Mississippi Division of Medicaid Coordinated Care Organization Program

PUBLIC COPY

Response to: RFQ # 20211210

March 4, 2022 at 2:00 PM CT

Submitted by:

Molina Healthcare of Mississippi, Inc.

Mississippi Division of Medicaid Coordinated Care Organization Program

TRANSMITTAL LETTER

Response to: RFQ # 20211210

March 4, 2022 at 2:00 PM CT

Submitted by:
Molina Healthcare of Mississippi, Inc.

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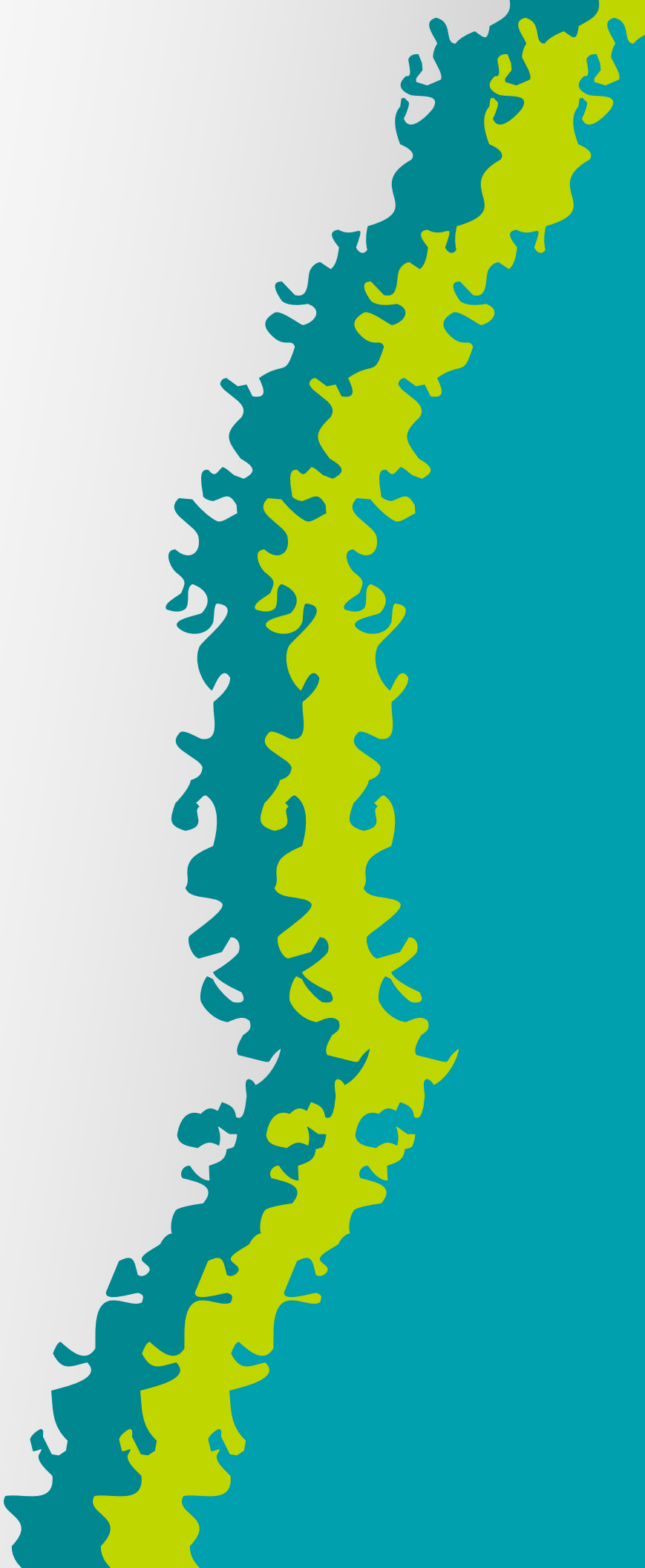
Transmittal Letter

MARKED



Bridget L. Galatas
Chief Executive Officer
Organization
Molina Healthcare of Mississippi, Inc.
188 E. Capitol Street, Suite 700
Jackson, MS 39201
Bridget.Galatas@Molinahealthcare.com
Tel: (888) 562-3758

March 3, 2022

Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

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

To Whom It May Concern:

Molina Healthcare of Mississippi, Inc. (Molina), as the Offeror, is pleased to submit our response to the State of Mississippi, Office of the Governor, Division of Medicaid (the Division) Request for Qualifications (RFQ) to provide services for the statewide administration of the Mississippi Division of Medicaid Coordinated Care Organization (CCO) Program, which consists of the Mississippi Coordinated Access Network (MississippiCAN) and the Mississippi Children's Health Insurance Program (CHIP). We share the Division's desire to improve health outcomes by improving quality, collaborating on innovative quality-based initiatives, increasing access to care by breaking down geographic and social determinants of health barriers, and ultimately making a commitment to truly improving the lives of Mississippi's citizens.

As a current Contractor in Mississippi, with the backing of our parent company, Molina Healthcare, Inc. (Molina Healthcare), an industry leader in providing healthcare services for approximately 5.2 million Members in government-sponsored programs nationwide, we bring the experience, dedication, and vision necessary to provide services statewide to MississippiCAN and CHIP populations through the CCO Program.

In accordance with RFQ § 4.1, Transmittal Letter, Molina identifies all material and enclosures being submitted in response to the RFQ within a Table of Contents as the final appendix to this Transmittal Letter. We also confirm the following statements and attach the requested items immediately behind this Transmittal Letter.

1. Molina is a corporation in the State of Mississippi.
2. Molina is registered to do business and is in "Good Standing" with the State of Mississippi. Molina's corporate charter number (Secretary of State Business ID) is 945711.
3. Molina is licensed by the Mississippi Insurance Department (MID) and provides a copy of the license and certificate of authority immediately following this Transmittal Letter.
4. Molina's Federal tax ID/employer ID number is 26-4390042.
5. Molina has not been sanctioned by a State or Federal government within the last ten (10) years[1].
6. Molina has not been suspended or debarred under Federal law and regulations or any other State's laws or regulations.

[1] The Offeror, its corporate parent, or a subsidiary of its corporate parent performing managed care services in another state has not been sanctioned, as defined by 42 C.F.R. § 438.702, by a State or Federal government within the last ten (10) years; however, various types of non-compliance items have been received and the Offeror shall produce a list of such items upon request.

7. Molina has experience in contractual services providing the type of services described in this RFQ. Currently contracted with the Division, Molina started providing the types of services described in this RFQ in Mississippi on October 1, 2018 for MississippiCAN, and November 1, 2019 for Mississippi CHIP. Furthermore, Molina Healthcare subsidiaries have 28 years of Medicaid managed care experience, including providing the type of services described in the RFQ. We document this experience, and our ability to provide the services outlined in Appendix A, Draft Contract, throughout our qualification response.
8. If Molina is awarded a Contract pursuant to the RFQ, Molina agrees that any lost or reduced Federal matching money resulting from our unacceptable performance of a task or responsibility, as defined in the RFQ, will be accompanied by reductions in State payments to Molina.
9. Molina has not been terminated from any project prior to the end of the Contract period.
10. Molina has not made and will not make any attempt to induce any other person or firm to submit or not submit a qualification.
11. Molina has not violated, is not violating, and promises that we 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.
12. Molina 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.
13. Molina agrees to the language of the Division's Business Associate Agreement (BAA) and Data Use Agreement (DUA) without expectation of negotiation.
14. Molina acknowledges receipt of the following amendments to the RFQ issued by the Division:
    - Amendment #1: Section 5—Enterprise Security Policy, January 21, 2022
    - Amendment #2: RFQ Mandatory Pre-Qualification Question and Answer Document, January 21, 2022
    - Amendment #3: RFQ Appendices D, E, F, G, and H in Word Format, January 21, 2022
    - Amendment #4: RFQ Questions and Answers, February 7, 2022
    - Amendment #5: RFQ Corrections and Clarifications, February 7, 2022
    - Amendment #6: Appendix A: Draft Contract Corrections and Clarifications, February 7, 2022
    - Amendment #7: Updated RFQ Appendices F and H in Word Format, February 7, 2022
    - Amendment #8: Additional MSCAN and CHIP Rate Information in Excel Format/SFY 2022 Preliminary CHIP Capitation Rates/SFY 2022 Preliminary MSCAN Capitation Rates, February 7, 2022
    - Amendment #9: Clarification of Amendment 4 Responses, February 10, 2022
    - Amendment #10: Summary of Pre-Qualification Conference (Held on Friday, January 14, 2022), February 11, 2022
    - Amendment #11: Reporting Manuals, February 11, 2022
    - Amendment #12: Responses Regarding Amendment 9, February 16, 2022
15. Molina has read, understands, and agrees to all provisions of this RFQ without reservation and without expectation of negotiation.
16. Molina certifies that our qualification will be firm and binding for 365 days from the qualification due date.
17. Molina is responsible for writing our own qualification in collaboration with Weber Associates; Burch Consulting, LLC; Sellers Dorsey & Associates, LLC; and Stephanie Clark Consulting, LLC.
18. Immediately following this Transmittal Letter, Molina provides a statement from each of our proposed Subcontractors signed by individuals authorized to legally bind the Subcontractor and stating the general scope of work to be performed.
19. Immediately following this Transmittal Letter, Molina provides a Secretary's Certification that I, Bridget Galatas, am the CEO signing the corporate qualification and that I have full authority to obligate and bind Molina Healthcare of Mississippi, Inc., to the terms, conditions, and provisions of the qualification.

20. Molina presently 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 we will not employ, in the performance of this Contract, any person having such interest.
21. Molina will not make any public disclosure or issue a news release pertaining to this procurement without prior written approval of the Division.
22. Molina'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. Immediately following this Transmittal Letter, Molina provides the following executed 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 (executed by Molina and all expected Subcontractors)
    c. DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters
24. Molina's qualification 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 to require modifications before acceptance.

At the core of our mission is a commitment to treat all Members like extended family. Molina is excited for the opportunity to continue serving Members throughout the State, providing the most outstanding care possible and furthering the Division's goal of really making a difference in the lives of Mississippians.

Sincerely,

Bridget Galatas

Bridget L. Galatas
Chief Executive Officer
Molina Healthcare of Mississippi, Inc.

4.1 Transmittal Letter

Appendix 1

Mississippi Insurance Department (MID) License and Certificate of Authority

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

MOLINA HEALTHCARE OF MISSISSIPPI, INC.
188 EAST CAPITOL STREET, SUITE 700
JACKSON, MS 39201

5760 I-55 NORTH, SUITE 150
JACKSON, MS 39211

HOME OFFICE

MISSISSIPPI

PRIVILEGE TAX LICENSE

MOLINA HEALTHCARE OF MISSISSIPPI, INC.

LICENSE NUMBER : 1700015

Type License: INSURANCE COMPANY	ISSUE DATE:	EXPIRATION DATE:
	1/1/2022	**12/31/2022**

AUTHORIZED LINES:
HEALTH MAINTENANCE ORGANIZATION

THIS LICENSE IS NOT TRANSFERABLE

MIKE CHANEY
COMMISSIONER OF INSURANCE

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

MOLINA HEALTHCARE OF MISSISSIPPI, INC.
5760 I-55 NORTH, SUITE 150
JACKSON, MS 39211

LICENSE NUMBER: 1700015

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

4.1 Transmittal Letter

Appendix 2

Acknowledgement of Amendments

STATE OF MISSISSIPPI
MS DIVISION OF MEDICAID
AMENDMENT
Reqest for Quote

RESPONSES REQUIRED BY:
Submission Date : 03/04/2022
Submission Time : 12:00:00 PST

RESPONSES OPENED ON:
Opening Date : 00/00/0000
Opening Time : 12:00:00 PST

VENDOR NO:
VENDOR NAME & ADDRESS:
(To be completed by Vendor)

Molina Healthcare of Mississippi, Inc.
188 E. Capitol St.
Suite 700
Jackson, MS 39201

SUBMIT NON-ELECTRONIC RESPONSE:
TO :
550 HIGH STREET SUITE 1000
WALTER SILLERS BUILDING
JACKSON MS 39201
US

DELIVERY POINT

RFx number : 3150003991
Smart number : 1628-22-R-RFQP-00001-V05
Buyer : Catherine Holland
Buyer Phone : (601) 35-9 91
Email : CATHERINE.HOLLAND@MEDICAID.MS.GOV

NOTICE TO VENDOR:
Amendment #12 - 2-16-22
Amendment #11 - 2-11-22
Amendment #10 - 2-11-22
Amendment #9 - 2-10-22
Amendment #4, #5, #6, #7, #8 uploaded on 2/7/2022
Amendment #1 - 1-21-22; Amendment #2 - 1-21-22; Amendment #3 - 1-21-22

Pursuant to PPRB approval for RFx 3180001372, the Division of Medicaid (DOM) is releasing a Request for Qualifications (RFx # 3150003991) to solicit offers from qualified, responsible, and financially sound vendors to deliver coordinated care services to all Mississippi Coordinated Access Network (MississippiCAN) and Children's Health Insurance Program (CHIP) populations. DOM seeks competitive written qualifications from Offerors for a contract with a term of four (4) years with two (2) optional one (1) year renewals.
The solicitation can be obtained via the agency's dedicated Coordinated Care Procurement website at https://medicaid.ms.gov/coordinated-care-procurement/. Inquiries should be directed to the procurement officer, Jeanette Crawford, at 601-359-2664 or submitted via email at MSCAN_CHIP@medicaid.ms.gov. Mandatory Letters of Intent must be received by 2:00 p.m., Central Time Zone, on Friday, January 7, 2022. DOM has a right to reject any and all offers. Qualifications must be received by 2:00 p.m., Central Time Zone, on Friday, March 4, 2022.
RFQ solicitation for offerors to provide services for statewide administration of the Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program that serves eligible children and adults in Mississippi, and the Mississippi Children's Health Insurance Program (CHIP), a coordinated care program for Mississippi children.

Vendor Telephone Number	Title	Date
1-888-562-3758	Chief Executive Officer	March 3, 2022

(Typed or printed) Name of Bidder	Signature of Authorized Bidder
Bridget L. Galatas	Bridget Galatas

RFx number : 3150003991				Submission Date : 03/04/2022		Time : 12:00:00 PST
Smart number : 1628-22-R-RFQP-00001-V05				Opening Date : 00/00/0000		Time : 12:00:00 PST
Item	**Change Indicator**	**Product No. / Mfg. Part No.**	**Description**	**Delivery / Req.date**	**Qty**	**Unit**
# 1			Product Category : 95856 Health Care Management Serv.		0.000	

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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, 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: Bridget L. Galatas

Signature: Bridget Galatas

Title: Chief Executive Officer

Company: Molina Healthcare of Mississippi, 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)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, Inc.
(Company)

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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, Inc.
(Company)

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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, Inc.
(Company)

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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, Inc.
(Company)

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) – 5~~10~~ 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) – ~~5~~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.~~

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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, Inc.
(Company)

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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, 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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, 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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, Inc.
(Company)

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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, Inc.
(Company)

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:

Bridget Galatas
(Signature)

Bridget L. Galatas
(Printed)

Chief Executive Officer
(Title)

Molina Healthcare of Mississippi, Inc.
(Company)

4.1 Transmittal Letter

Appendix 3

Subcontractor Scope of Work Statements

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement, Mississippi Division of Medicaid

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

Dear Office of Procurement:

This letter is to confirm Molina Healthcare, Inc. ("MHI") is considered a subcontractor for purposes of the above referenced RFQ, as it provides shared services to Molina Healthcare of Mississipi ("Molina").

This letter, signed by an authorized MHI representative, serves as a commitment for MHI to provide the list of services outlined below to Molina:

- Human resources and training
- Legal
- Facilities
- IT
- Marketing/Public Relations
- Corporate finance
- Claims
- Member/Provider call center overflow
- Clinical telephony
- Administrative Clinical program support
- Healthcare Services Support
- Network Management Support
- Quality
- Subcontractor Oversight

Sincerely,

Cristina Siepel

Cristina Siepel
VP, Human Resources

MARCH®
Vision Care
GROUP,
INCORPORATED

February 10, 2022

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO Office of Procurement, Mississippi Division of Medicaid

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

Dear Office of Procurement:

This letter is to confirm March Vision Care Group, Incorporated has entered into a subcontract to provide service to Molina Healthcare of Mississippi, Inc. ("Molina") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind March Vision Care Group, Incorporated, serves as a commitment to provide vision care services on behalf of Molina.

Sincerely,

John D. Ryan
Secretary and Treasurer
March Vision Care Group, Incorporated

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement, Mississippi Division of Medicaid

RE: Request for Qualifications, Mississippi Division of Medicaid Coordinated Care, RFQ # 20211210 and RFx # 3150003991

Dear Office of Procurement:

This letter is to confirm that Medical Transportation Management, Inc. (MTM) has entered into a subcontract to provide service to Molina Healthcare ("Molina") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind MTM, serves as a commitment to provide non-emergency transportation services to Molina.

Sincerely,

Alaina Maciá
President and CEO
Medical Transportation Management, Inc. (MTM)

Office of Procurement
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

TO: Office of Procurement, Mississippi Division of Medicaid

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

Dear Office of Procurement:

This letter is to confirm SKYGEN USA, LLC (SKYGEN) has entered into a subcontract to provide service to Molina Healthcare ("Molina") for the above referenced RFQ.

This letter, signed by the individual authorized to legally bind SKYGEN, serves as a commitment to administer dental benefits on behalf of Molina Healthcare. The scope of work performed by SKYGEN will consist of credentialing/recredentialing, claims administration, call center and utilization management.

Sincerely,

James Purko
Chief Financial Officer
SKYGEN USA, LLC (SKYGEN)

4.1 Transmittal Letter

Appendix 4

Secretary's Certification

MOLINA HEALTHCARE OF MISSISSIPPI, INC.

SECRETARY'S CERTIFICATE

I, the undersigned, do hereby certify:

1. That I am the duly appointed and acting Secretary of Molina Healthcare of Mississippi, Inc., a Mississippi corporation (the "Company").

2. That Bridget Galatas is the duly appointed and acting President of the Company.

3. That in accordance with Article IV, Section 7 of the Bylaws of the Company, the President shall be the Chief Executive Officer of the Company and shall have direction and control of the business and officers of the Company as well as have the general powers and duties of management usually vested in the office of President of a corporation.

4. That the Company intends to respond to the State of Mississippi Request for Qualifications to provide services for the statewide administration the Mississippi Division of Medicaid Coordinated Care Organization Program, which consists of the Mississippi Coordinated Access Network and the Mississippi Children's Health Insurance Program.

5. That as the Chief Executive Officer of the Company, Ms. Galatas has full authority to obligate and bind the Company to the terms, conditions, and provisions of the aforementioned request for qualifications.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 14th day of February 2022.

DocuSigned by:
Jeff Barlow
259B97707E8415...
Jeff D. Barlow, Secretary

4.1 Transmittal Letter

Appendix D

Certifications and Assurances Regarding Contingent Fees & Gratuities

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.

Molina Healthcare of Mississippi,
Name of Offeror

Bridget Galatas
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror

Bridget Galatas
Signature of person attesting for Offeror

March 3, 2022
Date

[END OF RESPONSE]

4.1 Transmittal Letter

Appendix D

Drug-Free Workplace Requirements Certifications (from Offeror & Subcontractors)

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: Molina Healthcare of Mississippi, Inc.				
Line 1 (Street Name and Number): 188 D. Capitol Street				
Address Line 2 (Suite, Room, etc.): Suite 700				
City: Jackson	State: MS	Zip Code: 39201	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

Molina Healthcare of Mississippi, Inc.

Name of Offeror

Bridget Galatas

Printed name of person attesting for Offeror

Chief Executive Officer

Title of person attesting for Offeror

Bridget Galatas

Signature of person attesting for Offeror

March 3, 2020

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, performers 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: Molina Healthcare, Inc.				
Line 1 (Street Name and Number): 200 Oceangate				
Address Line 2 (Suite, Room, etc.): Suite 100				
City: Long Beach	State: CA	Zip Code: 90802	County: Los Angeles	
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

Molina Healthcare, Inc.

Name of Offeror

Cristina Siepel — **Printed name of person attesting for Offeror**

VP, Human Resources — **Title of person attesting for Offeror**

Cristina Siepel — **Signature of person attesting for Offeror**

March 3, 2022 — **Date**

[END OF RESPONSE]

MARCH® Vision Care GROUP, INCORPORATED

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, performers 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: March Vision Care Group, Incorporated				
Line 1 (Street Name and Number): 6601 Center Drive West				
Address Line 2 (Suite, Room, etc.): Suite 200				
City: Los Angeles	State: CA	Zip Code: 90045	County: Los Angeles	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

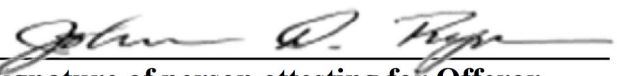
[ ] Check if there are workplaces on file that are not identified here.

---->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

March Vision Care Group, Incorporated
Name of Offeror

John D. Ryan
Printed name of person attesting for Offeror

Secretary and Treasurer
Title of person attesting for Offeror


Signature of person attesting for Offeror

February 10, 2022
Date

[END OF RESPONSE]

DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other thanIndividuals

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.

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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 impositionof 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 definitiondoes 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 inthe workplace;

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

D. Notifying the employee in the statement required by paragraph (a) that, as a condition ofemployment 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 paragraphD(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 agencyhas 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 paragraphD(2), with respect to any employee who is so convicted:

   (1) Taking appropriate personnel action against such an employee, up to and includingtermination, 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 implementationof 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 tableprovided below):

Place of Performance				
Name of Location: Medical Transportaton Management, Inc. (MTM)				
Line 1 (Street Name and Number): 16 Hawk Ridge Drive				
Address Line 2 (Suite, Room, etc.):				
City: Lake St. Louis	State: MO	Zip Code: 63367	County: United States	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

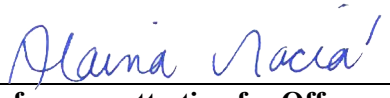
Check if there are workplaces on file that are not identified here.
---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and fornotification of criminal drug convictions. 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

MTM, Inc.

Name of Offeror

Alaina Maciá

Printed name of person attesting for Offeror



Signature of person attesting for Offeror

President and CEO

Title of person attesting for Offeror

1/26/2022

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: SKYGEN USA				
Line 1 (Street Name and Number): W140 N8981 Lilly Rd.				
Address Line 2 (Suite, Room, etc.):				
City: Menomonee Falls	State: WI	Zip Code: 53051	County: Waukesha	
Mailing Address (P.O. Box):	City:	State:	Zip Code:	County:

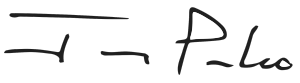
[ ] Check if there are workplaces on file that are not identified here.

---->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

SKYGEN USA
Name of Offeror

James Purko | CFO
Printed name of person attesting for Offeror | **Title of person attesting for Offeror**



2/10/2022
Signature of person attesting for Offeror | **Date**

[END OF RESPONSE]

4.1 Transmittal Letter

Appendix D

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

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.

Molina Healthcare of Mississippi, Inc.
Name of Offeror

Bridget Galatas
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror

Bridget Galatas
Signature of person attesting for Offeror

March 3, 2022
Date

[END OF RESPONSE]

Mississippi Division of Medicaid Coordinated Care Organization Program

Response to: RFQ # 20211210

March 4, 2022 at 2:00 PM CT

Submitted by:
Molina Healthcare of Mississippi, Inc.

Mississippi Division of Medicaid Coordinated Care Organization Program

TECHNICAL QUALIFICATION
(BLIND EVALUATION)

Response to: RFQ # 20211210

March 4, 2022 at 2:00 PM CT

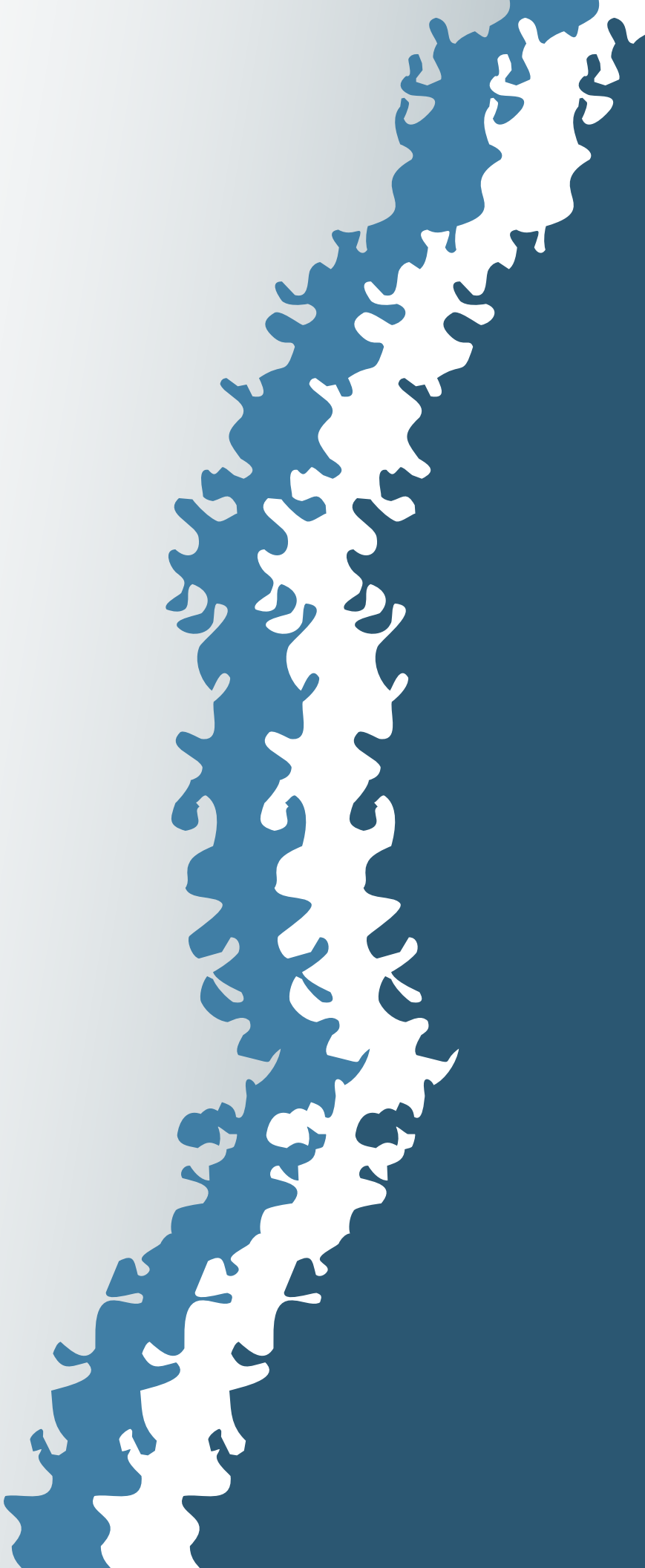
Submitted by:
Molina Healthcare of Mississippi, Inc.

