grievance requirements and standards. All Subcontractors will be contractually required to comply with our Grievance policies and procedures and DOM, State, and Federal requirements, including NCQA standards. In addition, we will review each Subcontractor's monthly performance metrics, which include but are not limited to:

- Total number of grievances
- Percentage resolved within the required timeframe
- Percentage of appeals overturned or denied and an explanation of each determination

The monthly performance metrics are reviewed during JOC, PIT, and QMC meetings, and oversight of Grievances is included in the Vendor Oversight Activities described above. As with any Grievance, we will promptly act on any grievances we receive from a Member, Provider, or DOM regarding a Subcontractor's performance. In addition, during audits, and more frequently as they are updated, Compliance reviews the Subcontractor's grievance and appeal letter templates to ensure inclusion of all required elements, such as Member's rights and responsibilities. We will ensure any changes to templates are approved by DOM prior to implementation of the template.

Managing Deficiencies

The Compliance Officer and other appropriate staff will work with Subcontractors to address any identified deficiency or contractual variance. We have the right to assess monetary penalties and/or terminate the Subcontractor specific delegated functions if the Subcontractor does not meet subcontract, delegation, or monitoring plan requirements. In the case of subcontract termination, we would ensure a smooth transition, performing the delegated activities directly or arranging for them to be completed by another DOM approved Subcontractor to facilitate no lapse in services.

Depending on the severity, the Compliance Officer may contact the Subcontractor immediately or call an ad hoc meeting to discuss and resolve issues when an issue is identified. We may hold onsite meetings at our office with executive-level Subcontractor staff to address issues in person. In instances of Member risk, we will require immediate corrective action of the deficiency and intervene as needed to ensure Member safety.

If we identify a performance deficiency, Compliance staff will partner with the Subcontractor to develop and implement a written plan of action that includes specific remediation and timelines. In these cases, the Compliance Officer or a designee will closely monitor the action plan results to ensure the deficiency is remedied and steps are taken to prevent the reoccurrence of the deficiency. In addition, if there are CAPs or quality improvement plans (QIPs), the QMC will review and monitor progress. We expect prompt Subcontractor improvement following any identified deficiency, generally within one to two months, and immediately in cases that relate to Member risk. Even after deficiencies have been remediated, we will continue to monitor Subcontractor progress and activity for an additional 6 to 12 months, depending on the nature and level of non-compliance.

4.3.3.5 Subcontractors – 20 points

Use the first provided form entitled “Subcontractor” to describe the any subcontractor the Offeror plans to use if chosen as a winning Contractor through this RFQ.

If the Offeror has worked with the subcontractor in the past three (3) years on a managed care contract, use the second form, “Prior Experience with Subcontractor” to give details about that experience.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Subcontractor				
Name of Subcontractor: Centene Management Company, LLC				
TIN/SSN (as applicable): [redacted]		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[X] Affiliate under the same common ownership**		
Address Line 1: 7700 Forsyth, Blvd.				
Address Line 2: N/A				
City: Saint Louis	**State:** MO	**Zip Code:** 63105	**County:** Saint Louis	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Description of Services to be Rendered by Subcontractor for this Contract: Certain administrative support services including information systems, encounter submission, claims processing support, Special Investigations Unit, Payment Integrity, Provider Data Management, Human Resources support, BH utilization management, disease management, Nurse Advice Line, BH/SUD 24/7 Crisis Line and language services.				
How will the Offeror monitor and manage this Subcontractor? Centene Management Company, LLC (CMC) will provide deliverables, including reports that will be reviewed at each quarterly Vendor Oversight meeting. Our Compliance Officer oversees the quarterly Vendor Oversight meetings with CMC and includes representation from senior leadership from various business units. Activities during these meetings include review of performance metrics/dashboards, reports, any business process changes or opportunities for process improvement and other regulatory updates. Minutes are recorded and approved each meeting and the Compliance Officer reports status updates to the Quality Management Committee. In addition, Magnolia's Compliance Officer works in collaboration with our respective business units to monitor CMCs day-to-day operations and engages in routine conversations to ensure our Members receive services as outlined in the Appendix A, Draft Contract. Magnolia's parent company, Centene Corporation, maintains a Delegated Vendor Oversight team that conducts annual audits of all Subcontractors. These audits include a review of policies and procedures and other functional areas including, but not limited to: HIPAA compliance, credentialing standards, claims processing and record reviews. Any findings that result from these annual audits are disseminated to the health plan and corrective action plans may be instituted as needed.				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: Magnolia Health Plan, Inc.				
Client Location				
Address Line 1: 111 East Capitol Street, Suite 500				
Address Line 2: N/A				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Nicole Litton				
Title: Compliance Officer				
Phone Number: (601) 863-2576	**Email Address:** nicole.g.litton@centene.com			
Work Details				
Number of covered lives: 166,273				
Time period of contract: 2011 - Present				
Total number of staff hours expended during time period of contract: CMC employs approximately 17,896 personnel nationally to provide support services to Medicaid affiliate health plans through management agreements. Staff hours expended on average to cover all contracts per year is 37,223,680.				
Personnel requirements: CMC employs approximately 17,896 personnel to support all Medicaid affiliate contracts. CMC has sufficient personnel to support the requirements of this RFQ.				
Geographic and population coverage requirements: Statewide coverage for the following populations: SSI, TANF Adults, Pregnant Women, Behavioral Health, TANF Kids, Foster Care.				
Publicly funded contract cost: N/A The contract between Magnolia and CMC is not publicly funded.				
Description of work performed under this contract				
Certain administrative support services including information systems, encounter submission, claims processing support, Special Investigations Unit, Payment Integrity, Provider Data Management, Human Resources support, BH utilization management, disease management, Nurse Advice Line, BH/SUD 24/7 Crisis Line.				

Subcontractor				
Name of Subcontractor: Dallas Printing, Inc.				
TIN/SSN (as applicable): [redacted]		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 315 Carrier Blvd				
Address Line 2: N/A				
City: Richland	**State:** MS	**Zip Code:** 39218	**County:** Rankin County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Description of Services to be Rendered by Subcontractor for this Contract: Dallas Printing will provide printing services, such as Member identification cards and other Member materials, on behalf of Magnolia.				
How will the Offeror monitor and manage this Subcontractor? Dallas Printing, Inc. (Dallas Printing) will provide deliverables, including reports that will be reviewed at each quarterly Vendor Oversight meeting. Our Compliance Officer oversees the quarterly Vendor Oversight meetings with Dallas Printing and includes representation from senior leadership within various business units, for example our Senior Director, Marketing and Communications. Activities during these meetings include review of performance metrics/dashboards, reports, any business process changes or opportunities for process improvement and other regulatory updates. Minutes are recorded and approved each meeting and the Compliance Officer reports status updates to the Quality Management Committee. In addition, Magnolia's Compliance Officer works in collaboration with our respective business units to monitor Dallas Printing's day-to-day operations and engages in routine conversations to ensure our Members receive services as outlined in the Appendix A, Draft Contract. Magnolia's parent company, Centene Corporation, maintains a Delegated Vendor Oversight team that conducts annual audits of all Subcontractors. These audits include a review of policies and procedures and other functional areas including, but not limited to: HIPAA compliance, credentialing standards, claims processing and record reviews. Any findings that result from these annual audits are disseminated to the health plan and corrective action plans may be instituted as needed.				

Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.

Prior Experiences with Subcontractor

Client's Name: Magnolia Health Plan, Inc.				
Client Location				
Address Line 1: 111 East Capitol Street, Suite 500				
Address Line 2: N/A				
City: Jackson	**State:** MS	**Zip Code:** 39201		**County:** Hinds
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Nicole Litton				
Title: Compliance Officer				
Phone Number: (601) 863-2576		**Email Address:** nicole.g.litton@centene.com		
Work Details				
Number of covered lives: 166,273				
Time period of contract: 2017-Present				
Total number of staff hours expended during time period of contract: Dallas Printing employs approximately 26 personnel to support their clients. Staff hours expended on average to cover all contracts per year is 54,080.				
Personnel requirements: Dallas Printing employs approximately 26 personnel to support their clients. Dallas Printing has sufficient personnel to support the requirements of this RFQ.				
Geographic and population coverage requirements: Statewide coverage for the following populations: SSI, TANF Adults, Pregnant Women, Behavioral Health, TANF Kids, Foster Care.				
Publicly funded contract cost: N/A The contract between Magnolia and MTM is not publicly funded.				
Description of work performed under this contract				
Dallas Printing provides printing services, such as Member identification cards and other Member materials, on behalf of Magnolia.				

Subcontractor				
Name of Subcontractor: Envolve Dental, Inc.				
TIN/SSN (as applicable): [redacted]		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[X] Affiliate under the same common ownership**		
Address Line 1: 8715 Henderson Road				
Address Line 2: N/A				
City: Tampa	**State:** FL	**Zip Code:** 33634	**County:** Hillsborough	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Description of Services to be Rendered by Subcontractor for this Contract: Envolve Dental Inc. will provide dental benefit management services on behalf of Magnolia, including claims processing and payment, quality improvement, utilization management, and network development and management.				
How will the Offeror monitor and manage this Subcontractor? Envolve Dental will provide deliverables, including reports that will be reviewed at each quarterly Vendor Oversight meeting. These reports and deliverables include information regarding data pertaining to utilization, claims payment metrics, quality initiatives, and network adequacy reports and data. Our Compliance Officer oversees the quarterly Vendor Oversight meetings with Envolve Dental and includes representation from senior leadership from various business units, for example our VP, Network Development. Activities during these meetings include review of performance metrics/dashboards, reports, any business process changes or opportunities for process improvement and other regulatory updates. Minutes are recorded and approved each meeting and the Compliance Officer reports status updates to the Quality Management Committee. In addition, Magnolia's Compliance Officer works in collaboration with our respective business units to monitor Envolve Dental's day-to-day operations and engages in routine conversations to ensure our Members receive services as outlined in the Appendix A, Draft Contract. Magnolia's parent company, Centene Corporation, maintains a Delegated Vendor Oversight team that conducts annual audits of all Subcontractors. These audits include a review of policies and procedures and other functional areas including, but not limited to: HIPAA compliance, credentialing standards, claims processing and record reviews. Any findings that result from these annual audits are disseminated to the health plan and corrective action plans may be instituted as needed.				

Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.

Prior Experiences with Subcontractor

Client's Name: Magnolia Health Plan, Inc.				
Client Location				
Address Line 1: 111 East Capitol Street, Suite 500				
Address Line 2: N/A				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Nicole Litton				
Title: Compliance Officer				
Phone Number: (601) 863-2576	**Email Address:** nicole.g.litton@centene.com			
Work Details				
Number of covered lives: 157,302				
Time period of contract: 2011-Present				
Total number of staff hours expended during time period of contract: Envolve Dental employs approximately 328 personnel nationally to support all client contracts. Staff hours expended on average to cover all contracts per year is 682,240.				
Personnel requirements: Envolve Dental employs approximately 328 personnel nationally to support all client contracts. Envolve Dental has sufficient personnel to support the requirements of this RFQ.				
Geographic and population coverage requirements: Statewide contract covering the following populations: TANF, SSI, Foster Care				
Publicly funded contract cost: N/A The contract between Magnolia and Envolve Dental is not publicly funded.				
Description of work performed under this contract				
Envolve Dental Inc. provides dental benefit management services on behalf of Magnolia, including claims processing and payment, quality improvement, utilization management, and network development and management.				

Subcontractor				
Name of Subcontractor: Envolve Vision, Inc.				
TIN/SSN (as applicable): [redacted]		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[X] Affiliate under the same common ownership**		
Address Line 1: 1151 Falls Road				
Address Line 2: N/A				
City: Rocky Mount	**State:** NC	**Zip Code:** 27804	**County:** Nash	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A

Description of Services to be Rendered by Subcontractor for this Contract:

Envolve Vision Inc. will provide vision benefit management services on behalf of Magnolia, including claims processing and payment, quality improvement, utilization management, and network development and management.

How will the Offeror monitor and manage this Subcontractor?

Envolve Vision will provide deliverables, including reports that will be reviewed at each quarterly Vendor Oversight meeting. These reports and deliverables include information regarding data pertaining to utilization, claims payment metrics, and network adequacy reports and data. Our Compliance Officer oversees the quarterly Vendor Oversight meetings with Envolve Vision and includes representation from senior leadership from various business units, for example our VP, Network Development. Activities during these meetings include review of performance metrics/dashboards, reports, any business process changes or opportunities for process improvement and other regulatory updates. Minutes are recorded and approved each meeting and the Compliance Officer reports status updates to the Quality Management Committee. In addition, Magnolia's Compliance Officer works in collaboration with our respective business units to monitor Envolve Vision's day-to-day operations and engages in routine conversations to ensure our Members receive services as outlined in the Appendix A, Draft Contract.

Magnolia's parent company, Centene Corporation, maintains a Delegated Vendor Oversight team that conducts annual audits of all Subcontractors. These audits include a review of policies and procedures and other functional areas including, but not limited to: HIPAA compliance, credentialing standards, claims processing and record reviews. Any findings that result from these annual audits are disseminated to the health plan and corrective action plans may be instituted as needed.

Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.

Prior Experiences with Subcontractor

Client's Name: Magnolia Health Plan, Inc.				
Client Location				
Address Line 1: 111 East Capitol Street, Suite 500				
Address Line 2: N/A				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Nicole Litton				
Title: Compliance Officer				
Phone Number: (601) 863-2576	**Email Address:** nicole.g.litton@centene.com			
Work Details				
Number of covered lives: 157,302				
Time period of contract: 2011-Present				
Total number of staff hours expended during time period of contract: Envolve Vision employs approximately 328 personnel nationally to support all client contracts. Staff hours expended on average to cover all contracts per year is 682,240.				
Personnel requirements: Envolve Vision employs approximately 328 personnel nationally to support all client contracts. Envolve Vision has sufficient personnel to support the requirements of this RFQ.				
Geographic and population coverage requirements: Statewide contract covering the following populations: TANF, SSI, Foster Care				
Publicly funded contract cost: N/A The contract between Magnolia and Envolve Vision is not publicly funded.				
Description of work performed under this contract				
Envolve Vision Inc. provides vision benefit management services on behalf of Magnolia, including claims processing and payment, quality improvement, utilization management, and network development and management.				

Subcontractor				
Name of Subcontractor: Medical Transportation Management, Inc.				
TIN/SSN (as applicable): [redacted]		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 16 Hawk Ridge Circle Drive				
Address Line 2: N/A				
City: Lake St. Louis	**State:** MO	**Zip Code:** 63367	**County:** St. Charles	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Description of Services to be Rendered by Subcontractor for this Contract: Medical Transportation Management, Inc. will provide non-emergency transportation services on behalf of Magnolia, including network development and maintenance, and Member and Provider Service calls.				
How will the Offeror monitor and manage this Subcontractor? Medical Transportation Management, Inc. (MTM) will provide deliverables, including reports that will be reviewed at each quarterly Vendor Oversight meeting. Our Compliance Officer oversees the quarterly Vendor Oversight meetings with MTM and includes representation from senior leadership within various business units, for example our Chief Operating Officer, and VP, Population Health. Activities during these meetings include review of performance metrics/dashboards, reports, any business process changes or opportunities for process improvement and other regulatory updates. Minutes are recorded and approved each meeting and the Compliance Officer reports status updates to the Quality Management Committee. In addition, Magnolia's Compliance Officer works in collaboration with our respective business units to monitor MTM's day-to-day operations and engages in routine conversations to ensure our Members receive services as outlined in the Appendix A, Draft Contract. Magnolia's parent company, Centene Corporation, maintains a Delegated Vendor Oversight team that conducts annual audits of all Subcontractors. These audits include a review of policies and procedures and other functional areas including, but not limited to: HIPAA compliance, credentialing standards, claims processing and record reviews. Any findings that result from these annual audits are disseminated to the health plan and corrective action plans may be instituted as needed.				

Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.

Prior Experiences with Subcontractor

Client's Name: Magnolia Health Plan, Inc.				
Client Location				
Address Line 1: 111 East Capitol Street, Suite 500				
Address Line 2: N/A				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Nicole Litton				
Title: Compliance Officer				
Phone Number: (601) 863-2576	**Email Address:** nicole.g.litton@centene.com			
Work Details				
Number of covered lives: 166,273				
Time period of contract: 2017-Present				
Total number of staff hours expended during time period of contract: MTM employs approximately 200 personnel to support all client contracts. Staff hours expended on average to cover all contracts per year is 416,000.				
Personnel requirements: MTM employs approximately 200 personnel to support all client contracts. MTM has sufficient personnel to support the requirements of this RFQ				
Geographic and population coverage requirements: Statewide coverage for the following populations: SSI, TANF Adults, Pregnant Women, Behavioral Health, TANF Kids, Foster Care.				
Publicly funded contract cost: N/A The contract between Magnolia and MTM is not publicly funded.				
Description of work performed under this contract				
Medical Transportation Management, Inc. provides non-emergency transportation services on behalf of Magnolia, including network development and maintenance, and Member and Provider Service calls.				

Subcontractor				
Name of Subcontractor: NCH Management Systems, Inc. D/B/A New Century Health				
TIN/SSN (as applicable): [redacted]		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 675 Placentia Avenue, Suite 300				
Address Line 2: N/A				
City: Brea	**State:** CA	**Zip Code:** 92821	**County:** Orange County	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Description of Services to be Rendered by Subcontractor for this Contract: New Century Health will provide Utilization management for specialty services such as cancer, hematology, and medical oncology services on behalf of Magnolia Health Plan, Inc. (Magnolia).				
How will the Offeror monitor and manage this Subcontractor? New Century Health will provide deliverables, including reports that will be reviewed at each quarterly Vendor Oversight meeting. These reports and deliverables include information regarding data pertaining to utilization, utilization management turn-around-time, telephone metrics, and denials and appeals. Our Compliance Officer oversees the quarterly Vendor Oversight meetings with New Century Health and includes representation from senior leadership from various business units, for example our VP, Population Health and Clinical Operations. Activities during these meetings include review of performance metrics/dashboards, reports, any business process changes or opportunities for process improvement and other regulatory updates. Minutes are recorded and approved each meeting and the Compliance Officer reports status updates to the Quality Management Committee. In addition, Magnolia's Compliance Officer works in collaboration with our respective business units to monitor New Century Health's day-to-day operations and engages in routine conversations to ensure our Members receive services as outlined in the Appendix A, Draft Contract. Magnolia's parent company, Centene Corporation, maintains a Delegated Vendor Oversight team that conducts annual audits of all Subcontractors. These audits include a review of policies and procedures and other functional areas including, but not limited to: HIPAA compliance, credentialing standards, claims processing and record reviews. Any findings that result from these annual audits are disseminated to the health plan and corrective action plans may be instituted as needed.				
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**				

Prior Experiences with Subcontractor				
Client's Name: Magnolia Health Plan, Inc.				
Client Location				
Address Line 1: 111 East Capitol Street, Suite 500				
Address Line 2: N/A				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Nicole Litton				
Title: Compliance Officer				
Phone Number: (601) 863-2576	**Email Address:** nicole.g.litton@centene.com			
Work Details				
Number of covered lives: 166,273				
Time period of contract: 2020 - Present				
Total number of staff hours expended during time period of contract: New Century Health employs approximately 75 personnel nationally to support all client contracts. Staff hours expended on average to cover all contracts per year is 156,000.				
Personnel requirements: New Century Health employs approximately 75 personnel to personnel nationally to support all client contracts. New Century Health has sufficient personnel to support the requirements of this RFQ.				
Geographic and population coverage requirements: Statewide coverage for the following populations: SSI, TANF Adults, Pregnant Women, Behavioral Health, TANF Kids, Foster Care.				
Publicly funded contract cost: N/A The contract between Magnolia and New Century Health is not publicly funded.				
Description of work performed under this contract				
New Century Health performs Utilization Management for specialty services such as cancer, hematology, and medical oncology.				