TABLE OF CONTENTS

4.2 Technical Factors (Unmarked)

4.2.1

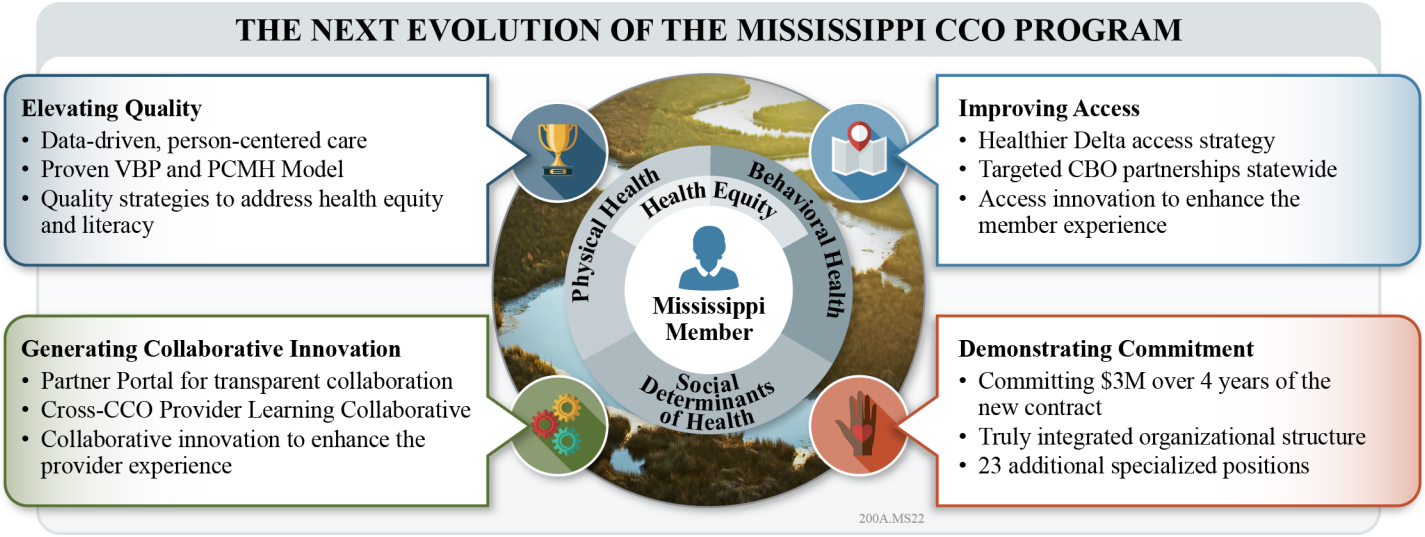
Executive Summary



4.2.1: EXECUTIVE SUMMARY

Highlights of Our Qualification

After a decade, Mississippi's Division of Medicaid (Division) has reflected on its achievements and is advancing the Coordinated Care Organization (CCO) Program in order to continue to improve health outcomes and quality of life for Members. This RFQ signals the Division's desire for a collaborative partnership with CCOs to bring the Division's successes together in a cohesive, integrated manner. The Division's approach will serve both the holistic needs of the individual and the health of the entire population for improved quality of life and equity for Members. The Division is seeking a partnership to realize its vision for the next evolution in MississippiCAN and CHIP—a partner who is deeply aligned with their goals. We are that partner, and in collaboration with the Division and Mississippi Members and Providers, ***a healthier Mississippi is on the horizon***.



Summary of the Proposed Approach

Our parent company and its affiliates bring decades of experience implementing and operating successful Medicaid and CHIP programs nationwide, improving health outcomes among Medicaid populations, and engaging our Providers to ensure quality care. Our approach is built upon our whole-person, high-touch, and community-driven philosophy of tailoring our support to meet the individualized needs of each Member and their family, no matter what their unique physical health, behavioral health (BH), or social challenges. ***We will live and work and raise our families where our Members live, work, and raise their families.*** This commitment underpins our approach and drive us to seek and expand partnerships with Providers, State agencies, community-based organizations (CBOs), and other CCOs to innovate and to support Members. We will bring our proven practices to benefit and best serve MississippiCAN and CHIP stakeholders.

Throughout our response, when we use the present tense, we are referencing the current practices and services operational in our health plans nationwide. When we write in the future tense, we are referencing practices and services that will occur in Mississippi under the new CCO Program. Additionally, unless otherwise specified our response to the Division's RFQ applies to both MississippiCAN and CHIP. Our approach for a successful CCO Program is aligned with matters central to the Division, as summarized below.

The Next Evolution of the CCO Program

Elevating Quality

As the Division advances its goal to elevate the quality of care, services, and outcomes for MississippiCAN and CHIP Members, ***we will align our efforts with those of the 2021–2024 Comprehensive Quality Strategy***, which seeks to ensure fidelity to high-quality care practices and maintain quality as one of the Division's top priorities. We are enthusiastic about collaborating with the Division and other stakeholders, such as the Department for Public Health and the other CCOs, to address key priority focus areas of maternal and infant health, chronic disease, and BH. Our multifaceted quality strategy supports Members to ensure they receive the recommended

care and engages Providers to adhere to evidence-based guidelines to move the needle on health outcomes, especially within the Division's priority areas.

Success with Diabetes

In one of our affiliated health plans, our targeted diabetes and glucose monitoring program resulted in an increase of **15 percentage points** in Comprehensive Diabetes Care HbA1c Control (<8.0%) HEDIS® measure, improving from the **25th to the 90th percentile**, which is above the Mississippi Medicaid average.

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Quality Is Integrated Into Every Step We Take. We reflect the Division's dedication to quality within our own organization. Our quality infrastructure and approach inform and are integrated into every element of our Medicaid programs. Our ongoing dedication to quality management (QM) processes and systems encompasses all aspects of health plan operations to successfully meet Members' evolving whole-person needs. We are experienced in designing and implementing quality programs that are tailored for each State, the demographics of the populations served, and the requirements of the contract. We will blend our comprehensive, structured quality assurance program with innovative community-based solutions that will strengthen relationships with Members and Providers, enabling us to connect more personally with them to influence the system and encourage the behavior changes necessary to achieve significant quality advances.

Our ongoing success in achieving NCQA accreditation demonstrates our dedication and commitment to improving quality and health outcomes. More than a dozen of our affiliate health plans have achieved NCQA accreditation, with most earning NCQA's Multicultural Health Care Distinction for their focus on improving culturally and linguistically appropriate services and reducing healthcare disparities. We have well-established policies and procedures in place to align to NCQA standards, as well as documented processes focused on clinical quality and improving culturally and linguistically appropriate services. ***We will obtain full NCQA accreditation as well as Multicultural Health Care Distinction in Mississippi if awarded.***

Quality over Quantity: Mississippi's Evolution in Provider Support

Critical to a high-quality CCO Program is ensuring quality at the point of care and supporting Providers to achieve consistent, high-quality care. We are committed to progressing the State's health priorities through our high-touch Provider model, an emphasis on PCMHs, and innovative value-based arrangements with Providers and care partners across the entire care delivery journey. We will fully engage our Providers early and often, giving them the support they need while ensuring that adherence to evidence-based guidelines at the point of care is the norm, not the exception. Our practice transformation team will work closely with the Provider Representatives to ensure Providers who are ready for value-based purchasing (VBP) or PCMH initiatives have the support they need to be successful. The journey to practice transformation is different for each Provider, and this team will ensure a tailored experience specifically designed to meet each Provider's needs.

Value-based Purchasing. For this next evolution in Mississippi Medicaid, the Division is focused on developing an achievable VBP model that prioritizes value over volume. Nationally, our Medicaid health plans bring almost 30 years of experience implementing innovative Provider VBP models and advancing Providers along the continuum toward improved quality, better health outcomes, cost efficiency, and Provider accountability. ***Leveraging our national experience, we will offer the opportunity for 100% of PCPs to participate in alternative payment model (APM) Category 2 VBP arrangements in Year 1 through a pay-for-quality program,*** which will ensure a majority of Members will be tied to a Provider participating in VBP.

Our value-based models offer true flexibility. We tailor our VPB arrangements to effectively incentivize provider performance, wherever providers are across a continuum of capabilities. We will employ our nationally proven VBP design and implementation process, customized to meet the needs of Mississippi Members and Providers, to collaborate with the Division and exceed the State's goals for improving health outcomes. This design and implementation process establishes a clear, guided pathway to excellence for Providers with the support of all health plan staff.

Strong Provider partnerships and comprehensive technical assistance and support are fundamental to our strategy. We leverage continuous quality improvement (QI) and VBP reporting and analytics tools to help Providers achieve optimal performance. We have structured our enablement and support model to assist, inform, and partner with Providers through advanced technology, data and analytics, and technical and clinical support services. To encourage practice transformation, we will launch a program offering Providers insightful,

actionable data to help their patients. Such data is critical to practice transformation, and this first step will help demonstrate its benefit and how to use it to support the success of the CCO–Provider trusted relationship.

Provider Representatives educate our Providers about the benefits of working with our practice transformation teams to improve their care performance and realize the income benefits of the VBR/pay-for-performance programs, as well as how to motivate assigned Members to close care gaps, and the many ways they can be rewarded for adhering to quality measures and meeting performance goals. Through this support, our Mississippi Providers will always understand how they are performing against goals to ensure targets are met or to identify and eliminate barriers to success through a continuous QI process. Our methods reduce administrative burden, provide seamless access to population- and Member-level data, and enhance Provider effectiveness and satisfaction.

Our VBP strategy recognizes the critical role social determinants of health (SDOH), health equity, and access play in ensuring the well-being of MississippiCAN and CHIP Members and makes these elements foundational to each of our VBP models. We will bring our broad experience with SDOH community-based programs and tailor our Mississippi VBP models to ***leverage both traditional and nontraditional Providers*** of care within care teams—such as peer recovery, family supports, and community health workers (CHWs)—with the goal of connecting each Member to the resources that will best meet their needs. We will also engage health centers serving American Indians and pay incentives for Z code screening, referral to CBOs, and follow-up to address SDOH.

Addressing Health Equity: VBP Success

Our Medicaid affiliate in another State partnered with two large integrated health systems to develop a sickle cell anemia pay-for-performance VBP arrangement in alignment with their population health program goal of **reducing inequities and disparities in the Black population**. Using incentives addressing quality of care and emergency room (ER) diversion, the total cost of care PMPM decreased by 25%, physical health brand-name prescription utilization decreased by 50%, and inpatient physical health and BH utilization decreased by 17% in the first year following implementation.

200K.MS22

Encouraging Adoption of PCMHs in Mississippi. A patient-centered model of care can positively impact the delivery of healthcare by reducing fragmentation, improving Member and Provider satisfaction, and helping individuals better manage chronic conditions, thereby preventing costly hospitalization and institutionalization and driving continuous QI. Our affiliates have extensive experience partnering with Medicaid agencies to expand and build upon PCMH programs with a focus on achieving specific quality goals. Our proposal is to build up Mississippi's PCMH infrastructure through collaborative, coordinated efforts that promote practice transformation toward truly integrated, comprehensive primary care delivery with NCQA PCMH recognition.

As a CCO, we will support Providers with all the tools they need to be successful in meeting their goals. We will continue to develop the capabilities of Providers currently operating as PCMHs or already recognized as PCMHs and help other willing Providers mature along the path to becoming PCMHs. This support will include Member engagement strategies designed to "wrap around" PCMH Members, incentive programs, health promotion activities, value-adds, and SDOH programs to support Member nonclinical needs integrated into PCMH workflows. ***We recommend including PCMHs in quality PIPs, including those that focus on Members with medium- and high-risk clinical needs and chronic conditions.*** We will monitor Member health outcomes over time to track PCMH performance and help PCMHs meet performance goals. PCMH outcomes will feed into and inform our population health and VBP programs.

Enhancing Quality: Mississippi's Next Evolution in High-touch, Person-centered Care Management

Our QM program is a critical element of our care management and population health programs, delivering data-driven, evidence-based strategies and innovative approaches that combine best practices, affiliate successes, and community-informed interventions. Our care management and population health intervention approach, customized for Mississippi, will cultivate and integrate a deep understanding of MississippiCAN and CHIP Members' physical health, BH, and SDOH, and the unique communities in which they reside, to holistically and effectively address Member needs across the care continuum. Our high-touch, individualized model will employ collaborative, effective interventions implemented through culturally appropriate solutions, tailored supports, targeted programs, critical value-adds, and specialized community-based staff.

Members will benefit from our grassroots approach to understanding the unique health conditions of Mississippians. From the Piney Woods to the Delta, each region and county has its own unique challenges and

strengths, and we collaborate with partners across the healthcare system to effectively support them. Our community focus means we can serve all Members effectively, regardless of where they live, through an approach that combines on-the-ground staff—like CHWs who help find hard-to-reach Members and an [redacted]

Strategies to Address Healthy Equity. We use our QM systems to identify and address health equity through our SDOH programs by developing and implementing strategies that solve for nonmedical social risk factors and needs that are relevant and critical to addressing identified health disparities. For example, we know that Black Mississippians experience a higher prevalence of diabetes compared to White residents, and we know that most counties in the Delta show the highest prevalence of diabetes. We will address this disparity by providing nutrition assistance, bringing education and resources to the community, and partnering with organizations, such as the *Family Resource Center of North Mississippi* and *Community Foundation of Northwest Mississippi*, that share our mission.

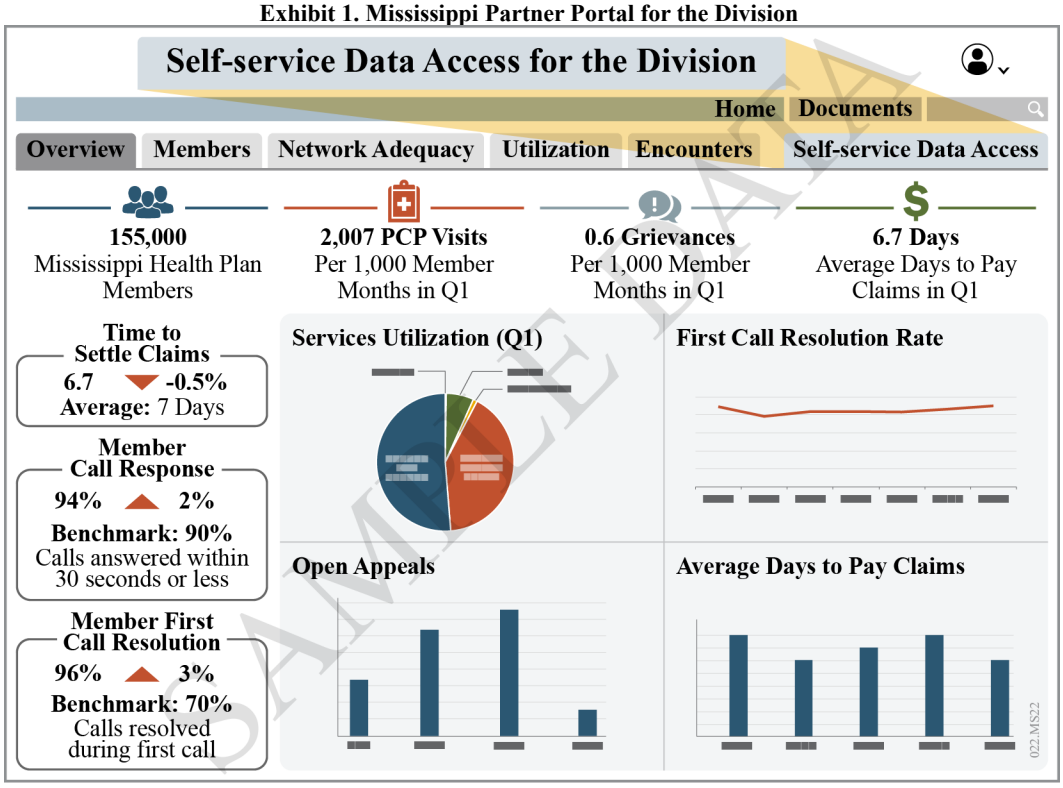
Strategies to Improve Health Literacy. Moving the needle on health outcomes and improving Members' quality of care requires empowering them with information, intuitive tools, and the means to be proactive, self-manage, and focus on preventive measures. We will develop health education programs for MississippiCAN and CHIP Members that are meaningful and culturally and linguistically appropriate, along with interventions that help Members learn about and engage in their health journey. To achieve these objectives, our education programs must be tailored to resonate with Members from Jackson to the Delta. We will provide Members with one-on-one support and educational opportunities on how to use technology, how to cook nutritious recipes, and the importance of physical activity. Our literacy program will establish reading nooks, installing bookcases and stocking books at FQHCs and other facilities. We will pair this focus on literacy with our quarterly education program that will ***engage prekindergarten and Head Start children and their families*** with learning opportunities in collaboration with school districts across the State.

The Next Evolution of the CCO Program

Generating Collaborative Innovation

For a Medicaid CCO Program to be successful, it is essential for a CCO to work in close collaboration with the Division, Members, Providers, and other stakeholders, including other Mississippi CCOs. Our goal is to enhance the Member and Provider experience, be the plan of choice for Members and Providers, and be the partner of choice for the Division in achieving the State's goals for the CCO Program.

Exhibit 1. Mississippi Partner Portal for the Division



Collaborative Innovation: A Transparent Partnership with the Division

Our customized Mississippi Partner Portal demonstrates our commitment to being a dedicated partner to the State through innovative transparency. Through a user-friendly, secure, and HIPAA-

compliant interface, ***authorized Division staff will be able to view snapshots of key data to monitor the efficacy and compliance of CCO Program initiatives and programs***. We will make key areas of reporting readily available and easily accessible in real time. As shown in **Exhibit 1,** within the Partner Portal, the Division can access all data relevant to care provided to Members, including encounters, utilization, and network, along with Subcontractor data. We will partner with the Division to ensure the categories of data presented on the Partner Portal meets Division needs.

Provider Complaint Portal Success
By implementing changes like the Provider Complaint Portal, regulator complaint volume has **decreased by 90%** in an affiliate health plan.
200L.MS22

Provider Complaint Portal. Leveraging the experience of one of our affiliate health plans, we will partner with the Division to develop, implement, and launch a Provider complaint portal to improve the dispute resolution process. We recognize that Provider complaints to the Division can often be broad and lack the details necessary for a CCO to conduct root cause analysis. The Provider complaint portal will serve as an outlet for Providers to submit complaints, or unresolved complaints, to the Division, giving the Division the ability to closely monitor the volume and types of issues that arise. The portal will be structured to encourage Providers to submit all elements necessary for a CCO to conduct research on the issue, including prioritization levels, and it will serve as an avenue for CCOs to be held accountable for working toward timely resolution or potentially facing a financial penalty. In our affiliate health plan, we worked with the regulator to implement a unique MCO tracking number Providers must use to show that they attempted to resolve the issue with the MCO first.

Collaborative Innovation: Working with Fellow CCOs

It is critical for CCOs to work together to achieve efficiencies, create an improved Provider experience, collaborate on being the best partner to the Division, and share information and best practices to ultimately benefit MississippiCAN and CHIP Members. For example, as the use of VBP grows in Mississippi, CCOs could collaborate on a VBP program to address health equity challenges, agreeing to collect standard metrics in order to ease Provider administrative burden while tackling a major issue in Mississippi, especially within the Delta.

In addition, we welcome the opportunity to work with the Division, other CCOs, and Providers to partner together through a cross-CCO Provider learning collaborative PIP. Collaboration across these organizations unifies Member messaging, promotes sharing of best practices, supports early identification of trends or systemic issues that may impede success, and concentrates available resources on identifying effective solutions. For example, creating a single Provider training program on cultural competency across all CCOs will both help Providers and foster consistency.

Collaborative Innovation: Working with Providers

It's our goal to become the plan of choice for Providers by collaborating with them to tailor our easy-to-use tools, VBP opportunities, and exceptional customer service provided by devoted staff. Because we know, improving the member experience first starts with improving the provider experience. Providers will have a locally based, dedicated Provider Representative as a consistent point of contact. ***Our Provider Representatives will be specialized in either primary care/FQHCs, specialty care, BH, claims payment, or hospital services.*** These tailored roles will ensure Providers have the benefit of a representative who has a deep understanding of their specific needs and will help establish the most essential element of successful CCO–Provider relationships—trust. In the table that follows, we highlight the many ways we will bring innovative collaboration to Mississippi Providers.

Collaborative Innovation Highlight	How It Enhances the Provider Experience
Access to Our Care Management Platform	We give contracted Providers—including nonclinical community service Providers—the ability to access our care management platform for Members under their care. This ***enables Providers to collaborate with one another in the care of Members within the region*** and coordinate care for Members if they move between regions.
Advancing Digital Provider Education	We will create computer-based training modules on our website for self-led Provider education. These will include topic-based training such as BH, DME, home health, EPSDT, well-child, PCMH, and substance use disorder (SUD). We will also ***create and post online videos*** on helpful topics to educate Providers on specific processes.
Automated EHR Access for PA Transactions	This process allows for electronic transfer of information between Provider and CCO digital platforms, which enables both organizations to ***streamline the PA process*** and lay a foundation for future automation of the process.

Collaborative Innovation Highlight	How It Enhances the Provider Experience
Document Attachment on Our Provider Portal	Through our Provider portal, Providers can ***add documentation to claims after they have been submitted***, regardless of whether they were initially submitted on paper or electronically.
Online PA Lookup Tool	PA lookup technology through the Provider portal enables Providers to ***quickly query*** whether a specific code requires PA.
Provider Contract Life Cycle Management Application	Our Provider contract life cycle management application, which resides in our client relationship management platform, ***accelerates the contracting process*** with efficient self-service tools to help reduce Provider administrative burden and potential contract data inaccuracies that may affect Provider accessibility and payment.
Secure Messaging Channel on Our Provider Portal	We have enabled two-way, secure Provider messaging through our Provider portal. ***Providers can ask questions related to Program eligibility and benefits, claims, and PAs.*** Our team typically responds within 24 hours, with most questions answered more quickly.
Specialty e-Consult Solution	Our specialty e-consult solution enhances primary care services by providing PCPs with access to top specialists in a variety of fields. Using text-based conversations, PCPs will receive feedback on diagnoses or care plans, input to support those waiting for specialist appointments, or help interpreting labs/diagnostic tests. This solution will ***empower PCPs to make informed clinical decisions and enable access to specialty care, regardless of where Members live.***

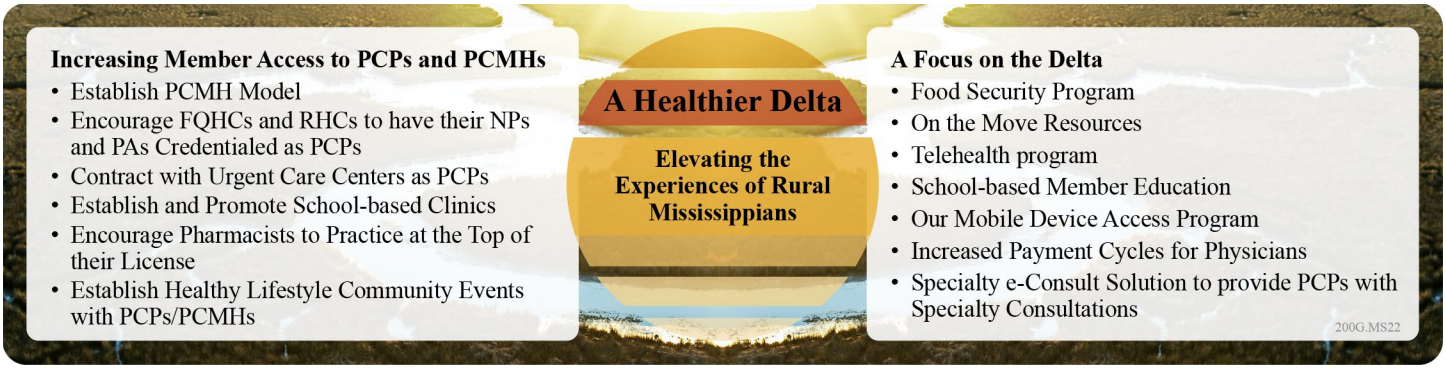
The Next Evolution of the CCO Program

Improving Access

Mississippi poses unique Provider network adequacy challenges due to its dispersed and largely rural population, with more than 100 areas declared Health Professional Shortage Areas and a Provider-to-patient ratio that ranks 50th in the country. We are ready to meet the State's challenges to serve MississippiCAN and CHIP populations with a proven, comprehensive, and innovative approach to network development and maintenance. Our network development strategy is designed to meet Members' diverse physical health, BH, and special healthcare needs. We consider Provider and Member geographic locations, distance and travel time, and Members' culture, ethnicity, and language. Our Provider Representatives and practice transformation team will monitor utilization patterns across practices and Provider sites, including PCPs and high-volume specialists, for potential trends and patterns related to appointment timeliness. Our Provider Representatives will engage our transformation team to ensure we have an appropriate number of Providers to support Members' needs. We will continuously evaluate our Provider network to identify areas of need and employ efficiency measures to improve availability.

For the next evolution of the CCO Program, we have designed an open and direct network that meets Members' healthcare needs and aligns with the State's goals of improving health outcomes and quality while enhancing the Member experience in a cost-effective manner. ***We will bring a fully contracted MississippiCAN and CHIP network that meets the Division's access and availability requirements for all covered benefits.***

Breaking Geographic Barriers to Access. Drawing on our national experience, and specifically in States similar to Mississippi, we will innovate to ensure Members can get the care they need—no matter where they live. For one of our affiliates, more than 50% of the population served lives in rural areas. From experience like this, we have gained deep understanding of how rural living impacts access, social risk, and health equity. This insight informs our multi-lever strategy to elevate the healthcare experiences of rural Mississippians, increase access to care for rural Members, and provide incentives and supports for rural Providers. For example, we will leverage this knowledge to develop rural-focused programs such as a food insecurity program that will bring together a CHW dedicated to addressing this problem and CBOs like Hearty Helpings Food Pantry and FoodCorps to promote nutrition and access to healthy foods in the Delta. Because we know you can't improve health outcomes in Mississippi unless you improve health outcomes in the Delta, ***we've designed a cadre of programs, services, and solutions to mitigate the challenges of access and sustainability for rural Members, and especially those in the Delta.***



Breaking SDOH Barriers to Access. Community resources are a vital component of our efforts to holistically care for Members, and we continue to innovate in addressing SDOH that can often be barriers to care. Our coordination approach is to build an integrated circle of effective support around each Member to meet their evolving needs through collaborative, long-term partnerships with Providers and CBOs with a customer focus they can trust. These relationships will form a community support structure that enables sufficient access and delivery of health services and supports and strengthens the entire community. Through boots-on-the-ground efforts from the Gulf Coast to the Tennessee line, we have engaged with CBOs, such as Community Foundation of Northwest Mississippi, to identify key partners to leverage and enhance SDOH assistance for Members.

We have created specialized positions to further support our efforts to meet Mississippi Members holistic care needs. Our community health workers are specialized in transportation, employment, substance use disorders, and OBGYN needs in order to target appropriate support to remove an exact barrier. These community health workers collaborate with our Health Equity and SDOH Manager as well as our community engagement team and care managers to ensure comprehensive care and support. Together with the Division, we can ensure all Members—regardless of location or socioeconomic factors—have improved access to needed care.

Improving Access for Members

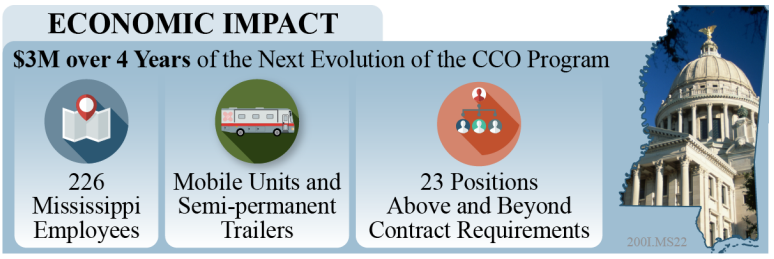
Our high-touch approach ensures we connect with Members early and often to build trust and help them better understand and take advantage of the benefits, services, and value-adds available to them to build healthier lives. We meet Members where they are, tailoring our outreach and engagement at the individual level and offering multiple modalities for them to receive information and communicate with us. From our welcome visits to our maternity support platform for Black women, we tailor our person-centered communication to meet whole-person Member needs. Going above and beyond our standard offerings, we will establish innovative solutions across the State that will increase access to care, while also engaging in the community to ensure proper education and connection to services, as highlighted in the table that follows.

Access Innovation Highlight	How It Enhances the Member Experience
Expanding Telehealth Services	Our telehealth program leverages a broad range of remote technologies and methods to provide Member access to healthcare services across a wide spectrum of health disciplines. We will increase access to physical health and BH services through local telehealth resources such as the ***University of Mississippi Medical Center's Project ECHO®*** and other major health systems within the Mississippi network, and through other certified resources such as our national telehealth provider.
Loneliness and Social Isolation Solution	Our solution offers 24/7/365 engagement for Members struggling with loneliness. Our innovative Member engagement and SDOH screening tool helps combat social isolation and reduce loneliness, ***resulting in reduced ER utilization and hospitalization and improved health outcomes while lowering costs.***
Maternity Support Platform for Black Women	Our maternity support platform for Black women is a culturally competent digital health platform that ***connects expectant mothers with critical resources*** to drive positive pregnancy outcomes. The health platform will work in concert with payers and the State to address the significant disparities in maternal health outcomes for Black mothers.
Mobile Health Program	Our mobile health program, ***which includes our mobile units and semi-permanent trailers***, will provide Members with access to a wide range of telehealth services, advance digital and health literacy, and help Members connect to other available community-based and government-sponsored programs and services. We will coordinate with other CCOs, CBOs, and other key stakeholders on initiatives and community events, such as free flu and COVID-19 vaccinations.

Access Innovation Highlight	How It Enhances the Member Experience
Remote Patient Monitoring	We will offer remote patient monitoring for Members with chronic conditions such as asthma, diabetes, hypertension, heart disease, COPD, and cancer, as well as high-risk pregnancies, ***allowing Members to engage in their own healthcare and improve adherence*** to care plans and health outcomes.
SDOH Closed-loop Referral System	Our SDOH closed-loop referral system connects Members to services and social programs that address SDOH issues in the communities we serve, such as access to food, housing, and transportation. It also allows us ***to monitor and ensure appropriate delivery of services to Members***. Our staff may refer Members to programs as needed.
Specialized High-risk OB and NICU Care Management Program	We have engaged in partnerships to develop an enhanced high-risk OB program with the goal of connecting potentially high-risk pregnant Members with coordinated care as early as possible. We will participate in program with a NICU-focused partner to offer an integrated, comprehensive solution that ***manages the utilization and care management needs of the neonatal population*** to improve their health outcomes. Further, we will collaborate with a maternity analytics platform partner for high-risk maternity data analytics and risk assessment technology.
In-home Welcome Visits	We will provide in-home welcome visits to Members who ***are high risk, have comorbidities, or are difficult to contact***. Within 30 days of enrollment, a nurse practitioner will visit the Member and help them navigate the Member information packet, mobile app, and Member portal. The nurse practitioner will assess for SDOH needs and help the Member complete the Health Risk Screening (HRS).

The Next Evolution of the CCO Program

Demonstrating Commitment



Our health plan is committed to partnering with the Division in achieving the State's goals for the MississippiCAN and CHIP populations, and we are dedicated to a seamless transition to the Division's next evolution of their CCO Program to achieve optimal outcomes for individual Members. From our mobile health program, which includes our mobile units and semi-permanent trailers, to our close partnerships with CBOs, we will demonstrate our ability to be a responsive, collaborative partner—one the Division can trust as a stable partner as well as an innovator in the field; one who is dedicated to improvement and efficiencies across the system of care; and one who works to improve relationships and the Provider experience.

1. Demonstrating Commitment: Proven, Complete Work Plan

Our comprehensive work plan for the CCO Program reflects our commitment to successful program implementation and management. Our disciplined approach to program management ensures a successful implementation of all components of the CCO Program Contract and promotes partnership with the Division throughout the life of the agreement. This success will be demonstrated through deliverables met on time with seamless continuity of care for Members. ***Our work plan represents best practices honed over the course of decades of successful program implementations, including 30 successful implementations over the past 5 years.*** Our adherence to project management best practices and our tailored approach to meeting the unique needs of each program has ensured implementation success.

Task Schedule. A systematic work plan provides a roadmap for a rigorous program management approach and systematic communication among all stakeholders. The most effective work plans are living documents that demonstrate interrelationships among all tasks. The work plan we have developed for the next evolution of the Mississippi CCO Program is broken down by task and subtask; it contains a schedule for the performance of each task included in each year of the Contract.

2. Demonstrating Commitment: Truly Integrated Staff Organizational Structure

Our robust staffing structure, proven in health plans nationwide, and our expert, Mississippi-based key personnel ensure a high-functioning and dynamic health plan, directly benefiting CCO Program Members and Providers. Our organizational charts for the CCO Program show our comprehensive organization and staffing during each project phase, and our design offers many benefits to Members and the Division.

True Integration of Physical Health, BH, and SDOH. As shown in our organizational chart within our response, we do not subcontract BH management; BH directors report up through the same Medical Director as

our physical health directors. In addition, our Population Health Director oversees our care management and BH teams, including our in-the-field CHWs and foster care management team, to support special populations and ensure true and full integration to meet the holistic health needs of Members. Further, we offer a position that is not required—our Mississippi-based Health Equity and SDOH Manager, who will report up to our Quality Management Director to ensure these elements are incorporated into our quality program.

Empowering Local Mississippi Leaders Supported by Shared Services. To ensure project success, it is critical to empower our local leaders with control over decisions that impact Mississippi Members, Providers, and the Division. Our use of shared resources allows us to offer MississippiCAN and CHIP stakeholders best practices proven across the country, consistency in oversight and quality assurance, and the ample resources of a nationwide MCO to ensure stability and support for the life of the Contract.

3. Demonstrating Commitment: Investment in Personnel and Specialized Positions

To build the Mississippi CCO Program on the strongest foundation possible, we leveraged our high-touch staffing model, tested and proven in health plans across the country, to determine that we need approximately 220 employees across the State to support the CCO Program. All staff are FTEs and are fully dedicated to this Contract. Our local staff will be supported by the resources and services of four highly qualified, well-vetted Subcontractors with experience serving Medicaid and CHIP populations. Led by an accomplished Chief Executive Officer (CEO) with a deep understanding of Mississippi and Medicaid, our proposed staff includes all RFQ-required positions and, in addition, ***23 positions above and beyond Contract requirements, added after careful consideration of Mississippi Member and Provider needs***. The following are highlights of our proposed personnel:

- **Foster Care Manager and Team.** Our Foster Care Manager and team of dedicated Care Managers will directly address the needs of Members in foster care, serving as a primary point of contact for MDCPS.
- **Health Equity and SDOH Manager.** This position will help define, implement, and evaluate our strategies to achieve equitable access to care and reduce disparities in clinical care and quality outcomes.
- [redacted]
- **Mobile Health Team.** This team will manage our mobile units and semi-permanent trailers, providing Members with access to a wide range of services in their communities.
- **Provider Quality and Practice Transformation Team.** This team will educate our in-network Providers on the opportunity to receive pay-for-performance bonuses for achieving QI objectives, including EPSDT performance.

4. Demonstrating Commitment: Understanding of the Mississippi Environment and CCO Program Requirements

Back in 2011, the Division successfully procured contracts for their Medicaid managed care program, and shortly after, transitioned Mississippi CHIP to managed care, completely rethinking and redeploying how healthcare in Mississippi was delivered not just to the individual, but to the entire population. Now, a decade later, the Division's commitment is demonstrated in its need to transform healthcare services to improve quality and Member outcomes while controlling costs to launch the next evolution of the CCO Program.

And the need is still great. Per the Mississippi Department of Health, the State ranks last in the nation, or close to last, in almost every leading health outcome, including diabetes (#49), high blood pressure (#49), low birth weight (#50), high cardiovascular death rate (#46), and premature death (#49). From the Neshoba County Fair to dinner on the grounds, we understand that many aspects of our health are interlaced with our traditions. And we know that influencing the system and instilling the behavior changes necessary to achieve significant health advances takes time. Along with unfavorable outcomes, the Mississippi healthcare environment is challenged by its current healthcare system, which suffers from Provider shortages and access challenges—particularly in rural areas like the Delta. And the pandemic has worsened these existing issues.

But the future is not dim, and ***a healthier Mississippi is on the horizon***. Those traditions that interlace with Mississippi's health are the same ones that can propel Mississippi's future. We share the State's passion and commitment to meeting Mississippi's unique challenges head on, bringing all stakeholders together to get to the root causes of these challenges and collaborating on innovative programs and initiatives to improve health outcomes. The Division's commitment is demonstrated within CCO Program requirements, with their emphasis on health equity, quality, access, collaboration, and commitment. As evidence of our true dedication to the State's goals and to the ultimate improvement in the CCO Program's delivery of care, we are ***committing $3 million over the 4 years*** of the new Contract. Our plan is to focus these investments on three areas we believe align with the Division's CCO Program requirements and achieve our dual goal of improving the lives and health of Mississippians:

$1.65M of $3M Commited to:

- **Community Foundation of Northwest Missisippi:** financial support to small organizations in Mississippi's Delta region to ensure families have access to healthy, fresh and nutritious food
- **Workforce Investment Network Job Centers:** funding to deliver work force development, on-the-job training and scholarships to young adults in Mississippi
- **University of Mississippi School of Nursing:** funding mobile clinics to deliver services at school parking lots in the Delta and Jackson when schools are closed for the summer
- **Family Resource Center of Mississippi:** funding to provide culturally competent and targeted support for Black pregnant women and new mothers
- **Mississippi Office of Physician Workforce:** Funding to provide addiction training for primary care providers

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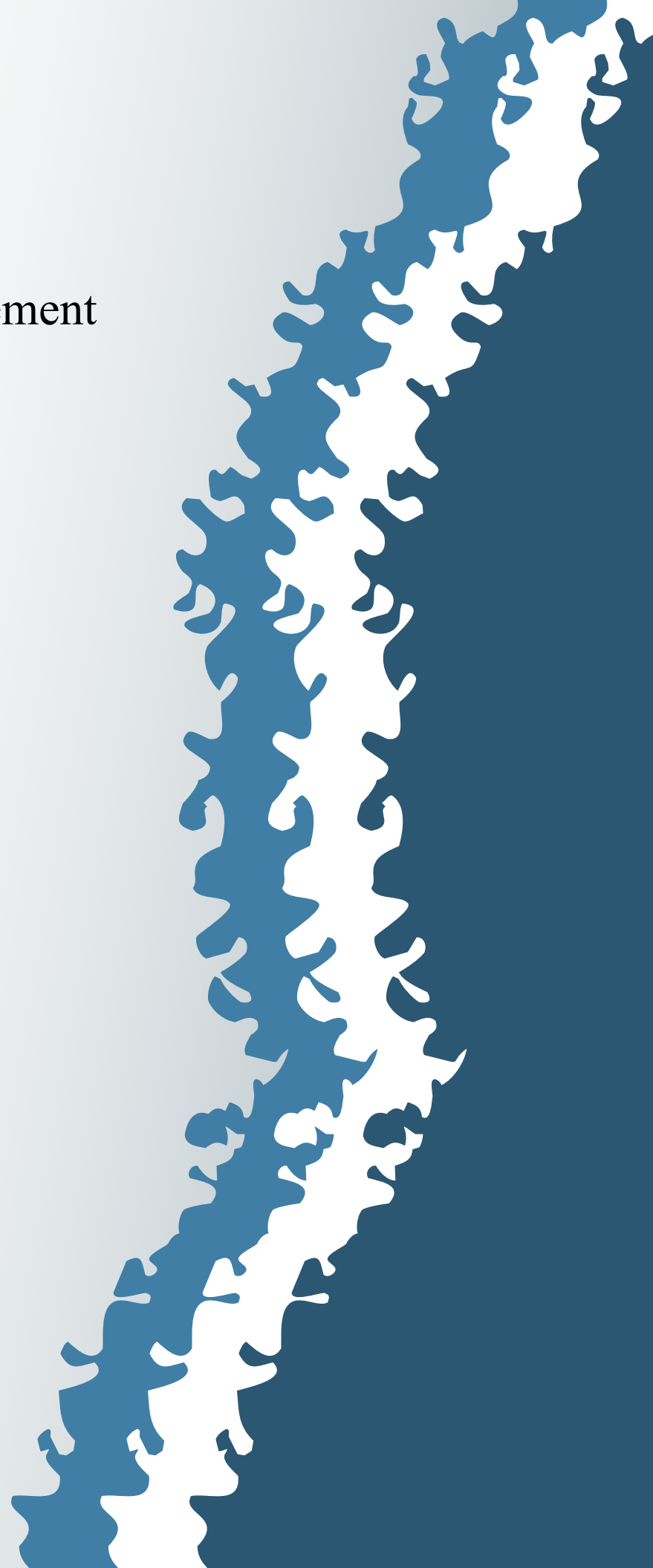
- **Food Security.** Mississippi has the highest rate of food insecurity in the nation, and the pandemic has increased food insecurity among families with children and among communities of color, who already faced hunger at higher-than-average rates before the pandemic. To positively impact Members' health, we believe this issue must be addressed.
- **Provider Transformation and Technology Enablement.** Providers are the most important element to ensuring the improvement of health outcomes in Mississippi. We believe it is our job to help elevate Providers and encourage their desire to leverage tools that will have a positive impact on their ability to care for their patients.
- **Healthy Pregnancies.** Mississippi has the poorest birth outcomes in the US. As a CCO in the State, we will work tirelessly to care for pregnant Members, but this is not a problem one CCO can fix. We believe that connecting Providers, CBOs, and State agencies will be critical to improving these outcomes and solving key issues—especially for Black mothers—such as early identification of pregnancy, teen pregnancy, health literacy, and meeting SDOH needs.

We bring initiatives, programs, and approaches proven to help improve access, reduce health disparities, and impact SDOH to achieve better health outcomes and improve Member and Provider satisfaction and engagement. By elevating quality, generating collaborative innovation, improving access, and demonstrating our commitment, we will help the State enhance quality while maintaining a cost-effective CCO Program. As Mississippi looks to the future, we are excited to support the Division's vision for the next evolution of the Medicaid CCO Program as a partner, collaborator, and innovator.

[END OF RESPONSE]

4.2.2

Methodology/Work Statement



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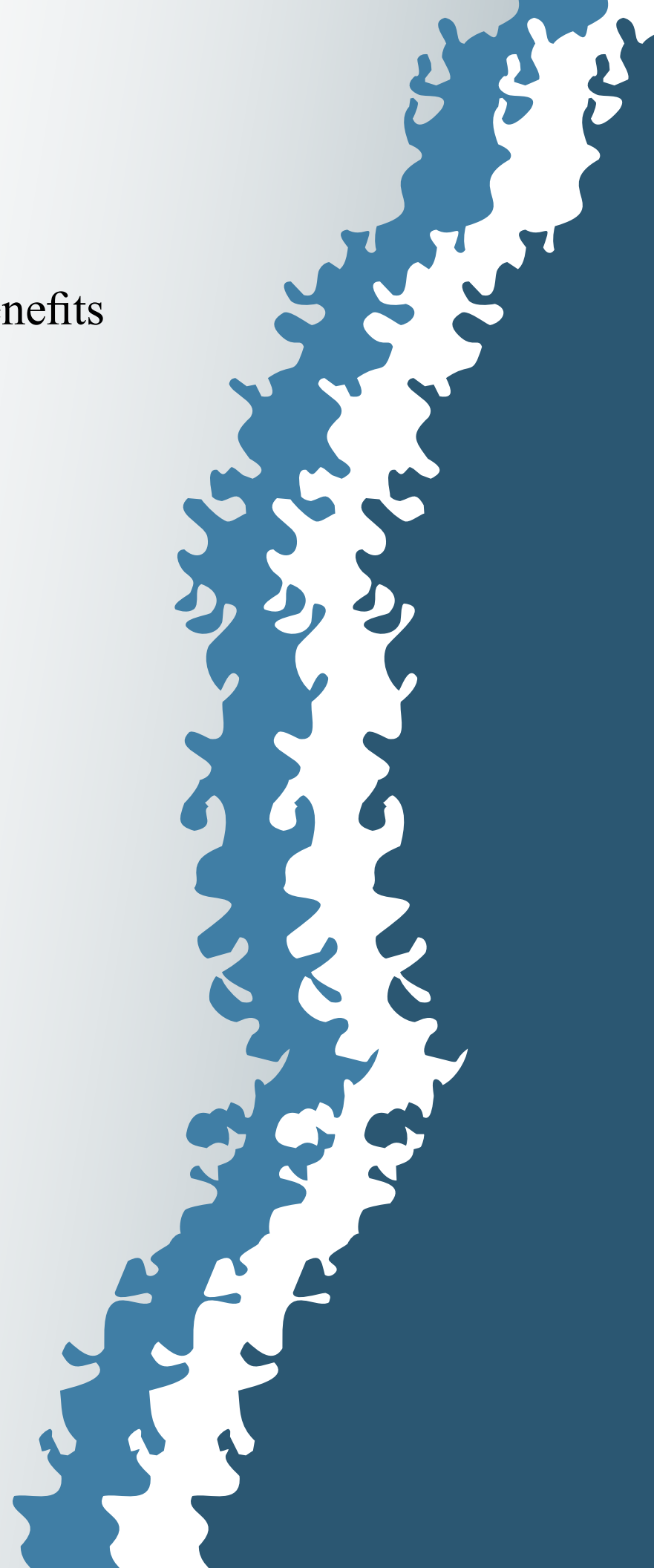
4.2.2.1

Member Services and Benefits



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4.2.2.1: MEMBER SERVICES AND BENEFITS

A. DELIVERY OF COVERED SERVICES

A.1.a. Delivery of Covered Services—Children

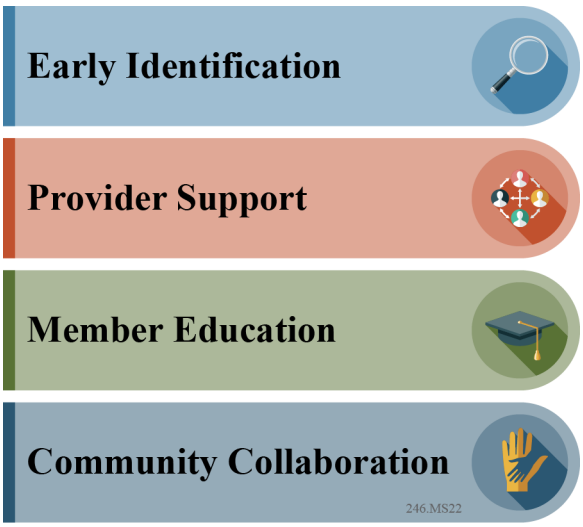
The EPSDT program is a cornerstone of Medicaid, intended to provide timely, robust developmental screening, early intervention, and continuing treatment and follow-up for physical health and BH conditions to maximize health and give every child the chance to fulfill their promise. While the CHIP well-child benefit differs somewhat from EPSDT, the underlying goal is the same. ***Throughout the nation, more than half of the Medicaid Members our affiliates serve are under age 21***, and we have developed and will bring effective approaches to connect both MississippiCAN and CHIP Members under age 21 to timely screenings, checkups, diagnosis, referrals, and follow-up treatment necessary to optimize health and provide a strong foundation for a healthy life.

To make real improvements in outcomes for Mississippi's children, ***our emphasis will be on the entire family, engaging children and their parents and caregivers to support access to recommended preventive services and needed follow-up care.*** Our approaches to ensure timely receipt of all required screenings and preventive and follow-up services will be the same for both MississippiCAN and CHIP Members, except as specifically noted in our response to RFQ § A.1.a.ii below.

A.1.a.i. MississippiCAN Services: Proposed Approach to Ensure Children Receive Timely Services, Periodic Health Screenings, and Appropriate and Up-to-date Immunizations

Our proposed approach includes the following elements (see **Exhibit 1**), which are detailed in subsections A.1.a.i.1–A.1.a.i.6.

Exhibit 1. Our Approach. Key to our success is a combination of activities ensure Children receive the services they need in a timely manner.



Early Identification of Overdue Services and Missing Follow-up. We will leverage our data integration and analytics capabilities to identify Members due and overdue for services, screenings, and immunizations. A key part of our approach will be to identify disparities in overdue services and missing follow-up, which we will use to develop improvements such as targeted outreach and staff or Provider training to reduce disparities.

Support for the Medical Home. The pediatrician/PCP is key as the point of delivery for timely screenings, preventive services, immunizations, and needed referrals for follow-up diagnosis and treatment. We understand the importance of, and make exceptional and multifaceted efforts to support, the PCP as the medical home in delivering timely, robust EPSDT services. We will require all Providers offering EPSDT services to be EPSDT-certified and to meet all EPSDT program requirements.

Member Education and Support. Our approach will include multifaceted, intensive Member education and support to promote and facilitate access to these services. Understanding the importance of a strong Member-PCP relationship in ensuring timely access, we will assist Members to select a PCP that meets their needs and preferences including gender, race/ethnicity, language, and location. Our dedicated EPSDT Coordinators (who will serve Members ages 0–20 at a ratio of 1:30,000) and Community Health Worker (CHW) will outreach to and support families of children with missed EPSDT visits to schedule and complete appointments, coordinate referrals, arrange for transportation, and help eliminate barriers to care, including those related to geography, health equity, and SDOH. We will also provide a ***comprehensive set of mobile health program solutions that reach Members in their communities*** to overcome barriers to accessing needed EPSDT and other preventive services.

Community Collaboration. We know from our Medicaid experience in multiple States, which includes groups that commonly experience disparities in utilization and outcomes, that reaching Members and effectively connecting them to needed services often requires working with or through CBOs that Members know and trust. A foundational element of our approach will be collaboration with these partners to maximize our ability to reach Members and connect them to recommended EPSDT and other services.

A.1.a.i.1. An Overview of Related Policies, Procedures, and Processes

Across the States and Medicaid populations we serve, we continually monitor effectiveness and refine our policies, procedures, and processes to incorporate best and successful practices in ensuring Members under 21 receive timely, robust developmental screening and early intervention. We will tailor and apply these practices in Mississippi, including specific procedures and processes that address issues common in the MississippiCAN population, such as disparities in preventive utilization and rural areas lacking adequate Provider availability.

Policies. Our policies fully align with State and Federal requirements related to EPSDT and other services, periodic health screenings, and immunizations, including periodic vision, dental, and hearing exams. For MississippiCAN Members, we will provide, arrange, or refer Members under the age of 21 for EPSDT services, including periodic health screenings as recommended by AAP Bright Futures and in accordance with the periodicity schedule established by the Division for EPSDT services, as well as appropriate and up-to-date immunizations using the ACIP Recommended Immunization Schedule. For Members in foster care, we will use and promote to pediatricians/PCPs the AAP's standards of care for children in foster care, which include more frequent follow-up visits and more in-depth evaluation of developmental status.

Procedures and Processes. We will employ the following procedures and processes to ensure timely services and screenings, immunizations, and treatment for child MississippiCAN Members.

Educate Members About Required Services and Available Support. As described in more detail in our response to A.1.a.i.2 below, we will use multiple methods throughout Members' enrollment with us to educate them about services and their importance as well as how we can support them in receiving appropriate access.

Educate and Train Providers About Required Services and Available Support. Our contractual requirements, Provider orientation, Provider manual, Provider website, and initial and ongoing Provider education (including targeted education for Providers who serve Members with high rates of EPSDT care gaps) will detail requirements for providing services and serving as the medical home and the support we can provide for ensuring compliance and assisting Members. Our Provider Representatives will train Providers on EPSDT requirements and Federal regulations, offering Division-approved policy and procedure trainings for EPSDT services to all Providers, along with retraining annually and as needed. We will conduct face-to-face training with Providers when possible. When that isn't appropriate (because of COVID-19 restrictions, for example), we will offer online and virtual options. We regularly reinforce the importance of EPSDT adherence and diligence through written materials (Provider manual, newsletter, and bulletins), face-to-face coaching, and electronic alerts through our Provider portal. Our Provider portal will offer toolkits containing evidence-based screening tools and guidelines.

Monitor for and Identify Members Due and Overdue for Services. We will use our data integration and analytics capabilities to identify Members who are coming due or overdue for services. We will generate monthly reports of Members overdue for services and outreach as described below. We will also integrate immunization data from MSDH's Immunization Registry into our system to monitor Member compliance with immunization schedules.

Outreach to and Assist Members Who Are Due and Overdue for Services. As detailed in our response to A.1.a.i.2, we will provide reminders to Members who are due for a required service or screening. Our EPSDT Coordinators and CHWs will perform outreach to overdue Members and assist them in addressing access barriers. For Members in care management, our Care Managers will arrange appointments, assist with referral forms, and arrange transportation as needed. We will collaborate with CBOs to effectively reach and support Members to access needed services. In areas with limited PCPs, high rates of overdue services, or disparities in utilization of services, we will offer our innovative mobile health program, which uses a mobile unit and semi-permanent trailers to bring services directly to Members.

Notify Providers of Members Overdue for Services and Support Them to Close and Prevent Gaps. We will provide pediatricians/PCPs a monthly list on the Provider portal of their assigned Members who are overdue for recommended services, screenings, and immunizations to support their own outreach to Members. For Providers such as FQHCs serving a high volume of children, we will offer to coordinate "clinic days" during convenient evening and weekend times for Members. We will contact the Provider's assigned Members who are due or overdue for services and offer them incentives, such as backpacks or school supplies, to encourage them to attend. Our EPSDT Coordinators and Provider Representatives will work with Providers to develop strategies to prevent gaps and improve performance. We will incentivize Providers to prevent and close EPSDT gaps through our VBP program, which includes pay-for-performance bonuses for achieving EPSDT goals

Monitor Compliance With Required Components and Referrals. We will monitor compliance with all required components and to ensure Members receive referrals as appropriate. This will include annual sampling and review of medical records from high-volume pediatricians/PCPs to check for EPSDT components and evidence of a referral when a screening indicates the need for additional diagnosis or treatment by a specialty Provider. care management staff will also monitor screening, assessment, and referrals for assigned Members.

A.1.a.i.2. An Overview of How We Encourage Members to Obtain Services

We will encourage MississippiCAN Members and their caregivers/legally authorized representatives to obtain services through the following methods.

Our encouragement to obtain services occurs at every Member touchpoint. All levels of our staff are trained to provide education to children and families about the importance of preventive services and assist in connecting to services.

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New Member Outreach. We outreach to the caregivers/legally authorized representatives of newly enrolled children to educate, encourage, and offer to help make appointments for required services. Our welcome call team makes at least three calls within two weeks to contact new Members who have not had a well-child checkup.

Pregnant Member Outreach. Upon notification of a Member's pregnancy, we immediately begin to educate her and the family on the importance of EPSDT/well-child visits. We encourage and assist the Member to select a pediatrician/PCP before the baby is born, educate on the importance of the PCP relationship, and when feasible (such as for planned c-sections), attempt to schedule the baby's first PCP visit prior to delivery. Education and awareness of recommended and essential well-child visits continues throughout the child's life and enrollment with us.

Initial and Ongoing Education and Support. We will provide multimodal education on the importance of EPSDT services, including dental and vision screenings, and the Bright Futures periodicity schedule, Member incentives for obtaining services, and how we can help Members access them. We send Members and their caregivers/legally authorized representatives information about available benefits and services within 30 days of enrollment, including the importance of preventive care; the periodicity schedule; how and where to access services, including transportation and scheduling; and reminders that services are provided at no cost. New mothers will receive this information within seven days following their child's birth.

Members and their caregivers/legally authorized representatives will have access to our secure portal 24/7/365, which allows them to view scheduled or missed appointments and access interactive preventive health prompts specific to their needs. In addition, all Members under 21 and their families/caregivers/authorized representatives will receive ongoing education on EPSDT services and how to access them, such as through Member newsletters and texts, as well as education and reminders at every Member touch point, such as from the Member services employees when on calls, along with offers to assist with scheduling and transportation. At every event and community engagement opportunity, our CHWs and Care Managers in attendance identify and provide on-the-spot support to Members who need help accessing needed services.

Reminders for Upcoming Services. We contact Members and their caregivers/legally authorized representatives to remind them of upcoming appointments and to follow up after missed appointments. Care Managers ensure care plans for Members under age 21 include all required EPSDT services and assist with scheduling appointments and transportation. If an appointment is missed, they perform outreach to reschedule.

Outreach and Support for Overdue Services. We monitor EPSDT and immunization utilization for all child Members, including foster children, to confirm they meet critical milestones. Our quality team will use an

EPSDT dashboard to identify instances of Member noncompliance. All noncompliant Members receive a letter educating them about the importance of the service for which they are overdue and information on how to contact us for assistance obtaining the service. We also outreach via text to Members who have opted into texting, and via Member services team calls to educate and assist Members directly. We will offer intensive support from our EPSDT Coordinators and CHWs to help Members resolve access barriers. For example, EPSDT Coordinators assist Members by finding Providers with weekend or evening hours, arranging for non-emergency transportation (NET) (for MississippiCAN Members), and referring Members for telehealth or home visits when necessary.

Tracking Appointment Compliance. For Members we assist in scheduling appointments, we track appointment compliance through claims and use our quality-of-care dashboard to identify those who have not kept scheduled appointments. We will automatically send missed appointment letters to Members, and our Member services call center will make reminder calls to them. We give Member visit noncompliance lists, generated from our quality dashboard, to Providers. We also use the dashboard to identify areas of the State where noncompliance is greater, so that we can develop targeted outreach and interventions.

Collaboration with Providers to Encourage Members. We will work closely with Providers and their staff to ensure children receive all EPSDT services, including up-to-date immunizations, along with necessary physical health, BH, vision, hearing, and dental services. For example, our EPSDT Coordinators will assist Providers to refer to our staff to continue outreach calls to bring Members into adherence. In addition to sending, and assisting Providers to act on, monthly lists and quarterly compliance reports and arranging clinic days with high-volume Providers as described previously, we will develop a pilot with a large clinic such as Premier Health to send co-branded postcards encouraging their patients to seek services. If the pilot is successful, we will broaden the effort with more Providers to reach more Members.