Subcontractor				
Name of Subcontractor: National Imaging Associates, Inc.				
TIN/SSN (as applicable): [redacted]		**The entity is a:** **[ ] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[X] Affiliate under the same common ownership**		
Address Line 1: 8621 Robert Fulton Drive				
Address Line 2: N/A				
City: Columbia	**State:** MD	**Zip Code:** 21042	**County:** Howard	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Description of Services to be Rendered by Subcontractor for this Contract: National Imaging Associates, Inc. (NIA) will provide specialty utilization management for high-tech and cardiac imaging; physical therapy, occupational therapy, and speech therapy; and interventional pain services on behalf of Magnolia Health Plan, Inc. (Magnolia)				
How will the Offeror monitor and manage this Subcontractor? NIA will provide deliverables, including reports that will be reviewed at each quarterly Vendor Oversight meeting. These reports and deliverables include information regarding data pertaining to utilization, utilization management turn-around-time, telephone metrics, and denials and appeals. Our Compliance Officer oversees the quarterly Vendor Oversight meetings with NIA and includes representation from senior leadership from various business units, for example our VP, Population Health and Clinical Operations. Activities during these meetings include review of performance metrics/dashboards, reports, any business process changes or opportunities for process improvement and other regulatory updates. Minutes are recorded and approved each meeting and the Compliance Officer reports status updates to the Quality Management Committee. In addition, Magnolia's Compliance Officer works in collaboration with our respective business units to monitor NIAs day-to-day operations and engages in routine conversations to ensure our Members receive services as outlined in the Appendix A, Draft Contract.				

Magnolia's parent company, Centene Corporation, maintains a Delegated Vendor Oversight team that conducts annual audits of all Subcontractors. These audits include a review of policies and procedures and other functional areas including, but not limited to: HIPAA compliance, credentialing standards, claims processing and record reviews. Any findings that result from these annual audits are disseminated to the health plan and corrective action plans may be instituted as needed.

Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.

Prior Experiences with Subcontractor

Client's Name: Magnolia Health Plan, Inc.				
Client Location				
Address Line 1: 111 East Capitol Street, Suite 500				
Address Line 2: N/A				
City: Jackson	**State:** MS	**Zip Code:** 39201		**County:** Hinds
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Nicole Litton				
Title: Compliance Officer				
Phone Number: (601) 863-2576		**Email Address:** nicole.g.litton@centene.com		
Work Details				
Number of covered lives: 166,273				
Time period of contract: 2011-Present				
Total number of staff hours expended during time period of contract: NIA employs approximately 774 personnel nationally to support all client contracts. Staff hours expended on average to cover all contracts per year is 1,609,920.				
Personnel requirements: NIA employs approximately 774 personnel nationally to support all client contracts. NIA has sufficient personnel to support the requirements of this RFQ.				
Geographic and population coverage requirements:				

Statewide contract covering the following populations: SSI, TANF Adults, Pregnant Women, Behavioral Health, TANF Kids, Foster Care.
Publicly funded contract cost: N/A The contract between Magnolia and NIA is not publicly funded.
Description of work performed under this contract
National Imaging Associates, Inc. (NIA) provides specialty utilization management for high-tech and cardiac imaging; physical therapy, occupational therapy, and speech therapy; and interventional pain services through a Subcontractor agreement with Magnolia Health Plan, Inc.

Subcontractor				
Name of Subcontractor: Turning Point Healthcare Solutions, LLC				
TIN/SSN (as applicable): [redacted]		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 1000 Primera Blvd				
Address Line 2: N/A				
City: Heathrow	**State:** FL	**Zip Code:** 32746	**County:** Seminole	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A

Description of Services to be Rendered by Subcontractor for this Contract:
TurningPoint will provide Utilization Management Services on behalf of Magnolia for musculoskeletal (Ortho and Spine) procedures.

How will the Offeror monitor and manage this Subcontractor?
Turning Point Healthcare Solutions, LLC (Turning Point) will provide deliverables, including reports that will be reviewed at each quarterly Vendor Oversight meeting. These reports and deliverables include information regarding data pertaining to utilization, utilization management turn-around-time, telephone metrics, and denials and appeals. Our Compliance Officer oversees the quarterly Vendor Oversight meetings with Turning Point and includes representation from senior leadership from various business units, for example our VP, Population Health and Clinical Operations. Activities during these meetings include review of performance metrics/dashboards, reports, any business process changes or opportunities for process improvement and other regulatory updates. Minutes are recorded and approved each meeting and the Compliance Officer reports status updates to the Quality Management Committee. In addition, Magnolia's Compliance Officer works in collaboration with our respective business units to monitor Turning Point's day-to-day operations and engages in routine conversations to ensure our Members receive services as outlined in the Appendix A, Draft Contract.
Magnolia's parent company, Centene Corporation, maintains a Delegated Vendor Oversight team that conducts annual audits of all Subcontractors. These audits include a review of policies and procedures and other functional areas including, but not limited to: HIPAA compliance, credentialing standards,

claims processing and record reviews. Any findings that result from these annual audits are disseminated to the health plan and corrective action plans may be instituted as needed.

Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No

If yes, fill out Prior Experience with Subcontractor for each applicable instance.

Prior Experiences with Subcontractor

Client's Name: Magnolia Health Plan, Inc.				
Client Location				
Address Line 1: 111 East Capitol Street, Suite 500				
Address Line 2: N/A				
City: N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Nicole Litton				
Title: Compliance Officer				
Phone Number: (601) 863-2576	**Email Address:** nicole.g.litton@centene.com			
Work Details				
Number of covered lives: 166,273				
Time period of contract: 2017-Present				
Total number of staff hours expended during time period of contract: Turning Point employs approximately 306 personnel nationally to support all client contracts. Staff hours expended on average to cover all contracts per year is 636,480.				
Personnel requirements: TurningPoint employs approximately 306 personnel nationally to support all client contracts. Turning Point has sufficient personnel to support the requirements of this RFQ.				
Geographic and population coverage requirements: Statewide contract covering the following populations: SSI, TANF Adults, Pregnant Women, Behavioral Health, TANF Kids, Foster Care.				
Publicly funded contract cost: N/A The contract between Magnolia and Turning Point is not publicly funded.				
Description of work performed under this contract				

TurningPoint provides Utilization Management Services on behalf of Magnolia for musculoskeletal (Ortho and Spine) procedures.

Subcontractor				
Name of Subcontractor: Vigilant Health				
TIN/SSN (as applicable): [redacted]		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 1040 River Oaks Drive, Suite 302				
Address Line 2: N/A				
City: Flowood	**State:** MS	**Zip Code:** 39232	**County:** Rankin	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Description of Services to be Rendered by Subcontractor for this Contract: Vigilant Health will provide diabetes self-management and education services, and training, medical nutrition therapy; and point-of-care laboratory testing and related services for Members with diabetes or prediabetes and enrolled in the Diabetes Care Group program services on behalf of Magnolia.				
How will the Offeror monitor and manage this Subcontractor? Vigilant Health will provide deliverables, including reports that will be reviewed at each quarterly Vendor Oversight meeting. These reports and deliverables include information regarding data pertaining to utilization and quality metrics. Our Compliance Officer oversees the quarterly Vendor Oversight meetings with Vigilant Health and includes representation from senior leadership from various business units, for example our VP, Population Health and Clinical Operations. Activities during these meetings include review of performance metrics/dashboards, reports, any business process changes or opportunities for process improvement, quality initiatives and other regulatory updates. Minutes are recorded and approved each meeting and the Compliance Officer reports status updates to the Quality Management Committee. In addition, Magnolia's Compliance Officer works in collaboration with our respective business units to monitor Vigilant's day-to-day operations and engages in routine conversations to ensure our Members receive services as outlined in the Appendix A, Draft Contract. Magnolia's parent company, Centene Corporation, maintains a Delegated Vendor Oversight team that conducts annual audits of all Subcontractors. These audits include a review of policies and procedures and other functional areas including, but not limited to: HIPAA compliance, credentialing standards,				

claims processing and record reviews. Any findings that result from these annual audits are disseminated to the health plan and corrective action plans may be instituted as needed
Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [X] Yes [ ] No **If yes, fill out Prior Experience with Subcontractor for each applicable instance.**

Prior Experiences with Subcontractor				
Client's Name: Magnolia Health Plan, Inc.				
Client Location				
Address Line 1: 111 East Capitol Street, Suite 500				
Address Line 2: N/A				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A
Direct Contact for Client				
Name: Nicole Litton				
Title: Compliance Officer				
Phone Number: (601) 863-2576	**Email Address:** nicole.g.litton@centene.com			
Work Details				
Number of covered lives: 34,561				
Time period of contract: 2019-Present				
Total number of staff hours expended during time period of contract: Vigilant Health employs approximately 140 personnel to support all client contracts. Staff hours expended on average to cover all contracts per year is 291,200.				
Personnel requirements: Vigilant Health employs approximately 140 personnel to support all client contracts. Vigilant Health has sufficient personnel to support the requirements of this RFQ.				
Geographic and population coverage requirements: Statewide contract covering the following populations: SSI, TANF Adults, Pregnant Women, Behavioral Health, TANF Kids, Foster Care.				
Publicly funded contract cost: N/A The contract between Magnolia and NIA is not publicly funded.				
Description of work performed under this contract				

Vigilant Health provides diabetes self-management and education services, and training, medical nutrition therapy; and point-of-care laboratory testing and related services for Members with diabetes or prediabetes and enrolled in the Diabetes Care Group program services on behalf of Magnolia.

[END OF RESPONSE]

4.3.3.6 Economic Impact
There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be located in Mississippi. Use the form provided in Appendix H to detail expected wages for those positions as well as any other positions the Offeror will locate in Mississippi. The Offeror should only describe positions that will be directly hired by the Offeror. The Offeror should not include positions to be filled by Subcontractors. Additionally, include a narrative explanation no longer than two (2) pages explanation of other investments, if any, that the Offeror plans to make in Mississippi.

Please see **Attachment 4.3.3.6 Appendix H Economic Impact** for the completed Economic Impact forms with expected wages.

Magnolia Brings Long-Term Economic Advantages to the State of Mississippi

For 11 years, Magnolia has served as a steadfast partner of the State by being a good steward of taxpayer dollars through strategic investments in innovative solutions and programs that improve health outcomes for all Mississippians. We proactively meet the evolving needs of our Members, Providers, stakeholders, and the communities we serve, as well as contributing to the local economy. As an organization located in Mississippi and staffed and operated by hundreds of Mississippians across the State, we are dedicated to continuing to partner with communities to improve and invest in the future of health care in Mississippi. ***We will invest $1 million to enable William Carey University (WCU) to develop the WCU College of Medicine (COM) Institute of Primary Care in Hattiesburg.*** We selected to partner with WCU COM because of their community-based training model and commitment to educate and train osteopathic physicians, nurses, and other primary care Providers who are dedicated to serving the medically underserved and diverse populations of Mississippi. The Institute will recruit and train students primarily from Mississippi and the Gulf South region and offer continuing education and residency resources to address the physician shortage in the region. This world-class facility will allow for advanced training in high-quality value-based care geared toward the specific needs of Mississippians including diabetes, hypertension, and cardiovascular disease. The development of the Institute will result in better quality and more quantity of physicians to improve outcomes and quality of life for all Mississippians and decrease cost outcomes for the State.

Our local team of nearly 350 Mississippi-based staff lives and works in the communities we serve and are intimately familiar with the social and health needs of our neighbors. We work with our Members, Providers, and communities every day to eliminate barriers to care, reduce health disparities, and improve quality outcomes while reducing costs. Backed by our parent company, Centene, and affiliate companies, Magnolia is proud to have contributed to a total economic impact of between $297 million and $324 million in the State of Mississippi in 2021.

Economic Impact on the State of Mississippi

Throughout the years, we have continued to enhance our impact on Mississippi's growth and economy. Our contributions include providing local jobs, building and opening new facilities, and supporting local businesses by purchasing goods and services. This has a multiplier effect that ripples through industries in the state. To objectively measure our economic impact, we use a nationally recognized computerized model called IMPLAN. IMPLAN uses sophisticated algorithms based on Mississippi economic profiles to estimate how spending in one industry circulates and positively impacts other industries. Using the IMPLAN, we report our economic impact using three factors:

- **Direct Effect -** total number of jobs and total employee compensation
- **Indirect Impacts -** revenue or activity generated by Magnolia, Centene, and affiliate purchases of goods and services
- **Induced Household Spending Impact - r**evenue generated by our employees and their families when they spend or reinvest their earnings

Investing in Mississippi

- Over $297 million in 2021 total economic impact
- Over $54 million in local and state tax revenue in 2021
- Over $2.1 million in contributions to local organizations since inception

The indirect and induced impacts are often referred to as the "ripple effect" as spending re-circulates through Mississippi's economy. ***Using this methodology, the University of Southern Mississippi (USM) conducted a study of our estimated total economic contribution to the state***. **Table 4.3.3.6.A** presents a breakdown of the total economic contribution of Magnolia's Mississippi annual operations in terms of jobs, labor income, GDP, and total output.

Table 4.3.3.6.A Estimated Economic Impact in Mississippi

[redacted]

Economic Impact Through Tax Revenue Obligations. The economic impact that we have returned to the State of Mississippi through tax revenue obligations includes amounts from Magnolia, Centene, and our affiliates who are all tax filers in the State of Mississippi. Magnolia's contributions support approximately ***$19 million in local taxes and $35 million in state taxes***. **Table 4.3.3.6.B** shows our indirect tax payments from the last five years. Our tax contribution is evidence of our growth, a testament to our success, and demonstrates a true commitment to improving the lives of Mississippians.

Table 4.3.3.6.B Summary of Mississippi Indirect Tax Payments

[redacted]

**Note: 2020 data is abnormal due to COVID-19 pandemic and is not representative of a typical year. The negative federal taxes for 2020 data represent a transfer from the federal government.*

Local Workforce Development Efforts. [redacted]mmitment to Mississippians, Magnolia collaborates with several universities, colleges, and other institutions throughout the state to support local workforce development efforts. We participate in college job fairs, hire from local colleges and universities, and engage in speaking engagements around the health care workforce. Additionally, we are partnering with institutions such as Jackson State University to create a pipeline program for Master's in Social Work students; and William Carey University, USM, Hinds Community College, and Meridian Community College to support the nursing pipeline.

Community Partnerships. Through local financial investments, contributions from the Centene Charitable Foundation, and community volunteerism, Magnolia has supported underserved and rural communities. To date, we are proud to work with and support more than 450 organizations from the Gulf Coast to Oxford. Since 2011, we have invested more than $2 million in Mississippi-based organizations, providing them with resources and support to care for the communities we jointly serve.

Change the World

Centene was recognized on the FORTUNE 2020 Change the World™ list of companies that have had a positive social impact through activities that are part of their core business strategy.

Supporting Organizations during the COVID-19 Pandemic. In response to the COVID-19 pandemic, Magnolia continues to serve the people in our communities. Highlights of our support include**:**

- **750** Walmart Gift Cards to various community organizations and Provider groups
- **200** Amazon Gift Cards to various community organizations
- **$46,000** to local food banks; Centene Charitable Foundation gave a large donation to MS Food Network
- **500** masks for CPS Case Workers
- **20,000** masks to the MS Dental Association
- **200** Samsung cell phones to Providers for patients who did not have a reliable phone for telehealth services

In addition, Magnolia assisted network Providers in Mississippi seeking relief amid the COVID-19 pandemic through the Small Business Administration and the CARES Act. We provided access to aid Mississippi Providers in grant writing and business loan applications, among other activities.

Creating stronger and healthier communities is central to Magnolia's mission to transform the health of the community, one person at a time. As your neighbor and local partner, ***we are proud to call Mississippi home***.

APPENDIX H: Organization and Staffing

The forms in this Appendix must be used by the Offeror to respond (either in whole or in part, depending on the instructions in the RFQ) to the following:

- 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked) – 20 points
- 4.3.3.3 Administrative Requirements (Marked) – 10 points
- 4.3.3.5 Subcontractors – 20 points
- 4.3.3.6 Economic Impact – 20 points

The Offeror must respond to all other portions of the Organization and Staffing portion of the RFQ in the manner and format stated therein. Answers should be presented in the Offeror's qualification in the order and format indicated within the RFQ.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

4.3.3.6 Economic Impact – 20 points

There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be located in Mississippi. Please provide the Offeror's expected wages for each of those positions.

Additionally, include a list of any other positions the Offeror will locate in Mississippi and include expected wages for each of those positions, as well as any other investment that the Offeror plans to make inside the state.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

Economic Impact: Wage Chart
Title of Position: Chief Executive Officer
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Chief Operating Officer
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Chief Financial Officer
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Economic Impact: Wage Chart
Title of Position: Medical Director (Chief)
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Perinatal Health Director
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Behavioral Health Director
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Economic Impact: Wage Chart
Title of Position: Chief Information Officer
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Economic Impact: Wage Chart
Title of Position: Compliance Officer
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Economic Impact: Wage Chart
Title of Position: Provider Services Manager
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Network/Contracting Manager
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Member Services Manager

If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Economic Impact: Wage Chart
Title of Position: Quality Management Director
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Care Management Director
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Population Health Director
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Economic Impact: Wage Chart
Title of Position: Utilization Management Coordinator
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Grievance and Appeals Coordinator
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Claims Administrator
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Economic Impact: Wage Chart
Title of Position: Data and Analytics Manager
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Title of Position: Clinical Pharmacist
If Position is not a Key Position, provide description: N/A (Key Position)

[redacted]

Economic Impact: Wage Chart
Title of Position: Vice President, Government Relations and Communications
If Position is not a Key Position, provide description: Responsible for establishing and maintaining executive level relationships with government officials to impact positive outcomes for health plan and members served. Lead market-level marketing and communication efforts internally and externally. Work with health benefit exchange and other internal and external parties for Ambetter product market position.

[redacted]

Title of Position: Care Manager (Social Work)
If Position is not a Key Position, provide description: Perform care management duties to assess, plan and coordinate all aspects of medical and supporting services across the continuum of care for select members to promote quality, cost effective care.

[redacted]

Title of Position: Care Manager (RN)
If Position is not a Key Position, provide description: Perform care management duties to assess, plan and coordinate all aspects of medical and supporting services across the continuum of care for select members to promote quality, cost effective care.

[redacted]

Economic Impact: Wage Chart
Title of Position: Social Service Specialist I
If Position is not a Key Position, provide description: Coordinate psychosocial services for members identified as having special needs and assisting members with utilization of medical and/or behavioral resources related to case management, disease management and discharge planning.

[redacted]

Title of Position: Social Services Specialist II
If Position is not a Key Position, provide description: Coordinate psychosocial services for members identified as having special needs and assisting members with utilization of medical and/or behavioral resources related to case management, disease management and discharge planning.

[redacted]

Title of Position: Referral Specialist I
If Position is not a Key Position, provide description: Assist in monitoring utilization of medical services to assure cost effective use of medical resources through processing prior authorizations.

[redacted]

Economic Impact: Wage Chart
Title of Position: Referral Specialist II
If Position is not a Key Position, provide description: Assist in monitoring utilization of medical services to assure cost effective use of medical resources through processing prior authorizations and act as trainer and mentor to less experienced staff.

[redacted]

Title of Position: Program Coordinator I
If Position is not a Key Position, provide description: Assist in activities related to the medical and psychosocial aspects of utilization and coordinated care.

[redacted]

Title of Position: Program Coordinator II
If Position is not a Key Position, provide description: Perform duties to assist in activities related to the medical and psychosocial aspects of utilization and coordinated care.

[redacted]

Economic Impact: Wage Chart
Title of Position: Community Health Services Representative I
If Position is not a Key Position, provide description: Responsible for delivering of a range of activities for individuals who are enrolled in the health plan for Medicaid or and Medicare in order to impact individual health outcomes and provide assistance to the clinical team of nurses and social workers. Activities include, but are not limited to outreach, community education, informal guidance and member support.