Our value-based purchasing strategy incentivizes providers to encourage Members to obtain services to prevent or close EPSDT gaps by tying reimbursement to EPSDT-related HEDIS measures, the Bright Futures periodicity schedule, and other applicable utilization metrics.

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Collaboration with the Community. We will partner with CBOs, Provider associations, State agencies, and other organizations to encourage Members to obtain services. For example:

- We will work with ***WIC*** to use their virtual maternal and pediatric care platform (which is primarily aimed at cross-promoting access to infant feeding support within both our organizations) to send targeted notifications about baby EPSDT visits to participating pregnant women and new moms.
- We will collaborate with the ***Boys & Girls Clubs*** and similar after-school programs on healthy lifestyles programming to encourage Members, parents, caregivers, and authorized representatives to obtain EPSDT services including regular checkups, screenings, and immunizations.
- We will partner with the ***Mississippi Education Department***, school district administrations, and school nurses to supply EPSDT education and provide a direct connection into our plan to refer Members needing assistance accessing services, including those that are part of an individualized education plan.
- We will partner with ***Head Start*** to educate parents and caregivers on EPSDT and the importance of obtaining services.

Bringing Services Directly to Members. To address access barriers due to geography and low Provider availability in some areas of the State, including the Delta, we will offer solutions that bring services directly to Members. For example, we will collaborate with the University of Mississippi School of Nursing to offer mobile healthcare services in the summer, when school-based clinics are closed.

Incentivizing Members to Obtain Services. We will offer incentives for MississippiCAN Members to seek regular care, as outlined in **Table 1** below.

Table 1. MississippiCAN Member Incentives for EPSDT Exams and Immunizations

Type of Screening	Incentives	Description
EPSDT Exam	Ages 0–21 years $25 gift card per year	To encourage Members to have annual, age-appropriate immunizations. HEDIS® Measure: CIS—Childhood Immunizations & IMA—Adolescent Immunizations
Scheduled Immunizations	Ages 0–18 months $20 gift card per year	To encourage Members to have annual, age-appropriate visits. HEDIS Measure: W30 and WCV

A.1.a.i.3. How We Anticipate the Approach Will Improve Health Outcomes

We anticipate that the approach we will bring to Mississippi will improve health outcomes by increasing utilization of preventive/well-care visits and screenings. These visits and screenings identify the need for further follow-up and treatment, which in turn improves health and reduces the need for acute utilization. ***Across all our affiliate health plans, more than 30 EPSDT-related HEDIS measures, such as immunization, well-child visits, adolescent well-care, and lead screening, exceeded the NCQA national average.*** During 2018 and 2019, ***100% of our affiliate health plans improved adolescent well-visit rates,*** one of the most challenging measures. One affiliate had a ***23% increase in well-child visits*** from 2019 to 2020 for Providers participating in a pay-for-quality VBP arrangement, and another ***achieved the 75th percentile for adolescent well-care visits.***

A.1.a.i.4. Our Process for Reminders, Follow-ups, and Outreach to Members

As described in our response to A.1.a.i.2, our processes for reminders, follow-ups, and outreach are comprehensive, with data-driven identification and multifaceted, high-touch Member support. In addition to our dedicated EPSDT Coordinators who lead our efforts, we support Providers to provide reminders, follow-up, and outreach and leverage our community partners to help us connect Members to needed services.

Reminders and Follow-ups. Our EPSDT Coordinators lead our targeted outreach to remind families when screenings or identified services are due. This includes "birthday reminder" mailers and our secure portal available 24/7/365 to view scheduled or missed appointments and access interactive preventive health prompts. Care Managers monitor and follow up with Members to ensure appointments are kept; if not, they perform outreach to reschedule.

Outreach. We will tailor additional outreach to Members with open preventive or screening care gaps or noncompliance with the periodicity schedule. We perform outreach via phone and mail to Members and caregivers/legally authorized representatives when appointments are missed or overdue to counsel them on the importance of regular visits and extend invitations to our scheduled mobile unit visits and healthy lifestyle community events. We will also contact MDCPS for foster care children to ensure that missed appointments are rescheduled. Our EPSDT Coordinators and CHWs will help Members with access barriers.

Collaborating with Providers and CBOs on Reminders, Follow-Up, and Outreach. We notify Providers of their assigned Members overdue for services to support their own reminders, outreach, and follow-up. We will also work with the CBOs that Members know and trust to leverage those relationships to help us reach Members and connect them to services. ***For example, we will work with WIC to provide notifications on needed EPSDT services to be sent to new moms using WIC's virtual maternal and pediatric care platform.***

A.1.a.i.5. How We Plan to Communicate to Members That Cost-sharing in Any Form Is Not Allowable on Benefits for Family-planning or Pregnancy-related Assistance

We will communicate to Members and their parents/legally authorized representatives that cost-sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance through a wide variety of methods. These will include information in the Member handbook, website, Member portal, and our Member mobile app. Member services call center staff will communicate this information to Members during any call that relates to these benefits. Care management staff will communicate this information to Members during the care planning process as well as when assisting or reminding Members to access these services. We will also add the information to the back of our ID cards and will communicate the message through a banner on our website, a push campaign of text messages to Members, messaging on social media platforms, and information at our Member information assistance desk at all Member events.

A.1.a.i.6. Innovative Methods We Will Use to Augment Our Approach

We will augment our approach with innovative methods such as the following that we have used successfully in other States to move the needle on Member compliance with EPSDT and immunization services.

Provider Incentives. Through our VBP program, we will incentivize Providers to prevent and close EPSDT and immunization gaps. To help them be successful, we will generate Provider-specific lists of Members

overdue for services to support their own outreach. We will also offer technical assistance with outreach and partner with Providers to host clinic days to encourage Members to obtain services.

Mobile Health Resources. We will deploy mobile units and semi-permanent trailers that bring EPSDT and well-child services, immunizations, screenings, telehealth services, Member education, and assistance to the communities where they are most needed. We will select these communities through data analysis that identifies high rates of noncompliance as well as areas that show disparities in compliance. We will also work with community partners to obtain input on areas of highest need.

Community Engagement. We will amplify the power of organizations around the State to improve children's health by partnering with child-focused community-based programs. Examples include our Interfaith Manager working with churches to encourage Members to access services, and partnerships with CBOs such as Healthy Start and after-school programs to offer education and screenings.

Making the Delta Healthier. In the Delta, we will target the Division's goals and make measurable progress on EPSDT services and outcomes. For example, we will partner with the ***University of Mississippi School of Nursing and University of Mississippi Medical Center (UMMC) to bring healthcare to underserved families living in the Delta***. Our program will provide healthcare access for families where they live by funding the university's mobile clinics for nine weeks in the summer, when school-based clinics are closed. We will also deploy our mobile units and semi-permanent trailers, bringing preventive services and education directly to Members.

A.1.a.ii. CHIP Services: Proposed Approach to Ensure Children Receive Timely Services, Periodic Health Screenings, and Appropriate and Up-to-Date Immunizations

Our proposed approach to ensure child CHIP Members receive timely services, periodic health screenings, and appropriate and up-to-date immunizations is the same as our approach to ensuring timely services for MississippiCAN Members, as described previously, except as described below.

A.1.a.ii.1. An Overview of Related Policies, Procedures, and Processes

Our policies, procedures, and processes for ensuring timely CHIP services are the same as for MississippiCAN as described in A.1.a.i.1, except as follows.

Policies. For CHIP Members, we will provide, arrange, or refer Members ages 0–19 for the full range of well-baby care, well-child care, and other screenings as defined in, and in accordance with, the CHIP State Health Plan and the Draft Contract, including periodic health screenings and appropriate and up-to-date immunizations using the immunization schedule for all Members recommended by ACIP, as well as periodic vision, dental, and hearing exams, according to the recommendations of the United States Preventive Services Task Force.

Procedures and Processes. For CHIP Members, our Quality Specialists will be responsible for the procedures and processes carried out by EPSDT Coordinators for our MississippiCAN Members to ensure timely services, periodic health screenings, and appropriate and up-to-date immunizations.

A.1.a.ii.2. An Overview of How We Encourage Members to Obtain Services

Our approach to encourage CHIP Members to obtain services is the same as that for MississippiCAN Members as described in A.1.a.i.2, except as follows.

Identification of Members Who Need Services. We will identify all new CHIP Members, as well as active Members who are noncompliant for well-child services, for direct outreach.

Member Incentives. We will offer incentives for CHIP Members to seek regular care, as outlined in **Table 2.**

Table 2. CHIP Member Incentives for Immunizations and Well-child Exams

Type of Screening	Incentives	Description
Scheduled Immunizations	$25 gift card per year	To encourage Members to have annual, age-appropriate immunizations. HEDIS Measure: CIS—Childhood Immunizations & IMA—Adolescent Immunizations
Annual Well-Child Exam	$25 gift card per year	To encourage Members to have annual, age-appropriate visits. HEDIS Measure: W30 and WCV

A.1.a.ii.3. How We Anticipate the Approach Will Improve Health Outcomes

We anticipate that our approach will improve outcomes for CHIP Members in the same ways that our approach will improve outcomes for MississippiCAN Members as described in A.1.a.i.3. For an affiliate with a large CHIP population, Providers in a pay-for-quality VBP arrangement similar to what we propose for Mississippi achieved ***10% higher HEDIS measure rates of Well-Child Visits in the 3rd, 4th, 5th, and 6th Years*** than nonparticipating Providers.

A.1.a.ii.4. Our Process for Reminders, Follow-ups, and Outreach to Members

Our process for reminders, follow-up, and outreach to CHIP Members follows the same approach as that for MississippiCAN Members as described in A.1.a.i.4.

A.1.a.ii.5 How We Plan to Communicate to Members That Cost-Sharing in Any Form Is Not Allowable on Benefits for Family-planning or Pregnancy-related Assistance

We will communicate to Members that cost-sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance in the same ways that we describe for MississippiCAN in A.1.a.i.5.

A.1.a.ii.6 Innovative Methods We Will Use to Augment our Approach

Innovative methods we will use to augment our approach to ensuring CHIP Members receive timely services are the same as those we will use for MississippiCAN as described in A.1.a.i.6

A.1.b. Addressing Racial, Ethnic, and Geographic Disparities in Delivery and Outcomes for Children

Drawing on our experience and in alignment with national best and emerging practices regarding health disparities, we will identify and address disparities in service delivery and outcomes for children associated with race, ethnicity, language, disabilities, or geographic location. When we identify a disparity, we will determine root causes and develop interventions in collaboration with our Providers and community partners.

Provider Collaborations. We will collaborate with pediatricians/PCPs to promote a broad understanding of disparities and the social and community factors that may impact service delivery and outcomes for children. In addition to our robust cultural competency training, we will provide education on the connection between disparities and noncompliance with regular visits, screenings, and immunizations and offer a broad range of support for addressing disparities, including providing reports indicating Members with disparities in access or outcomes. Our Provider quality and practice transformation team will assist Providers participating in our VBP program to increase outreach to improve access to services and outcomes for their child Members with disparities.

In-home Nurse Practitioners Program for New Babies. To address the known disparity in outcomes for Black mothers and infants, we will offer home visits and health literacy education by nurse practitioners for postpartum Black mothers to improve well-child visits. This program achieved ***a 47% immunization rate in one of our affiliate health plans—9% above the State's minimum performance level***.

Mobile Health Program Resources. We recognize that more than half of Mississippi's residents—including a greater percentage of minorities—live in rural areas like the Delta that have low Provider availability that results in geographic disparities in access, which in turn drive disparities in outcomes. We will use our mobile health program resources and focus our efforts to make the Delta healthier by bringing care to the neighborhoods and communities where it is most needed. Well-child checkups, screenings, and immunizations will all be possible in underserved neighborhoods through our innovative initiatives using a mobile unit and semi-permanent trailers, making transportation and telehealth available, and partnering with local Providers to extend the reach of their services.

[redacted]

CHWs. Our CHWs, who live in the communities they serve, will help build trust with Members and their parents/caregivers in their communities and assist them to find and access care. To address racial and ethnic disparities, we will hire CHWs who reflect the racial and ethnic diversity of the areas they serve.

Expansion of PCP Services. To address disparities in access in identified geographic locations, we will expand the number of places children can receive care through the expansion of services to include urgent care centers, school-based clinics, and other nontraditional Providers.

Community-based Partnerships. In addition to soliciting input on disparities interventions from our CBO partners to ensure relevance to targeted Member populations, we will collaborate with CBOs to implement interventions and reach Members and their families/caregivers. Examples include working with the Boys & Girls Clubs and Head Start on tailored education to address health literacy among families of school-age and preschool Members with identified disparities in access or outcomes.

A.2 Behavioral Health Services

We understand and support the Division's need for solutions in BH and SUD services. To deliver the strongest treatments, we will bring to the State a strong background and approach that combines the Division's goals of quality, collaborative innovation, access, and commitment to BH and SUD issues.

A.2.a. Direct Behavioral Health and Substance Use Disorder Experience—Children and Youth

One of our affiliates that serves children and youth in a carve-out program for individuals with serious mental illness achieved an almost 30% reduction in admits/1000 in 2020 accompanied by a significant and continued year-over-year increase in outpatient utilization.

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We offer direct experience in service delivery and payment for BH/SUD services for pediatric and adolescent BH conditions and SUD, including SUPPORT Act compliance, through our affiliates in multiple States. Our affiliates currently ensure service delivery and payment for BH/SUD services similar to or the same as MississippiCAN and CHIP services for nearly 240,000 children and adolescents. ***A differentiating feature of our experience is that our affiliate plans have directly managed benefits, ensured the quality of service delivery, developed networks, and administered claims for these services since 2006, rather than delegating these functions to a BH Subcontractor*** as many other health plans have done or currently do. This enhances our ability to integrate and provide timely holistic data to Providers, as well as to oversee and manage the quality of services.

As a national health plan serving multiple States, we offer Members with BH and SUD needs access to a comprehensive network of Providers with the expertise, compassion, and depth of knowledge needed to provide integrated, holistic care for all Members, especially children and adolescents. We also maximize the crucial role played by Community Mental Health Centers (CMHCs) through collaborative partnering, and we propose solutions including telehealth for those Members experiencing barriers to access.

Our plans providing children, adolescents, and adults with BH/SUD services, including both Medicaid and CHIP plans, comply with all State and Federal laws and regulations, including those related to care management, access, and availability with respect to BH/SUD services. Our provision of BH/SUD services meets and exceeds the requirements set forth in 42 CFR §§ 438.900–438.930 and is compliant with all requirements related to the SUPPORT Act, which includes compliance with drug utilization review (DUR) requirements, the implementation of an antipsychotic medication monitoring program for children, and fraud and abuse identification requirements for the use of controlled substances.

Compliance with the SUPPORT Act

We have extensive experience managing delivery of and payment for BH/SUD services in compliance with the provisions of the SUPPORT Act. For example, our affiliates have experience monitoring concomitant prescribing practices of psychotropic medications (alpha agonists, stimulants, mood stabilizers, and antipsychotics) and identifying excessive doses and prescriptions for very young children. For complex cases, our Medical Director conducts a peer-to-peer review with the Provider. This strategy enhances identification of children who are being prescribed medications outside of clinical guidelines or for off-label use. ***In 2018, one of our affiliates reduced the ambulatory payment classification measure by 9% and decreased psychotropic***

polypharmacy among children and adolescents by 30%. We will build on this experience to collaborate with the Mississippi PBA to identify and address psychotropic polypharmacy among child and adolescent Members.

A.2.b. Direct Behavioral Health and Substance Use Disorder Experience—Adults

We also offer Mississippi significant experience in service delivery and payment for adult BH/SUD services. Most of our affiliate plans provide BH services for adults, currently covering nearly 750,000 across the nation. Rather than subcontract, ***we directly manage benefits, ensure the quality of service delivery, develop networks, and administer claims effectively and efficiently to improve Member outcomes and quality of life and ensure Provider satisfaction.*** This enhances our ability to integrate and provide timely holistic data to Providers and to oversee and manage the quality of services.

One of our affiliates that serves adults in a carve-out program for individuals with serious mental illness achieved a 44% reduction in admits/1000 in 2020 accompanied by a significant and continued year-over-year increase in outpatient utilization.

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Our integrated approach reflects the expertise, compassion, and depth of knowledge needed for successful holistic care. As with children and adolescent Members, we will maximize the crucial role played by CMHCs through collaborative partnering.

Compliance with the SUPPORT Act

We have extensive experience managing delivery of and payment for BH/SUD services for adults in compliance with the SUPPORT Act. For example, our affiliates use a pharmacy DUR program to prevent fraud and abuse of controlled substances and improve quality of patient care by educating Members, Providers, and pharmacies about therapeutic issues; reviewing the efficacy of drug management operations; identifying and flagging claims that could indicate opioid abuse; and equipping Providers and pharmacists with guidelines on opiate use. We will build on this experience to collaborate with the Mississippi PBA to identify and address inappropriate prescribing and drug utilization.

A.2.c. Approach to Delivery and Payment for Behavioral Health/Substance Use Disorder Services

We offer proven approaches to the delivery of and payment for BH/SUD services. This section outlines our proposed approach for MississippiCAN and CHIP Members, including adults, children, and adolescents.

Direct Management of Service Delivery and Payment

A differentiator of our approach is that we do not use a Subcontractor for delivery, management, or payment for BH/SUD services. We will deliver **staff, resources, and processes** to provide fully integrated BH and physical health services, including network development, management, UM, and payment of BH and SUD claims. This allows us to tightly manage service delivery and quality of care through direct Provider relationships and by ensuring that all BH/SUD data is integrated in real time with all other Member data.

Dedicated Staff to Support Behavioral Health/Substance Use Disorder Service Delivery

Our Mississippi health plan will include ***several staff positions dedicated to BH****:* a Medical Director who is dedicated to addiction medicine, a child psychiatrist, a mid-level psychiatric nurse practitioner, BH Medical Director, and a BH specialized care management team including CHWs who specialize in SUD. These specialists will bring the expertise and focus necessary to ensure an integrated approach to everything we do. We will also offer dedicated BH Provider Representatives for specialized support to BH/SUD Providers. They will be assigned to specific Providers to promote relationship development and give the Provider a known pathway for obtaining support and resolving any issues.

Support for Delivery of Timely, High-quality, Appropriate Services

We will offer a wide range of support to Providers to help them deliver BH/SUD services effectively in order to reduce ER visits, inpatient admissions, and readmissions, and to improve quality of life for Members. Our initial and ongoing education and training is offered in person and online to meet Provider preferences and schedules. Our training will focus on health disparities, including disparities in BH/SUD service utilization and outcomes, and how Providers can help to prevent and address them. Support resources we will offer include:

- **Mental health education—SUD resources for Providers.** Through a large and highly respected online platform for mental health education, and in ***partnership*** with the MS Office of Physician Workforce, we will ***give specialty Providers and PCPs free access to a multimodal, on-demand***

mental health course library with certification training for all licensed clinical mental health professionals on numerous evidence-based treatments such as medication-assisted treatment and mindfulness.

- **BH toolkit and quick reference guides.** We will offer an online toolkit and quick reference guides for PCPs and community Providers to provide guidance on common mental health and substance use conditions, such as depression, suicidality, SUD, anxiety, ADHD, dementia, Alzheimer's, and the psychological impact of COVID-19. Topics will include a BH screener, BH HEDIS tips, and evidence-based and CMS guidance. These resources will enable PCPs to effectively screen for and appropriately treat BH conditions within the primary care setting and identify when a referral is appropriate.
- **Pain safety initiative—opioid safety resources.** We will deploy this online resource for Providers as part of our pain safety initiative to improve the safety of Members who suffer from opioid use disorders and to prevent problems related to opioid use. Shared with specific Providers based on our claims data, this resource facilitates safe opioid prescribing and pain management alternatives.

Stepped Care Approach

We will support the development of ***integrated healthcare partnerships*** between physical health and BH/SUD Providers to promote a "stepped care" approach that delivers the most effective, least resource-intensive treatment appropriate to the Member's current needs, stepping up to specialist services and back down to the PCP as the Member's needs change. We will develop referral pathways for PCPs so that they are easily able to refer Members to a BH Provider when indicated. Our Provider Representatives and care management staff will assist PCPs with referrals as needed. To further support PCPs to appropriately treat BH conditions and SUD, particularly in areas with low or no specialist availability, we will offer a ***telehealth e-consult platform*** that allows Providers in rural areas access to our BH and SUD experts for support and medication assistance.

Promotion of Telehealth to Expand Access

Through our Provider transformation and technology enhancement program, *we* ***will provide grant funding*** to incentivize Providers to expand, enhance, and further develop their telehealth capabilities, helping to address health equity and disparities by providing greater access to care in rural communities. For example, we have discussed potential grant funding options with the University of Mississippi to extend their practitioner program through the summer months. We will also invest in Provider education opportunities and initiatives to encourage a greater level of telehealth adoption. In addition, we will proactively encourage further Provider adoption of telehealth by educating them on virtual healthcare delivery capabilities, reimbursement, and opportunities through incentives, such as VBP programs.

We will work with Providers to offer telehealth services in underserved areas and will partner with the **UMMC Center for Telehealth** and **UMMC Medical Center** to expand access to BH specialists for Members in areas that lack BH/SUD Provider availability or in areas in which we identify access disparities.

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Support for Communication and Integration

In addition to establishing referral pathways for PCPs to BH/SUD Providers to ensure timely referrals, we will support communication between physical health and BH/SUD Providers through contract requirements and Provider education that specifies when communication should occur and the types of information Providers should share. Care Managers will support this communication for their assigned Members, such as sharing the BH treatment plan with the PCP and vice versa and coordinating follow-up visits with the BH Provider for Members with inpatient discharges. We will further support integration of care by providing timely, integrated data on our Provider portal to give each treating Provider a holistic view of the Member's needs and treatment.

Transition of Care Support

Effective management of transition from a BH or SUD inpatient stay is essential to ensure that the Member is connected to outpatient support through follow-up care with a Provider to reduce the likelihood of an avoidable readmission. Our transition of care team helps facility staff to identify the optimal post-discharge level of care, placement options, barriers to placement, and support and services required to achieve a successful discharge. We will assign personnel from our transition of care team to Mississippi hospitals and health systems to assist with smooth and seamless transitions for Members. One innovative strategy we have deployed uses best practice, peer-driven care coordination, integrated within the care management team, at the point of BH admission. Highly trained Peer Support Specialists work in real time with facilities and our Care Managers to

identify and engage high-risk/high-need Members and elevate Member voice and choice. Results from this program include a 39% reduction in BH hospitalizations. Our Medical Director specialized in addiction medicine, child psychologist, psychiatric nurse practitioner, and BH Medical Director will be available as resources to our transition of care team and facility staff to consider options and develop transition plans that effectively meet Member needs.

Alternative Payment Models (APMs) to Improve Quality of Service

Our Provider Representatives specializing in BH will coordinate with our Provider quality and practice transformation team to support BH Providers in successfully participating in our VBP program. We recognize that BH Providers vary from single-practitioner offices to organizations affiliated with large health systems, so our team will tailor support depending on the Provider's needs.

We have been a leader in developing APMs with integrated Providers and BH specialty Providers to promote improved preventive care and enhanced care coordination for individuals with complex needs. Our work has demonstrated improved results in preventive and chronic care measures and has led to reduced utilization of high-cost services. Our models target specific opportunities for system-wide quality improvement among Members diagnosed with BH conditions and SUDs (e.g., high-risk pregnant women, suicide risk, ER utilization rates) and collaboratively support each Provider.

Collaboration with the Division and Other State Agencies

We will collaborate with the Division to identify opportunities for quality improvement that we can use to drive our APMs and risk arrangements with Providers. We will attend regular meetings with the Division and DMH to discuss approaches and the needs of Members, including those not enrolled in our health plan.

Member Education and Resources

We offer a variety of strategies and resources to ensure that Members have all the information they need to understand and appropriately access services for their BH and SUD needs. Examples include the following.

Crisis Line. Our Behavioral Health/Substance Use Disorder (BH/SUD) line gives Members 24/7/365 support should a BH crisis arise. This line will be fully integrated with our plan and will handle immediate referrals to the appropriate Care Manager.

Electronic Resources. Members have access to website information and resources on depression, anxiety, and suicide prevention, including the National Suicide Prevention Hotline and SAMHSA's Disaster Distress Helpline for assistance related to a specific disaster such as a hurricane or school shooting. We will recommend free cell phone apps for meditation, guided breathing exercises, and yoga. For Members who need reliable access to cell phones and the Internet, we will provide free cell phones preloaded with the appropriate apps through our mobile device access program. Our mental health education platform offers programs that target the specific needs of Members and their families.

Community Engagement and Partnerships. Through our mobile health program resources such as our mobile unit and semi-permanent trailers, our Care Managers and CHWs will engage with Members to provide education and referrals, including helping parents recognize stress and depression in their children. Under our family wellness program, we will partner with Providers and public housing authorities to engage families in lifestyle changes that improve mental health and achieve stress reduction.

Peer Support Services. We will employ certified Peer Support Specialists who have real-life experience in recovery from BH conditions and SUDs. Peer Support Specialists are trained to *share their unique lived experience* with BH disorders, providing emotional support, teaching skills, providing practical assistance, and connecting Members with resources and opportunities. These specialists are skilled in motivational interviewing and in serving as role models and inspirations for long-term recovery.

Our Peer Support Services Help Members Achieve Positive Outcomes

- 39% decrease in BH hospitalizations
- 38% increase in use of outpatient BH services like counseling
- 41% increase in use of supportive BH services
- 39% increase in connection to PCP
- 60% increase in Member engagement in a State with a goal of a 50% increase

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A.2.d. Innovative Methods to Augment Our Approach

Our strategy to address BH and SUD for Members of MississippiCAN and CHIP will include innovations that engage Members and their legally authorized representatives, Providers, and community partners. Below, we highlight innovative programs to serve Members through our integrated physical health and BH service delivery model.

Integrated Model of Care

We offer a ***true integrated care management program*** staffed with trained, licensed therapists and social workers who collaborate with Providers to manage both physical health and BH conditions. Many companies say they offer an integrated model, but we have a track record of actually delivering an integrated model. We offer a practiced and proven approach for Mississippi to ensure individuals are connected to the right services and support regardless of where they enter the system of care.

Proof of Our Success

In one of our affiliate health plans, our integrated model of care resulted in:

- 47% penetration rate for mental health services for Members with an identified need
- 41% engagement in SUD treatment for Members with an SUD
- 32% penetration rate for SUD services for Members with an identified need
- 15% reduction in physical health inpatient admissions
- 17% reduction in ER visits

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A key element of our model is early identification of BH/SUD needs to promote rapid access to services. We identify Members through various entry points, including self-referral and referrals from Providers, caregivers, and guardians. Our care management, UM, and pharmacy departments may send referrals to our navigation team via direct or warm-handoff referrals from one BH Care Manager to another. ***CHWs who specialize in SUD*** act on all referrals and offer Members assistance to address immediate and long-term needs.

Once we identify a Member with a serious and persistent BH condition or SUD, we will assign a Care Manager who specializes in BH/SUD to serve as the Member's point of contact, assess the Member's risk level, assemble the care team, and work with Providers to ensure that the Member receives the full range of physical health and BH services they need. The Care Manager works with the Member using motivational interviewing and a trauma-informed, person-centered approach to develop a single care plan incorporating both BH and physical health services as well as non-covered and social services. The Care Manager works to prevent an unnecessary inpatient admission and improve the Member's health and quality of life. For those with SUD, we will offer intensive support as needed from CHWs who specialize in SUD.

The goal of our Care Managers is to help Members achieve optimal wellness and close any care gaps in clinical and social risk factors. Care Managers use our SUD dashboard to monitor utilization, non-fatal overdoses, and external parameters, such as the Bree collaborative and STOP method. This dashboard allows us to track treatment and outcomes in real time.

Specialty Models of Care

- We further enhance the care management services we provide to Members with specific SUD issues using specialty models of care developed in-house with input from stakeholders, Members, and Providers, including:
- **SUD**. This trauma-informed model of care incorporates Provider training and Member education and is integrated to address both physical health and BH needs.
- **Opioid use disorder.** Our care management and utilization review teams are trained to identify the needs of individuals who may have an opioid use disorder diagnosis. The care management team will employ a specialized model of care designed for this population. Our Care Managers are trained in motivational interviewing, which is known to be the most effective technique with this population. We offer CHWs who specialize in SUD, who are assigned to these cases to improve efficiency of care coordination for Members at risk for opioid-related morbidity through rapid coordination of appropriate resources and treatment services. This model of care improves Member engagement in care coordination, decreases opioid use and misuse in this population, and empowers Members to successfully manage post-program completion and support recovery.

Use of our opioid model of care has decreased inpatient admissions (from 90.4/1,000 to 88.6/1,000) and ER visits (from 341.4/1,000 to 306.8/1,000) for Members with opioid use disorder stratified at high-to-moderate risk. **From January 2016–April 2019, opioid utilizers fell by 37%, opioid prescriptions by 39%, and prescriptions exceeding 90 morphine milligram equivalent (MME) by 54%.**

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- **Serious mental illness (SMI)/serious emotional disturbance**. Our model of care for the treatment of SMI and serious emotional disturbance offers specialized support for both adults with an SMI diagnosis and children through age 17 with serious emotional disturbance. The model focuses on the Member's unique needs, educates and empowers Members and their caregivers to effectively manage their condition, assists these Members during transitions of care, and ensures these Members' co-occurring conditions are being appropriately screened and treated, with any risk of suicide addressed. The goal is a graduated, progressive process that helps Members develop resiliency and progress along a continuum to improve their quality of life.

Pain Safety Initiative

We will offer comprehensive resources to Members/legally authorized representatives and Providers to address the opioid crisis, focusing on decreasing the number of new narcotic treatments for Members, identifying risky courses of treatment, and streamlining access to medications that help treat opioid abuse. Through this initiative, we will refine best practice approaches to opioid use disorder interventions. For MississippiCAN and CHIP, we will add a Medical Director who specializes in the opioid use disorder model of care, and we will include an opioid/pain safety resource page on our website for families to learn about the risks and safe use of opioids. The site will also have information on how to approach having a discussion with prescribers about medication regimens and how to access services if a Member/legally authorized representative feels they need help.

Programs Addressing Stress and Bullying

According to the CDC's 2019 Mississippi Youth Risk Behavior Survey, 18.5% of high schoolers reported being bullied on school property in the previous 12 months. Mississippi youth may also face stress from daily challenges, such as an unstable home, insufficient food, and homelessness, as well as added pressures from the pandemic. We will partner with CMHCs, local schools, and law enforcement to educate children and their parents/legally authorized representatives on how to recognize if a child is being bullied, or even if a child is the aggressor, and to develop concrete solutions and steps to address bullying. ***We will also partner with local and national CBOs, like the Family Resource Center of North Mississippi, to provide programs that focus on self-esteem, self-confidence, and positivity,*** and that address underlying SDOH.

School Nurse and Counselor Support for Behavioral Health/Substance Use Disorder Identification

The school environment is often where BH issues first present. Our strategy will support early identification and family involvement to get children and adolescents the treatment they need. We will pilot a program in Mississippi to conduct training on BH/SUD for school nurses and counselors through our mental health education platform. We will deploy many of the same resources offered to PCPs, including courses on the platform especially designed for educators, to allow them to identify and obtain assistance for children and youth with BH/SUD issues. Our platform includes Mental Health Ally for Educators, a series of courses designed to teach topics like mental health, suicide prevention, substance use, and diversity and bias.

Programs Addressing Loneliness and Social Isolation

We will deploy a solution to engage Members at risk of experiencing adverse health outcomes due to social isolation and loneliness. We will pair the solution with care management, using data to identify Members who need additional support to further improve interventions. When one of our affiliate health plans deployed this program, ***41% of Members improved loneliness scores, 82% of those also improved their depression score, and Members experienced a 57% reduction in medical costs.***

A.2.e. Addressing Racial, Ethnic, and Geographic Disparities in Behavioral Health Services Delivery and Outcomes

We understand that Members may face cultural barriers, in addition to socioeconomic and geographical barriers, especially in the area of BH/SUD services and outcomes. We use our predictive risk and stratification platform to identify subsets of the population experiencing health inequities or disparities. Our health equity dashboard provides enhanced data mining and analytics capabilities to identify racial, ethnic, and SDOH disparities at the county and Member levels and to combine criteria to determine where we will target resources to address the greatest needs. We drill down and perform root cause analysis on these metrics to understand the full scope of

the disparity, including driving factors we need to address to reduce gaps in care. We will use this data to tailor specific programs, interventions, and Member engagement to each community. The following are some examples of how we will address identified disparities.

Expansion and Support of PCMHs. We will build up Mississippi's PCMH infrastructure by supporting practice transformation toward a truly integrated, comprehensive primary care delivery model with NCQA PCMH recognition. Our Provider quality and practice transformation team will support Providers recognized as PCMHs and help willing Providers mature along the path to providing medical home care, which includes screening, appropriate treatment, and referral and coordination of BH/SUD services. This support will include timely, impactful sharing of integrated physical health, BH, and SUD data as well as provision of training, evidence-based practice guidance, technology and reporting, and innovative tools to support integrated care.

[redacted]

Mobile Health Program Resources. We will leverage our mobile health program resources to overcome racial and ethnic disparities by bringing BH education and treatment to the neighborhoods and communities with gaps or disparities in access. We will offer innovative initiatives using our mobile unit and semi-permanent trailers, transportation options, and collaboration with local Providers—including FQHCs—to provide a bridge to BH and SUD specialists' services.

Telehealth Services. BH services provided in a private, familiar setting may help break down cultural barriers to access. We will leverage telehealth services in new ways, working with Providers to offer telehealth services in underserved areas, using our mobile health program resources to facilitate telehealth BH appointments for residents near where they live, and leveraging our telehealth Partner to offer BH services via telehealth appointments the Member can participate in from home. We will partner with the ***UMMC Center for Telehealth*** and ***UMMC Medical Center*** to expand access to BH specialists through telehealth. To increase access to high-speed Internet for telehealth, we will offer Members in our care management program free cell phones and enhanced cell phone services through our mobile device access program.

Culturally Aligned CHWs. Our unique type of CHWs, who live in and reflect the diversity of the communities we most need to reach, will help build trust with Members in their communities, connect with CBOs, and help Members find and access BH/SUD services. In addition, we will have specialized CHWs focused on SUD to elevate the level of support they are providing to Members who are struggling with SUD.

Expansion of PCP Role. We will seek to support and expand the role of trusted PCPs in diverse communities to provide and promote BH/SUD services to make it easier for Members with culturally based reluctance to accept care and referrals. We will build BH measures into our VBP program, encouraging PCPs to offer BH/SUD services and screenings. A BH pay-for-performance program will provide added funding and attention to key HEDIS BH measures to incentivize Providers.

Cultural Competency Training/Assistance for Providers. People of color have historically been negatively affected by prejudice and discrimination in the BH care system. To address Provider bias, both conscious and unconscious, we will offer a training course in cultural competency for our BH Provider community. The online course includes concepts such as the intersection of cultural identity and BH experiences and teaches Providers to practice in a culturally responsive manner. Our Provider Representatives will also be available to provide disparity assessments and technical assistance to address identified issues with Provider practices.

A.3.a. Direct Experience in Perinatal and Neonatal Service Delivery and Payment

Our affiliate plans have extensive experience in perinatal and neonatal service delivery and payment, including incentivizing Providers to improve quality and access for these services. We have provided coverage for 934,000 births across the country in the past 10 years and cover more than 9,000 NICU stays per year for Members. This experience extends to addressing issues common in Mississippi, such as high rates of low birth weight and preterm births, which put babies at higher risk of numerous health problems later in life, including obesity, hypertension, diabetes, and heart disease.

Spotlight on Outcomes

One of our affiliates implemented a new NICU program. In the first quarter:

1. NICU average length of stay was 19% lower, a reduction of 1.59 days per stay.
2. NICU cost per claim was 14% lower, a reduction of $1,239 per NICU claim.
3. The NICU cost allocation PMPM was 15% lower, a reduction of $3.71PMPM.

195B.MS22

A.3.b. Approach to Delivery and Payment for Perinatal and Neonatal Services

We have made it a priority to lead the nation in maternal and neonatal care by delivering timely access to high-quality and comprehensive care throughout mothers' and babies' clinical journeys. Our goals include better health outcomes, financial sustainability, and elimination of racial disparities. Our approach to delivery of and payment for these services includes the following.

Across our health plans, over 77% of pregnant Members had a prenatal visit, including 76% of Black pregnant Members.

239H.MS22

Early Identification, Assessment, and Risk Stratification to Facilitate Timely Service Delivery

Finding and engaging pregnant women is typically the greatest obstacle to timely delivery of perinatal services, but we identify nearly all mothers before delivery. We leverage predictive analytics with a median gestational age at identification of less than 10 weeks, allowing for timely enrollment in prenatal care and earlier engagement in preventive measures. We find many pregnant moms before their first prenatal visit. In Mississippi, we will collaborate with Providers to implement new VBP arrangements and APMs that incentivize Providers for critical notifications relating to pregnancy and newborns.

We also conduct a comprehensive risk stratification and needs assessment that enables us to target Members with risk factors for quick outreach to connect them to prenatal services as soon as possible. Algorithms we use deliver the highest predictive power, including outcomes for both Mom and baby. They incorporate both clinical factors (e.g., history of preterm delivery, gestational diabetes, SUD) and SDOH (e.g., food insecurity, transportation access, domestic violence) and also account for condition and severity, which enables more accurate prediction of poor outcomes absent intervention. Our risk stratification engine runs in real time to provide ongoing monitoring for changes in each pregnant woman's condition that may warrant greater support.

Support for Delivery of Timely, High-Quality Perinatal Services

Providers are a critical component of our efforts to drive transformation and improve perinatal outcomes. We will work with OB/GYNs and PCPs to implement shared quality goals. Nationally, at least half of our affiliated health plans have 80% of Medicaid and CHIP Members tied to Providers participating in VBP arrangements. Our goal in Mississippi and nationally is to increase that percentage to nearly 100%.

Collaboratively developed VBP models using standard metrics can help Providers focus their efforts and build the infrastructure they need to successfully participate in these APMs. We will meet Providers where they are in VBP readiness and enable them to succeed by providing flexibility in financing, quality evaluation metrics, and opportunities to advance to more sophisticated VBP arrangements along the continuum of risk. For those Providers who are ready to make the transition to VBP or PCMH arrangements, we will deploy our practice transformation initiative to ease the administrative burden and encourage quality performance improvements and Member outreach to drive improved maternal and child outcomes.

Supporting Effective, High-Quality Neonatal Service Delivery

Our NICU program supports facilities and neonatal Providers to deliver effective, high-quality neonatal services through the promotion of evidence-based care and timely authorization of services, from the initial admission notification to discharge. We will facilitate direct communications by phone, email, mail, and fax between our NICU UM solution staff and Providers and our care management staff. Nurses with our NICU UM solution will provide education to ensure babies are supported while in the NICU and when discharged. In Mississippi, we will collaborate with Mississippi hospitals that have NICU units, especially UMMC (Jackson); North Mississippi Medical Center (Tupelo); and Le Bonheur Children's Clinics.

Our affiliated health plan's NICU program resulted in an overall reduction in average length of stay of 23% in the first quarter following implementation compared to the quarter prior to implementation.

239I.MS22

Member Education and Engagement

Engaging Members through education and information is a critical piece of our approach to ensure they are getting needed services and ultimately improving outcomes. Members need to know how early and regular healthcare can improve their lives and those of their unborn children. ***We will work with various organizations (especially in the Delta and on the Coast), such as Healthy Start***, to conduct infant mortality and SIDS education to stress the importance of neonatal care, safe sleeping, and other critical elements to help keep babies safe. We will also deploy innovative methods to encourage Members to seek appropriate care during the perinatal and neonatal period. These touch points include home visits, text messages, real-time access to lactation consultants, boots-on-the-ground neighborhood support, and mobile health program resources.

A.3.c Innovative Methods to Augment Our Approach to Perinatal and Neonatal Innovations

We will augment our approach to delivery of and payment for these services through the following methods.

Investment in Healthy Pregnancy

We are committing a portion of ***our $3 million investment in Mississippi*** to improve pregnancy outcomes. Through our partnership with Family Resource Center of North Mississippi, we will launch a program to provide targeted, culturally competent support to Black mothers, with a focus on teen pregnancy in the Delta. The program will increase completion of prenatal and postpartum visits and improve birth outcomes via:

- Weekly contact with Members that includes clinical and/or social support
- Maternal health support, both in person and via an accessible virtual platform
- Education regarding benefits, value-adds, and community resources to address SDOH needs and encourage completion of recommended health visits and care
- Deep collaboration with care management and transitions of care teams to optimize Member support, developing a plan with the Member's goals and objectives at the forefront

Use of Artificial Intelligence to Enhance High-risk Pregnancy Detection

Our maternity analytics platform incorporates an innovative ***artificial intelligence-enabled early pregnancy identification tool*** that will analyze claims and other data to deliver a daily prioritized list of the most urgent high-risk OB cases due to alcohol/drug use, history of NICU admissions, asthma, diabetes, maternal age, previous preterm deliveries, and cardiac-related conditions. The program will also address Members' SDOH, including health literacy, food insecurity, transportation, and access to healthcare, and education needs specific to prenatal and postpartum care. This tool will identify potentially high-risk pregnancies earlier, including Members identified by a risk score and validated by condition diagnosis, enabling us to connect these Members to service delivery and care management as early in their pregnancy as possible. The report also allows us to identify in real time

Spotlight on Outcomes

In one affiliate health plan with a significant rural population, the early pregnancy report resulted in improvements in the first year, including:

- A 25% increase in identification of high-risk OB eligible Members
- A 15% increase in identification of high-risk OB rising-risk eligible Members

195C.MS22

when a Member's risk score increases from a "normal" threshold to potentially high-risk due to a change in condition.

On-the-Ground Engagement to Connect Members to Service Delivery

We will implement intensive, on-the-ground efforts to engage Members in service delivery, including working with community partners that Members know and trust. We will hire CHWs from, and deploy them in, the communities they will serve to engage and educate Members and connect them to services. We will also bring our mobile units and semi-permanent trailers into communities with low Provider availability and high rates of disparities, such as the Delta, to bring preventive services and social support directly to Members. We will also provide education and engagement through our healthy lifestyle community events, which will target pregnant moms as a key area of focus.

Clinical Model of Care

Our end-to-end maternity care solution ensures continuity and consistency of care through four aspects:

- **Early identification**, assessment, and risk stratification (described above).
- **Obstetrical care coordination and care management.** We ensure all women receive timely and equitable prenatal care. We integrate certified nurse midwives and community-based perinatal care coordination services into our maternal health model of care to improve access and reduce disparities. For those with high-risk pregnancies, we offer a high-risk OB team of dedicated clinicians with experience in obstetrics, labor and delivery, and neonatal care to develop and implement evidence-based and clinician-approved care plans tailored to the woman's clinical and social needs. Care Managers help the pregnant Member access services and support within her community to improve outcomes.
- **Neonatal care management**. We engage over 85% of families entering the NICU and have sustained participation from 65% of them through the first year of their baby's life. From Day 1, the goal is a healthy and safe return home for Mom and baby. We support appropriate and standardized care, leveraging the insights from nearly 100,000 cases to inform predictive and prescriptive analytics housed within our proprietary, NICU-centric platform. These insights and expertise also support a safe and timely transition home for the NICU graduate and have helped reduce readmission and ER visits by more than 50%.
- **A focus on the baby's first year of life.** Planning for a baby begins when Mom is pregnant. Our Care Managers educate and coordinate with Mom about her baby's needs before birth, with support such as early education on breastfeeding; help gathering baby essentials, including diapers and wipes; and planning for baby's pediatrician selection and well-child visits. The relationships forged between our care management team and the family continue during the transition home. Care Managers encourage proper postpartum care for Mom, continued maintenance of therapies and interventions delivered during the prenatal period, and ongoing assessment. Commonly accessed postpartum resources include special supplemental nutrition, postpartum depression screening, breast pumps, and diaper banks. The Care Manager's focus for baby includes establishing a medical home, supporting and educating the family around outpatient follow-up care needs, helping them understand the importance of well-child visits and age-based periodicity, and connecting them to resources to solve gaps in care associated with SDOH.

In one of our affiliate plans, prior to engagement in our OB care management program, 96% of pregnant Members had no PCP visit, preventive immunization, or preventive physical exam. **Following engagement in the program, 100% of Members had a preventive visit or service.**

239J.MS22

Electric Breast Pump Program

Our electric breast pump program will provide 100 pregnant Members with a single-user electric breast pump. We will identify mothers who complete six prenatal visits, agree to enrollment in care management services, and have a desire to breastfeed their infant for at least the first six months of life. The project will follow the enrolled Members from pregnancy until six months postpartum. The goal is for mothers to breastfeed for six months or longer to improve health outcomes for mothers and babies. Enrolled Members will be contacted by a certified lactation consultant weekly and as needed to provide breastfeeding support and education.

Virtual Maternal and Pediatric Care Platform

In partnership with WIC, we will provide a free app to Members to offer education, reminders, and support for pregnant and new moms. We will leverage our Mississippi Provider network to help promote the program so

that more WIC participants can access the app. The app includes breastfeeding and lactation video support in both English and Spanish, prenatal care reminders, additional EPSDT/well-child reminders, and general education on the importance of preventive care screenings. The app also connects new mothers with a nurse or live lactation consultant any time, day or night.

Member Incentives and Value-adds

We will offer a range of incentives designed to encourage Members to obtain services and improve maternal and infant outcomes. Examples are shown in **Table 3** below.

Table 3. Member Incentives and Value-adds to Improve Maternal and Infant Outcomes

Type of Screening	Incentive	Description
Prenatal Care (MississippiCAN, CHIP)	1st Trimester: $25 gift card 2nd Trimester: $25 gift card 6 prenatal visits: Car seat	To motivate and remind Members to take care of their unborn babies and bodies by going to these checkups HEDIS measure: PPC-Prenatal
Postpartum Care (MississippiCAN)	$25 gift card	To motivate and remind mothers to receive these checkups HEDIS measure: PPC-Postpartum

A.3.d. Addressing Racial, Ethnic, and Geographic Disparities in Perinatal and Neonatal Service Delivery and Outcomes

As described in A.2.e, we use our predictive risk and stratification platform and health equity dashboard to identify subsets of the population experiencing health inequities or disparities and conduct root cause analysis to determine how best to tailor interventions to reduce disparities. This will include identifying and addressing disparities in pregnant and postpartum populations. Examples include the following.

Cultural Competency Training/Assistance for Providers

To address both conscious and unconscious bias, we will offer cultural competency training for our Providers. This online course includes concepts such as the intersection of cultural identity and experiences with the health care system. Our Provider quality and practice transformation team will also be available to provide disparity assessments and technical assistance to address identified issues with Provider practices.

Collaboration with CBOs That Members Know and Trust

We will implement intensive, on-the-ground efforts to engage Members in service delivery, including working with community partners that Members know and trust. For example, ***in partnership with Family Resource Center of North Mississippi***, we will provide culturally competent and targeted support for pregnant women and new mothers, with a special focus on Black teen pregnancy, in 16 counties.

Engagement in Services Using Staff from Member Communities

We integrate certified nurse midwives and community-based perinatal care coordination services into our maternal health model of care to engage Members with disparities and connect them to services. ***We will hire from within the communities we serve in Mississippi*** and supplement through engagement of other support resources to ensure understanding of community assets, resources, social mores, and perceptions of healthcare.

Deployment of Mobile Health Program Resources in Low-access Areas

To overcome geographic disparities, we will bring care to the neighborhoods where it is most needed. Through a combination of mobile units and semi-permanent trailers, we will increase access to screenings, prenatal care, and Member education and engagement in rural areas, particularly the Delta and the Coast. Our mobile health program will use all available data to target the areas and types of services needed. These resources can also be used in partnership with Provider groups and CBOs.

Targeted Solutions to Address Disparities Among Black Members

Significant disparities in perinatal and neonatal service delivery and outcomes exist among Black MississippiCAN Members. In addition to the partnership with Family Resource Center of North Mississippi previously described, we have already developed several interventions to effectively address these disparities and will collaborate with the Division, Providers, and community partners to further tailor them to the unique characteristics of the State and MississippiCAN and CHIP Members.

Proposed Mississippi Black Maternal and Infant Health PIP. We will collaborate with the Division, key Providers, and community agencies on a PIP to identify, address, and mitigate disparities in Mississippi's maternal and infant health outcomes. Our PIP will align with the Division's quality standards and the most recent version of CMS External Quality Review Protocol. Because consistency of approach can amplify results, we propose establishing a statewide CCO work group to share data and best practices and develop uniform Provider educational materials and programs that promote a safe and supportive maternal and infant care experience for Black women. We would be happy to take a leadership role in forming this work group.

Intensive Outreach to Connect with Members. We will deploy a culturally competent pregnancy and postpartum support platform for Black women to enhance our ability to engage Black expectant mothers and connect them with services and critical resources to drive positive pregnancy outcomes. We will promote this digital solution through a geography-specific direct-to-consumer advertising and outreach campaign targeting Black moms through forums used by the target audience.

A.4. Delivery of Covered Services—Chronic Conditions

We offer a strong program of person-centered care for the Member, with treatment and management of chronic conditions as part of an overall care continuum that integrates physical health with BH. Our goals include prevention, management, and reduction of complications for Members to improve their health and quality of life. We use evidence-based protocols to support the management of each condition or comorbid conditions to meet the Member where they are in their health journey. ***Our targeted condition support programs provide intensive education as well as innovative care management programs at all risk levels.*** We place particular focus on diseases that are chronic or very high cost, including diabetes, asthma, hypertension, obesity, congestive heart disease, cardiovascular diseases, chronic kidney disease, organ transplants, ADHD, SMI/SUD, HIV/AIDS, sickle cell anemia, and high-risk pregnancies.

Spotlight on Outcomes

In an affiliate health plan, the use of our Care Managers and CHWs resulted in significant improvement:

- An increase of 15 percentage points in Comprehensive Diabetes Care HbA1c Control (<8.0%) HEDIS measure, improving from the 25th to the 90th percentile.

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A.4.a How We Will Implement Innovative Programs to Improve the Health and Well-being of Members Diagnosed with Diabetes and Prediabetes

Our diabetes and prediabetes programs are best-in-class condition support programs that both educate and empower Members and their caregivers to effectively manage the condition and improve outcomes and quality of life. We will manage Members across the care continuum, from our diabetes prevention program to intensive care management, depending on the Member's needs. We will take bold steps to address the entire spectrum of diabetes in Mississippi, from prevention for the 35% of Mississippians with prediabetes to management, improvement, and treatment for the 14% of the population with diagnosed diabetes and the estimated 3.4% of the population who are undiagnosed. We will implement our programs through:

- **Early identification of Members with these diagnoses**. We identify and engage Members early in their disease trajectory. We connect them to preventive services and ongoing treatment in order to improve outcomes and quality of life and reduce the need for ER and inpatient utilization.

- **Provider relations to provide evidence-based care**. Our specialized team of Provider Representatives will empower and equip our Providers to provide patient education, screenings, and timely treatment during annual checkups. We will train Providers on the resources available for diabetes prevention and treatment, including food security and obesity support programs. Through our data for Providers program we will share integrated data to give them a clearer picture of the chronic conditions their Members are experiencing. For those who are ready to participate in VBP or other APMs, our Provider Representatives will engage our Provider quality and practice transformation team to collaborate with Providers to create performance measures around improvements in chronic condition prevention and management.
- **Member engagement and support**. Our programs promote health literacy regarding the specific condition and recommended care, self-management, and appropriate access to health and social services needed to prevent, delay, or minimize exacerbation of the condition. We provide education to identified Members to increase knowledge of their condition and of how early intervention and lifestyle changes may improve their

future health outcomes and well-being. We also emphasize the importance of accessing recommended care and promote a strong Member-Provider relationship. Member education on the signs, treatments, and risks of diabetes will be delivered through every department in our organization via a variety of methods, including our mobile health program resources, community events, our Member mobile app, website, and home mailings. We will also identify SDOH needs, such as food insecurity, that impact Member condition and assist them in connecting to community resources. A key element of our Member engagement approach is to collaborate with CBOs that Members know and trust to reach, educate, and engage Members in care.

- **Care management support**. For Members with unmanaged conditions, barriers to access, or higher health or social risks, we offer support through our care management team. Care Managers will work with the Member and family/caregiver to develop a self-management plan, which may include elements such as measuring blood sugar and exercising. Certified diabetes educators will provide specialized education on nutrition and diabetes management skills. Our CHWs will contact Members to provide in-home visits for those with barriers to accessing care in the community. We will contact Members who are due for A1c tests, retinal eye exams, and nephropathy testing, and will schedule in-home visits via our in-home nurse practitioners program to complete the exams when necessary.

Innovative Programs to Address Diabetes

Every Member of our health plans who is diagnosed with diabetes is automatically enrolled in our specialized diabetes care management program. In this program, designed from the ground up especially for Medicaid and CHIP Members experiencing or at emerging risk of developing diabetes, we use condition-specific assessments, guideposts, and action plans to surround the Member with person-centered care designed to improve their quality of life and achieve positive outcomes.

Our Care Managers are armed with clinical best practices to manage Members with diabetes; identify disease-specific needs; understand Members' ability to self-manage their diabetes; and address gaps in care, such as missed preventive visits, and Member concerns. Care Managers will educate Members on triggers and symptoms, and how to recognize a crisis. They will also stress the importance of attending PCP and specialist appointments and taking medications as prescribed. Members will learn self-monitoring and self-management skills like monitoring their blood glucose and keeping food diaries and medication logs. Care Managers reach out to Members with care gaps to assist with appointment scheduling, transportation, and barriers to compliance.

We also employ unique and innovative methods to connect Members with the care they need, including:

- **Glucose monitoring program.** Through a pilot program with an academic health center, we will provide ***remote patient monitoring***, allowing eligible Members diagnosed with type 1 diabetes to self-monitor their blood sugar at home. We will provide the glucometers and stay in close touch with network Providers to provide education to their patients. The initial pilot program will last for four months, with plans to expand the program throughout the State.
- **Mobile health program services.** We will provide diabetes education, screenings, and exams for Members in their communities through our mobile health program's mobile units and semi-permanent trailers. For example, we will use these mobile resources to offer diabetes testing and other services in high-risk communities during the nine weeks when the school clinics are closed for summer, ensuring that treatment and education can continue. The mobile health program can work in concert with our care management team to provide on-the-spot services where access is limited.

- **Nutrition support.** Through our food security efforts and healthy food education and resources, we will bring fresh foods to communities through farmers market and food truck programs, and we will help Members and their families learn to cook and eat healthier meals. Our community engagement team will host events and partner with CBOs to hold nutrition and cooking classes for families and kids to teach them how to read food labels, avoid too much salt and sugar, and prepare healthy meals.

A.4.b. Direct Experience in Service Delivery and Payment for Members with Chronic Health Conditions

Our affiliate plans have direct experience in multiple States over many years with service delivery and payment for Members with chronic conditions. We manage, oversee, and pay for delivery of evidence-based services to

treat chronic conditions, supporting and incentivizing Providers to help their patients manage chronic conditions and avoid complications. **Table 4** below shows a sample of outcomes demonstrating our successful experience with delivery and payment for these services.

Table 4. Chronic Conditions Interventions and Successful Outcomes

Chronic Condition	Affiliate Interventions	Outcomes
Heart Disease	Providers were given a toolkit with clinical guidelines, best practices, tips to increase compliance, and education on hypertension and related measures.	Increased 6 percentage points for the HEDIS measure Statin Therapy for Patients with Cardiovascular Disease Received Statin Therapy—Total, improving from the 25th to the 90th percentile.
Asthma	We formed a partnership with two community organizations serving children and families to complete in-home assessments to identify asthma triggers, and to offer home visits with an asthma educator to instruct Members and their families on proper inhaler/medication use, triggers, symptoms, and prevention.	Improved from below the 25th percentile to the 50th percentile in both Medication Management for People with Asthma: Medication Compliance 75% (age 19–50) and Asthma Medication Ratio (age 19–50) HEDIS measures. They increased 8 percentage points in the first measure and 6 points in the second.
COPD	Our CHWs collaborated with our QI Specialists to contact Members diagnosed with asthma and considered at risk for COPD. Health educators called Members who were either missing a controller medication or were discharged from the ER with an asthma diagnosis.	Increased by 15 percentage points, rated highest among plans in use of spirometry testing, and reached the HEDIS 75th percentile in use of bronchodilators.
Obesity	For a large rural population, Provider engagement teams visited PCP offices to review the HEDIS Provider scorecard and weight assessment and counseling clinical guidelines, best practices, and tips to improve compliance.	Weight Assessment and Counseling for Nutrition increased 11 percentage points, and Counseling for Physical Activity increased 13 percentage points.