[redacted]

Title of Position: Community Health Services Representative II
If Position is not a Key Position, provide description: Responsible for delivering of a range of activities for individuals who are enrolled in the health plan for Medicaid or Medicare in order to impact individual health outcomes and provide assistance to the clinical team of nurses and social workers. Activities include, but are not limited to outreach, community education, informal counseling, and member support.

[redacted]

Title of Position: Provider Data Coordinator I
If Position is not a Key Position, provide description: Perform day to day functions to maintain appropriate databases and create reports to monitor network compliance with State requirements.

[redacted]

Economic Impact: Wage Chart
Title of Position: Provider Data Coordinator II
If Position is not a Key Position, provide description: Perform day to day functions to inbound requests and maintain provider database. Audit analyses on completed requests and monitor compliance status of submitted requests.

[redacted]

Title of Position: Quality Practice Advisor
If Position is not a Key Position, provide description: Establishes and fosters a healthy working relationship between large physician practices, IPAs and the health plan. Educates providers and supports provider practice sites regarding the National Committee for Quality Assurance (NCQA) HEDIS measures and risk adjustment. Provides education for HEDIS measures, appropriate medical record documentation and appropriate coding. Assists in resolving deficiencies impacting plan compliance to meet State and Federal standards for HEDIS and documentation standards. Acts as a resource for the health plan peers on HEDIS measures, appropriate medical record documentation and appropriate coding. Supports the development and implementation of quality improvement interventions and audits in relation to plan providers.

[redacted]

Title of Position: Senior Trainer – Auditor (Clinical)
If Position is not a Key Position, provide description: Develop, conduct, administer and analyze clinical training programs, conduct audits of clinical systems entry and/or processes, and assist in development of audit tools

[redacted]

Economic Impact: Wage Chart
Title of Position: Senior Manager, Finance
If Position is not a Key Position, provide description: Oversee the maintenance of accurate financial records and financial analytic functions.
[redacted]
Title of Position: Supervisor, Community Health Services
If Position is not a Key Position, provide description: Supervise daily activities of community health services team and the delivery of a range of activities for individuals enrolled in the health plan for Medicaid or and Medicare. These activities benefit the organizations in impacting individual health outcomes and provides assistance to our clinical team of nurses and social workers.
[redacted]
Title of Position: Business Analyst III
If Position is not a Key Position, provide description: Perform various analysis and interpretation to link business needs and objectives for assigned function.
[redacted]

Economic Impact: Wage Chart
Title of Position: Clinical Appeals Coordinator
If Position is not a Key Position, provide description: Act as the liaison for all statewide appeals, fair hearings, review organizations, and other external type appeals. Responsible for ensuring that all appeal letters generated comply with both State and NCQA requirements.

[redacted]

Title of Position: Senior Care Manager (RN)
If Position is not a Key Position, provide description: Perform care management duties to assess, plan and coordinate all aspects of medical and supporting services across the continuum of care for select members to promote quality, cost effective care.

[redacted]

Title of Position: Supervisor, Quality Development (Call Center Operations)
If Position is not a Key Position, provide description: Oversee daily member and provider services operations of call centers toward achievement of successful call outcomes and organizational goals/initiatives, including quality call audits and training.

[redacted]

Economic Impact: Wage Chart
Title of Position: Contract Negotiator I
If Position is not a Key Position, provide description: Recruit physician, hospital, and ancillary service providers to sign network participation agreements that are in accordance with Corporate, health plan and State guidelines. Ensure that all necessary documentation and information are included.

[redacted]

Title of Position: Concurrent Review Nurse I
If Position is not a Key Position, provide description: Promote the quality and cost effectiveness of medical care by applying clinical acumen and the appropriate application of policies and guidelines to emergent/urgent and continued stay reviews.

[redacted]

Title of Position: Concurrent Review Nurse II
If Position is not a Key Position, provide description: Promote the quality and cost effectiveness of medical care by applying clinical acumen and the appropriate application of policies and guidelines to emergent/urgent and continued stay reviews.

[redacted]

Economic Impact: Wage Chart
Title of Position: Concurrent Review Nurse II
If Position is not a Key Position, provide description: Promote the quality and cost effectiveness of medical care by applying clinical acumen and the appropriate application of policies and guidelines to emergent/urgent and continued stay reviews.

[redacted]

Title of Position: Claims Liaison I

If Position is not a Key Position, provide description: Serve as a liaison between the plan, claims, providers, and various departments to effectively identify and resolve claims issues.

[redacted]

Title of Position: Prior Authorization Nurse I
If Position is not a Key Position, provide description: Promote the quality and cost effectiveness of medical care by applying clinical acumen and the appropriate application of policies and guidelines to prior authorization requests.

[redacted]

Economic Impact: Wage Chart
Title of Position: Prior Authorization Nurse II
If Position is not a Key Position, provide description: Promote the quality and cost effectiveness of medical care by applying clinical acumen and the appropriate application of policies and guidelines to prior authorization requests.

[redacted]

Title of Position: Senior Prior Authorization Nurse
If Position is not a Key Position, provide description: Promote the quality and cost effectiveness of medical care by applying clinical acumen and the appropriate application of policies and guidelines to prior authorization requests.

[redacted]

Title of Position: Customer Service Representative I
If Position is not a Key Position, provide description: Respond to customer inquiries via telephone and written correspondence in a timely and appropriate manner.

[redacted]

Economic Impact: Wage Chart
Title of Position: Customer Service Representative II
If Position is not a Key Position, provide description: Resolve customer inquiries via telephone and written correspondence in a timely and appropriate manner.
[redacted]
Title of Position: Provider Relations Specialist I
If Position is not a Key Position, provide description: Perform duties to act as a liaison between providers, the health plan and Corporate. Perform training, orientation and coaching for performance improvement within the network and assist with claim resolution.
[redacted]
Title of Position: Provider Relations Specialist II
If Position is not a Key Position, provide description: Perform health plan provider orientations and conduct ongoing educational outreach with a focus on improving quality and financial outcomes within the provider network. Act as liaison between providers and the health plan to enhance the business relationship.
[redacted]

Economic Impact: Wage Chart
Title of Position: Contract Audit Specialist
If Position is not a Key Position, provide description: Audit provider information to ensure consistency in provider setup and contract language. Ensure accurate and safe storage of all provider contract files.
[redacted]
Title of Position: Business Analyst IV
If Position is not a Key Position, provide description: The Business Analyst supports enterprise strategy and delivery of analytic services by performing various analyses and interpretations to link business needs for assigned functions. The analyst will collaborate within and across analytic functions, with business partners, and with customers to ensure appropriate flow of information, requirements, and strategic partnerships to support delivery of leading-edge analytics that answer important business questions.
[redacted]
Title of Position: Business Analyst IV (Healthcare Analytics)
If Position is not a Key Position, provide description: The Business Analyst (Healthcare Analytics) supports enterprise strategy and delivery of analytic services by performing various analyses and interpretations to link business needs for assigned functions. The analyst will collaborate within and across analytic functions, with business partners, and with customers to ensure appropriate flow of information, requirements, and strategic partnerships to support delivery of leading-edge analytics that answer important business questions.
[redacted]

Economic Impact: Wage Chart
Title of Position: Contracts Coordinator
If Position is not a Key Position, provide description: Assist with the contract submission process and the auditing of provider information systems (AMISYS) for consistency and best practices in Provider set up.

[redacted]

Title of Position: Supervisor, Medical Management (Clinical)
If Position is not a Key Position, provide description: Supervise the day-to-day operations of the medical management, utilization, and case management functions.

[redacted]

Title of Position: Senior Contract Negotiator
If Position is not a Key Position, provide description: Coordinate and negotiate hospital, physician (IPAs, PPMs, individual providers, multi-specialty groups) and ancillary service agreements that are in accordance with corporate, health plan and State guidelines.

[redacted]

Economic Impact: Wage Chart
Title of Position: Claims Business Analyst
If Position is not a Key Position, provide description: Serve as the claims payment and claims configuration expert for plan and various departments to effectively identify and resolve claims issues. Act as the subject matter expert for the claim's payment structure.
[redacted]
Title of Position: Manager, Compliance & Reporting
If Position is not a Key Position, provide description: Design and implement programs, policies, and practices to ensure State and Federal program contract compliance, as well as compliance with federal and state legal and regulatory requirements.
[redacted]
Title of Position: Provider Network Administrator
If Position is not a Key Position, provide description: The Provider Network Administrator is the internal and external liaison for the Provider Network Management Department who maintains positive working relationships with participating physicians, participating physician groups (PPG's), hospitals and/or ancillary providers within an assigned area. Responsible for daily administration and operation of the contractual provider relationships including overseeing accurate and current provider databases, providing training, education and information to providers, coordinating regulatory filings and rollouts, and researching, analyzing and resolving complex problems dealing with contract loading, division of financial responsibility interpretation, contract rate and language interpretation, appeals, grievances and eligibility.
[redacted]

Economic Impact: Wage Chart
Title of Position: Supervisor, Referral Services
If Position is not a Key Position, provide description: Supervise the day-to-day operations of the utilization and case management areas.
[redacted]
Title of Position: Senior Manager, Quality Improvement
If Position is not a Key Position, provide description: Provide leadership and direction for continuous quality improvement (QI) initiatives to improve efficiency, processes and demonstrate improved quality. Provide and analyze reports to identify trends, opportunities and recommend initiatives aimed at improving quality of care and services provided by the organization.
[redacted]
Title of Position: Senior Manager Customer Service
If Position is not a Key Position, provide description: Plan, manage, and oversee all customer service functions to meet overall business goals and objectives.
[redacted]

Economic Impact: Wage Chart
Title of Position: Senior Manager, Operations
If Position is not a Key Position, provide description: Oversee operations, and business strategy utilizing cross-functional departments to meet strategic objectives.
[redacted]
Title of Position: Director, Risk Adjustment
If Position is not a Key Position, provide description: Key strategic leader responsible for driving the Risk Adjustment for various lines of business and achieving related revenue targets. This includes identifying opportunities to improve completeness as well as accuracy of risk adjustment data submitted to CMS and HHS. This leader is also responsible for the development, analysis and reporting of key risk adjustment metrics, as well as overseeing analyses of new legislation and regulations regarding Risk Adjustment and assessing the impact of any changes in the programs.
[redacted]
Title of Position: Senior Director, Medical Management
If Position is not a Key Position, provide description: Direct medical management program including utilization management, case management, and quality improvement in accordance with the mission, philosophy, and objectives of the plan and in conjunction with corporate goals and objectives.
[redacted]

Economic Impact: Wage Chart
Title of Position: Director Medical Management (Ambetter, Medicare)
If Position is not a Key Position, provide description: Direct medical management program including utilization management, case management, quality improvement and credentialing in accordance with the mission, philosophy, and objectives of plan and in conjunction with Corporate goals and objectives.
[redacted]
Title of Position: Director, Quality Improvement
If Position is not a Key Position, provide description: The Director of Clinical Quality Management is responsible for the operations of Clinical Quality Management (CQM) within the Company. The Director of CQM is also responsible for ensuring conformance to the Company's quality system in accordance with customer and company requirements.
[redacted]
Title of Position: Medical Director
If Position is not a Key Position, provide description: Direct and coordinate the medical management, quality improvement and credentialing functions for the assigned business unit based on, and in support of the strategic plan, establishing the strategic vision and attendant policies and procedures.
[redacted]

Economic Impact: Wage Chart
Title of Position: Contract Implementation Analyst
If Position is not a Key Position, provide description: Perform day to day duties and testing of contract implementation, including UAT to ensure that systems accurately reflect a contract's negotiated terms.

[redacted]

Title of Position: Finance Analyst III
If Position is not a Key Position, provide description: Compile and analyze financial information for the company. Lead various financial project

[redacted]

Title of Position: Vendor Management Analyst
If Position is not a Key Position, provide description: Assist with all vendor activity, including but not limited to dental, ancillary, pharmacy and vision vendors for the Health Plan

[redacted]

Economic Impact: Wage Chart
Title of Position: Claims Research Specialist
If Position is not a Key Position, provide description: Perform duties to act as a liaison between provider relations, provider services, the health plan and corporate to investigate and resolve claims inquiries.

[redacted]

Title of Position: Trainer I
If Position is not a Key Position, provide description: Responsible for developing and conducting a variety of training programs and/or auditing tools.

[redacted]

Title of Position: Community Relations Representative I (Community Health Worker)
If Position is not a Key Position, provide description: Provide sales coverage and develop best possible market penetration for all lines of business to present to prospective members in assigned territory in accordance with company's policies and programs. Provide greater access to health insurance, by providing education, assistance and coordinating community outreach to individuals.

[redacted]

Economic Impact: Wage Chart
Title of Position: Community Relations Representative III
If Position is not a Key Position, provide description: Manage, develop, implement, and sustain community relations programs and initiatives throughout the state.
[redacted]
If Position is not a Key Position, provide description: Responsible for analytical data needs. Handle complex data requests, reports, and predictive data modeling.
[redacted]
Title of Position: Data Analyst II
If Position is not a Key Position, provide description: Responsible for analytic data needs of the business unit.
[redacted]

Economic Impact: Wage Chart
Title of Position: Senior Director, Sales & Marketing
If Position is not a Key Position, provide description: Direct and oversee marketing communications programs that effectively describe and promote the organization, with an emphasis on marketing, brand strategy, message development, and execution.

[redacted]

Title of Position: Project Coordinator I
If Position is not a Key Position, provide description: Provides support with various activities and projects. This support will include tracking and coordinating projects to ensure prescribed activities are carried out in accordance with specified objectives and acting as a liaison between department and project management software or key project personnel

[redacted]

Title of Position: Program Coordinator I
If Position is not a Key Position, provide description: Assist in activities related to the medical and psychosocial aspects of utilization and coordinated care.

[redacted]

Economic Impact: Wage Chart
Title of Position: Program Coordinator II
If Position is not a Key Position, provide description: Assist in activities related to the medical and psychosocial aspects of utilization and coordinated care.
[redacted]
Title of Position: Provider Data Coordinator I
If Position is not a Key Position, provide description: Perform day to day functions to maintain appropriate databases and create reports to monitor network compliance with State requirements.
[redacted]
Title of Position: Provider Data Coordinator II
If Position is not a Key Position, provide description: Perform day to day functions to inbound requests and maintain provider database. Audit analyses on completed requests and monitor compliance status of submitted requests
[redacted]

Economic Impact: Wage Chart
Title of Position: Pharmacy Coordinator I
If Position is not a Key Position, provide description: Perform duties to support the efforts pharmacy department in the development, coordination and maintenance of the health plan's pharmacy program.
[redacted]
Title of Position: Pharmacy Coordinator II
If Position is not a Key Position, provide description: Perform duties to support the efforts pharmacy department in the development, coordination and maintenance of the health plan's pharmacy program. Provides support for escalated issues and special projects as assigned.
[redacted]
Title of Position: Clinical Provider Trainer
If Position is not a Key Position, provide description: Develop and implement trainings to educate network providers and their staff on the company's clinical philosophy and evidence-based practice methods. Collaborate with other staff, departments and health plan staff for maintaining and monitoring the delivery and effectiveness of the training program and identify solutions to challenges.
[redacted]

Economic Impact: Wage Chart
Title of Position: Senior Trainer
If Position is not a Key Position, provide description: Responsible for developing and conducting a variety of training programs and auditing tools.
[redacted]
Title of Position: Child Health Coordinator I
If Position is not a Key Position, provide description: Conduct outreach (via telephone and mail) to encourage enrollees to access preventive care; assist with making appointments and arrangements as necessary.
[redacted]
Title of Position: Project Manager I
If Position is not a Key Position, provide description: Plans, organizes, monitors, and oversees projects utilizing cross functional teams to deliver defined requirements and meet company strategic objectives.
[redacted]

Economic Impact: Wage Chart
Title of Position: Project Manager II
If Position is not a Key Position, provide description: Plans, organizes, monitors, and oversees projects utilizing cross functional teams to deliver defined requirements and meet company strategic objectives.

[redacted]

Title of Position: Project Manager III
If Position is not a Key Position, provide description: Plans, organizes, monitors, and oversees projects utilizing cross functional teams to deliver defined requirements and meet company strategic objectives.

[redacted]

Title of Position: PCMH Director
If Position is not a Key Position, provide description: Responsible for leading and overseeing all aspects of Patient-Centered Medical Home (PCMH) program for Magnolia's PCMH network in Mississippi. As part of the Provider Network Management Team, the PCMH Program Director works cross-functionally to effectively engage PCMH Primary Care Providers to improve overall population health and stability and decrease the healthcare cost curve. The PCMH Program Director ensures that PCMH-enrolled practitioners become active participants in managing their patient population through risk stratification, appropriate planning, and allocation of resources to meet the patient's needs.

[redacted]

Economic Impact: Wage Chart
Title of Position: Senior Prior Authorization Nurse
If Position is not a Key Position, provide description: Promote the quality and cost effectiveness of medical care by applying clinical acumen and the appropriate application of policies and guidelines to prior authorization requests.
[redacted]
Title of Position: Denial Coordinator
If Position is not a Key Position, provide description: Generate and process denial letters and Notice of Action (NOA) for pre services, leveling of care and denied medical services.
[redacted]
Title of Position: Supervisor, Provider Data Management
If Position is not a Key Position, provide description: Review and audit inbound and completed provider data requests to ensure accuracy, completeness, and compliance. Review and resolve complex issues and communicate status reports to management.
[redacted]

Economic Impact: Wage Chart
Title of Position: Supervisor, Clinical Grievance and Appeals
If Position is not a Key Position, provide description: Supervise nurses in a highly regulated department responsible for performing medical necessity case reviews for appropriateness of medical care and service. Supervise the day-to-day clinical operations and functions within the department, ensuring productivity and quality metrics are met.

[redacted]

Title of Position: Supervisor, Program Coordination
If Position is not a Key Position, provide description: Perform collaborative duties for the development and implementation of all Coordinated Care programs (OB/NICU, Asthma, Diabetes, ER, General/Catastrophic); Provide support and supervision to ensure quality and continuity of services delivered to Members, Providers and staff.

[redacted]

Title of Position: Senior Manager, Provider Relations
If Position is not a Key Position, provide description: Oversee provider network to ensure appropriate access to care and quality member outcomes. Develop and implement activities for the recruitment and retention of effective providers. Partner with providers to monitor member health outcomes and oversee provider contract performance.

[redacted]

Economic Impact: Wage Chart
Title of Position: Lead Data Analyst
If Position is not a Key Position, provide description: The Data Analyst (Healthcare Analytics) will have the opportunity to make a significant impact through the discovery, development, and implementation of leading-edge analytics that answer important business questions. The analyst will collaborate with key corporate and health plan business partners for the purpose of identifying and delivering robust reporting and analytics capabilities to drive improved business performance.
[redacted]
Title of Position: Lead Member Advocate
If Position is not a Key Position, provide description: Act as an advocate for the Member and a liaison between the Health Plan and Provider(s) to ensure availability and access to care while coordinating the day-to-day work function of the Community Relations area, acting as a "go to" person for the department. Establish a community presence, promote Member education, identify, and resolve any systemic barriers that limit Member's access to appropriate care.
[redacted]
If Position is not a Key Position, provide description: The Accreditation Manager, will be responsible for maintaining organizational readiness for accreditation and renewals by maintaining on-going work-plans, ensuring completion of on-going activities, conducting policy and procedure reviews, and communicating changes in accreditation standards to affected business owners. Works in conjunction with applicable business owners to make sure that policies are written when required and that all policies are in compliance with accreditation standards, including but not limited to NCQA Health Plan Accreditation Standards.
[redacted]

Economic Impact: Wage Chart
Title of Position: Manager Quality Improvement
If Position is not a Key Position, provide description: Manage and develop data necessary to analyze trends over various timeframes. Manage the data mining process and analysis using internally supported database programs. Collaborate with various departments and other key business units to identify areas for process improvement initiatives.
[redacted]
Title of Position: Manager, Customer Service
If Position is not a Key Position, provide description: Plan and manage assigned customer service function at the health plan to meet overall business goals and objectives.
[redacted]
Title of Position: Manager, Case Management
If Position is not a Key Position, provide description: The Case Management Manager effectively manages a case management team and provides leadership and management of the services and activities of the regional case management function. Actively promotes an organizational culture committed to high quality customer service to clients and their families, physicians, and other members of the health care delivery system. Works collaboratively with contracting department, provider relations and administrators for the development and maintenance of clinically appropriate, cost-effective case management processes. Develops policies and procedures to improve efficiency and ensure a focus on outcomes.
[redacted]

Economic Impact: Wage Chart
Title of Position: Supervisor, Pharmacy Specialist
If Position is not a Key Position, provide description: Perform duties to implement a pharmacy benefit management program. Aid the Director of Pharmacy in formulating and administering related organizational policies and procedures including quality, compliance, and pharmacy utilization management.

[redacted]

Title of Position: Lead Compliance Coordinator
If Position is not a Key Position, provide description: Ensure compliance with State contract and regulatory reporting and deliverable submission and tracking and recordkeeping. Oversee and monitor HIPAA privacy regulation, special project assignments and compliance training company wide.

[redacted]

Title of Position: Grievance and Appeals Coordinator
If Position is not a Key Position, provide description: Analyze and resolve verbal and written claims and authorization grievance/appeals from providers and members. Resolve all State inquires related to complaints, grievances and appeals.

[redacted]

Economic Impact: Wage Chart
Title of Position: Workforce Analyst II
If Position is not a Key Position, provide description: Assist with maximizing the effectiveness of scheduling, systems, performance metrics, data analysis, reporting and overall operational functions for all lines of business and all locations. Evaluate staffing adjustments and re skilling of agents as necessary to provide adequate phone coverage.

[redacted]

Title of Position: Workforce Analyst I
If Position is not a Key Position, provide description: Use ACD phone system to assist with maximizing the effectiveness of scheduling, systems, performance metrics, data analysis, reporting and overall operational functions for all lines of business and all locations. Evaluate staffing adjustments and re skilling of agents as necessary to provide adequate phone coverage.

[redacted]

Title of Position: Senior Executive Assistant
If Position is not a Key Position, provide description: Relieves the executive of administrative type functions in order to increase the time the executive has available for senior level responsibilities.

[redacted]

Economic Impact: Wage Chart
Title of Position: Quality Improvement Specialist I
If Position is not a Key Position, provide description: Support the data management and quality improvement initiatives for assigned functional areas
[redacted]
Title of Position: Quality Improvement Coordinator I
If Position is not a Key Position, provide description: Analyze, develop, implement, and monitor clinical quality improvement initiatives to achieve healthy outcomes.
[redacted]
Title of Position: Quality Improvement Coordinator II
If Position is not a Key Position, provide description: Conduct review of delegated entities for compliance with quality, service performance and utilization, credentialing reviews and medical record audits. Perform community activities related to clinical initiatives such as health fairs and communicate with agencies and providers.
[redacted]

Economic Impact: Wage Chart
Title of Position: Quality Specialist I
If Position is not a Key Position, provide description: Perform quality review to ensure a high level of customer service.

[redacted]

Title of Position: Quality Reporting Specialist
If Position is not a Key Position, provide description: Organize and assemble various quality indicators which are reported to the Quality Management Risk Management Committee. Coordinate Quality of Care (QOC) tracking process and the operational department reporting to ensure timely submission to the payors.

[redacted]

Title of Position: Health Equity Director
If Position is not a Key Position, provide description: The Health Equity Director will provide leadership and management to define, implement, and evaluate strategies to achieve equitable access and reduce disparities in clinical care and quality outcomes. This strategy will include tracking, assessing, and improving disparities in care, and supporting the diverse cultural, language, economic, education and health status needs of those served by Magnolia.

[redacted]

Economic Impact: Wage Chart
Title of Position: Community Engagement Specialist
If Position is not a Key Position, provide description: Develop, implement, and provide oversight for Health Equity programs. Ensure the successful integration of cultural competency into operational programs. Oversee cultural competency requirements to external stakeholders and government agencies, including government relations, network Providers, and delegated entities. Lead and coordinate workforce staff development in cultural competency.

[redacted]

[END OF RESPONSE]

4.3.4 MANAGEMENT AND CONTROL

The Management and Control Section shall include details of the methodology to be used in management and control of the program, program activities, and progress reports. This Section will also provide processes for identification and correction of problems. Specific explanation must be provided if solutions vary from one phase to another.

4.3.4.1 DAY-TO-DAY MANAGEMENT

1. Program management approach;

Magnolia Health Plan (Magnolia) will leverage the experience and understanding we have gained as a Coordinated Care Organization (CCO) for the MississippiCAN program since 2011 to successfully implement and continue to serve Mississippi Medicaid and CHIP beneficiaries through the CCO Program. Our high-touch approach and local operating model form the core of our business philosophy and reinforce our continued collaborative relationship with DOM. We have demonstrated our effectiveness through the partnerships we have built and maintain with our Members, DOM, Providers, community advocates, and other stakeholders. Our implementation will be supported by the infrastructure, experience, and resources of our parent company, Centene Corporation (Centene). Centene's reputation is built on an impeccable record of successful implementations across the nation, whether it is a new health plan, reprocurement, or product expansion. During its over 36-year history, Centene has developed the expertise and specific tools required to successfully launch CHIP, Medicaid, and other public sector managed care plans. Centene manages more than 26.6 million Members across the United States, including adults, children, seniors, individuals with special needs, and other populations.

Enterprise Business Implementation Model (EBI Model)

Magnolia bases our program and project management methodology on the same successful model we used to implement Magnolia's initial operations in 2011, our population expansion in 2012, our re-procurement of the MississippiCAN Program in 2014, our Mississippi CHIP Program implementation in 2015, the MississippiCAN inpatient carve-in in December 2015, and most recently, the MississippiCAN reprocurement in 2017. Our EBI tools and templates have been developed to specifically meet the needs of Mississippi Medicaid and CHIP managed care projects. They encompass the following key areas described throughout the response:

- Project scope
- Project communications
- Resource planning
- Work Plan and Schedule
- Risk management
- Quality control
- Cost management

Five Elements of Success

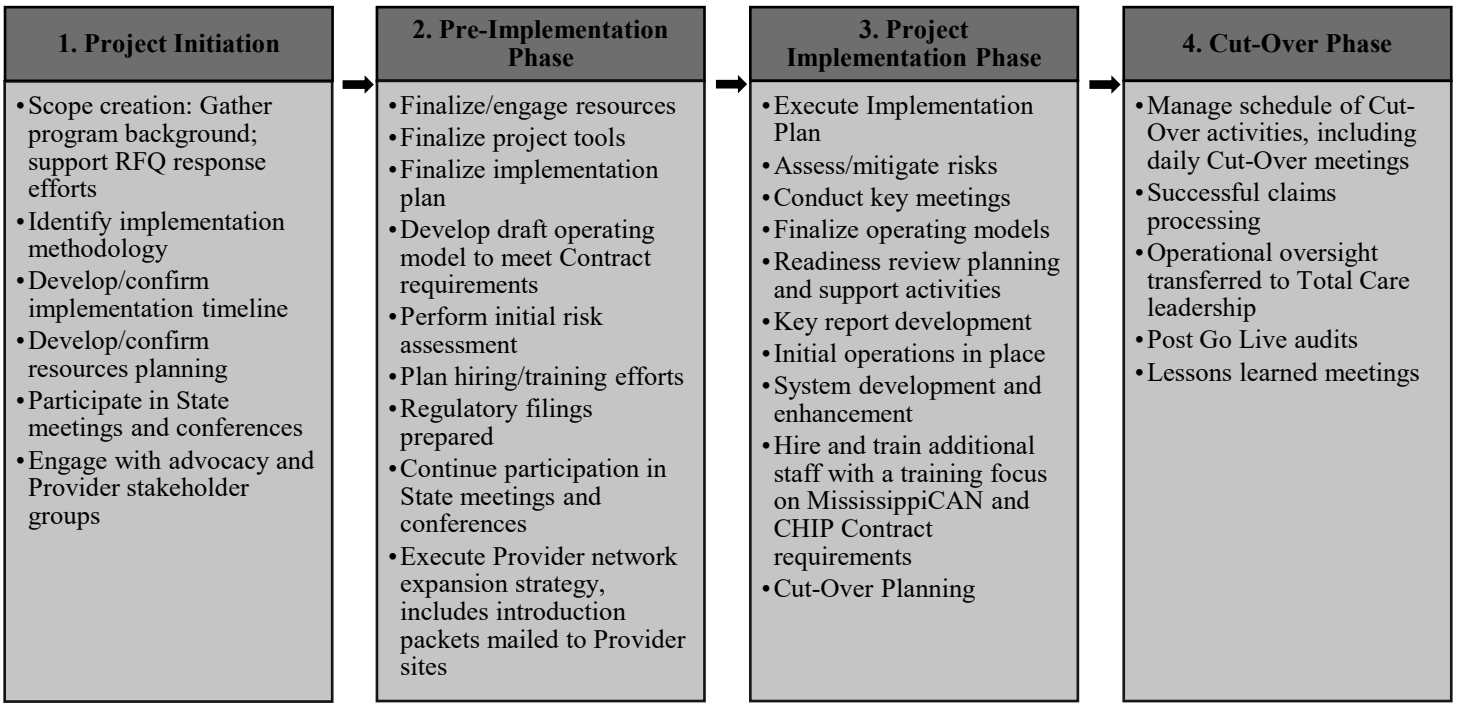
Our project management approach consists of five key elements, each of which is briefly discussed here and further addressed in response to subsequent questions.

1. **Project Lifecycle Methodology.** A consistent project lifecycle methodology with defined stages and activities to ensure progress to implement the CCO Contract requirements timely and efficiently
2. **Dedicated, Local, and Highly Specialized Professionals.** The deployment of dedicated, local, and highly specialized professionals with defined levels of authority to implement CCO Contract requirements and support ongoing operations
3. **Customized, Consistent Communications Plan.** A customized communications plan that ensures adequate and timely reporting to executive management and department personnel and ensures consistent communication between implementation participants
4. **Industry-standard and Proprietary Tools.** A set of industry-standard and proprietary tools to define accountability, track progress, and identify and mitigate risks to implementing the CCO Contract requirements

5. **Proactive Systematic Review.** A proactive systematic review of implementation progress, issue identification/assessment, alternatives analysis, and resolution

Project Lifecycle Methodology. Magnolia's project lifecycle methodology provides a solid framework for managing key implementation activities according to a defined set of proprietary standards and the unique needs of DOM. See **Figure 4.3.4.1.A** below for a graphic demonstration of our methodology.

Figure 4.3.4.1.A Magnolia's Project Lifecycle Methodology



This approach, with oversight by the Magnolia Project Implementation Team (MPIT), enables us to effectively manage the implementation and deploy the following activities:

- Applying standards and metrics to each phase of the implementation/development life cycle
- Assigning functional owners who can make decisions and ensure project progress/success
- Assigning key milestones and deliverables to each phase with specific ownership
- Reporting weekly status to key stakeholders
- Continually assessing for risk and developing risk mitigation strategies to ensure resolution of every issue
- Establishing initial operations and operating models as well as system development and support strategies
- Clarifying escalation paths at the beginning of the project to facilitate timely response, priority, and resolution

Project Initiation Phase. During the Project Initiation Phase, Magnolia gathers key information regarding the program, including specific Contract requirements and our proposal offerings, to understand the scope of the implementation. We identify our methodology, approach, resources needed, and engage with all stakeholders to understand any specific nuances and expectations far in advance.

Pre-Implementation Phase. Magnolia initiates the Pre-Implementation Phase at the time of our proposal submission in response to DOM's Request for Qualifications (RFQ). We customize our pre-implementation activities based on Division requirements. During this Phase, Magnolia reviews, revises, and documents scope; communicates Division requirements; and develops revised timelines and resource plans. The Pre-Implementation Phase also typically includes the final preparation prior to execution of the Work Plan. During the Pre-Implementation period, the MPIT, comprised of Magnolia and key subcontractor staff and Centene's Business Integration Team, works closely with DOM to ensure that essential activities or deliverables for this phase are completed.

Key activities for the Pre-Implementation Phase include, but are not limited to:

- ***Scope Creation:*** Includes research and data collection conducted by the MPIT with support as needed from Centene's Business Integration Team. We compile information into a Kick-Off presentation to ensure all project resources share a similar understanding of the implementation project.
- ***Assessing RFQ and Contract:*** Includes the MPIT and Centene Business Integration Team working together to assess new and essential program elements and initiatives to be addressed in the implementation process.
- ***Finalizing Implementation Methodology:*** Includes the development and approval of the specific methodology to be used to manage the implementation process.
- ***Developing and Confirming Initial Implementation Timeline:*** Includes developing an initial draft of the implementation schedule to establish timing of key project deliverables. The MPIT reviews the timeline with each integrated lead to ensure the alignment of Work Plan activities and identification of additional resource needs.
- ***Resource Planning:*** Identifies and confirms resources needed to support the implementation schedule and obtains senior leadership approval to engage these resources.
- ***Finalizing and Engaging Resources:*** Integrates the project resources proposed during Resource Planning and this culminates in a series of Implementation Kick-Off meetings as needed, with internal and external resources to ensure consistent understanding of the Implementation Work Plan.
- ***Establishing Project Tools:*** All required implementation project tools are confirmed, labeled and where appropriate, tools and templates are pre-populated.
- ***Finalizing Work Plan:*** All required implementation milestones, supporting activities, delivery dates, and accountabilities are confirmed with each implementation team Member to ensure appropriate support.
- ***Refining Operating Model (as necessary):*** Using current operating models as the base, MPIT Members submit revised functional area operating models to Magnolia Leadership for review and approval.
- ***Assessing Risk:*** The MPIT assesses revised operating models, integrated IT testing schedule, and the CCO Contract to identify immediate program risks.
- ***Miscellaneous:*** The MPIT initiates, as required, other critical activities prior to the Implementation Phase, such as hiring and training planning.

Project Implementation Phase. Notification of the Contract award typically initiates Project Implementation Phase activities. If, however, Magnolia needs to support aggressive Division implementation timelines, certain activities may begin prior to Contract award or finalization. This period includes all activities required to ensure an effective implementation in alignment with the timing for the enrollment of Magnolia Members. Specifically, key implementation activities during this Phase include, but may not be limited to:

- ***Work Plan Execution:*** Activities such as the revision or development of policies and procedures required for Magnolia operations and CCO Contract compliance; revisions or development of Member and Provider materials; continued network development; and preparation to implement clinical protocols and transition strategies.
- ***Risk Assessment and Mitigation:*** Includes continuous identification, documentation, and assignment of risks for resolution and mitigation planning; and tracking of key decisions on program models.
- ***MPIT and Division Meetings:*** Includes conducting standard and recurring internal meetings to monitor project scope, schedule, and key deliverables; review implementation progress; discuss any areas requiring

operational clarification; and continue resolving issues and mitigating risks. With Division approval, we will continue established meetings between MPIT and Division project leadership.

- ***Staff Hiring and Training:*** Includes recruiting and hiring additional staff needed to ensure support for the implementation of all CCO Contract requirements. During this phase, we develop staff training materials and curricula that will be provided to existing staff and new staff.
- ***Operating Model Revision(s):*** Includes further review, validation, revision, and refinement of functional operating models developed in the Pre-Implementation Phase based on additional information gathered through activities of the Pre-Implementation and Project Implementation phases.
- ***Readiness Review:*** In addition to recurring meetings, we also conduct a series of internal operational readiness reviews prior to Go Live to ensure every functional area is prepared to implement all MississippiCAN and CHIP Contract requirements.
- ***Key Report Development:*** Includes modifying current reports in conjunction with DOM, or if necessary developing draft copies of required reports that are used to monitor Magnolia performance after CCO Contract implementation.
- ***Cut-Over Planning:*** Includes developing and communicating clear expectations and timelines for the activities that need to occur during the weeks leading up to, and immediately following CCO Contract Go Live.
- ***System Development:*** Throughout this Phase, our corporate IT Lead and Business Integration Team Lead work with our local MPIT leads to gather new technical and business requirements and prepare key systems for Contract Go Live. We conclude the IT systems development and updating process with end-to-end testing activities, which follow test data through the system. System development, updates, and documentation are managed through an agile process.

Cut-Over Phase. The Cut-Over Phase marks the formal implementation of all new Contract requirements and includes validation that business process metrics meet targeted thresholds. All new Contract requirements cycle through the Cut-Over Phase to meet Division requirements under the CCO Contract. We manage a schedule of Cut-Over activities including daily Cut-Over meetings as needed to review issues, escalate to the Steering Committee and Executive Steering Committee (see Committee details below) for assistance in removing critical Go Live barriers, and provide ongoing status reporting to all leadership involved in the project. At this point, the Steering Committee verifies that the project meets all Division and Magnolia requirements.

During the week of Go Live, we conduct MPIT and all-employee meetings to announce, communicate, and create a shared understanding of the CCO Contract going forward. We also conduct a pre-delegation audit and daily metrics review of subcontractor performance to ensure that contractual requirements are met as well as immediately remediate any issues that are identified. As part of our efforts for continuous improvement, we conduct post Go Live reviews at periodic intervals (e.g., 30, 60, and/or 90 days) from the first day of the new Contract period.

Dedicated, Local, and Highly Specialized Professionals. Magnolia's proven methodology includes the balanced combination of executive oversight, Senior Leadership engagement, and technical expertise to ensure a compliant and accurate implementation.

Magnolia's Project Steering Committee (Steering Committee). Magnolia's Steering Committee is comprised of our Senior Leadership Team and is responsible for providing strategic oversight for changes required by the project that impact the overall health plan. The Steering Committee is also the project governance body to which key business decisions and project issues are escalated and resolved, and requires communication on matters that change the scope of the project and its deliverables. The Steering Committee supports the CEO in determining which issues should be escalated to the Executive Steering Committee. Magnolia's Project Lead staffs the Steering Committee and provides all status reports required and requested.

Magnolia Project Implementation Team (MPIT). The MPIT includes Magnolia's and Centene's Integrated Leads and Subject Matter Experts (SMEs), including Subcontractor representatives, responsible for the design and implementation of any new process, program, or technology solution required by CCO Contract requirements.

Magnolia's Project Leadership and Management. The project leadership and management team below is responsible for delivering the implementation within the specified timeline, budget, and scope while ensuring delivery of a quality product. Issues that cannot be resolved at this level are escalated to the Executive Steering Committee. Our project leadership and management team is detailed in **Table 4.3.4.1.A**.