A.4.c. Approach to Service Delivery and Payment for Chronic Health Conditions Services

Our approach will promote early identification so that we engage Members in services as early as possible and support and incentivize Providers to deliver timely, evidence-based care to prevent or slow condition progression and improve Member outcomes and quality of life. Our approach also includes expanding access through telehealth. To reinforce Provider education and support their service delivery efforts, we will offer condition-specific programs that promote Member health literacy, self-management, and appropriate, timely access to needed health and social services to impact their condition.

Early Identification of Members with Chronic Health Conditions

We identify Members as having chronic health conditions through a combination of the HRS; our proprietary risk stratification and predictive modeling platform; data analytics; and claims review. We also conduct screenings among those subpopulations experiencing unique high risks for chronic disease. These subpopulations may include Members with disabilities, specific comorbidities, specific environmental risk factors, or a history of high or inappropriate service utilization. These screenings help identify potential chronic conditions at an earlier stage, when treatment can be more effective.

Provider Support and Incentives

Our specialized Provider representative team will equip Providers with evidence-based resources for treatment and provision of patient education. As part of our practice transformation initiative, we will incentivize Providers to deliver effective treatment to help Members keep their chronic conditions under control and prevent acute utilization. For example, our VBP program offers Providers incentives for improving HEDIS measures related to diabetes, obesity, and annual physicals. In one of our affiliates, we deployed a similar pay-for-quality VBP contract with an association of 14 FQHCs. The plan provides regular reporting, claims assistance, community outreach, and Provider support. Participating Providers continue to increase their quality scores for chronic conditions such as diabetes and routinely earn annual VBP bonuses of $300,000 to $550,000.

Telehealth

We will leverage our telehealth capabilities to increase access to health services for our Members living with chronic conditions, especially those residing in rural areas or experiencing other social and equitable barriers that inhibit their ability to access health benefits and services. Our organization has effectively used our advanced telehealth capabilities to facilitate virtual access to needed services, reducing

costs by providing an alternative to expensive urgent care and ER visits. Further, our data shows that our telehealth services have provided efficient means of access for 16% of individuals who would have otherwise not sought health services. ***Through a coordinated effort with UMMC, we will use telehealth to increase access to local Providers in the Mississippi network.*** We will also offer access with certified national Providers through our national telehealth Provider and our specialty e-consult solution.

Condition Management Programs

We offer disease management programs that focus on chronic or high-cost diseases, including diabetes, asthma, hypertension, obesity, congestive heart disease, cardiovascular diseases, chronic kidney disease, organ transplants, ADHD, and SMI/SUD, HIV/AIDS, sickle cell anemia, and high-risk pregnancies. Through our care management program, our Care Managers use condition-specific assessments, guideposts, and action plans to surround the Member with person-centered care designed to improve their quality of life and result in positive outcomes. Our care management program promotes ability, confidence, and change in self-management of chronic conditions. Care Managers educate individuals on clinically effective methods for dealing with their chronic disease or condition. All our clinical practice guidelines are consistent with national standards for disease and chronic illness management.

A.4.d. Innovative Methods to Augment Our Approach

We will implement innovations that improve access to care and address health disparities for higher risk populations based on geography, race, ethnicity, language, disability, and SDOH. The following outlines some of our proposed innovations to reach more Members with chronic health conditions in Mississippi.

Community Partnerships

Through community partnerships, we will broaden the reach of our education to engage with more Members and their families in the communities where they live and through organizations they trust. For example, in our family wellness program, we will engage with low-income families through a proposed partnership with the ***Meridian Housing Authority (neighboring Mountain View, Sowashee, and Mt Barton complexes) and the Mississippi Children's Museum, located nearby***, to host a program that will focus on improving the social/emotional wellness, health/nutrition, and healthy physical habits of children and families. We will also offer a quarterly educational program to Head Start and pre-K programs, teaching children about good dental hygiene and smart (healthy) eating habits and building self-esteem.

Remote Patient Monitoring

In coordination with UMMC, we will offer and cover remote patient monitoring for Members with chronic conditions, such as asthma, diabetes, hypertension, heart disease, COPD, and cancer, as well as high-risk pregnancies. This will allow Members to actively engage in their healthcare and improve adherence to treatment plans and health outcomes.

School-based Collaborations

We will work with nursing associations and schools to provide education and assessments for such common chronic conditions as asthma, childhood obesity, and depression. We will recruit and contract with qualified school clinics and school-based Providers to ensure timely access to services. These contracts will include Jackson-Hinds Comprehensive Health Center, the only FQHC operating school-based clinics, along with several school districts throughout the State to provide services. We understand and value the role school clinics and school-based Providers play in the provision of care to MississippiCAN and CHIP Members.

Asthma Management

Our multifaceted asthma program reinforces and supports Provider condition management by increasing knowledge and action against uncontrolled asthma among our Members.

Education and Support. We will help Members, parents, and caregivers be aware of the identification, treatment, and triggers surrounding asthma in the life of the Member. We will provide education on asthma medications, symptoms, and self-management via our website, mobile app, texting (for those opted in) and mailings in the Member's requested primary language. We also provide education and support face-to-face as needed, such as through mobile units and semi-permanent trailers used to bring preventive services and education to Member communities.

We will further extend education into our communities by collaborating with Providers, healthcare facilities, schools, and organizations, including the American Lung Association and the Mississippi School Nurses Association. Our educational materials will include a video on the proper use of an asthma inhaler. This video will be shared with patients and family members via statewide clinic educational television as they await their visit in their Provider's office.

We will also encourage Members to keep well-child visits and asthma care checkups as planned and remind them about important vaccinations.

Care Plan. We work with Members to develop a care plan to identify and reduce environmental factors and triggers and improve condition management. The care plan includes development of an asthma self-management plan with the Member and Provider to manage any changes in condition.

Value-adds. We will offer a value-add for pest control services and home assessment for high-risk Members with asthma.

Obesity Support

To help the 36% of Mississippians who are obese, we will provide innovative programs to promote prevention and weight loss among both children and adults. This is a significant population health challenge, as obesity increases the risk for depression, heart disease, cancer, type 2 diabetes, high blood pressure, and high cholesterol. Obesity is often a generational issue, with poor eating habits and lack of exercise passed down in families. We will engage the whole family to adopt healthier habits together through the following programs:

- Our ***pediatric obesity program*** will support healthy nutrition through deploying registered dietitians to work closely with Members, parents, or caregivers to develop a healthy and individualized nutrition plan that meets the Member's and family's needs. Members, parents, or caregivers are encouraged to work closely with their Providers, including FQHC and medical homes, to determine appropriate diet, exercise, and pharmacological recommendations. For Members ages 8 through 17 who are in the 85th percentile or more in weight and referred by the PCP, we will offer participation in the ***Kurbo® by WW weight loss program for adolescents***.
- Our ***fitness-in-education program*** will encourage 12- to 17-year-old Members to get their annual wellness exam. We will provide education and incentives to help them adopt a healthier lifestyle. The program will provide tools, such as a free Fitbit personal fitness tracker device, to encourage completion of an annual age-appropriate EPSDT/well-child/well adolescent visit. The program will expand the role of Providers in obesity prevention and reduction efforts, reduce kids' sedentary lifestyle by promoting outdoor physical activity, and improve nutrition knowledge regarding healthier food choices. Outreach will occur through postcards, mailers, phone calls, educational materials, and incentives.
- Our ***adult obesity program*** will support adult Members in their weight loss and healthy eating through ***memberships in WW*** and ***nutrition consultations*** with our health management team.

- Our ***food security programs*** will bring healthy food to the areas of the State where obtaining fresh foods is the most challenging. Through our farmers market initiative and food truck appearances, Members and families can pick up fresh foods. Our community events will showcase cooking demonstrations for the local neighborhood, and our family wellness initiative will offer cooking classes and healthy cookbooks for families who participate.

Self-monitoring Hypertension

We will help Members self-monitor their blood pressure in their homes. Our ***self-measured blood pressure monitoring and loaner program*** will target adult MississippiCAN Members who have been diagnosed with hypertension and meet the eligibility criteria for this program. Through the program, we will lend Members blood pressure monitoring devices they can use at home to help them identify opportunities for better control and management. Consistent monitoring helps reduce the risk of complications that could occur as a result of uncontrolled high blood pressure. The program will include training and support. For those Members who find it difficult to adhere to the self-monitoring program, we will engage them in a higher level of remote patient monitoring through a telehealth partnership.

A.4.e. Addressing Racial, Ethnic, and Geographic Disparities in Delivery and Outcomes of Members with Chronic Conditions

We will identify disparities in delivery and outcomes for Members with chronic conditions using a combination of proprietary and publicly available tools and internal and external data. We will identify geographic areas and populations that are at highest risk for having uncontrolled chronic conditions and apply our quality performance and predictive modeling tools to analyze delivery and outcome indicators by race, ethnicity, geography, age, and other factors that can result in disparities. We use the data as a foundation for root cause analysis to identify contributing factors, and then ask for feedback from Providers and CBOs to balance what we learn from the data with real-life experiences. This combination of information helps us decide where to target our interventions. We will work with Providers and CBOs to design programs that address the identified disparities and develop interventions that target those populations in culturally appropriate and effective ways. Our collaborative and community-focused approach will improve access to care and reduce disparities in utilization and outcomes for Members with chronic conditions.

Culturally Appropriate Outreach

We will promote culturally appropriate outreach through the use of individuals in specialized roles who reach directly into the communities where our Members live, work, and play:

- Our **CHWs**, who work in the community where they—and our Members—live, and who are as diverse as the people they serve, will work diligently to engage difficult-to-reach Members, work with our specialized Provider Representatives to forge connections with Providers and CBOs, and help the healthcare services team understand individual and overall SDOH needs of the community. In this unique model, they will build trust with our Members and connect them to our plan, our Providers, and other resources they need.
- [redacted]
- We will deploy culturally aligned certified **Peer Support Specialists** who have real-life experience living with chronic conditions and can share their experience with condition management, teaching, providing practical assistance and support, and connecting Members with resources. These specialists provide role models and inspiration for successful management and improvement in quality of life.

Bringing Services Directly to Member Communities

In areas where access is limited geographically and where the highest racial and ethnic disparities exist, we will deploy our unique mobile solutions that bring care to the populations, communities, and neighborhoods where it is most needed. Our **mobile health program** resources, including our mobile units and semi-permanent trailers, will take screenings and treatment into every corner of the State, with special emphasis on areas with limited access to PCPs and specialists. We will staff these venues with nurse practitioners and others who can conduct screenings and provide education on chronic conditions.

Targeted Chronic Condition Management Programs

We will focus targeted efforts on helping high-risk populations identify and manage chronic conditions with a focus on black populations where there is a higher prevalence of chronic conditions in Mississippi. Below are examples of needs we have identified among the Mississippi population:

- **Hypertension.** To address the higher prevalence of hypertension among the Black population, we will deploy innovative solutions to help with management, including telemonitoring of blood pressure and partnerships with Providers, such as FQHCs for regular checkups and medication management, and CBOs such as the American Heart Association and churches, for Member education and screenings. Our food security and nutrition services will also be deployed as part of this program.

- **Childhood obesity.** We will bring an intensive focus to combatting childhood obesity in Mississippi communities with significant Black populations, especially the Delta. Our innovative programs, such as ***our healthy lifestyle fitness program, our fresh food initiatives, our nutrition and cooking classes for families, and our weight loss programs targeted at children and teens***, will all be used to address this epidemic.

- **Childhood asthma.** Our unique community-centered model that includes CHWs and in-home nurse practitioner visits can be used to help families address childhood asthma. Directed by our Care Managers, these home-focused resources, including our pest control value-add, can be deployed to help eliminate asthma triggers, educate the family on asthma management tools, and stress the importance of medication.
- **Diabetes.** We will bring special focus on identifying and treating Black Members at risk of and diagnosed with diabetes. This program will include targeted screenings through churches, schools, our mobile health program, and community events, as well as intensive efforts by our Care Managers and CHWs to encourage enrollment in our specialized diabetes care management program for those Black Members who are diagnosed with diabetes. We will also make diabetes screening and treatment a focus in our initiative to make the Delta healthier.
- **Prenatal care.** Prevention of chronic conditions starts early, and our efforts to improve care for Black mothers and infants will be an important part of this effort. Initiatives like ***our Black maternal and infant health PIP, our digital solution to improve maternal and child outcomes, and our mobile health program resources*** will all play a part in identifying underlying chronic conditions among pregnant moms and ensuring that babies start life on the right path to prevention and early detection of chronic conditions. These initiatives are outlined in more detail in subsection A.3 above.

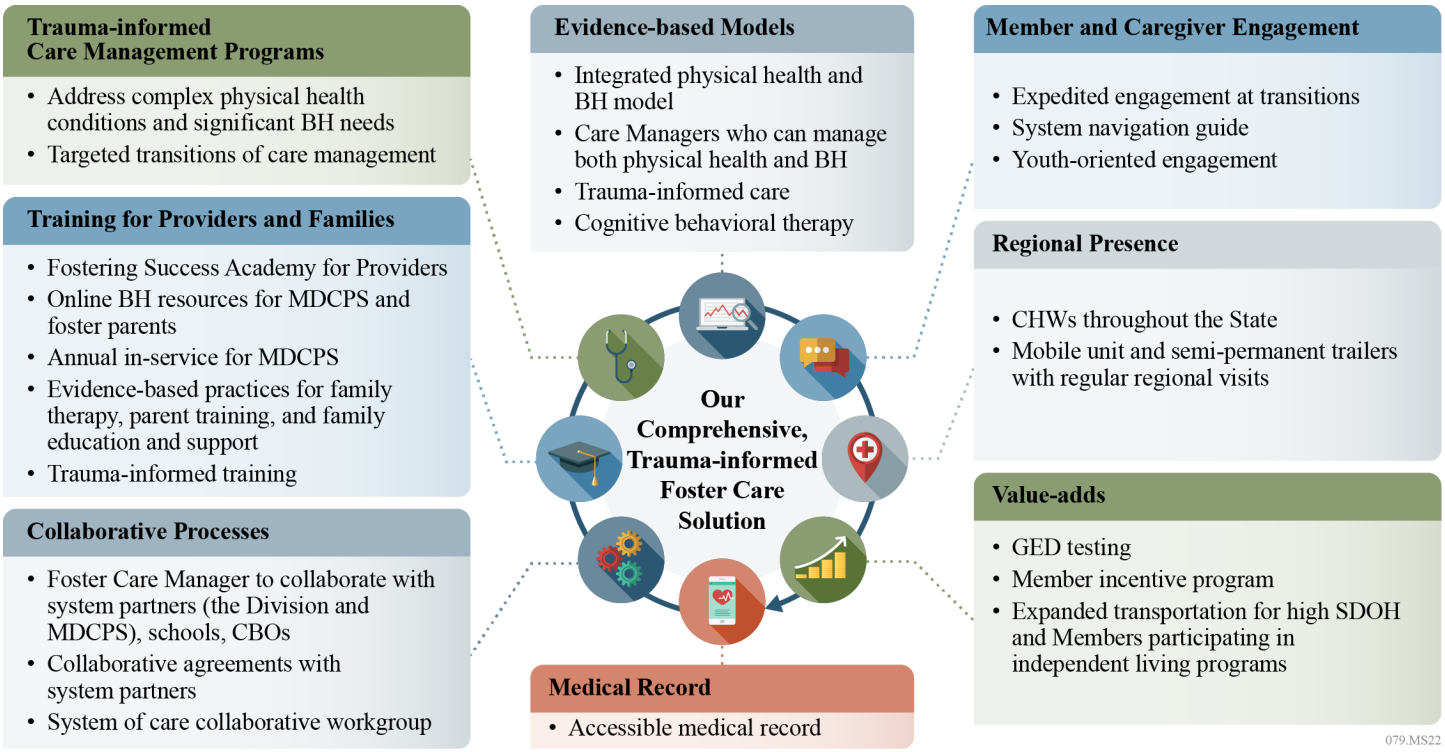
A.5.a. Our Experience or Capacity to Manage the Care of Foster Children

Across our health plans, we serve more than 15,000 children and youth in foster care. To address their unique needs, including those receiving adoption assistance and aging out of care, we have established a trauma-informed system of care that integrates physical health, BH, and social services across the continuum of care and placement changes while supporting caregivers, families, and MDCPS to meet the child's needs and achieve permanency.

Our system of care is Member- and family-centered, community-based, and culturally and linguistically appropriate. To provide consistency and facilitate relationship-building, we assign each Member to a dedicated Foster Care Manager who serves as a single point of contact for the Member, caseworkers, caregivers, family, and others involved in the child's care. The Care Manager coordinates the exchange of information across the continuum. Our approach offers expedited engagement and access to trauma-informed services critical to effective treatment of this population, which has higher rates of health issues, including emotional and behavioral needs, disabilities, and educational and developmental delays, compared with children not in foster care. In Mississippi, we will support this system with a network of internally managed Providers to address the physical health, BH, dental, and vision needs of Members in foster care.

As shown in **Exhibit 2,** ***we offer Mississippi a comprehensive solution*** to meet the needs of Members in foster care. This solution includes close coordination with system partners and Providers; Member and caregiver assistance with system navigation; a readily accessible Member record that reduces duplication of services; and a comprehensive set of trauma-informed interventions for each Member based on their individual needs and circumstances.

Exhibit 2. Trauma-informed Foster Care Solution. Our approach offers a comprehensive solution to serve foster care Members and their caregivers/legally authorized representatives.



In Mississippi, we will employ the following solutions for the children and youth in foster care:

- **Targeted care management programs.** We will automatically enroll all Members in foster care into the high-risk care management category. Care Managers will engage Members or their legally authorized representatives throughout the assessment and care planning process, including oversight of the interdisciplinary care team (ICT). Our targeted care management programs and interventions support foster care Members and their caregivers, including their specific needs related to complex physical health and BH conditions, transitions of care, transition to adulthood, and pregnancy. We will collaborate with the PBA to address psychotropic medication utilization. Our programs meet each Member and caregiver at their point of need to provide the right types and intensity of interventions to promote resiliency and permanency and improve Member health outcomes.
- **Dedicated foster care staff.** We will appoint regional Foster Care Managers, reporting to the Care Management Director, who will have extensive foster care case management experience and a pediatric background. These Care Managers will serve as a point of contact for caseworkers, resource families, and foster care Members. Our foster care team members will be assigned by region and will work closely with other Members of the care management team, including our nurses, licensed BH professionals, and CHWs. In addition, all care management team members will be trained on the foster care system of care, trauma-informed care, and working with individuals with special health needs (i.e., autism, serious emotional disturbances, developmental delays, and chronic health conditions).
- **Evidence-based models.** We will apply evidence-based practices to improve healthcare for children in foster care, particularly physical health and BH screenings, other comprehensive exams, and periodic follow-up exams and care. We will use the AAP guidelines for preventive services for children in foster care, which recommend more frequent preventive visits and development screenings. We will equip Providers with evidence-based tools and resources for BH and SUD screening and treatment to effectively serve the roughly half of all foster care children diagnosed with mental health disorders, as well as those who have experienced parental SUD issues.
- **Member engagement.** We will structure opportunities to continuously obtain and act on youth and family input to ensure a person-centered approach to engagement. We offer a variety of specialized communication with young Members, including mobile app text alerts and Member incentives designed for their age group.

- **Support for transition out of foster care**. Our framework for engaging Members who are preparing to transition out of foster care is trauma-informed and promotes stability and permanence. Our Care Managers will work with MDCPS to ensure we have the information necessary to ensure continuity of care. For aging-out youth, we will offer transition to adulthood planning built on best practices in other States, such as preparation for youth aging out of foster care to address needs related to health, safety, job readiness, financial management, life decisions, and relationships. We will address SDOH needs through our CHWs, connecting them to community-based resources to support independent living and financial assistance programs. For example, we will ***develop partnerships with Youth Villages and their LifeSet program*** to link Members to cell phone programs and food resources. We will work with the Hinds County Human Resource Agency for utility assistance. We will also offer transportation to help Members transition to living on their own.

A.5.b Working Collaboratively with MDCPS to Determine Medical Necessity and Provide Documentation of Medical Services

Our system of care will comply with all policies for the relevant Federal and State agencies, such as MDHS, MDCPS, or the Division, related to this population as well as associated State and Federal requirements. Our team will work collaboratively with MDCPS and the Division through the following people and processes:

- **Dedicated Foster Care Manager and team.** Our Foster Care Manager and their team of dedicated liaisons will serve as a primary point of contact for MDCPS and provide regular outreach and accessibility to MDCPS for coordination of care. They will establish a process for outreach and follow-up with county MDHS agencies to ensure that they are notified of all EPSDT-eligible Members under their supervision who are due to receive EPSDT screenings and follow-up treatment.
- **Expedited intake.** We will assist MDCPS with the time-sensitive nature of the initial health assessment, Comprehensive Health Assessment (CHA), and BH assessment needed for children entering the foster care system, as well as periodic and ongoing EPSDT services, including dental and vision screenings and services. Our Foster Care Manager and team will offer MDCPS a dedicated phone line, our Provider services call center line (automatic voice response), and a dedicated foster care email inbox to ensure that urgent needs, such as screenings and services related to changes in placement or the Modified Settlement Agreement requirements, can be communicated and coordination can begin. Upon identification of new foster care children and adolescents, we will send MDCPS caseworkers a welcome letter that includes the Care Manager's contact information, materials outlining the benefits of our care management program, and information about our reports.
- **UM process.** To address the abrupt changes in placement, health status, and behavioral issues that often occur for these Members, we will work closely with MDCPS to provide timely services during these periods of change. For example, to ensure continuity of care following a change in placement, our foster care staff will work closely with MDCPS to assist Members whose PCP relationship, medications, transportation, and other daily needs may have been disrupted. This may include identifying options for a new PCP and arranging for an initial visit or coordinating with the PBA to transfer prescriptions to a new pharmacy.
- **Enhanced care coordination.** We will provide intensive coordination services that reduce system fragmentation and ensure timely access to care. For example, we will arrange for urgent screenings and assessments when a new foster care Member enters MDCPS State custody or when a new need is identified for current foster care Members.
- **Medical necessity review.** When a foster care child is admitted to the hospital, we will engage the Member or their legally authorized representative and MDCPS caseworker immediately. Our specialized Care Manager will coordinate services across the care continuum, beginning at the time of admission, through discharge, and after the child has returned safely to his or her living environment.
- **Data sharing and regular meetings with MDCPS.** We will attend monthly meetings with the State, regular task force meetings, collaborative meetings, visits to MDCPS regions, and in-services. We will also provide monthly reports related to Modified Settlement Agreement requirements as outlined in subsection A.5.c below.
- **Collaborative processes.** We will develop collaborative agreements and provide training on the needs of Members in foster care for all Care Managers and other relevant staff in our plan.

- **Training for MDCPS, resource families, and Providers.** We will offer MDCPS staff in all regions annual in-service training (with continuing education unit credits) to educate them on managed care services and how we support MDCPS workers, foster parents, and Members. They will be able to access our mental health education platform for training. We will also provide training on trauma-informed care to all Providers and staff and will offer it to caregivers and resource families.

A.5.c Capacity to Provide MDCPS Access to All Data and Documentation

We will ***have a dedicated business analyst assigned to MDCPS*** to provide all data and documentation in accordance with their needs. Not only will we comply with Contract requirements impacting the provision of services for Members in foster care, but we will also provide committed support to the Division in its efforts to accurately identify and subsequently serve the medical needs of foster children. We will deliver reporting capabilities, a secure and convenient report through which MDCPS caseworkers can review each child's current health status, utilization, medications, and whether they have attended wellness exams. These reports are produced quarterly, and customized reports can be developed and delivered on a regular or ad hoc basis.

We will also provide monthly reports related to Modified Settlement Agreement requirements, including:

- Initial health screening (required within 72 hours for new foster care Members)
- Comprehensive medical exams (EPSDT) (within 30 days for new foster care Members)
- Periodic and ongoing medical exams per EPSDT periodicity schedule (all foster care Members)
- Dental and vision utilization (within 90 days for new foster care Members and every 6 months thereafter for all foster care Members)
- Utilization of services report related to recommended follow-up
- Psychological/neuropsychological testing needs
- Psychotropic medications claims report

A.5.d Innovative Methods to Augment Our Approach

We will bring the following innovations to Mississippi to meet the needs of Members in foster care of all ages:

- **Telehealth visits and remote patient monitoring**. We will provide urgent care services using telehealth and remote patient monitoring for those foster care Members with medically fragile conditions, easing the burden on foster parents and ensuring that Members are receiving the care they need. A significant benefit to this approach is that if the Member has a change in placement, established remote patient monitoring services can move with the child.
- **Hygiene products.** We will provide duffel bags with hygiene products to regional MDCPS offices for foster care Members who are changing placement and do not have access to luggage or basic hygiene products.
- **Ready access to the Member's medical record.** Children aging out of the foster care system will have a copy of their electronic health record that captures their physical, dental, vision, and mental health history.
- **Child without placement strategy.** We will work with MDCPS to assess barriers related to foster care Members who are a child without placement. We will collaboratively establish a process that includes coverage of flexible care days to reduce the likelihood of foster care Members being placed in hotels or MDCPS offices once they are discharged from an inpatient setting.
- **Expanded transportation**. We will support transition-age youth (ages 14–21) by offering expanded transportation to independent living training sessions. Independent living training is an integral part of the transitional living plan and helps to prepare foster care Members with life skills, including communication skills, social development, employment, money management, decision-making, study skills, housing, daily living skills, self-care, and youth law issues. We will expand NET to remove barriers and support independent living training participation for these youth.
- **Community events for foster care.** In areas with a high concentration of children in foster care, we will partner with CBOs or regional MDCPS offices to host events for foster care kids and their foster families during periods of transition, such as back to school, and will provide wellness education for families and packets for kids to ease their transitions. Our mobile health program's mobile unit will be available for health education and benefit coverage questions.

- **Training for Providers and families.** Through our ***Fostering Success Academy, we will bring Providers and their staff members together to promote widespread adoption of trauma-informed and evidence-based***

practices across our system of care. Providers can access training and resources using multiple modalities, including in-person classes, personalized coaching, webinars, peer consultation, and online resources. Foster parents will also be able to leverage our mental health education platform for training.

- **Opportunities for collaboration with MDCPS regional offices**. We will organize and attend quarterly meetings to discuss trends, the needs of the foster care population, and points of ongoing collaboration.

A.5.e. Addressing Racial, Ethnic, and Geographic Disparities in Delivery and Outcomes for Foster Children

Our Members in foster care are racially and ethnically diverse. Here are our proven techniques for reaching children in the most meaningful ways that are trauma-informed and culturally and linguistically sensitive to help address and reduce disparities.

[redacted]

- **CHWs**. Our CHWs are recruited from the communities they serve and are aligned with the racial and ethnic makeup of their communities. Their role is to address health disparities and SDOH, such as transportation challenges and housing instability, by helping Members access care and meeting Members where they are—in their homes, at our mobile units or semi-permanent trailers, or on virtual visits. They will work throughout Mississippi's most disadvantaged neighborhoods, assisting Members in foster care who may have barriers to accessing care. CHWs will provide wellness and preventive care education and boots-on-the-ground support for these Members in concert with their Foster Care Manager.
- **Expansion of PCP services.** We will expand the number of places Members in foster care can receive care in communities experiencing significant disparities, including urgent care centers, school-based clinics, and other nontraditional Providers. Busy foster families may find it easier and more convenient to access care in these nontraditional settings, especially in places where access is limited.

- **Fostering a healthy lifestyle.** To combat childhood obesity, especially among Black children in foster care, we will partner with CBOs to address these needs through assessments, stronger PCP relationships, and Member and family education on healthy eating, stress relief, and exercise. We will bring our food security initiatives, nutrition and healthy eating programs, and mindfulness tips to this program. Additionally, if a foster care Member is between 8 and 17 years of age and in the 85th percentile or more in weight and obtains a PCP referral, we will offer them participation in the Kurbo by WW weight loss program for adolescents. Our goal is to empower children to take ownership of their health, especially by adopting a healthy lifestyle, relieving stress, and staying active.