Table 4.3.4.1.A Magnolia Project Leadership and Management Team

Magnolia Project Implementation Team Members		Roles and Responsibilities
President and CEO (Executive Sponsor)	Plan President & CEO	The Business Sponsor provides executive oversight for the project and is responsible for: • Project business case analysis • Ensuring availability of project funding • Approving the Implementation Project Charter • Project status reporting to the Executive Steering Committee • Ensuring consistent communication between senior management and the project team • Approving/addressing material budget and scope variances • Ensuring project issues resolution • Overseeing timely execution of Implementation Work Plan • Chairs weekly Senior Leadership Team (SLT) Meetings
Project Lead	Chief Operating Officer	The Business Sponsor provides executive oversight for the project and is responsible for: • Project business case analysis • Ensuring availability of project funding • Approving the Implementation Project Charter • Project status reporting to the Executive Steering Committee • Ensuring consistent communication between senior management and the project team • Approving/addressing material budget and scope variances • Ensuring project issues resolution • Overseeing timely execution of Implementation Work Plan • Chairs weekly Senior Leadership Team (SLT) Meetings
Project Senior Leadership Team (SLT)	President & CEO; Chief Medical Director; VP, Medical Mgmt; COO (Project Lead); VP, Medical Affairs; VP, Finance; Compliance Officer; VP, Pharmacy Operations; Sr. Director, Quality	The SLT works closely with the CEO and Project Lead and: • Serves as the project Steering Committee • Guides the implementation and provides strategic direction, Contract compliance, budget, and project resources • Balances health plan and implementation priorities • Recommends initial project budgets • Reviews/approves critical program and business process design decisions • Reviews and recommends Project Change Control requests • Escalates issues and barriers to the CEO and Project Lead • Monitors project execution through participating in the weekly Steering
Centene's Business Integration Team	Professional project management professionals experienced in implementing complex initiatives	The Business Integration Team supports Magnolia's Project Lead, SLT, and the MPIT with activities such as customizing and/or developing project management tools and protocols to support the implementation process and continuous improvement.

Functional Project Team. The functional project team consists of the Integrated Leads and Business SMEs who are responsible for implementation activities needed to meet new program requirements as described in the Draft Contract and provide operational and/or technical oversight. Their roles and responsibilities are listed below in **Table 4.3.4.1.B.**

Table 4.3.4.1.B Functional Project Team

Magnolia Functional Project Team Members		Roles and Responsibilities
Integrated Leads (Magnolia and Centene)	Integrated Leads are accountable for complete business and IT delivery of specific business processes from project initiation to cut-over. They are accountable for oversight and/or delivery of functional operations within the organization, as well as implementation deliverables.	• Manage the delivery of the business processes according to the • project budget/costs, schedule, and quality constraints • Ensure project IT/business solutions comply with Division, • corporate and IT policies, procedures, and practices • Manage departmental resource allocation • Develop Release Management Plan • Perform issues/risk/decisions management • Monitor implementation and post-implementation dashboards

Business Subject Matter Experts	Subject matter experts on Magnolia's and Centene's business operations. They provide specialized and focused support to the overall project.	• Develop and provide input on standard business operating models • and templates • Assist in project issue/risk resolution and decision management • Provide functional area expertise to Integrated Leads • Monitor implementation and post-implementation dashboards

Information Technology (IT) Implementation Team. Centene's IT Implementation Team is comprised of experienced IT Program Managers who will support Magnolia's Project Implementation Team (MPIT) throughout the implementation process. Prior to Contract go-live, a dedicated IT Program Manager will serve as a liaison between our centralized IT resources and local Magnolia staff to help facilitate and coordinate integration and deployment of new systems, applications, and processes across all functional areas (e.g., enrollment, contracting, Member and Provider services, claims and encounters, and data and analytics).

Centene's Enterprise Executive Steering Committee (Executive Steering Committee). Centene's Executive Steering Committee functions as the corporate oversight body for Magnolia's CCO Contract implementation. The Executive Steering Committee, comprised of Centene and Magnolia senior executives, focuses on ensuring projects stay focused on strategic objectives and meet established requirements. The Executive Steering Committee meets weekly, demonstrating the level of commitment needed for successful implementations, and ensuring appropriate resource allocation and strategic guidance. The Executive Steering Committee:

- Guides cross-project implementations from an enterprise point of view with respect to strategic direction, Contract compliance, budget, and organization resources
- Balances corporate and health plan priorities
- Approves project budgets
- Resolves cross-project issues
- Removes cross-project barriers
- Monitors project execution through recurring governance meetings and weekly status reports
- Serves as the highest escalation point for project issues and barriers

Customized, Consistent Communication Plan. By carefully managing communications, Magnolia ensures that all stakeholders understand exactly what needs to be delivered, the scope of work required, who to contact to obtain needed information or to resolve problems, and the current project status at any given point in time. The Project Lead takes a proactive role in ensuring effective communications on this project, and we formalize our implementation communications in our CCO Implementation Communications Plan (Communications Plan). Details on the program status reporting are described in further detail below. The Communications Plan provides the structure for communicating:

- Project scope, schedule, activities, and deliverables
- Project management monitoring and control
- Direction for Integrated Leads to drive the work effort
- Project progress (schedule, cost, and quality)
- Risk and issue identification, tracking, and mitigation
- Anticipated project trends

The Communication Matrix in **Table 4.3.4.1.C** provides a high-level summary of the type and frequency of meetings and other communications we provide during the Implementation Period:

Table 4.3.4.1.C Communication Matrix

Type of Communication	Objective	Medium	Frequency	Audience	Owner	Deliverable
Kick-Off Meeting	• Introduce Project Team Members, provide project overview, review objectives, and clarify roles	• In person • Conference Call	• Within one week after Contract Award	• Project Sponsor • MPIT • Centene Business Integration	• Project Lead	• Agenda • Meeting Minutes

Type of Communication	Objective	Medium	Frequency	Audience	Owner	Deliverable
				Team		
Centene Executive Steering Committee (ESC)	• Review status of CCO Implementation • Take action on key decisions • Approve project budget changes above specific threshold • Discuss identified risks, issues, and barriers	• In person • Conference Call	• Weekly	• Centene ESC Members • Magnolia President and CEO • Magnolia Project Lead	• Business Sponsor	• Agenda • Meeting Minutes
Magnolia Steering Committee (MSC)	• Review project status including risks, issues, and barriers • Review key decisions by ESC • Identify issues for escalation to Centene ESC	• In person	• Biweekly until three weeks prior to Go Live, then weekly	• Project Sponsor • Magnolia Senior Leadership Team	• Project Lead	• Agenda • Meeting Minutes • Risk/Issue Log • Status Reports
Functional Leads Meeting	• Review status of project deliverables and progress against Work Plan • Discuss actions needed to correct identified risks, issues, and overdue deliverables • Communicate decisions/ concerns from MSC/ ESC • Identify issues for escalation to MSC	• In person • Conference Call	• Weekly	• Functional Leads	• Project Lead	• Agenda • Meeting Minutes • Status Reports
Project Workgroup Meetings	• Discuss status of workgroup deliverables and progress against Work Plan • Discuss actions needed to correct identified risks, issues, and overdue deliverables • Discuss and develop process and technical design solutions for project • Identify issues for escalation • Report workgroup activities and status at Functional Leads Meeting	• In person • Conference Call	• Weekly	• Functional Leads • Magnolia and Centene Technical SMEs • SLT Members as needed	• Functional Lead	• Agenda • Meeting Minutes
Project Status Reports	• Report the project status including activities, progress, costs, and issues	• Email • Meeting Handouts	• Weekly	• Project Sponsor • Project Team • MSC • ESC	• Project Lead	• Project Status Reports

Industry-Standard and Proprietary Tools. Magnolia uses a set of industry-standard and proprietary tools and templates for project management and control to define accountability, track progress, and identify and mitigate risks for implementation. These tools enable us to document and track project deliverables and timing,

task/activity dependencies, and resources.

Microsoft Office Project. Magnolia uses Microsoft Office Project to develop our Implementation Work Plan and resource (e.g., time and manpower) plans. The Work Plan is the basis for assigning responsibilities to individuals and teams, monitoring progress, communicating status, and taking corrective action when necessary. We determine progress by comparing actual work performed against Work Plan deliverables. This enables timely corrective action when performance deviates significantly from the plan. The Work Plan includes the time (e.g., duration) required to complete each task and identifies relationships between tasks so we can easily see the impact one task has on another. This enables the MPIT to make changes, as needed, to ensure the overall objectives and timeline remain on course. Magnolia's Project Lead maintains the Work Plan and each Functional Lead provides updates for their respective portion of the Work Plan.

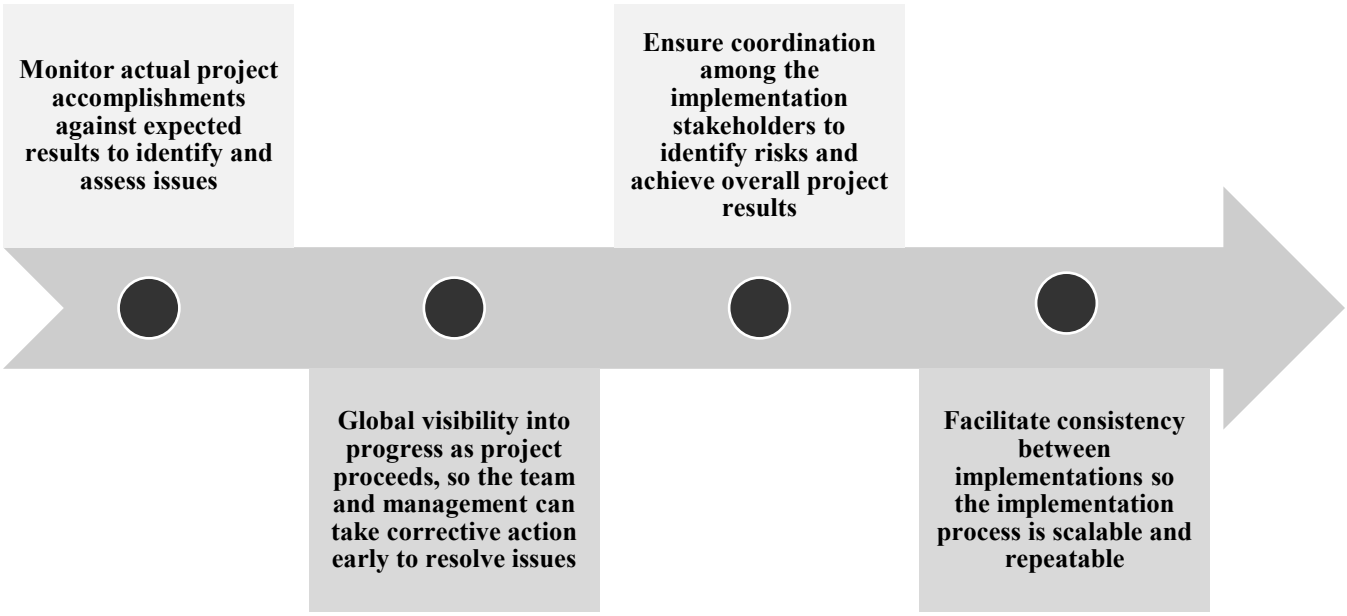
SharePoint and Teams. For many years, Centene has used a corporate-wide intranet site as our version-controlled document repository. This site operates on a top-tier Microsoft SharePoint platform and is fully integrated with Microsoft Office. For Magnolia's CCO Contract implementation, we will create a dedicated project implementation Sharepoint site, which includes a standard directory structure. Magnolia uses the site as a single point of reference for all implementation participants. This site houses documentation such as operating models, diagrams, staffing models, business requirements documents, and technical design materials, specific to the business processes being developed for the new Contract. The project site contains final versions of the RFQ and Contract, as well as our CCO proposal. The site also includes access to Division announcements, Magnolia specific news articles, and project control documentation along with a calendar of upcoming implementation events. Further, as an advancement of our SharePoint platform, we are deploying Microsoft Teams to enhance team collaboration and project delivery, along with enhanced levels of document storage and sharing.

Compliance Management System (Compliance System). Upon Contract award, our Compliance Officer, with input from DOM as required, reviews the new Contract and documents all Contract and operational requirements in our Compliance System, Magnolia's innovative tool for tracking and monitoring our compliance with all Contract requirements. Recognized as a leading Compliance software system across all industry segments (including healthcare), our Compliance System allows Magnolia to effectively administer, document, and monitor our internal governance, as well as our contractual and regulatory requirements, all in auditable and transparent fashion. The Compliance System provides for workflow enabled policy and procedure formulation (with total history of documentation and sign-offs); distribution of documents to appropriate internal departments and subcontractors; systematic tracking of compliance activities (also with auditable records of management approval and cited contract and regulatory mandates); and ongoing, proactive assessment of compliance risks.

With the Compliance System, Magnolia can link the new Contract requirements and related federal and State regulations with internal compliance activities during implementation and beyond, including revisions to or development of policies, procedures, and processes. The Compliance System allows Magnolia to create a virtual evidence room documenting our compliance with Contract requirements and enables the Compliance Officer to perform assessments and monitor compliance by functional area. The Compliance Officer also uses a suite of compliance software to manage the development, quality review, approval, and timely submission of all reports and deliverables to DOM. Any corrective action plans are monitored and tracked within our compliance software applications. Magnolia's state-of-the-art tracking and reporting system enables respective groups to manage requests and ensure we submit timely deliverables to DOM by reducing manual entry of recurrences, documenting review and approval by appropriate parties, and improving reporting capabilities to demonstrate compliance and/or opportunities for improvement.

Proactive Systematic Review. A key to success is our ability to proactively identify and mitigate risks and barriers; recognize, appropriately escalate, and address problems; and diligently monitor progress to keep the project on task and meet major milestones. The objectives of our systematic review process and program controls are described below. **Figure 4.3.4.1.C** is a visual depiction of our approach to systematic review and issue identification and resolution.

Figure 4.3.4.1.C Systematic Review Process


Monitor actual project accomplishments against expected results to identify and assess issues
Global visibility into progress as project proceeds, so the team and management can take corrective action early to resolve issues
Ensure coordination among the implementation stakeholders to identify risks and achieve overall project results
Facilitate consistency between implementations so the implementation process is scalable and repeatable

2. Program control approach;

Magnolia's program control approach defines the standards against which we manage our implementation, monitor implementation targets, address deviations, and manage our operational performance after implementation. Program control provides a system for managing and monitoring implementation as it progresses, ensuring that we meet Magnolia and Division requirements and timelines and provide information to implementation leadership, teams, and stakeholders to make necessary corrections and adjustments. Our President and CEO, as well as our Senior Leadership Team, work closely with Magnolia's Project Lead and Centene's Business Integration Team to manage all metrics for the implementation project, and operational metrics that are affected by implementation. Our Project Lead uses our standard tools and processes to assess our overall implementation performance and our readiness for Go Live. During implementation, the following areas are monitored to ensure project success:

- Critical success factors as defined by the MississippiCAN and Mississippi CHIP RFQ and Appendix A, Draft Contract
- Pre-defined operational measures
- Functional area progress against the Work Plan and Schedule
- Updates and discussion of open issues and actions executed to resolve the issue
- Updates and discussion of risks and actions if risks have been realized

During operations, the following areas are monitored to ensure program success and compliance:

- Pre-defined contractual and Magnolia operational measures
- Functional area compliance with MississippiCAN and CHIP Draft Contract requirements and standards
- Updates and discussion of open issues and actions executed to resolve the issue
- Updates and discussion of risks and actions if risks have been realized

Implementation Controls

During implementation, there are three critical areas we monitor to ensure implementation project success:

Financial Controls. On a weekly and monthly basis, the Project Lead works with our Chief Financial Officer to gather and distribute information such as the following to the Steering Committee for review and action:

- Originally approved and base-lined budgets
- Current budgets, considering approved changes
- Actual spending
- Qualitative overview of any variances to approved budgets

Quality Controls. On a weekly and monthly basis, the Project Lead works with the MPIT to gather and report on leading and lagging indicators such as the following to the Steering Committee for review and action:

- Pre-defined implementation success metrics
- Pre-defined operational metrics
- Critical success factors as defined by the CCO RFQ and Contract

Schedule Controls. On a weekly and monthly basis, the Project Lead works with the MPIT to gather and report on performance information against metrics such as the following to the Steering Committee for review and action:

- Critical milestones
- Target completion dates
- Percentage complete
- Actual completion dates
- Current status, from a qualitative perspective
- Issues and risks
- Additional notes

Change Control Process

Work Plan (activities/tasks), schedule, and/or quality changes that may occur during the course of the CCO implementation are a normal and essential part of managing an implementation. In such cases, Magnolia uses a defined Change Control process to document, estimate, and approve the execution of required or requested changes. To support this process, the MPIT uses a set of guidelines and documentation (Change Request Form and Change Request Log) to communicate and request these changes and track progress. In addition, we establish approval and escalation thresholds for changes that occur. The following outlines the responsible party for approval based on schedule and budget thresholds:

- **Steering Committee.** Change that impacts the schedule or budget and adds one day past the planned schedule for project or critical path milestones and over budget variance threshold.
- **Magnolia Project Lead.** Change that has any impact to schedule or budget and adds one day past the planned schedule for the project or critical path milestone up to budget variance threshold.
- **Integrated Lead.** Can approve any scope changes for work that does not impact the schedule or budget. They are not authorized to change the schedule for the project or critical path milestones and may not approve an increase in budget.

Operational Controls

Program management and control provides a system for managing and monitoring operations after implementation Go Live. Program control ensures that we meet Magnolia and Division contractual requirements and provide information to leadership, functional departments, and stakeholders to make necessary corrections and adjustments. Our President and CEO, as well as our Magnolia Senior Leadership Team (SLT), work closely with our Chief Operating Officer and Compliance Officer to manage all operational metrics and ensure compliance with CCO Contract requirements and Magnolia standards. For ongoing operations, we monitor the three critical areas below to ensure program compliance. The Magnolia SLT meets every other week to review and discuss any operational issues and identify remediation.

Financial Controls

On a monthly and quarterly basis, the VP of Finance gathers and distributes information such as the following to the SLT for review and action:

- Current budgets, considering approved changes, compared to originally approved budgets
- Actual spending
- Qualitative overview of any variances to approved budgets

Quality Controls

On a monthly and quarterly basis, the Vice President of Quality works with the functional department leads to gather and report on operational performance indicators such as the following to the SLT for review and action:

- Pre-defined contractual and Magnolia performance measures
- Monitoring and trending of key functional area metrics
- Quality Improvement Toolkit (QIT) dashboard and library of other dashboards that includes areas from each department
- Implementation of the Quality Management Committee
- Complaint, Grievance, and Appeal Monitoring
- Monitoring Provider satisfaction using scheduled and ad hoc surveys
- The performance of each functional department is also reviewed by the Performance Improvement Team (PIT) monthly and the Quality Improvement Committee (QIC) quarterly

Compliance Controls

On a monthly and quarterly basis, the Compliance Officer works with the functional department leads to gather and report on contractual operations indicators such as the following to the SLT for review and action:

- Pre-defined contractual and Magnolia operational measures
- Functional area compliance with CCO Contract requirements and objectives
- Monthly management meetings and monthly executive leadership meetings with DOM
- Compliance review of subcontractors in bi-weekly executive team meetings and ad-hoc meetings with subcontractors as needed.

We will also work with DOM to manage the potential transition of Members during the Open Enrollment period that will allow for Member choice. We will put in place operational controls and work with DOM to effectively transition Members to ensure continuity of care.

Implementing & Overseeing Contractual Requirements

As an example of our ability to successfully implement and oversee contractual requirements, in 2021, Magnolia processed 99.83 % clean claims within 30 days, with an average turnaround time of less than 19 days – exceeding the Division's requirements.

3. Manpower and time estimating methods;

Magnolia's primary resource-planning objective is to allocate sufficient time and appropriate specialization and talent to facilitate a successful implementation and effectively manage ongoing operations that meet the requirements established by DOM. Through our years of experience serving as a MississippiCAN and CHIP plan, we have gained expertise to continually optimize our manpower and time estimating methods.

Program Implementation Staffing

Our implementation Work Plan activities and tasks drive resource requirements, estimated based on the duration required to complete activities, deliverables, and outcomes. We base our determination of required tasks and estimates of duration on Magnolia's and Centene's experience implementing new, expanding, and reprocured business, leveraging tools such as Microsoft Project. We create specific and realistic time requirements to minimize risk to sustainable operations. We further determine manpower and time in Magnolia's Work Plan analytically by conducting a gap analysis between current operations activity, duration outcomes, and staffing levels required by the new Contract. We also consider dependencies between and among tasks in the Work Plan when estimating resources. Our resource management process ensures that the appropriate resources achieve Division objectives. Resource management includes estimating requirements and identifying, documenting, and assigning resources that possess the appropriate skill set necessary to support required Work Plan activities. Successfully coordinating these resources across time and functional areas depends heavily on our Project Lead effectively communicating any changes to resource needs to the Steering Committee. Our Project Lead discusses any changes to resource requirements during Steering Committee meetings, including tasks and the estimated time commitments required to obtain approval for the assignment.

Meeting Ongoing Staffing Needs. Each functional area within Magnolia monitors and trends key metrics relevant to that specific area using our Centelligence Reporting and Analytics Platform solutions to inform an objective forecast of staffing needs well before those requirements materialize. Centelligence is our proprietary and comprehensive family of integrated decision support and reporting and analytics solutions. Centelligence provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with drill-down capabilities. Our Centelligence decision support system measures and trends claims volume by claim type; including trends in complex claims. We also measure and monitor caseloads per Care Manager and authorization requests by type per Utilization Management Nurse.

To maintain our Call Center service level standards, we use our innovative **Workforce Management Software** to support a responsive, scalable staffing model. Based on years of Call Center data analyses for Magnolia and affiliate health plans, the software factors in call-type complexity, historical call duration, call patterns including seasonal variation, market maturity, and eligibility categories specific to Mississippi to determine appropriate staffing, analyzing down to 30-minute increments when needed. This predictive approach allows for effective staffing by notifying us of rapidly changing situations in volume or call duration. We translate all of this information into staffing forecasts.

4. Sign-off procedures for completion of all deliverables and major activities (Note: The level of final sign-off on deliverables at the Division level will depend on the specific Deliverable).

Sign-Off Procedures for Completion of all Deliverables and Major Activities

For implementation and on an ongoing basis, Magnolia identifies and tracks all key required milestones, deliverables, and major activities to completion using the tools identified in **Table 4.3.4.1.D** with final sign-off by the accountable parties identified.

Table 4.3.4.1.D Deliverables Sign Off Process

Sign-Off Document	Document Description	Accountable for Final Sign Off
CCO Contract Requirements Analysis	Identifies new requirements and deliverables as set forth in the CCO Contract.	Magnolia Steering Committee
Project Charter and Scope	The **Project Charter** is a comprehensive project description that details the scope, objectives, deliverables, and overall approach for the work to be completed. It serves as a critical source document for initiating, planning, executing, controlling, and monitoring the project. The Project Charter is an evolving document that is continuously revised to reflect any changes. The **Project Scope** document provides the scope framework for the implementation and documents the scope management approach; roles and responsibilities as they pertain to project scope; scope definition; verification and control measures; scope change control; and the project's work breakdown structure.	Executive Sponsor
Work Plan, Schedule, and Deliverables Matrix	The Work Plan, Schedule, and Deliverables Matrix identify, by functional area, the tasks and program deliverables that must be developed and implemented; dependencies; task owners; and the timeline for delivery of these items. The Integrated Leads are accountable to manage the work packages, deliverables, and tasks for their respective areas and provide project status updates to the Project Lead and Steering Committee as required.	Magnolia Steering Committee (MSC)
Project Communications and Risk Management Plans	The Project Communications Plan defines the communication requirements for the project, and how/what information is communicated to the MPIT, Steering Committee, Executive Steering Committee, Division, and other stakeholders. The Risk Management Plan describes how Magnolia identifies, analyzes, and responds to project risks.	Executive Sponsor
Executive Project Status Reports	Provides status of CCO implementation; identifies key risks, issues, and potential barriers to implementation success.	Magnolia Steering Committee
SME and Functional Lead Weekly Project Status Report	Provide status of all functional area and/or workgroup implementation activities.	Integrated Leads
Change Requests	Requests to change any aspect of the approved Scope, Work Plan, timeline, or budget for the Project.	See approval thresholds above in 4.3.4.1.2, Change Control Process
Decisions/Issues/ Next Steps Tracking Forms and Log	Tracking Forms are used to document, monitor, and communicate critical and cross-functional issues/decisions to the Project Lead and Steering Committee. Forms provide insight into the options considered in the decision making or issue resolution process; rationale for option/solution selected; individuals involved in the decision/resolution, and critical next steps to implement decision/resolution. The Project Lead tracks all decisions in the Tracking Log.	Integrated Leads; decisions impacting overall strategic objectives; or budget, schedule, or quality are escalated to the MSC for sign off.
Risk Mitigation Plans and Risk Register	Mitigation Plans document activities and timelines for mitigating identified risks. Risk Register tracks open risks and is used to guide all risk review discussions.	MSC must approve all medium- and high-level Mitigation Plans and authorize closure of these risks. The Project Lead approves low-level Mitigation Plans and authorize closure of risks.
Readiness Review Plan and Audit Tools and Cut-Over Calendar and Work Plan	The Readiness Review Plan and Audit Tools describe specific activities related to assessing readiness immediately preceding Go Live and the tools that are used to assess readiness. The Cut-Over Calendar and Plan provide the timeline and activities associated with ensuring that Go Live and post Go Live milestones are met.	MSC

Sign-Off Document	Document Description	Accountable for Final Sign Off
Operating Model Changes	Documentation of any operating model changes recommended to address new program, technical, and other Contract requirements.	MSC unless specific project budget thresholds are exceeded. In such cases, Executive Steering Committee approval would be required.
Technical Design	IT Functional Leads and SMEs develop technical design documents which document new applications required, if any, to respond to and meet CCO Contract requirements. Technical design review validates design against functionality required and requested.	VP, IT
Questions Log for DOM of Medicaid	Documents MPIT implementation questions/issues requiring clarification or decisions from DOM.	Compliance Officer, with input from MSC as needed

5. Management of performance standards, milestones, and/or deliverables;

As outlined above, Magnolia's management and implementation approach includes a clear understanding of project scope; effective communication with all project stakeholders; assignment of ownership for deliverables; appropriate scheduling of work; identification of potential risks; evaluation of the work against financial, quality, and schedule standards; and use of fiscal discipline throughout the course of the project. Additional detail about how we ensure the timely completion of all required deliverables and manage performance standards is provided below.

Implementation Monitoring Process

Magnolia regularly assesses key Work Plan performance indicators of the overall health of our implementation project. Through this process, we are able to provide assurances to DOM and Magnolia's SLT that project objectives are being achieved. Our progress reviews include issue identification and assessment, alternatives analysis, and issues resolution. These activities include specific key performance indicators, tools, and Work Plan activities that represent review of implementation progress. By closely monitoring the overall progress of the implementation, we can implement immediate and consistent corrective actions and develop "total project" audits when performance deviates significantly from the Work Plan. The overall objectives of our monitoring process are to:

- Monitor actual project accomplishments against expected results
- Provide global visibility into progress as the project proceeds, so that the MPIT and Steering Committees can take immediate corrective action when project performance varies from original plans
- Ensure coordination among the Steering Committee, Project Lead, Functional Leads, and SMEs to achieve overall project results.

We monitor our implementation progress through the Project Structure, implementation standards, and activities described in this narrative related to our Communications Plan and Matrix, Project Control Approach, and Sign-Off Procedures.

Implementation Monitoring Tools. Magnolia uses our industry-accepted and proprietary project management and implementation tools to ensure a clear understanding of project scope; facilitate effective communication with all project stakeholders; assign ownership of deliverables; ensure appropriate scheduling of work; identify issues and potential risks; and evaluate of the quality of the work, while using fiscal discipline throughout the course of the project.

Implementation Monitoring Meetings. Our standard recurring meeting structure and schedule facilitates proactive review of implementation progress. Our regular Workgroup and Functional Lead Meetings with MPIT Members and key SMEs confirm progress on deliverables, identify and discuss any issues impacting implementation timeliness, and determine issues and barriers that need to be escalated to the Steering Committee for resolution.

Steering Committee Readiness Reviews. At key points leading up to Go Live, the Project Lead and Steering Committee conduct and/or oversee Readiness Reviews to ensure Magnolia is fully prepared to implement all new program and Contract requirements. During the review, the Functional Leads from each area reviews their current state of preparedness including, but not limited to staffing levels, training plans, IT system readiness, and work flow documentation. The Steering Committee identifies new and remaining risks and require the immediate implementation of Risk Mitigation Plans to ensure operational readiness. Typically, these reviews occur 30 days prior to Go Live; however, the number and frequency of these reviews can vary depending on the required program, system and process changes, and the level of readiness demonstrated during the review. Depending on the area being reviewed, the Steering Committee requests the expertise and assistance of corporate resources such as IT, Claims, Internal Audit, and Compliance to conduct or assist with the Reviews.

Lessons Learned Meetings. Post Go Live, Magnolia collects both positive and negative feedback about the effectiveness of our implementation approach so that we can make adjustments for future Magnolia implementation projects. We hold lessons learned meetings at distinct intervals after Go Live (typically 30, 90, and 180 days after go-live). Participants in the lessons learned meetings vary depending on their involvement in the project at that particular phase of the implementation. During these meetings, we ask Functional Leads to provide feedback related to implementation effectiveness, including areas of success and areas for improvement. The Project Lead gathers these recommendations and reports them to the Steering Committee. After Steering Committee review, those recommendations for which there is consensus are archived for future implementation projects.

Ongoing Monitoring Process

The Magnolia Senior Leadership Team (SLT) meets every other week to review and discuss any operational issues and identify remediation. Every functional department is responsible for reporting to the SLT operational status and any issues that arise. Our Population Health and Call Center staff monitor daily metrics to ensure compliance. Magnolia conducts a monthly audit of Utilization Management Care Management to ensure they are meeting standards and implement remediation if needed. We conduct full functional area assessments annually by breaking out the Contract to ensure compliance with all areas. We monitor our Provider network to ensure it is comprised of the appropriate mix of Providers to serve Members in a timely manner and in the right setting. Our ongoing efforts to measure adequacy include reviewing monthly complaint reports, out-of-network utilization, and using geo access mapping software at least quarterly to evaluate network adequacy.

We also review monthly metrics and annual audits of subcontractor performance to ensure that contractual requirements are met and to immediately remediate any issues that are identified. Our state-of-the-art Compliance System allows Magnolia to effectively administer, document, and monitor our internal governance, as well as our contractual and regulatory requirements, all in auditable and transparent fashion. The Compliance System provides for workflow enabled policy and procedure formulation (with total history of documentation and sign-offs); distribution of documents to appropriate internal departments and subcontractors; systematic tracking of compliance activities (also with auditable records of management approval and cited contract and regulatory mandates); and ongoing, proactive assessment of compliance risks. With the Compliance System, Magnolia links the CCO Contract requirements and related Federal and State regulations with internal compliance activities. The Compliance System allows Magnolia to create a virtual evidence room documenting our compliance with Contract requirements and enables the Compliance Officer to perform assessments and monitor compliance by functional area; and to manage the development, quality review, approval, and timely submission of all reports and deliverables to DOM. Any corrective action plans are input into the Compliance System to monitor and track progress.

6. Internal quality control monitoring;

Internal Quality Control Monitoring

Implementation Quality Control Monitoring. Magnolia internally monitors three critical areas to ensure implementation project success: financial, quality, and schedule controls. In addition to measuring our performance against these metrics, we consolidate and review any material issues (over or below threshold,

below quality threshold, behind schedule, etc.) in our standing Functional Lead and Senior Leadership Team meetings and assign and monitor corrective actions, as required, until resolved. At least monthly, and at critical points throughout the project, the Project Lead reports our performance against all key metrics to the Steering Committee, Project Team, and other key stakeholders for review and for action, when required. We immediately escalate all critical and material issues following our established escalation process.

Operational Quality Control Monitoring. Once the Go Live has occurred and operations commence for the new Mississippi CCO Contract, Magnolia transitions to our standard operational oversight processes. As part of the operational oversight processes, the following areas are monitored to ensure program success and compliance:

- Pre-defined contractual and Magnolia operational measures
- Functional area compliance with CCO Contract requirements and standards
- Updates and discussion of open issues and actions executed to resolve the issue
- Updates and discussion of risks and actions if risks have been realized

For ongoing operations, we monitor the following quality areas below to ensure program compliance. The Magnolia Performance Improvement Team (PIT) meets monthly, and the Quality Improvement Committee (QIC) meets quarterly. The Sr. Director of Quality Improvement works with the functional department leads to gather and report on operational performance indicators such as the following to the SLT for review and action:

- Pre-defined contractual and Magnolia performance measures
- Monitoring and trending of key functional area metrics
- Generation and monitoring of Quality Improvement Toolkit (QIT) dashboard and library of other dashboards that includes areas from each of the departments
- Implementation of the Quality Management Committee
- Complaint, Grievance, and Appeal monitoring
- Monitoring of Provider satisfaction using scheduled and ad hoc surveys
- Monitoring of the Magnolia webpages to ensure accuracy

7. Program status reporting, including examples of types of reports; and,

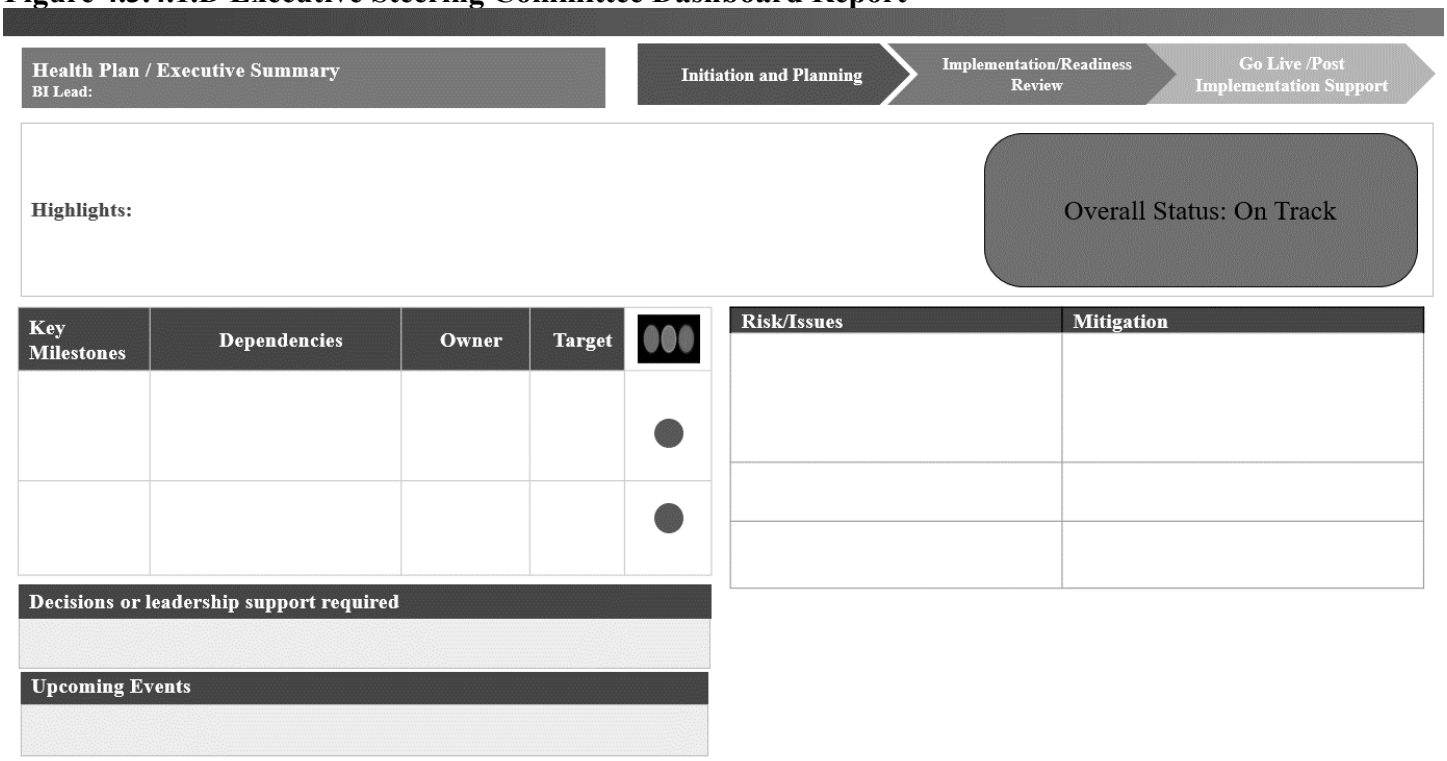
Program Status Reporting and Examples of Types of Reports

In addition to the multitude of Work Plan status reports available through Microsoft Office Project – such as Critical Milestone Status Reports – and the status reporting associated with risk management and issues/decisions, Magnolia also uses a variety of report templates to capture and communicate program status at different levels of the organization. The level of detail and type of information included in these different status templates vary based on the reason for the report and its audience. For example, our weekly Steering Committee Status Report provides information summarizing the status of activities assigned to each functional area. The Executive Steering Committee update report provides a high-level dashboard on key risks and issues currently impacting the project. Each of these report templates is then used as a basis for our regularly scheduled meetings. If the standard reports require any changes to the frequency, format, and/or content, we adjust them to ensure compliance with the Mississippi CCO Contract.

Magnolia utilizes a formal system of documentation to monitor, track, assess, and report progress with each selected project. We have established points of accountability to collect and report information on the project implementation. Examples of Project Status Reporting are highlighted in the following sections.

Executive Steering Committee Implementation Dashboard Report. Magnolia's CEO and Project Lead prepare and present a weekly implementation status dashboard report to Centene's Executive Steering Committee. The report includes a Project Summary, Functional Area Status Update, Risks/Issues and Mitigation, and Decisions/Next Steps. Please see **Figure 4.3.4.1.D** below for an example of our implementation report.

Figure 4.3.4.1.D Executive Steering Committee Dashboard Report



Magnolia Steering Committee Status Report. Each week, Magnolia's Project Lead prepares and presents a status summary to the Magnolia Steering Committee using our Steering Committee Status Dashboard Report. The Report is organized as follows:

- Progress for reporting period for each functional area
- Activities planned for the upcoming period
- Key Issues, Risks, and/or Decisions for reporting period
- Status of major milestones and priority activities

Functional Lead Status Reports. Daily, our Work Force team sends reports of each functional team's performance to key management staff. Performance is monitored in real time, and adjustments are immediately made to ensure Members' calls are quickly answered. Senior leadership and management staff review these reports and follow up with the Functional Leads with any questions or to discuss how to resolve open issues and behind-schedule items. Work Force also uses the information from the status report to update the Work Plan and the Steering Committee Status Report referenced above.

Our implementation approach includes a rigorous post-implementation monitoring process through which we monitor daily metrics to ensure successful transition and a seamless experience for Members and Providers. Following implementation, daily team meetings continue to occur, employing the same issue identification and reporting process previously described, until all issues are resolved.

8. Approach to the Division's interaction with contract management staff.

Magnolia understands that to consistently achieve our implementation objectives, we must engage in regular two-way communications with DOM, community Providers and stakeholders, and among our internal

leadership and the project team. Constant and open communication helps to mitigate identified risks and enables us to quickly resolve identified implementation issues as they arise.

Approach to Division's Interaction with Contract Management Staff

Magnolia considers DOM staff to be an integral part of our implementation and operations teams. To promote active and regular engagement with Division staff, we develop a plan for interaction that ensures the Division's input is considered in all relevant aspects of the Mississippi CCO implementation and operations.

Pre-Implementation. During the Pre-Implementation Phase, our Plan President and CEO and Project Lead identify key personnel from specific functional areas to meet with Division staff with the respective expertise to address relevant implementation issues. Selection of Magnolia's key contacts will ensure alignment with those identified by DOM. We have found our most successful implementations and data exchanges have occurred when we hold regularly scheduled meetings between health plan representatives, Division staff, and DOM's fiscal agent to discuss project status, risks and problems, and work collaboratively toward mutual resolution.