A.6.a. Direct Experience in Service Delivery and Payment for Dental Services as a Medical Service

We have extensive experience in the delivery and payment of dental services in compliance with EPSDT and CHIP guidelines for children and Medicaid emergency/palliative care requirements for adults.

We administer Medicaid, Medicare, and Medicare-Medicaid dental benefits in multiple States throughout the country. To promote timely access to quality dental care for every eligible Member in MississippiCAN and CHIP, we will directly contract with a comprehensive statewide network of dental Providers. We offer dental services in four States using this direct-contracting model in which our networks are meeting 100% of time and distance requirements. While ***we own and manage our dental Provider network***, we use a dental services Subcontractor for administrative functions, including credentialing, claims processing, call centers, and UM. Our partnership with this dental services Provider has been in place since 2017, spanning four States and multiple health plans. Our delegation oversight team verifies that we provide Members with premium service, monitor performance, address any urgent Member needs, and meet monthly with our Subcontractor to advance the goals of dental services. Our dental services Subcontractor met 100% of performance measures for claims, call center, UM, and credentialing/recredentialing across all four States in 2021.

A Strong Statewide Direct Provider Network

We commit to implementing a scholarship program for minority Mississippi dental school students who commit to serving Members in underserved areas to encourage more diverse dental Providers

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Capacity to manage dental service delivery and payment is demonstrated by a robust network. Our dental network will include Provider specialties such as general dentistry, pediatric dentistry, oral and maxillofacial surgeons, orthodontists, and periodontists. We will incorporate Providers operating in a variety of settings, including individual practices, groups, clinics, health systems, and community health centers.

Promoting timely access, accountability, and rapid response to evolving Member needs, we will directly contract with dental Providers across Mississippi, including FQHCs that provide dental services. For both general and subspecialty dental Providers, our dental network will meet 100% of the time and distance standards across the State for adult and pediatric dental care in both urban and rural counties.

Our direct-contracting model provides many advantages over other CCOs that outsource their entire dental services benefit, such as the following:

- Whole-health line-of sight to close gaps in care and offer Members quick, easy assistance when needed to locate a dental Provider and/or schedule an appointment.
- Direct Provider access to our specialized dental Provider Representatives for questions and support as well as direct access to our Dental Director for peer-to-peer discussions.
- A smooth process for resolving complaints, grievances and appeals, and prompt authorization of services.

With support from our Provider representative team, our Care Managers can help Members connect to general dentists in their community who can perform specialty services (e.g., root canal or tooth extraction) as needed. We will quickly identify the necessary Provider as close to a Member's home as possible while recognizing there may be certain specialized services that require travel beyond 30 miles. In those cases, we will offer no-cost transportation so the Member can reach their appointment.

Engaging Members in Preventive Dental Care

We have demonstrated strong performance in promoting equitable dental access and engaging Members to obtain preventive dental services and . Our engagement strategies include:

- **Integrated outreach.** To streamline the Member experience, we integrate outreach activities, such as our EPSDT Coordinators providing education about dental care at the same time they provide reminders about overdue preventive care.
- **Dental mobile app.** We will deploy an interactive dental mobile app that guides Members to network Providers, educates them about dental care, and delivers personalized education, satisfaction surveys, and reminders about overdue preventive visits or upcoming scheduled appointments. Members can easily locate nearby dentists who meet their preferences (such as language or accessibility) and immediately get turn-by-turn directions to the Provider's office. The app includes quick access to benefits, their virtual Member ID card, and links to our website and Member services call center.
- **Provider partnerships.** We will partner with Providers such as the Mississippi Pediatric Dental Association to amplify our outreach. We will also ***partner with Jackson-Hinds Comprehensive Health Center to host days at their clinic when Members get priority appointments and kids get a prize when they leave.*** We will offer a children's dental education program during which dental school students demonstrate proper teeth cleaning and kids receive an hourglass, toothpaste, and toothbrush.

A.6.b. Innovative Methods to Augment Our Approach

To achieve the Division's goal of quality, collaborative innovation, access, and commitment, we will bring the following innovations to augment our approach to dental service delivery and outcomes.

- **Expanded services/value-adds**. We will offer **preventive dental services for adults ages 21 and older** as a value-add. Services will include two oral evaluations and two cleanings per year. **Pregnant women** will be offered two additional cleanings during their pregnancy and postpartum period at no cost (up to three per year during year of pregnancy).
- **Provider engagement initiative.** The COVID-19 pandemic had a significant impact on utilization of dental services, with many Members fearing infection. We will implement a dental quality initiative to improve

utilization of preventive services. ***Providers will receive a $100 incentive payment*** for providing preventive and diagnostic care to Members who did not see a dentist in 2021. Providers will receive an ***additional $50 incentive*** for providing preventive services six months after the initial visit. We will run reports on missed dental services, match those Members with local Providers, and perform joint Member outreach with matched Providers. This will underscore for Providers the importance of serving Medicaid Members in their practices.

- **Capitalizing on mobile dental care.** We will work with a partner to bring mobile dental services into communities. To ensure convenient access, we will deploy mobile dental partners to provide dental care at locations such as schools, nursing facilities, FQHCs, and public health departments. We will also pursue other opportunities to deploy mobile care, such as partnering with Head Start programs to reach our youngest Members. We will target Mississippi communities where Members have lower utilization rates and those with limited Provider access.

- **Anesthesia services.** We will partner with a national Provider of dental anesthesia services to bring anesthesia care and services directly into dental offices. This eases access for children who would otherwise need to obtain dental care at a hospital or surgery center, which often leads to long wait times and higher costs. This partnership will also foster continuity of care because children can remain with their general dentist. ***Our partnership with this Provider in one State is projected to save 25% in anesthesia costs (compared to performing those services in a hospital or outpatient surgery center) and in another State has resulted in 15% higher utilization of anesthesia services.***
- **Fluoride applications in PCP offices.** We also propose to explore with the Division the idea of allowing PCPs to apply fluoride to promote good oral health to their patients.
- **Collaborative partnerships.** We will seek opportunities to partner with dental schools and organized dentistry groups to increase access and collaborate on dental care education. We will also develop a Mississippi dental advisory committee where we can invite these groups to participate and talk about updates, trends, and issues. Our National Dental Director and Mississippi Medical Director will lead this committee.

A.6.c. Addressing Racial, Ethnic, and Geographic Disparities in Delivery and Outcomes of Dental Services

We will conduct routine data analysis to identify Members who are not obtaining timely dental care and areas of the State with geographic disparities in access and test and implement solutions to reduce disparities, meet dental care needs, and boost oral health literacy. Through regional Member focus groups and consultation with Providers and CBOs, we will gather insight about the specific drivers, such as reduced rates of preventive visits for Members in certain counties, that contribute to unmet dental care needs. Strategies we will use to address disparities in dental service delivery and outcomes include the following.

Increase the Number of Providers in Underserved Areas. Studies have shown that underserved minority populations are more likely to seek treatment from dental Providers to whom they feel culturally connected. To encourage more diverse dental Providers, especially in rural areas of Mississippi, we ***will implement a scholarship program for minority Mississippi dental school students who commit to serving Members in underserved areas***. In one State where we implemented this program, we offered scholarships for dental students willing to practice in a disadvantaged area. A loan repayment program, in which we would repay dental school loans for every year a graduate agrees to practice in an underserved area, would also encourage recent dental school graduates to remain in those areas. Statistics have shown that dentists who have practiced in an area for five years are likely to stay there.

Collaborative Strategies to Increase Access. Our dental network team will monitor dental claims data and reports to proactively identify network access opportunities. When a need for access is discovered—whether for routine or specialty dental care—our dental team will identify potential dentists for recruitment; work with existing Providers to expand their availability; encourage non-Medicaid Providers to enroll in the MississippiCAN and CHIP programs; and increase access to dental care into more FQHCs serving Black, rural, and low-income populations. We will also expand access to care through these community partnerships. For example, in another State, we supported an FQHC in establishing a school-based health center that included a co-located dental practice within the high school. We also propose to collaborate with other CCOs serving MississippiCAN and CHIP Members to develop strategies to boost access in counties with a limited number of

dental Providers. In addressing access disparities, we will synchronize our efforts with local and statewide organizations to amplify results. We commit to taking the lead on organizing this collaboration if approved by the Division.

A.7.a. Direct Experience in Service Delivery and Payment for Vision Services

We offer experience managing vision service delivery and payment through our vision services Subcontractor. Since 2001, this Subcontractor has served Members in nearly all our affiliate plans. They offer a robust, diverse network of optometrists and opticians who practice in both retail outlets and private locations. They achieve and maintain ***100% of access standards*** despite common challenges presented by urban and rural geographies.

Our Subcontractor offers a self-serve Provider platform that enables end-to-end administrative oversight and support for eye care professionals. Basic functions include e-management and tracking of eyeglass prescriptions and orders; benefit, eligibility, and claims information; and education and training materials. Our vision services Subcontractor has configured its Provider platform to notify an eye care professional at the time of eligibility verification when a dilated retinal exam is required. The Provider platform also prompts eye care professionals to use the appropriate CPT II codes at billing to close HEDIS care gaps.

We are fully accountable for and tightly oversee the vision services we subcontract. Our approach to oversight, detailed in our response to RFQ § 4.2.2.7, includes reporting and file exchange requirements, service-level agreements, audits, revocation and termination/sanctions, and other requirements that ensure quality care.

A.7.b. Innovative Methods to Augment Our Approach

To augment our approach to dental service delivery and outcomes, we will offer the following innovations:

- **Value-adds.** We go beyond the standard Medicaid benefit to offer the following:
  - One eye exam per year and one pair of eyeglasses every calendar year (non-EPSDT-eligible beneficiaries)
  - Two eye exams per year and 2 pairs of eyeglasses every calendar year for Members under 21 (EPSDT-eligible beneficiaries are eligible for more services if determined to be medically necessary)
  - An extra $100 beyond Medicaid standard coverage for frames or lenses each year
  - One free replacement pair of eyeglasses for kids within one year of getting their glasses
  - A $25 gift card as an incentive for Members to get an annual diabetic eye exam
- **PCP notifications.** Achieved through analytics and reporting, our Subcontractor's proprietary claims platform will generate and send a letter to both the CCO and the Member's PCP. The letter will detail services rendered by the eye care professional, including any patient observations or findings.
- **Dilated retinal exam notifications.** Diabetic retinopathy is the leading cause of blindness in the United States. To promote and drive required screenings for people living with diabetes who are at high risk of diabetic retinopathy, our vision Subcontractor will perform monthly analytics to identify diabetic Members previously treated by a participating Provider who have not received their annual dilated retinal exam. Our Subcontractor then notifies Providers to contact the Member to schedule the exam. Our Subcontractor will repeat this process monthly for each eligible Member until the screening has been completed.

A.7.c. Addressing Racial, Ethnic, and Geographic Disparities in Delivery and Outcomes of Vision Services

- **Diversity, equity, and inclusion focus**. Our vision Subcontractor is committed to serving diverse populations with equity in quality of care and experience. The Subcontractor enforces this commitment within its Provider network. ***The Subcontractor offers a variety of continuing education courses to our optometric network about minority populations and economic diversity***. Our Subcontractor thoroughly investigates and acts on any feedback received from partners or Members that indicates its Providers are behaving contrary to the nondiscriminatory language outlined in their Provider agreements. All complaints and grievances *involving perceived or actual instances of discriminatory practices are swiftly and effectively addressed* by our vision Subcontractor. The Subcontractor's inclusion and diversity committee provides recurring training for all staff.
- **Diabetic screenings and retinal eye exams for the Black community.** To address the higher incidence of diabetes in the Black population and identify Members who may have uncontrolled or undiagnosed diabetes, we will partner with our vision Subcontractor to include diabetic retinopathy screening as part of our

programs aimed at identifying and treating diabetes. These exams will be promoted through our mobile health program, community collaborations, and healthy lifestyle events in high-risk Black neighborhoods.

A.8 Additional Items

A.8.a. Cost-sharing or Copayments

MississippiCAN Cost-sharing and Copayments

We will not apply cost-sharing or copayments on any services for MississippiCAN Members.

CHIP Cost-sharing and Copayments

We will not apply cost-sharing to the following services for CHIP Members:

- Preventive services, including immunizations, well-baby and well-child visits
- Routine preventive and diagnostic dental services and routine dental fillings
- Routine eye examinations, eyeglasses, and hearing aids
- Family-planning or pregnancy-related assistance

We will require cost-sharing and copayments for CHIP Members as outlined in **Table 5**.

Table 5. Copayments and Cost-sharing for CHIP Members

Coverage Plan	Provider Visit	ER Visit	Copayment Maximum
MSCHP 01	$0	$0	$0
MSCHP 02	$5 per visit	$15 per visit	$800 per coverage period
MSCHP 03	$5 per visit	$15 per visit	$950 per coverage period

Member Communication on Cost-sharing

We will communicate this information to Members and their parents/legally authorized representatives through the following clear and upfront methods, which will also emphasize that cost-sharing is not allowable on benefits for preventive services or pregnancy-related assistance:

- Member handbook
- Member ID card
- Our website
- Our Member mobile app
- Member services call center
- Open enrollment materials

Provider Training and Assistance on Cost-sharing

We will conduct regular training to make Providers aware that cost-sharing and copayments are not allowed on certain services. We provide multiple modalities for thorough Provider training and education, including reinforcement of our cost-sharing arrangements.

We track CHIP Member out-of-pocket maximums and notify the Member and PCP when the Member reaches their maximum out-of-pocket amount as well as their family maximum out-of-pocket limit. We will monitor their claims, and if the Member exceeds their maximum out-of-pocket amount, we will work with the Provider to refund the Member the exceeding amount.

A.8.b. Practices and Policies to Ensure Adequate Access to NET

Our practices and policies to ensure adequate access to NET include the following.

Contract with Reliable Vendors That Have and Know How to Build Adequate Networks. Our NET services for MississippiCAN Members will include use of a leading transportation Subcontractor that offers rural and urban networks in more than half of the United States and has the experience to build networks quickly and efficiently in new locations. Additionally, our Subcontractor trains its employees and Providers in cultural competency annually as part of the company's diversity, equity, and inclusion and compliance programs, ensuring delivery of culturally competent services.

Support Members to Access NET. We educate Members on the NET benefit and how to access it in our Member handbook, website, Member portal, and via Member services call center employees on calls with Members regarding appointments or needed care. Our Care Managers and CHWs will help MississippiCAN Members and their caregivers access and schedule NET to office visits, pharmacies, healthcare facilities, and

other appointments related to EPSDT and healthcare services. Our Subcontractor offers a mobile app, self-serve tools like online scheduling, and real-time tracking of transportation so that Members can easily arrange NET on their own. Through our mobile device access program, Members may also qualify for a free cell phone preloaded with this app, which will facilitate their ability to access NET.

Continuously Monitor and Address NET Gaps. We constantly assess the availability of NET services offered by our Subcontractor, such as through geomapping and monitoring Member complaints. When we identify a gap in the network, we will work quickly and collaboratively with our Subcontractor to address the gap and ensure adequate access to NET for our MississippiCAN Members. We work as a team with our Subcontractor to strive for continuous improvement in helping Members achieve their health goals.

A.8.c. Additional Proposed Innovations for Delivery of Member Services or Benefits

In addition to the innovations in many areas we describe throughout our response above, we are also committing $3 million to support innovation in key areas that will impact service delivery in alignment with Division goals:

Healthy Pregnancy. This investment will target birth outcomes disparities among Black mothers, with a focus on teen pregnancy in the Delta.

Provider Transformation and Technology Enablement. This investment will help Providers improve quality and outcomes through tools that will have a positive impact on their ability to care for their patients.

Food Security. Investment in services to improve food availability and quality will support and reinforce Provider delivery of services to promote general health and manage chronic conditions and perinatal health.

A.8.d. Additional Practices to Address Racial, Ethnic, and Geographic Disparities

In addition to practices described previously, we will implement and build on the following practices to promote equity from top to bottom in our organization to prevent or reduce disparities:

- We require every employee to complete annual cultural competency training. By building awareness of the differences among cultures and providing tangible ways to improve cultural competency, our employees improve their interactions with both coworkers and Members.
- We will also require every employee to complete initial and annual training in health equity and disparities.
- In our talent acquisition and talent management practices, we have launched initiatives to improve diversity and representation at the director level and above. In our health plans, we hire employees who reflect the diversity of the Members we serve.
- We have launched employee engagement strategies to share knowledge and understanding of the importance of diversity and provide support and opportunity for our diverse employees.

B. MEMBER SERVICES CALL CENTER

B.1 Member Services Call Center Operations

We will engage our MississippiCAN and CHIP Members and work with Providers to deliver compliant, robust, and innovative physical health, BH, and SDOH services through our local, Member-centric approach. Our Mississippi Member services call center will be a critical connection point for helping Members engage with the services available to them.

Our affiliate health plans continuously meet and exceed industry standards:

- **Service level 94.1%** (industry avg. 80%)
- **Call quality 92.5%** (industry avg. 75%–90%)

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Today, our Member services call centers across all health plan affiliates handle more than three million Medicaid Member calls per year. This experience will allow our local health plan to establish support to help Members understand and navigate through the physical health and BH/SUD services available to them.

We will ensure that our Mississippi Member services call center is equipped with the necessary staff, training, technology, tools, processes, and supports to meet all Contract requirements as detailed in RFQ § 4.2.2.1 B, Member Services Call Center, as well as the Draft Contract § 5.1, Member Services Call Center.

B.1.a Member Services Call Center Location and Hours Verification

When our Members' needs arise, it is critical for them to be able to reach the Member services call center. We understand how important a local call center with extended hours will be to engage our MississippiCAN and CHIP Members. Our proposed call center will comply with all Contract requirements, be located in Mississippi, and ***be fully staffed seven days a week.*** As required in the Contract, our call center will be open Monday through Friday from 7:30 a.m. to 8:00 p.m. CST. Because Members have needs or questions that fall outside those hours, ***we will also staff our local call center from 8:00 a.m. to 5:00 p.m. CST every weekend*** and offer Members a live chat function for simple, self-service activities every day. Member services call center and chat hours will be communicated through our website, Member portal, mobile apps, and all Member communications.

B.1.b Member Services Call Center Performance Standards and Monitoring Process

We continually monitor Member services call center performance to ensure effective staffing levels are in place and performance standards meet and/or exceed all Contract requirements outlined in Draft Contract § 5.1.6.

Key performance indicators will include average speed of answer, abandonment rate, call volume, calls handled, service level, and call quality. We will monitor extended hours call volumes to ensure our hours meet the needs of our Members and adjust to deliver optimal support. ***Today, our affiliate health plans meet or exceed the Division's requirements*** as specified in Draft Contract § 5.1.6 and shown in **Table 6**.

Table 6. Affiliates' Call Center Performance. Our enterprise-wide Member services call center results for 2021 meet or exceed the Division's requirements.

Performance Measure	2021 Enterprise Results	Meets or Exceeds the Division's Requirements
Service Level Percentage	94.1% within 30 seconds	✓
Average Speed to Answer	11 seconds	✓
Average Hold Time	< 2 minutes	✓
Call Abandonment Rate	< 3%	✓
Live Answer, Once Queued	98.7%	✓
Calls Monitored by Quality Assurance	3.77%	✓

Using our state-of-the-art workforce management system, key performance indicators will be monitored in real time by workforce management team and call center operations leadership to enable intraday adjustments to staff levels in 30-minute increments. By using cross-trained call center employees, leads, supervisors, and backup staff throughout our affiliate plans, we can adjust staffing levels to address volume spikes that are part of typical call arrival patterns as well as those that may occur unexpectedly. We conduct daily, weekly, and monthly reviews to determine longer-term staffing needs based on a staffing ratio proportionate to the number of Members, call volume, call arrival patterns, average call handle time, staff utilization, and other advanced staffing analysis metrics. Metrics will be reported quarterly to the Division. As required, we will record calls received at the call center and monitor no less than 3% for compliance with customer care guidelines and Contract requirements. We will document and report our findings to the Division quarterly and make recordings available upon request within five business days. Records are maintained for at least six months.

To improve our Members' experiences, our new technology will also monitor for sentiment analysis and keyword recognition. These Member behaviors will promote real-time escalations if Member services call center employees require help from leaders or other specialists.

B.1.c. Accommodating Non-English Speaking, Hearing-impaired, and Visually Impaired Callers

Our Mississippi Member services call center operations will be designed to accommodate and trained to handle all Member types, including non-English speaking, hearing-impaired, and visually impaired people, or those with other communication needs. We will combine best practices from our affiliate health plans to deliver optimal services to all MississippiCAN and CHIP Members in a culturally competent way.

Accommodating Members Who Are Non-English Speaking. Our local Mississippi Member services call center will support Spanish-speaking Members. We can also connect Members who speak other languages to interpreter services 24/7/365. Interpreters have advanced, healthcare-focused training, enabling them to clearly

communicate with Members with even the most complex health-related needs. Interpretation will be available in more than 250 languages at no cost. Parents or legally authorized representatives may also request document translation services by contacting Member services call center employees. Members will be made aware of these services through health and education materials, welcome letter, website, Member ID card, and Member handbook.

Accommodating Members Who Are Hearing-impaired or Visually Impaired. Our health education and Member materials will be available in braille, large print, or audio recordings for Members who are deaf, blind, hard of hearing, or visually impaired. We will include information on the availability of TTY/TDD relay services for those who are deaf or hard of hearing when calling the Member services call center, Nurse Advice Line, or the BH/SUD line. Our Member website, Member portal, and Member mobile app will comply with Section 508 requirements, providing special formatting for electronic content for ease of use with low-vision equipment and technology such as screen readers.

Commitment to Providing Culturally and Linguistically Appropriate Services

Several of our affiliate health plans have earned the NCQA Multicultural Health Care Distinction, certifying that we are a culturally and linguistically sensitive organization and provide outstanding services in collection of race, ethnicity, and language data; provision of language assistance; cultural responsiveness; QI of culturally and linguistically appropriate services; and reduction of healthcare disparities. We commit to maintaining this endorsement in our pursuit of optimal health outcomes for MississippiCAN and CHIP Members.

B.1.d. Process to Ensure a Member's Immediate Medical Needs Are Properly Handled

We will ensure that the immediate medical needs of MississippiCAN and CHIP Members are met through multiple access points during and after regular business hours.

Member Services Call Center Automatic Call Distribution (ACD)/Self-service. Our customizable ACD system will be configured for Mississippi-specific call handling requirements. It will feature upfront self-service prompts for the BH/SUD line and Nurse Advice Line. A Member selecting one of these self-service prompts will be taken directly to the Nurse Advice Line or BH/SUD line for triage and support.

Member Services Call Center. Our Member services call center employees will be trained and equipped to identify Members who call and require immediate medical support. When a Member has questions that fall outside of our regular Member services call center inquiries, our employees will warm transfer the Member to their Care Manager, other qualified clinical member of the care management team, the Nurse Advice Line, a medical Provider, or 911, based on the specific medical need.

Nurse Advice Line. All Members and legally authorized representatives will have access to a dedicated, 24/7/365, toll-free, multilingual Nurse Advice Line, which serves as our after-hours line for issues, inquiries, and problems. The Nurse Advice Line is URAC and NCQA accredited and staffed by RNs who have between 15 and 20 years of acute care experience. On-call PCPs and other physicians support RNs in providing culturally competent, comprehensive, and personalized clinical services. For callers seeking BH/SUD services, we offer 24/7/365 access to properly licensed BH professionals (see response to RFQ § B.1.g for more information). If at any time during a call a nurse identifies a Member who requires emergency services, the staff will immediately warm transfer the Member to 911 and stay on the line to ensure that help arrives.

B.1.e Member Services Call Center Employee Training

Our comprehensive training approach as show in **Exhibit 3**, immerses Member services call center trainees in our culture, dedication to individualized customer service, and focus on quality in every interaction. Trainees learn about Medicaid, details about Mississippi's specific program benefits, services, MississippiCAN and CHIP populations' diverse cultures, and how we supply care management to Members with the greatest needs. Member services call center employees will participate in a variety of adult-learning modalities to prepare them to deliver service excellence to every Member across their health journey. We will recruit Member services call

center employees from diverse and underserved communities in Mississippi who already understand Mississippi's unique cultural needs.

Initial Training. All Member services call center employees will receive four weeks of soft-skill, program, and system training, 14 days of classroom study, and a nesting period during which they answer live calls with support from supervisors. We will tailor our training to the specific needs of both the MississippiCAN and CHIP populations.

Exhibit 3. Member Services Call Center Training Components are Mississippi-specific and encompass all areas needed to ensure Members receive individualized customer service

Mississippi-specific Training. We will facilitate ongoing training with our Member services call center employees on the unique elements of Mississippi and its Members. Topics will include differences in populations (their needs, available services, and requirements), unique culture, geography, barriers to care across populations, and contracts.

Cultural Competency Training. Guided by our national cultural competency plan, our Member services call center employees will be immersed in how to facilitate respectful conversations through person-first language, cultural sensitivity, patience, enhanced listening skills, and genuine interest in each caller. Our Member services call center employees will learn how to assist Members with special needs and those with limited English proficiency or diverse cultural backgrounds.

Care Management Training. Our care management training will equip our Member services call center employees to understand health equity, how disparities impact health and wellness, and how to recognize and address when a Member is experiencing health inequity. Specifically, our staff will be trained in the disparities experienced by Mississippians and how to identify when a Member can benefit from our care management person-centered benefits and community-based resources. All Member services call center employees will receive tools, techniques, and resources to ensure cultural competency and recognition of implicit bias that Members may experience. Member services call center employees will learn how to build trust with Members and connect them to the right care management resources.

Ongoing Training. Member services call center employees will attend daily supervisor-led team huddles to learn about news and updates, and they will receive monthly, one-on-one coaching (or more often, as needed). Our weekly call monitoring program ensures Member services call center employees adhere to training, policies, and procedures and our service standards. Our call center learning and development team develops and facilitates quarterly and annual Member services call center training to share changes or updates to program benefits and services, policies and procedures specific to MississippiCAN and CHIP, new or changed program requirements, systems, and soft skills. We track and document completion of initial and ongoing training.

B.1.f Member Services Call Center Service Interruption

In the instance of a natural disaster or other event rendering our Mississippi Member services call center operations inoperable, our ACD will ***automatically route callers to overflow call center*** operations located throughout the United States, ensuring seamless continuity of service for our MississippiCAN and CHIP Members. Our network of Member services call centers gives us the ability to provide Mississippi with failover system redundancy and support capabilities. All Member services call center employees, including those located in our overflow offices, will be appropriately trained on MississippiCAN and CHIP benefits and services as well as the specific populations served as part of the program. Our call routing system will be set up to ensure Member services call center employees in all overflow offices routinely handle MississippiCAN and CHIP Member calls on a weekly basis to ensure they stay well versed on Mississippi programs/benefits should we need to shift to them in the event of a business continuity response. If alternate sites are required, Members can expect communications systems such as telephones, fax services, and email to remain functional.

B.1.g 24/7/365 Access to Crisis Intervention for Behavioral Health/Substance Use Disorder

Both Member services call center technology and trained employees will identify and prioritize Members in emergency and crisis situations. Members who are experiencing a BH/SUD crisis and call into the Member services call center will immediately hear a prompt in the ACD that, when selected, transfers them to our BH/SUD line. If the Member reaches our Member services call center, employees will evaluate the severity of a Member's condition and guide, refer, or warm transfer to the appropriate course of care, including the BH/SUD line. If the Member reaches any other departments, those employees will have the ability to directly warm transfer Members to the BH/SUD line.

BH/SUD line: The BH/SUD line, available 24/7/365, will be staffed by licensed clinical social workers. Our Mississippi BH/SUD line will triage and resolve BH crisis situations to meet or exceed all minimum performance standards outlined in Contract requirements specified in RFQ § 5.1.3.1.1, Behavioral Health/Substance Use Disorder. BH/SUD licensed clinical social workers will determine the severity of illness and appropriate action that leads to a safe outcome, including referring Members to the appropriate level of care or service, psychiatric services, other community services, hospital ER, the local suicide hotline, mobile crisis services, other crisis response systems, or 911 when appropriate. Our licensed clinical social workers will provide emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating emergency services. We will connect Members and their legally authorized representatives to community resources and connect them to follow-up care if not admitted for inpatient care and treatment to determine the need for any further services or referral to services within 72 hours of crisis resolution, including local CMHCs and BH Providers.