Implementation and Ongoing Operations. Magnolia is committed to remaining engaged with DOM throughout all phases of the Mississippi CCO implementation project and during operations. We are available to meet with DOM's contract management staff at a date, time, location, and frequency agreed upon with DOM. The frequency of these meetings will be determined at the beginning of the Implementation Phase and will be evaluated on a regular basis to ensure they continue to meet the needs of the project and DOM. In addition to the monthly status meetings, we will participate in subgroup and subcommittee meetings as required and requested by DOM.

Throughout the implementation project and during operations, we track questions that require input or decisions from DOM in a Questions and Answers Grid. This grid includes each question, the date submitted, the person from Magnolia asking the question, the person at DOM who provides the response, the date the question was answered, and the answer provided by DOM. We organize this information into a formal Questions and Answers document, which ensures that the information is accurately and consistently communicated across the Magnolia functional areas and that we minimize the number of disruptions to Division staff. Our robust management and control efforts and partnership with DOM position Magnolia to seamlessly implement new programs and enable us to continue to provide best-in-class services for the CCO program.

[END OF RESPONSE]

4.3.4.2 PROBLEM MANAGEMENT

1. Assessment of program risks and approach to managing them;

When a risk is identified, two factors are assessed that characterize the impact a risk might have to the implementation effort or operations:

1. **Probability** – What is the likelihood the risk will occur, and how does it impact the implementation?
2. **Impact** – How extensive would the impact be to either the schedule and/or cost for leaving the risk unaddressed?

Once characterized, a risk is documented in the Risk Log and subsequently mapped onto a grid to be evaluated in the context of other risks identified for the implementation or at a point in time during ongoing operations. Each risk is assigned an owner who develops a risk mitigation plan to reduce the risk to an acceptable level through specific steps. Progress on the risk mitigation plans are tracked on a weekly basis and reviewed at the Functional Team meetings and by the Magnolia Senior Leadership Team bi-weekly.

Risk Documentation and Tracking

- **Risk Log:** All issues and risks are documented on a Risk Log, which lists issues based on probability (the likelihood that the problem will occur) and impact (to what degree the problem may impact the project schedule or costs). Using this stratification, Magnolia team Members can ensure all issues are tracked and addressed in a proactive and consistent manner. The Risk Log is not simply a listing of potential issues; it also documents assignment of accountability and includes a high-level description of the tasks necessary to resolve the problem or mitigate the risks.
- **Other Tools:** Issues and risks that may require input or decisions from DOM are tracked via a Questions and Answers Grid that include each question, the date submitted, the person from the implementation team requesting the clarification, a reference to a specific department, state agency document or contract section, the date the question was answered, and the answer provided by the department. Lastly, if any issue requires additional decisions or activities not captured in the work plan, we document and track accountability and completion on our Key Decisions and Next Steps Document.
- **Risk Mapping:** Once the risks are identified and the risks priority levels are determined, the Business Implementation Management Team uses the Risk Map to provide visual documentation of the risk and to track movement as the risk is managed. Those risks identified in red receive immediate attention by the project or operations team.

2. Anticipated problem areas and the approach to management of these areas, including loss of key personnel and loss of other personnel; and

Anticipated Problem Areas and the Approach to Management of These Areas

As a contracted Coordinated Care Organization with DOM today, we do not anticipate significant problem areas as we implement the new CCO Contract requirements. Our infrastructure, staffing and operating models, and policies and processes are in place and operating efficiently. We are committed to continuing to partner with DOM to support operational transparency throughout implementation and the duration of the Contract. We conduct daily monitoring of functional area metrics and encourage an atmosphere where all of our Magnolia employees feel comfortable to bring problems or issues to directly leadership once they are anticipated or identified.

Business Continuity and Disaster Recovery Plans. Magnolia views emergency response, continuity of operations, and disaster recovery as more than a prudent business practice – it is an integral component of being a service-oriented organization. We have thoroughly documented Business Continuity (BC) and Disaster Recovery (DR) Plans with defined roles and procedures so that our entire workforce knows what action to take in the event of an emergency (e.g., natural disaster, pandemic, and system failure or system disruption). In addition, we maintain, update, and test at least annually our BC and DR plans in conjunction with Centene's Business Continuity Management organization.

Key and Technical Personnel Change Notification. While we do not anticipate significant problem areas as we implement the new CCO Contract requirements, we have, however, identified the approach we would

deploy to address the loss of Key Personnel and the loss of Technical Personnel. In advance of any plans to change, hire, or reassign staff designated as Key Personnel, Magnolia will notify an appropriate contact within DOM within five business days of learning that the key position is vacant or anticipated to be vacant within the next 30 calendar days. Prior to diverting any specified essential personnel, Magnolia will notify DOM in writing with justification and sufficient detail to allow evaluation of the impact on the delivery of covered services. With approval from DOM, Magnolia will strive to fill key management personnel positions that have been vacated as quickly as possible and within 90 days, with individuals demonstrating a comparable set of skills and qualifications. We will submit approvals to DOM no later than 15 business days before the replacement's start date. **Table 4.3.4.2.A** below highlights Magnolia's approach to managing potential personnel problems.

Table 4.3.4.2.A Approach to Management of Problems

Area of Potential Problem	Approach to Management of Problem
Loss of Key Personnel	**Interim Coverage Capabilities.** Magnolia is fully staffed to perform all existing and new Contract requirements. However, to address the risk that a vacancy may occur with one of our Key Personnel, Magnolia has prepared a contingency plan, which includes a list of required backup corporate or health plan personnel who can step in on an interim basis as we aggressively recruit to fill the position. All Key Personnel positions are aligned with Key Personnel at Centene who are experienced and able to provide additional support where and when needed.
	Internally Developed Key Personnel Candidates. Executives from Magnolia, affiliate plans, and our corporate offices regularly assess staff who demonstrate promotion potential. Designated individuals work on selected assignments and projects that provide them with the targeted experience they need to assume specific leadership roles. This system assures a pool of talented, well-trained, experienced, and motivated employees who can easily step into many levels of leadership within the organization, and provides smooth transitions, consistency in operations and superior expansion capabilities. If we are unable to locate Key Personnel candidates internally at Magnolia, we outreach to our affiliate plans and corporate colleagues to identify any such individuals who could potentially fill a vacant Key Personnel position.
	Internal Electronic Posting of Vacancies. Magnolia posts open positions internally on our company-wide intranet so employees at all Centene subsidiaries have access to these employment opportunities and can quickly apply and be considered.
	Enterprise-Wide Applicant Database. Magnolia and all our affiliate organizations across the country share an active Key Personnel resume and candidate database and consistently maintain a dialogue with qualified Key Personnel candidates in order to keep a steady flow of strong potential applicants "in the pipeline." By continuously evaluating parties who have an interest in employment, Magnolia is better able to quickly and efficiently fill open Key Personnel positions.
	External Recruitment Sources. Magnolia's Human Resources department works with Centene's talent acquisition team to immediately post job vacancies on Centene's corporate website, which is also accessible via the Magnolia website. We also post job vacancies on job board websites including CareerBuilder.com, Monster.com, Diversity.com, indeed.com, and LinkedIn; Senior Employment Access - placement service for adults 50+; local staffing resources including Aerotek and Adecco; and for certain Key Personnel, Magnolia deploys Executive Search Firms and other agencies, which can facilitate the sourcing for key leadership roles.
	Leadership Development and Succession Planning: a Source for Key Personnel. All Magnolia supervisors, managers, and executives are targeted and encouraged to participate in Centene's corporate leadership development programs, such as the Seven Habits Signature Program, Leadership Through People Skills, Centene Academy of Leadership Excellence (CALE), and Centene Leadership Institute (CLI). In addition, individuals who express an interest in assuming Key Personnel roles within the organization may attend the Preparing for Leadership training program. Centene uses the information from this program to identify individuals who are prepared to assume leadership roles within the organization. Should Magnolia lose a Key Personnel staff person, candidates engaged in these succession planning programs provide an additional source of well-qualified, highly trained staff who could serve as candidates for the vacant position. Magnolia understands that key management positions cannot be vacant for more than 90 calendar days and will notify DOM within five business days when we become aware of a vacancy or when we anticipate a vacancy within the next 30 calendar days. Magnolia will not fill a key staff vacancy without prior approval from DOM.
Loss of Technical Personnel	Qualified technical personnel such as Claims Processors, Care Managers, and Customer Service Representatives, Utilization Management Nurses, and Information Technology personnel are critical to successful health plan operations. Magnolia's Senior Leadership Team understands this and meets weekly to discuss any potential staffing issues. They identify staff from other functional areas that may be able to fill a

Area of Potential Problem	Approach to Management of Problem
	position temporarily, or to offer assistance in an area with a recent vacancy. In the event a vacancy does occur, Magnolia acts immediately to recruit and hire a qualified candidate for that position. In the absence of a qualified candidate, Magnolia deploys the following strategies to ensure technical positions are covered appropriately.
	Enterprise Level and Health Plan Cross Training. Cross training offers professional development opportunities, improves understanding of different positions and Magnolia as a whole, leads to better coordination and teamwork, and improves overall efficiencies. Cross-trained employees can temporarily fill in for absent co-workers. For example, Provider Services Representatives and Customer Service Representatives (CSRs) are cross-trained to perform each other's role; and Member Connections Representatives are cross-trained to assist Program Coordinators. Cross training ensures that program staff can provide backup support to their peers in the event that turnover does occur.
	Electronically Linked Claims Operations. Our national claims staff work in three geographically separate (but electronically networked) service centers. Each center is capable of backing up the other to maintain consistent service to Magnolia and its affiliates. Key claims personnel capable of processing Magnolia claims are present in each of these centers.
	Promoting from Within. The first step our management staff take after making sure a technical position is covered is to electronically post the job so that any qualified candidate within the Centene family of companies can apply. This feature and process enables Magnolia to rapidly fill vacant positions with qualified candidates.
	External Recruitment Sources. Magnolia uses the same external resources as described for Key Personnel to recruit candidates for technical positions. The Senior Manager of Human Resources immediately posts the job vacancy on Centene's corporate website, which is also accessible via the Magnolia website. We also post job vacancies on job board websites including CareerBuilder.com, Monster.com, Diversity.com, indeed.com and LinkedIn; Senior Employment Access - placement service for adults 50+; and local staffing resources including Aerotek, Adecco, and Craigslist. For technical positions, Magnolia may also deploy employment agencies.
	Systems to Assist with Identifying Potential Staffing Needs. Each functional area within Magnolia monitors and trends key metrics relevant to that specific area using our Centelligence Reporting and Analytics Platform to inform an objective forecast of staffing needs well before those requirements materialize. Centelligence provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with drill-down capabilities. Through Centelligence, we have the ability to report on all datasets in our platform, including those for HEDIS, well-baby and well-child services, claims timeliness, Performance Improvement Project informatics, and other critical aspects of our operations. We also measure and monitor caseloads per Care Manager and authorization requests by type per Prior Authorization Nurse. To maintain our Call Center service level standards, we will continue to use our innovative Workforce Management Software to support a responsive, scalable staffing model. Based on years of call data analyses for Magnolia and other affiliate health plans, the software factors in call-type complexity, historical call duration, call patterns including seasonal variation, market maturity, and eligibility categories specific to Mississippi to determine appropriate staffing, analyzing down to 30-minute increments when needed. This predictive approach allows for effective staffing by notifying us of rapidly changing situations in volume or call duration. We translate all of this information into staffing forecasts.

3. Approach to problem identification and resolution.

Approach to Problem Identification and Resolution

Through our Risk Management processes, Magnolia's management and senior leadership teams identify unforeseen issues and problems that require resolution. As problems/issues are identified during implementation, the Project Lead and MPIT manage and monitor these issues as frequently as daily during critical times but, at minimum, during the weekly Project Team and Steering Committee meetings. Magnolia's Project Lead reviews the status of each open issue and for issues that remain open, the MPIT Steering Committee discusses any progress that has been made and determines what actions and updates are necessary. Magnolia's Project Lead determines which issues or problems need to be escalated for resolution to the Steering Committee, and the Steering Committee determines which issues need to be escalated to the Executive Steering Committee. Magnolia uses a similar process during operations, as the Chief Operating Officer and the

Compliance Officer determine – based on functional area compliance and quality reviews – which issues or problems need to be escalated for resolution to the Senior Leadership Team.

Issue Log. Magnolia uses an Issue Log to track and monitor issues until resolution is reached. Magnolia's Project Lead and Compliance Officer maintain the log, which provides the Magnolia team with a consolidated list of all open issues that require team coordination or resolution. It also identifies which issues require escalation and to whom or which entity. We use the same RAID (Risks, Actions, Issues, and Decisions) Project Issues Log that we use for risk identification and tracking.

We assign an owner to each issue to ensure it is addressed and resolved by a central accountable resource. We also assign each issue a priority level of high, medium, or low. Any issue that impacts delivery of a critical path milestone or impacts multiple functional areas without a workaround resolution is rated "high." Any issue that impacts delivery of a critical path milestone for a specific functional area with or without a workaround resolution is rated "medium." Any issue that does not impact delivery of a critical path milestone but may impact one or multiple functional areas and may be required for a functional area to move forward with delivery, is rated "low." Our approach to problem identification and resolution encompasses all functional areas described above.

[END OF RESPONSE]

4.3.4.3 BACKUP PERSONNEL PLAN

If additional staff is required to perform the functions of the Contract, the Offeror should outline specifically its plans and resources for adapting to these situations. The Offeror should also address plans to ensure the longevity of staff in order to allow for effective Division support.

Plan and Resources for Backup Personnel

As a current CCO in Mississippi, Magnolia is well positioned and fully prepared to perform the functions of Appendix A, Draft Contract. We recognize sustaining successful operations and quality outcomes depends on our ability to maintain a staffing level appropriate for supporting all Appendix A, Draft Contract requirements and performance standards. As such, we have a comprehensive plan and processes in place to ensure all needed backup staffing support and resources can be deployed expeditiously to effectively and seamlessly respond to fluctuations in our Membership, staffing turnover, and program and policy changes. At a high level, our approach and plan includes but is not limited to:

- **Management Structure Informed by Data.** We hold weekly leadership meetings to ensure adequate staffing models are in place and to identify emerging issues when backup staffing or resources (permanent or temporary) are needed. Additionally, ad hoc meetings can be scheduled at any time to discuss emerging issues or staffing needs. Should a risk be identified, the issue will be immediately escalated to the Leadership team for action, recommendations, and resolution.
- **Utilization of Systems, Processes and Data Analytics.** We have a robust set of data analytics and management reports that our management team utilizes to identify gaps in resources and implement an action plan.
- **Cross Training.** Magnolia staff are cross trained to support all products to ensure flexibility and ability to adapt to changing situations.
- **Leveraging Resources.** If needed, we leverage staff from our affiliate health plans or Centene's corporate office, who can quickly step in on an interim basis during implementation and other periods of peak activity to supplement staffing.

Assessing and Planning for Additional Staff. We have in-depth experience forecasting and anticipating required staff to perform the requirements of the contract. Magnolia's Senior Leadership team meets weekly to discuss any staffing issues and to identify staff from other functional areas that may be able to fill a position temporarily or assist in an area that is experiencing an increased need and requires additional staff. We forecast the volume of staff required to support the MississippiCAN and CHIP programs based on several factors, including Membership estimates and services to be provided. We also use several management tools to determine required staffing resources, such as Call Center staffing ratios. Our Call Center continuously monitors call wait times and call volume to identify call surges and high periods of demand. The Call Center Workforce Analyst monitors call center activity and works with the management team to initiate necessary staffing changes to ensure sufficient coverage for all inbound call queues and to redistribute Customer Service Representative (CSR) staff resources in real time.

Proactive Methods to Identify Staffing Need. Magnolia's Senior Leadership team also plans for future expansions or specific instances, contract implementations, programmatic or policy changes and transitions that require additional staff. We consistently monitor staffing levels and needs and conduct forecasting to prepare for changes to enrollment. For example, in December 2012, due to program changes that included the addition of the Medicaid expansion population, Magnolia experienced an increase in Membership, from 32,000 to 76,000 Members in a short period of time. Additionally, in 2015 DOM expanded the populations to include CHIP beneficiaries and we successfully transitioned 17,000 CHIP Members. To plan for this increase in Membership, we determined appropriate staffing levels and started the recruitment, hiring and training process well in advance of the deadline. We also arranged for backup call centers from our health plan affiliates to service any increased spike in call volumes to ensure Members received all needed care and service level performance standards. In addition, we assessed current staff and placed them in different roles in order to fill immediate gaps. Magnolia will follow this same process in the future should we realize any additional increase in Membership, program expansions, or programmatic changes.

Systems to Assist in Identifying Trends. Each functional area within Magnolia monitors and trends key metrics relevant to that specific area using our Centelligence Reporting and Analytics Platform and Workforce Management Software to inform an objective forecast of staffing needs well before those requirements materialize. Centelligence trends claims volume by claim type; including trends in complex claims. We also measure and monitor caseloads per Care Manager; and authorization requests by type per Prior Authorization Nurse. To maintain our Call Center service level standards, we will continue to use our Workforce Management Software to support a responsive, scalable staffing model. Based on years of call data analyses for Mississippi and other affiliate health plans with similar populations, the software factors in call-type complexity, historical call duration, call patterns including seasonal variation, market maturity, and eligibility categories specific to Mississippi to determine appropriate staffing, analyzing down to 15-minute increments when needed. This predictive approach allows for effective staffing by notifying us of rapidly changing situations in volume or call duration. We translate all of this information into staffing forecasts.

Cross Training. Cross training offers several benefits to employees. Cross training offers professional development opportunities, improves understanding of different positions and Magnolia as a whole, leads to better coordination and teamwork, and improves overall motivation. Cross training means learning new skills, which makes employees more valuable and often more engaged. From a management perspective, cross-trained employees can temporarily fill in for absent coworkers. For example, our Customer Service Representatives are cross-trained to address both Member and Provider calls and issues. Similarly, Members of our Integrated Care Team in Medical Management are cross-trained to ensure coverage and continuity (i.e., Member Connections Representatives are cross-trained to assist Program Coordinators). Cross training staff increases employee morale and ensures that program staff are able to provide backup support to their peers, as necessary to ensure an ongoing high level of performance or in the event of employee absence or turnover.

Staff Turnover Contingency Plans. To address the risk that a vacancy may occur with one of our key personnel/staff Members, Magnolia has prepared a contingency plan which includes a list of required backup corporate or health plan personnel who can step in on an interim basis. To further support an immediate need, Key Staff positions are aligned with key personnel at Centene who are experienced and able to provide additional support where needed. Magnolia understands that key management positions cannot be vacant for more than 90 calendar days and will notify DOM within five business days when we become aware of a vacancy or when we anticipate a vacancy within the next 30 calendar days. We will fill a key staff vacancy only with prior approval from DOM.

All Key Staff and Other Staff Positions. The Senior Leadership team meets weekly to discuss any staffing issues and to identify staff from other functional areas that may be able to fill a position temporarily or to offer assistance in an area with a recent vacancy. In the event a vacancy does occur, Magnolia will act immediately to recruit and hire a qualified candidate for that position. Magnolia and all of our health plan affiliates across the country share an active resume and candidate database and consistently maintain a dialogue with qualified candidates to keep a steady flow of strong potential applicants “in the pipeline.” By continuously evaluating parties who have an interest in employment, the organization is able to quickly and efficiently fill open positions. Open positions are posted internally on our company-wide intranet so employees at all Centene subsidiaries have access to open employment opportunities. We also post open positions externally on the Magnolia website. Additionally, Centene has implemented an integrated model for our Talent Acquisition teams that allows them to recruit proactively with direct input from Magnolia leadership. This integrated approach allows Talent Acquisition and recruitment teams to work directly with the hiring leaders to enhance recruiting efforts.

Longevity of Staff

Low Staff Turnover. Maintaining low voluntary and involuntary turnover rates and retaining trained and knowledgeable staff are priorities for Magnolia. Reducing staff turnover leads to increased productivity, decreased training time, and decreased costs associated with recruitment, interviewing, and hiring. Our retention strategies and programs, comprehensive benefits package, and employee recognition programs, along with our diverse working environment that promotes professional and personal development, help Magnolia maintain a

low turnover rate in a very competitive market. Our success in this area is demonstrated by an average annual staff turner that is lower than the national average of 19% for the health care industry. Magnolia and our affiliate subcontractors share a variety of turnover management practices and retention strategies that have a proven track record of success. These organizations share a centralized Human Resources function, allowing for robust cross-organization communication and more effective management of challenges as they arise.

Centene and Magnolia's retention strategies to reduce turnover include a "promote from within" policy, regular reviews of salary scales, and training programs that address employees' areas of interest and career paths. Additionally, Centene provides employees of all its subsidiaries a broad array of work life programs, such as flex-time, tuition reimbursement, and paid time off which includes personal, vacation, and sick time. Magnolia has some of the highest employee engagement of the Centene companies and is above the national average for the health care industry.

Leadership Development and Succession Planning. All Magnolia supervisors, managers, and executives participate in Centene's corporate leadership development programs. Topics addressed in these programs include:

- Leaders of Character
- Leadership Assessment
- Vision of Centene's Future and Expectations of Leadership
- Constructing a Budget
- Good to Great
- Execution: The Discipline of Getting Things Done
- Strategic Planning
- Employment Law
- Establishing Performance Expectations
- Conducting Performance Reviews

In addition, for non-management individuals who express an interest in assuming leadership roles within the organization, they may attend the Preparing for Leadership training program. Our succession planning has two goals: (1) to help employees attain their professional goals and (2) to implement a structured approach that will allow us to grow future leaders for all levels of the company. The program begins with gathering information from a variety of sources including a Myers-Briggs Type Indicator assessment, an individual planning resume completed by the employee, and input from both the individual's immediate and second level supervisors. After all information is assembled, a Member of Centene's Organizational Development Department meets with the employee and his or her supervisor to design a Personal Development Plan including career-enhancing assignments, projects, and courses to assist the employee in attaining their professional goals. At the organizational level, the company uses the information from this program to identify individuals who are prepared to assume leadership roles within the organization.

Healthy Pathways Wellness Program. Since 2007, Centene has been committed to offering Healthy Pathways, an employee workplace wellness program that promotes a healthier lifestyle and personal accountability through health risk assessment, biometric screening, health coaching, a built-in incentives program, education, and mobile and online support services. This personalized wellness program helps employees better manage their health, reduces employee absenteeism, and improves job satisfaction. Through this program, employees' health objectives can be met by assessing their current health status and defining personal goals, such as weight loss, smoking cessation, and/or implementing a healthier diet. This workplace wellness program helps participants easily find the resources needed to achieve better health, while having fun and potentially earning incentives.

Supporting a Healthy Workforce

For the past several years, Magnolia has received recognition as the third healthiest workplace in Mississippi. The Mississippi Healthiest Workplace Awards recognizes the top employers across the state who show excellence in providing employer health and wellness programs and healthy workplace environments. This program is a collaboration of the Mississippi Business Group on Health, the Mississippi Business Journal, the Mississippi State Department of Health, and the Mississippi Association of Self-Insurers.

For over 10 years, the Healthy Pathways program has provided Magnolia employees with the resources they need to feel their best physically and emotionally. All Magnolia benefit-eligible employees can participate in the program and earn incentives. Our preferred health plan option provides medical coverage to employees at a reduced monthly premium and eliminates the co-insurance associated with the standard health plan option.

Staff Training. Our ability to retain staff is determined, in part, by the quality of our training programs. In addition to new hire orientation and job specific training, Magnolia offers training and opportunities for career growth through our online training system, as well as through our parent company, Centene. We provide tools for individual employees and management level staff to support professional and personal development. Courses include but are not limited to: goal setting, performance management, conducting performance appraisals, diversity, preparing for leadership, and supervisor orientation. We also offer customer service training programs to improve service to our Members and Providers. These include, but are not limited to phone etiquette, resolving customer complaints, and "Be the Best."

Staff Recognition and Appreciation Programs. We recognize that our employees are our most valuable asset. We take many opportunities throughout the year to recognize our staff for the effort they put forth on a daily basis interacting with our Members and Providers to ensure we provide high quality service delivery. Magnolia has an activities committee, which consists of Magnolia staff that plan activities and events for all employees throughout the year. Examples of employee recognition and appreciation programs include:

- ***Employee Appreciation Week.*** For a week in the spring each year, Magnolia honors its employees with a series of fun activities in observance of Employee Appreciation Week. The week includes themes where employees are encouraged to dress according to the theme, such as Hat Day and Tropical Shirt Day; Trivia contests, BINGO, and Guessing Games; special meals and snacks; and drawings for gift cards.
- ***Key Contributor Awards.*** This program is a spot bonus program designed to allow managers a way to reward employees for exceptional performance above and beyond their normal daily responsibilities.
- ***Holiday Meals.*** On various holidays, Magnolia provides meals for employees to show appreciation.
- ***Seasonal Activities.*** Company-sponsored picnics; holiday parties and baseball games.

Supporting Employees Through Challenging Times. As the past several years have presented extraordinary challenges including the COVID-19 pandemic and Hurricane Ida, Magnolia staff have demonstrated their resiliency and commitment to Mississippi's most vulnerable residents. In recognition of their hard work and dedication to the Members we serve, we are proud to support our employees. For example, Centene implemented the Everyday Impact Award that has provided an extrinsic value award aside from compensation or promotion. The award is recognized by that employee's leadership and can be given by any employee by another for impactful work that is done.

[END OF RESPONSE]

4.3.4.4 EMERGENCY PREPAREDNESS PLAN

The Offeror should discuss its services and staffing continuity plans should an emergency, including but not limited to a natural disaster, pandemic, or act of public enemy, occur during the life of the Contract.

Integrated Approach to Emergency Response

Magnolia along with our parent company, Centene, view emergency response, business continuity, and disaster recovery as more than prudent business practices – they are integral components of being a service-oriented organization. We employ Continuity of Operations and Disaster Recovery (DR) planning best practices to anticipate and respond to disasters and emergency conditions in a timely manner. We engineer our hardware, software, and processes in our Management Information System (MIS) to ensure high availability of our applications, appropriate partitioning and systems monitoring, and prioritization to ensure IT systems, data, and software are available to Members, Providers, and staff after disaster identification. Centralized services in our enterprise-wide data centers will provide resiliency and redundancy to our continuity and disaster recovery planning. We view continuity and DR planning as a high priority to ensure service excellence. Our continuity and recovery solutions, as described in further detail below, allow for a variety of options depending on the type and severity of the event.

Continuity of Operations and Disaster Recovery Plans. We have access to a centralized, enterprise-wide business continuity management (BCM) organization which provides support, coordination, oversight, continuity of operations plan development, and maintenance of our overall business resiliency. Magnolia staff, in partnership with BCM, maintain and oversee our currently operational continuity of operations and DR plans, as well as supplemental continuity plans. We conduct regular assessments of our continuity of operations plans in the form of scenario-based exercises. The frequency of these exercises is determined by the plan's overall criticality. Our DR plans, updated at least annually, include comprehensive and clearly articulated data backup, DR, and emergency mode of operations policies and procedures; and are compliant with HIPAA, 45 CFR 164.308, and all relevant Mississippi and federal regulations.

Magnolia in Action

Due to our robust continuity and DR Plans, Magnolia maintained normal operating service levels before and during the COVID-19 pandemic, at no point dropping any calls. All information systems remained online and available, including core systems, websites and secure portals, and data exchange subsystems. Additionally, at the beginning of the pandemic, our Care Management staff outreached to Members to ensure they had a management plan and proper supports in place. We maintained the ability to receive eligibility data, as well as electronic claims and authorizations. We lost no data during the pandemic and faced no data security incidents. Our full-mesh, multi-vendor Wide Area Network allowed all staff to quickly and seamlessly transition to a 'work from home' environment.

Supporting Continuity of Operations and DR Plans. We also maintain a number of supporting plans detailing emergency response, crisis and incident management, and pandemic operations procedures. These supporting plans are based on protocols established by the World Health Organization (WHO) and the Centers for Disease Control (CDC) to respond to and recover from situations impacting our employees and business operations. Our confidential pandemic plan in particular provides strategies to reduce pandemic-related impacts to our staff and operations.

Supporting Mississippians in Times of Need. Similar to many businesses, governments, and entities across Mississippi, the United States, and the world, Magnolia's and Centene's emergency preparedness has been put to the test as we have collectively responded to the COVID-19 pandemic. As Hurricane Ida pummeled the Gulf Coast in August 2021, our staff demonstrated extraordinary resiliency and commitment to vulnerable Mississippians. While these events have presented unprecedented challenges, Magnolia's continuity plans enabled us to ensure Members continued to have access to critical services.

Starting in Spring of 2020, Magnolia quickly stepped up to partner with DOM in supporting MississippiCAN Members during the COVID-19 pandemic, implementing supports that span financial, social, and health care needs. We followed defined procedures to ensure that Members and Providers had access to needed resources, supports, and services. For Members in care management, our CM team reached out to high-risk Members and Members that tested positive for COVID-19 to assist with coordinating any needed services. We informed all Members via text message, our website, and mailed letters on COVID-19 including steps on how to stay

healthy, what to do if you do not feel good, how to access Magnolia's 24/7 telehealth appointments, Member Services, and BH Crisis Line.

Magnolia made efforts to support Members in other ways since the beginning of COVID-19. Magnolia has provided the following to support Mississippi communities during the pandemic:

- **750** Walmart Gift Cards to various community organizations and Provider groups
- **200** Amazon Gift Cards to various community organizations
- **$46,000** to local food banks and Centene Corporate Charitable Foundation gave a large donation to MS Food Network
- **500** masks for CPS Case Workers
- **20,000** masks to the MS Dental Association
- **200** Samsung cell phones to Providers for their patients without a reliable phone for telehealth services

Employee Training. We use several methods to train and educate Magnolia employees on continuity of operations programs. Training programs and presentations for crisis management, DR, emergency response, and other continuity of operations issues are available through organizational and enterprise-wide channels. Once all our employees are able to safely return to regular in-person engagement in our office spaces, we will periodically conduct emergency preparedness drills to outline and address emergency procedures, such as evacuation routes, inclement weather processes, tornado shelter locations, and fire and earthquake procedures. In addition, BCM will partner with members of our local leadership response team to conduct continuity exercises based on plan priority, which serve the dual purpose of highlighting recent plan updates, as well as regular continuity of operations re-training for our key employees. Information about our plans is also available to our leadership response team at any time.

Executing BCP for Inclement Weather

In the event of an emergency, Magnolia's top priorities are the safety of our staff and continued service to our Members. In 2021, due to the widespread impact of Hurricane Ida, Magnolia leadership took quick action. Our Call Center leadership activated the emergency closure greeting for all inbound calls, and employees with remote access and the ability to work from home were instructed to do so. The office closures had minimal impact on business operations and we were able to open all locations the following business day.

Timely System Availability Communications

Communication with Staff. Impacted staff will be notified via our advanced Everbridge emergency notification system, which ensures swift notification to staff members in a crisis or emergency, no matter what happens to local or regional communications systems. The system can send voice, SMS text, and email messages to all work contacts in our human resources information system to provide critical information on delayed office openings, building power outages, hazardous weather, evacuations, and system unavailability. Not only do we have staff trained on this notification system locally, but should a disaster inhibit our ability to notify our staff, we can rely on our trained affiliates across the country not impacted by a local disaster to operate the system on our behalf, ensuring 24/7 coverage and redundancy. During the May 2021 infrastructure crisis and resulting power outages, Everbridge notifications enabled Magnolia's leadership team to quickly take action and leverage Centene support to ensure no disruption in calls.

Timely Communication with Suppliers and DOM. Further, our continuity of operations plans have structured communication processes used to update suppliers and DOM in the event of a disaster or emergency impacting system availability. Magnolia's Compliance Department is responsible for providing DOM with a detailed explanation of the disaster and its impact related to critical business functions upon disaster or disruption discovery. For extended disruptions, we will provide DOM with a detailed plan to resume operations.

Communication with Providers and Members. We have the ability to quickly update our public website to provide emergency-appropriate information for Providers and Members, including tips for preparation, where to access resources, alerts and updates, and service outage notifications. All data populating our secure Provider and Member Portals is housed in our secure data centers, ensuring Member record accessibility for Providers and Members no matter where they are in the event of an emergency. Further, Magnolia's care management staff will conduct outreach to our Members as appropriate to develop specific strategies to ensure they have

access to necessary resources and continuity of care. Depending on the emergency, we will customize the voice scripts in our Interactive Voice Response (IVR) to inform calling Providers and Members of the situation and route their calls accordingly.

Real-Time Emergency Monitoring, Management, and Reporting

To supplement our emergency and disaster preparedness processes and expertise, Magnolia and our centralized Crisis Management resources will leverage customized solutions from a leading provider of emergency management and continuity services to track weather-related and other adverse events likely to impact our Mississippi staff, Members, and Providers. Key emergency response staff (i.e., Chief Operating Officer, Call Center Managers, Facilities Manager) will receive detailed reports, dashboards, and email alerts coordinated with the National Weather Service or other governmental agencies which provide office-specific forecasts on inclement weather (winds, storm surge, tornado, hurricane, etc.), enabling us to proactively act on anticipated impacts. For example, we have access to an Interactive Common Operational Picture, which offers a real-time visualization of all weather-related events likely to impact our offices. From there, we are able to notify impacted staff, including any employees in the field, to ensure appropriate action is taken. This common operational picture also features a Member data layer used to predict Member impacts at the county-level. We will then be able to proactively conduct outreach to those Members to verify they have the supports they need and reinforce continuity of care. In addition to reporting, we will have on-demand, 24/7 access to experienced emergency managers and meteorologists who can join our crisis response calls and offer their unique expertise. These meteorologist briefings will provide real-time and location-specific forecasts to offer our leadership additional clarity in making strategic emergency response decisions.

Data Center Failover Site Approach

To mitigate disruption of service and avoid loss of data, Centene owns and operates two geographically separated enterprise data centers, connected by a fully redundant wide area network (WAN), where all of Magnolia's core application data is housed. We will be expanding to three data centers for enhanced levels of continuity and service resiliency for our operations in Mississippi. These facilities employ redundant environmental, power, and networking systems, backup capability, and are hardened to withstand natural disasters. As data is created in our production environments, it will be immediately replicated in the associated recovery data center. In an event requiring a failover from the primary to the alternate site, we would leverage this back-up replicated data and infrastructure located at the alternate site to continue essential business functions. This architecture will provide our critical applications and infrastructure the necessary resilience and service stability to quickly resume essentially business functions within established recovery time objectives (RTOs) or other contractual/regulatory guidelines for service levels, and all remaining operations timely following a disruption. Further, our centralized Incident Response Operation Center (IROC) is made up of systems analysts, engineers, and management staff who will continuously monitor all production systems for performance, service availability, and capacity utilization to anticipate and address situations before problems arise. If we experience a system failure or interruption, IROC will immediately invoke and coordinate response and restoration procedures and activate a temporary virtual command center with a pre-designated incident management team, inclusive of Magnolia leadership, to ensure essential business functions are recovered and restored. All of our affiliated Subcontractors use the same resilient technology architecture and capitalize on the same contingency planning, assuring Magnolia the best possible coordinated response to potentially disrupting emergencies for our most critical business operations.

Systems Backup and Recovery

Magnolia performs full and complete system backups nightly on all servers utilizing enterprise-class backup software and online tape backup technology with off-site replication to our designated recovery data center, ensuring robust recovery and resiliency capabilities. Our DR processes leverage leading technologies and off-site storage to fully recover data and systems from the effects of a disaster and minimize the recovery period. In the case of an outage, the designated recovery data center

Data Centers Built for Resiliency

Our data centers have a seismic importance factor of 1.5 and can withstand winds up to 165 miles per hour.

will restore critical business services including systems, databases, and applications, and can sustain this for three months or longer. From there, all other systems and applications will be restored in accordance with Division priority, as well as in accordance with the results of our annual comprehensive risk and threat assessments, to ensure Division satisfaction with our recovery capabilities and mutually agreed upon recovery time and point objectives (RTOs and RPOs). We will align with Division-defined minimum RTO and RPO timeframes as required.

Keeping Key Functions Online

Member and Provider Services Call Center Operations. In the event of a disaster, all business functions that rely on our telecommunications system have top priority – specifically our Member and Provider Services Call Centers. Our Mississippi-based call center is engineered with several levels of redundancy, allowing for immediate, automated rerouting of inbound calls to our out-of-state Regional Service Center or other affiliates. This will ensure our Members and Providers do not experience a disruption in service or access to care. Staff at our Regional Service Center have access to the MississippiCAN and CHIP knowledge base, including DOM's approved scripts, guaranteeing levels of service and consistently accurate information to callers as our Mississippi Customer Service Representatives.

Claims Operations. Magnolia's claims operations will be supported from one of our six claims processing centers located across the country dedicated to our claims. The centers are securely networked for voice and data connectivity with all data centers, as well as our offices. Our automated claims workflow system can instantly route our claims workload amongst any of the claims centers, with staff at each trained to handle our claims.

Magnolia Office Closed or Incapacitated. We maintain robust policies and procedures to allow for remote work and remote access informed by HIPAA and the HITECH Act. All applications are run centrally from our data centers, and our virtual standardized desktops connect to centralized data via a WAN. We review and update our procedures annually to align with industry best practices, risk assessments, and federal and state mandates. Privileged remote access will be provisioned only with approval and role-based or business justification. We have developed and will continue to maintain an online COVID-19 Resource Center to support our workforce as they rapidly transitioned to a work from home environment in response to the COVID-19 pandemic. Provided resources include help for getting connected remotely, training guides, video tutorials, and more.

Testing Plan

Magnolia partners with our centralized BCM and DR teams to maintain and test our continuity of operations and DR plans annually as required by applicable federal and State regulations. Such testing will assure we meet RPOs and RTOs, and that our offices can continue to serve Members, their families, and Providers in the event a data center or system is unavailable. All of our testing methods include structured documentation of lessons learned, which are then utilized to improve response times and address gaps in our plans. Magnolia will provide test results within 30 days of the request from DOM. Our continuity and DR testing procedures include:

Annual DR Simulation Test. We conduct full-scale, comprehensive testing of our MIS recovery capabilities by simulating a disaster to validate that we can deliver systems in an emergency. This simulation will thoroughly test all relevant hardware, software, personnel, communications, procedures, supplies and forms, documentation, transportation, utilities, and alternate site processing. Results of this test, including any failure points or corrective action plans, will be made available as part of an annual report to the State. Magnolia approaches interruption testing (actual activation of our DR strategy) with extreme caution and will only conduct it as needed or required to avoid disruption of normal operations.

Recognized Industry Leader

For our coordinated and timely response to COVID-19, Forbes ranked Centene 14 on its Corporate Responders Ranking, which assessed how well the largest U.S. public employers mobilized to meet the challenges of COVID-19 and protect the health and safety of our employees, Members, and support communities.

Walkthroughs. We perform regular walkthroughs of the specific steps documented in our DR plans to confirm effectiveness and identify potential gaps, bottlenecks, or other weaknesses. These walkthroughs reflect updated

business objectives, allowing us to better respond to changing threats.

Parallel Testing. Magnolia regularly conducts parallel testing by running reports on data in our primary and contingency data centers and comparing results to assess the effectiveness and accuracy of our backup and recovery processes. Output discrepancies would indicate needed process or technology changes.

[END OF RESPONSE]