B.2 ACD System

Member services call center operations are streamlined through our ACD system, which operates across our health plan affiliates in other States. It routes Members to the appropriate department or provides access to self-service features automatically and complies with all Contract requirements as specified in RFQ § 5.1.1, Automatic Call Distribution System. Our ACD is available 24/7/365 and gives Members, parents, and legally authorized representatives access to services to meet their immediate or urgent physical health or BH/SUD needs or simpler self-service options. Members can use the ACD to quickly connect into our Nurse Advice Line or BH/SUD line, request ID cards or PCP changes, and verify eligibility for services.

Capability

The following capabilities are HIPAA-compliant and available 24/7/365 to Members:

- Programmed to answer calls on first ring and direct Members to the appropriate Member services call center employee queue during staffed hours or to self-service as selected by the Member
- Choice of routing to English, Spanish, or other languages as needed, or to speak directly to a Member services call center employee, the Nurse Advice Line, or BH/SUD line for assistance
- Uses natural language understanding or touch-tones to help route Members to the proper Member services call center employee queues, in compliance with RFQ requirements
- The average hold time never exceeds two minutes

Capacity

Our Member services call center operations will be able to handle any required configuration and call volume, based on the Mississippi program populations. If call volume approaches capacity, our ACD data informs Member services call center operations to expand capacity to accommodate the higher volume. ***In 2021, our affiliate health plans' Member services call centers responded to more than 180,000 calls per month and more than two million calls for the year. Our ACD is scalable to more than 10 times that amount***.

Reporting

We will meet all monthly ACD performance reporting requirements as outlined in the Contract. We use data collected from our phone system for quality assurance and improvement, fulfillment of reporting and program monitoring, and confirmation of appropriate staffing. At the request of the Division, we will document compliance in these areas and submit all data requests to the Division within 20 business days of the request. Additionally, our ACD advises Members that calls are monitored and recorded for quality assurance purposes. We record and monitor all required operational functions, as specified in the Contract, and can produce reports daily, weekly, or monthly, or as needed by the Division.

Oversight of ACD reporting is provided by our workforce management department, which oversees the Member services call center operational performance. The department is responsible for ensuring adequate reporting, appropriate staffing, and scheduling. Our plan Chief Executive Officer will also provide oversight by monitoring performance measurements through a monthly dashboard report. The dashboard will include detailed performance metrics, including service level, call volume, calls handled, speed of answer, and quality.

C. MEMBER HANDBOOK

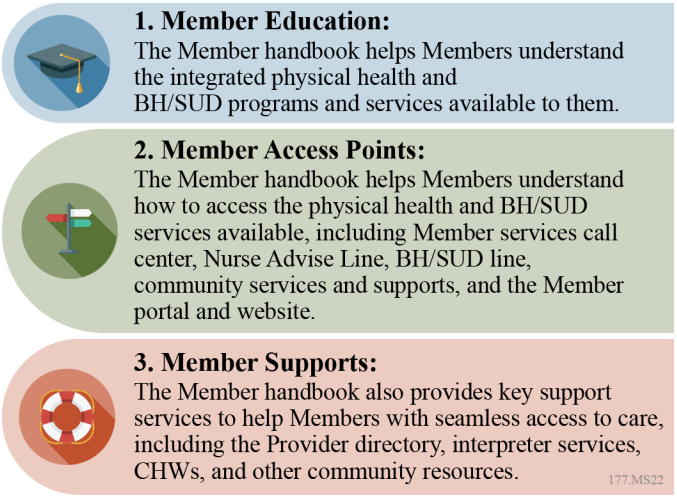
We will mail the Member handbook to all Members within 14 business days after notice of enrollment. The Member handbook will be available in English, Spanish, or the Member's preferred language (if known), and can be requested in over 250 languages, plus audio, braille, or large print for those with visual or functional impairments. To encourage Member choice in how they receive information, we will also email the Member handbook if the Member prefers. It will be written in plain language at or below the third-grade reading level. It will also be available in paper form and on our website, the Member portal, and all mobile apps for easy access.

We will tailor the content of our MississippiCAN and CHIP Member handbooks to comply with handbook requirements from the Division CCO Procurement Appendix, § 5.4, 42 CFR § 457.1207 and 42 CFR 438.10 for each covered population. We recognize contents are subject to Division review and approval. In compliance with the Draft Contract, we will submit a copy for review no fewer than 60 calendar days prior to distribution. We will review our Member handbook and quick start guide annually and submit any changes to the Division for review and approval no fewer than 60 calendar days prior to distribution. We further recognize any material changes to a handbook are subject to the review and approval of the Division in advance of release.

C.1 How the Member Handbook Will Inform Members About Accessing Services

The Member handbook is an important tool to help MississippiCAN and CHIP Members understand how to begin their health journey. It will take them step-by-step through how to engage with each program, benefits, and coverage, including how to connect with important resources like the Member services call center, Nurse Advice Line, BH/SUD line, and the care management team. It will be comprehensive and easy to navigate, with a simple table of contents and hyperlinks for Members who may only have access on their phones.

Exhibit 4. Comprehensive Member Handbook. Our Member handbook helps Members understand how to access physical health and BH/SUD services.



Connecting Members with Physical Health and Behavioral Health/Substance Use Disorder Services

To help our Members access the physical health and BH/SUD services they need, our Member handbook will focus on three primary functions, as shown in **Exhibit 4**:

Member Education. The Member handbook will include program, benefits, and services information in the following areas:

- **Benefits.** We will explain what is covered under the MississippiCAN and CHIP programs.
- **Services**. We will identify programs and services that make it easy for Members to get physical health and BH/SUD care.
- **Care management.** We will cover programs to support chronic conditions, extra help managing a health problem, education programs, and guidelines for preventive health checkups and services.
- **BH.** We will identify BH/SUD programs and emergency services.
- **Vision and dental benefits.** We will provide information for both MississippiCAN and CHIP Members.

Member Access Points. The Member handbook shows Members the many ways they connect to their physical health and BH/SUD services, including the following:

- **PCP and first appointment.** We will focus first on ensuring that Members know who their PCP is and how to connect with them, schedule their first appointment, and change their PCP.
- **Common questions and support.** We will include important contact information, services available, and self-service options, such as changing contact preferences or self-referring to care management.
- **Emergency or urgent help.** We will help Members understand what to do when they are having a problem that may need more support, with contact information for the Nurse Advice Line and BH/SUD line.

Member Supports. The Member handbook will also have resources that can help Members better access available physical health and BH/SUD services, including:

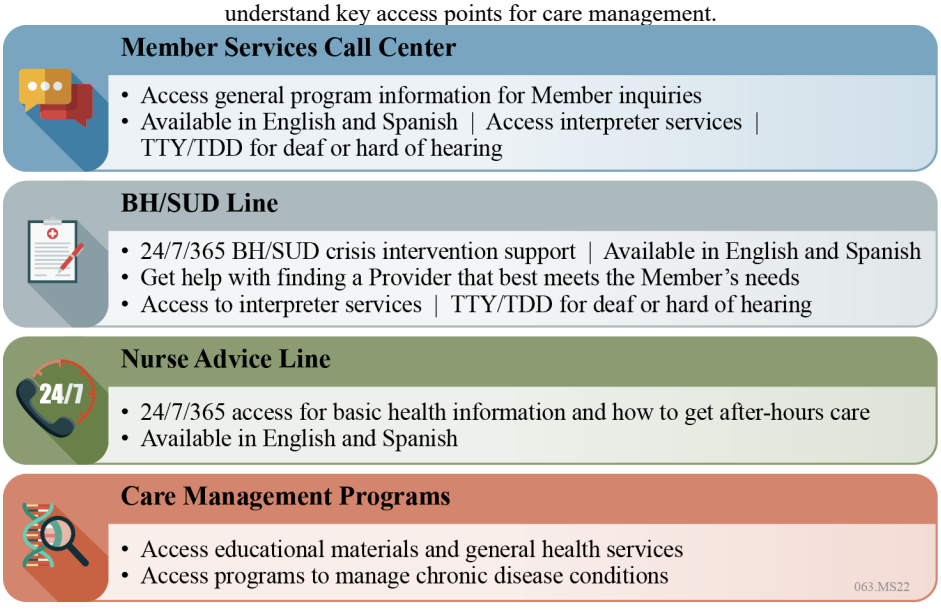
- **Provider directory.** We will offer a highly searchable Provider directory, available in paper, website, and mobile formats. The directory will offer easy-to-understand, comprehensive Provider profile information, helping Members make the right Provider choice.
- **Interpreter services.** We will help Members who are non-English speaking, hearing impaired, or visually impaired find interpreter services.
- **CHWs.** We will connect Members with CHWs who can assist them in navigating the healthcare system and accessing community-based programs.
- **Community resources.** We will identify DMH, regional CMHCs, and other local and regional Mississippi organizations that support physical health and assist with SDOH.

C.2. How the Member Handbook Informs Members About Care Management

The Member handbook will educate Members on what care management is, including when and how to engage with our care management team for chronic conditions, emergent situations, or extra help managing a health condition. Our Member handbook's overview of care management is meant to remove any mystery about it and demonstrate ***how easy it is to engage our key access points for assistance and guidance*** while also offering valuable self-referral information if a Member wishes to pursue treatment on their own.

The Member handbook will walk Members through the care

Exhibit 5. Key Access Points. Members can use the Member handbook to understand key access points for care management.



management process, what they can expect, and important access points to engage with care management. It will guide Members to contact the Member services call center, where employees can help identify Members needing care management and connect them with Care Managers who can help meet their physical healthcare or BH/SUD needs (see **Exhibit 5**. Key Access Points).

In addition, the Member handbook will explain what a care management plan is, how care management teams work, and how to include family members or legally authorized representatives in the process. There will also be a care management checklist that helps Members through the process and a place to record notes, such as their Care Manager's name and contact information.

Member Handbook Cross-CCO Collaboration

We would be happy ***to join a Division-sponsored, collaborative CCO effort to create a State-endorsed Member handbook beyond the stated requirements, which would facilitate education across the entire MississippiCAN and CHIP populations***. We have seen a similar collaboration produce a Member handbook that makes it easier for Members to know where, when, and how to access services.

D. WEBSITE AND MOBILE APPLICATION

Engaging our Members and keeping them well-informed early and often in their health journeys is our top priority. Our website, Member portal, and Member mobile app will reflect the culture and people of Mississippi and help Members understand their benefits, connect to Providers, and access important information about how to connect to available physical healthcare and BH/SUD services. Each of our affiliate health plans has a tailored website, and we will do the same for the MississippiCAN and CHIP programs. Features on our website, Member portal, and Member mobile app provide Members with easy ways to access information and connection points for physical healthcare and BH/SUD services as show in **Table 7**.

Table 7. Website, Member Portal and Member Mobile App Features. Our Member-centric online capabilities are compliant and innovative.

Website	Member Portal	Member Mobile App
Our website will provide Members with up-to-date information: • Programs, Provider network, Member services call center, care management, and grievances and appeals • Health education addressing priorities in Mississippi, including chronic conditions, weight management, healthy habits, and tobacco cessation • Recent and seasonal health concerns, such as COVID-19 • Instructions on how to recognize an emergency and what to do, including a BH crisis	Our Member portal will include information and functionality to help Members access physical health and BH/SUD services easily and efficiently: • Consumer-friendly content • Member handbook, including Member rights • Download and print Member ID card • Grievance and appeal process • Important contact information for social services • Direct connect to Nurse Advice Line • Ability to self-refer for care management • Provider search capabilities by location and specialty • Important medical claims information (lab and imaging results, medications, key health appointments) • Two-way communication between Member and plan • Announcements about new Providers available in Member's geography	Our mobile app provides Members with real-time communications: • Person-centered secure messaging and live chat • General information on recent and seasonal health concerns • Instructions on what to do in a physical health or BH/SUD emergency • Push notifications • Face ID/touch ID login • Member engagement, such as gamification and incentives • Telehealth access to a major local medical center Provider, our national telehealth Provider, and other Providers • Enhanced Member health alerts and health tracking • Onboarding alerts, texts, and emails
Additional Contract requirements: Our website, Member portal, and mobile app will comply with all Contract requirements		
• Unique URL for each covered population • ADA compliant • Usage analytics • Responsive for mobile phone and tablet • News section for important notices • Secure, two-factor authentication for PHI-related information		• Link to Member portal (from website) • Other information or access to services as directed by the Division • Secure mobile application with unique login credentials for each Member • Downloadable in commonly used mobile application platforms

D.1 Ensuring Members Are Well-informed About the Portal and Mobile App

Since the COVID-19 pandemic began, more information has become available online about healthcare, resulting in questions and confusion for our Members. It is even more important now for Members to have access to the right tools and resources to help answer their questions and connect them to the care they need. We will tap into almost 30 years of experience from our affiliate health plans to design a communication plan for our Members that helps keep them informed about online resources. We will use constant monitoring of usage and feedback from our Members through satisfaction surveys, including Net Promoter Score, to assess improvements to our online tools with a goal of improving usage across our Member population year over year.

Informing New Members. All new Members will receive a Member handbook, welcome call, and texts to direct them to more details about their online resources. The Member handbook describes the Member portal and mobile app (an example in **Exhibit 6**), instructs Members how to log in the first time, describes self-service options to keep their information up-to-date, and instructs them how to access important appointment dates or their Provider directory.

Exhibit 6. Our communications through the Member mobile app keep Members informed and engaged.

Ongoing Communications to Keep Members Informed. We will employ several tactics to keep our Members aware of available online resources and how to access them, encouraging use and engagement:

- **Member services call center.** Employees will be trained to use their time with Members to identify those not using online resources, help them with access and setup, and share the services available.
- **Email communications, text messages, and push notifications.** We will use email and text messages to connect Members to features of our online resources and push important notifications from their mobile app.
- **Social media.** We will use social media platforms that our Members frequent to promote our Member portal and encourage Members to sign in.
- **Community supports.** We will train our community partners on the features of our online resources and share links to digital instructions to share with Members who use their supports.
- **Mobile help.** For Members who access services via our mobile help and semi-permanent units, we will have staff available to assist, Internet access, and tablets for them to use to sign into the Member portal, along with instructions on how to access the portal on their cell phones by downloading our mobile app.

Informing Members in Care Management. For Members who are part of our care management program, care management team members will encourage use of the Member portal for important care plan information, including access to the Provider directory, upcoming appointments, and easy two-way communications between the Member and their care team.

Informing Members of Changes or Improvements. Just-in-time communications will be sent to Members to inform them about any changes made to online resources, including emails, text messages, push notifications, phone and in-person outreach, and the website's "Important News" section.

Informing Members Through Providers. As part of our Provider onboarding, we will educate them on both the Provider portal and our Member online tools, equipping them with information to share with their Members about how to access, features, and login instructions.

D.2 Functions Beyond Those Required Available to Members Through Our Website and App

As outlined in our response to RFQ § 4.2.2.1 D1, our website, Member portal, and mobile apps will comply with all features and capabilities Contract requirements from the Draft Contract § 5.8.4. We continually upgrade our Member online toolset and recognize that expanding functional capabilities in this area will enhance the overall Member experience and connection to actionable information. We will deploy functions outside of Contract requirements to improve our Members' overall online experience and help connect them with the tools and resources they need. Examples for MississippiCAN and CHIP include the following:

Website Functions Beyond Requirements

We will launch a self-serve COVID-19 chatbot on our Member website, which allows Members to check vaccine eligibility, learn more about the virus, and enter symptoms related to COVID-19 or stress and anxiety. Based on Member inputs across other affiliate health plans, the chatbot guides Members with higher risk to call their PCP or the Nurse Advice Line. Those with lower risk are led to educational information. So far, our chatbot across our affiliate plans has received over a quarter million unique visits.

Member Portal and Mobile App Functions Beyond Requirements

Our Member portal will contain:

- An updated Provider directory that displays each PCP's photo, gender, language, and whether they are accepting new patients. We also provide a link to the PCP's website, if available. Members can also view Provider ratings (one to five stars) or select or change their PCP.
- Referral authorization documents, care plans, care use recaps (ER and inpatient), medication fill histories, allergies tracked, and risk assessment availability and results.
- Collection of Members' phone numbers, addresses, and emails, along with preferred contact method.
- Ability for Members to submit questions and comments to members of their healthcare team, including Member services call center employees and their care team participants. Members can receive responses through their secure communications.
- BH/SUD mental health education platform focused on fast-tracking support and information when needed.
- Member mobile app will offer mobile chat features.

Additional Innovations

- As a value-add, Members who are part of the care management program and have identified barriers in communication with their care team may receive ***free cell phone, tablet, and Wi-Fi services featuring unlimited talk and text messaging and access to 911***.
- For MississippiCAN and CHIP, we will deploy a ***Member dashboard on the Member portal*** that includes a simple snapshot of each Member, including plan name, Member ID number, PCPs and specialists, and Care Manager information. The dashboard will also offer Members easy-to-use self-service options, including:
  - Picture/replica of Member's ID card and ability to request or print a card online
  - A message center with Member's most recent two-way messages with Member services call center employees or other care team participants
  - Priority placement of BH/SUD education links
  - Easy step-by-step instructions to change their PCP
  - Ability for Member to select their preferred communication method

Innovate Through Technology: Improving Transportation for Pregnant Moms

An affiliate partnered with a smart ride company and major university to establish a program that gives pregnant women access through a mobile app to on-demand transportation and rides to appointments, pharmacies, food banks, and grocery stores. Our affiliate offers this on-demand transportation as a value-add. Initial data shows that, with this on-demand service, 5% fewer moms had low-birth-weight babies and 15% fewer babies had NICU stays.

E. MEMBER EDUCATION AND COMMUNICATION

Our Member education, communication, and engagement will be tailored, targeted, personalized, and delivered at regular intervals based on Member needs and preferences For example, ***we will develop a catalog of Member health education materials and tools that promote self-management and offer a range of health and social topics, including chronic conditions, stress, and depression.*** Supporting tools, including diaries (e.g., a weight diary) can assist Members in tracking progress against their goals. Driven by best practices from our affiliate health plans, our education and communication approach will offer creative methods to engage Members where they are in their health journeys. Our comprehensive communications strategy will be executed with a variety of modalities to meet Members' needs. We will connect with our Members early and often to build trust and help them better understand and take advantage of the benefits, services, and value-adds available to them to build healthier lives and communities. We will tailor our person-centered communication to meet holistic Member

needs and make it easy for them to lean on us when they need support. In addition, we will collect and manage each Member's preferred communications method. Our communications will be timely, accurate, and results oriented.

E.1 Methods to Inform and Encourage Use of Member Service Call Center

Our Member services call center will serve as the main point of contact for our MississippiCAN and CHIP Members seeking help and resolution for inquiries, issues, and concerns. To ensure that Members understand the important functions of our Member services call center, we will develop and execute initial and ongoing communication campaigns as shown in **Table 8**, encouraging Members to connect and engage with our Member services call center for their needs. Our communication plan will be tailored to our Members and their preferences, use proven and innovative tactics to reach our Members, and be regularly refreshed based on their effectiveness and engagement from our Members.

Table 8. Member Services Call Center Communication Methods inform and encourage use of the Member Services Call Center

Initial Member Communications at Enrollment	Ongoing Communications for Existing Members	Additional Communication Vehicles
• Member information packet with Member handbook and description of Member services call center and how to connect • Welcome calls • Welcome email and text • In-person welcome visit for Members in care management	• Twice-monthly email reminders about important features of Member services call center and how to get access to care management, grievances and appeals, and Providers • Text messages with quick links to connect to Member services call center • Two-way messages with Member services call center employees through the Member portal • Social media campaigns to reach Members where they are	Our community partners will also play an important role in communicating and connecting Members to the Member services call center: • FQHCs and community mental health partners will be equipped with print and digital information about important Member services call center contact information and how Members can connect. • Community events will provide another outlet to educate and inform Members about the services the Member services call center can provide. • Our Member information desk at all Member events provides real-time solutions or connections for Members.

E.2 Methods to Inform and Encourage Use of Care Management

Many MississippiCAN and CHIP Members will benefit from care management services and we will use multiple methods to communicate, educate, encourage and engage Members about the care management program. This includes our Member handbook; Member information packet (print and digital); outbound calling campaigns; email and text messages; the presence of care managers at our community events, mobile units and semi-permanent trailers; and through our website, Member portal, and mobile apps.

We also identify a Member's need for care management in several ways. Members may:

- Be placed in care management at enrollment, based on mandatory assignment requirements in the Contract.
- Be Determined to be a candidate for care management during initial contact by the Member services call or Providers.
- Choose to self-refer to care management.

We will mine our risk stratification data frequently and continuously to identify Members as high risk and initiate care management team outreach. In all scenarios, it is important for Members to understand the function of care management and how to engage in the program and available services.

Informing Members Placed in Care Management at Enrollment. Members are routed directly to care management at enrollment through our initial risk stratification process or mandatory assignments. If we can access new Members' historical information, we will identify those with special healthcare needs early in their enrollment and get them to the right resource on our care management team. These Members will receive communications from their assigned Care Manager and accompanying Member materials that describe the care management process.

Informing Members Identified for Care Management. Members can be identified for care management at any point during their enrollment. Identification happens via frequent, continuous, and ongoing mining of our

risk stratification data, which refreshes our Members' risk scores semimonthly and reapplies an updated risk score for each Member. Our care management team will contact all Members who are moderate-to-high risk. We also receive referrals from internal departments (including the Nurse Advice Line, UM team, care management, BH, and Medical Directors), external entities (such as State agencies, schools, CBOs, Providers, PCPs, and specialists), and Members or legally authorized representatives. All Members referred to and engaged with care management are assessed, which is the first step toward building the Members' personalized care plan.

Informing Members Who Self-refer to Care Management. We recognize that every interaction we have with Members is a way to know them better, and we waste no time in reaching out to Members who experience a triggering event or responding to resolve immediate needs like hunger, housing, or transportation. Our approach allows Members to reach out for help when they need it in whatever way they feel most comfortable.

Whether Members start in care management, experience an event that places them in care management, or receive a referral to care management, we will continue educating them on the functions, benefits, and what to expect every step of the way to ensure they are comfortable with our program and utilize all the resources available to them.

E.3 Developing and Maintaining a Comprehensive, Evidence-based Health Education Program

Based on experience across our affiliate health plans, we understand the direct links between health education, health literacy, and health outcomes. We will develop health education programs for MississippiCAN and CHIP Members that are meaningful and culturally and linguistically appropriate, and interventions that help our Members learn about and engage in their health journey. We understand that, to get Mississippians to engage in their healthcare journeys, our education programs must resonate with Members from Jackson to the Delta. For example, we know that two of the most significant health issues facing Members in Mississippi today are obesity and diabetes. We will design specific health education programs to tackle these challenges and more.

- **Weight management program.** Our weight management program provides a healthy lifestyle approach that supports our Members' weight management needs. Health professionals work closely with our Members to develop an individualized weight management plan and encourage them to work closely with their Providers, including FQHC and PCMH connections, to determine appropriate diet, exercise, and pharmacological recommendations. Members will experience coaching and education on disease signs, symptoms, and exacerbation; develop thoughtful goals toward successful self-management; and receive easy-to-use tools and materials.
- **Diabetes support program.** Our diabetes support program provides education and empowerment to our Members to effectively manage their condition. By identifying and engaging Members early in their disease, our team of health professionals provide one-on-one teaching to increase knowledge of their condition, encourage Members to learn about the importance of exercise and healthy nutrition, aid in developing a self-management plan with their Providers, establish strong PCP and PCMH connections, and foster adherence to a prescribed treatment plan and/or medications.

Executing, Adjusting, and Maintaining Health Education Programs

We use the Institute for Healthcare Improvement (IHI) model—an evidence-based, nationally recognized QM/QI methodology designed to promote rapid cycles of improvement—to evaluate the effectiveness of our health education strategies and drive changes to our approach, as necessary. Our QM Director will collaborate with our Medical Director and department leads to lead cross-functional reviews so we can remain nimble in defining, implementing, monitoring, and refining our programs and health education materials. We cite the evidence supporting the development of our Member health education materials in our interventions and evidence summaries of MCG chronic care guidelines. During monthly reviews, the team will review and strategize to improve results across all Mississippi regions. Extending the reach of our QM team into the community, our Quality Specialists will work collaboratively with our community engagement team, Provider Representatives, and other community-based staff to collaborate with CBOs and Provider partners to identify improvements for health education programs. For example, if our analysis finds that individuals in the Delta are not responding to outreach materials, we will contact local partners to ensure culturally appropriate, relevant materials.

E.3.a Program Overview

Our health education programs will be available for all MississippiCAN and CHIP populations and will start with a focus on the biggest issues facing Mississippians today: asthma, diabetes, heart failure, hypertension, depression, COPD, weight management, tobacco cessation, and nutrition. We will promote health education by leveraging our data analytics and our strong partnerships with CBOs and Providers.

Accountabilities. Our health educational program performance will be monitored monthly on operational and leading performance indicators. Operational indicators allow us to monitor metrics like Member engagement rates, unable-to-reach rates, and refusal/decline rates. This will allow us to swiftly adjust program elements that have the most impact on Member engagement. Leading indicators measure utilization metrics like avoidable inpatient admissions and Member ER visits.

We will use a wide range of tools to assess the effectiveness of our health education activities, including:

- Our **Member advisory board,** which serves as an avenue to obtain feedback from Members regarding health education materials and programs
- **HEDIS** and other clinical performance data that we stratify by race, ethnicity, and language to assess for disparities and use to measure the effectiveness of our health literacy program
- **Monthly reporting** from our QI Provider partners regarding Member education, referrals, enrollment, and program completion
- **The CAHPS®** survey, which asks Members a wide range of questions about their satisfaction and other topics, including how often their PCPs explain things in a way that's easy to understand and how often Providers discuss specific things Members can do to prevent illness
- **Potentially preventable events,** such as ER visits, admissions, and readmissions, which should be reduced when Members seek appropriate care based on our health education efforts

Proposed Education Activities. We understand Mississippi is looking for opportunities to: 1) impact health and quality of life by lowering SDOH barriers to care and outcomes; 2) enhance the effectiveness of prenatal, well-child, and primary care engagement; 3) raise treatment compliance and understanding levels within chronic condition populations; and 4) provide timely connection to BH/SUD support. We also understand our messaging and education may have regional differences. What works in the Delta may not work on the Gulf Coast. We will specifically design our programs to assist MississippiCAN and CHIP Members and their families work with their Providers to prevent problems, stay healthy, and create a self-management plan while living with chronic health conditions. **Table 9** highlights some of our education efforts relevant to Mississippi concerns.

Table 9. Education Programs That Will Keep MississippiCAN and CHIP Members Healthy

Education Initiative	Education Program Examples
Asthma	• For Members age 2 and older who have a diagnosis of asthma. • Members and legally authorized representatives will learn from their Care Manager about symptom identification and control, trigger avoidance, and their prescribed asthma medications.
Diabetes	• For Members age 18 and older who have a diagnosis of diabetes. • Members will learn from their Care Manager about healthy eating, including limiting carbohydrates in their diet, monitoring their blood sugar, knowing their HbA1c level, and the importance of daily activity and following the diabetes self-management plan outlined by their Provider.
Heart Failure	• For Members age 18 and older who have a diagnosis of heart failure. • Members will learn from their Care Manager about heart-healthy eating, monitoring their weight, reporting symptom changes to their Provider, and the importance of daily activity and taking their medications as directed by their Provider.
Depression	• For Members age 18 and older who either have a diagnosis of depression or may be experiencing symptoms of depression. • The program promotes early identification of symptoms and provides education, guidance, and support. Members will learn from their Care Manager about life coping skills, available services, treatment options, and community support.
Tobacco Cessation	• For Members age 18 and older who are ready to quit tobacco use. • A specially trained Health Educator will work closely with Members to develop a tobacco cessation plan of care that is individualized to meet their needs and support them through the quitting process.
Weight Management	• For Members age 18 and older who are interested in losing weight (excluding those Members scheduled for bariatric surgery).

Education Initiative	Education Program Examples
	• A Care Manager works closely with Members to develop a weight management plan of care that is individualized to meet their needs and assist in achieving their weight loss goals.
Prenatal, Well-child, and Primary Care	• Population health education and outreach campaigns through emails, text messages, and social media. • Access to digital tools to foster self-management and promote preventive health services and age-appropriate screenings, such as EPSDT wellness visits, well-woman annual exams, screenings, and immunizations. • Culturally sensitive education materials in print and online focusing on Black mothers seeking timely prenatal care and encouraging health literacy for healthy birth outcomes. • Well-child education using our mobile units and semi-permanent trailers promoting the importance of well-child visits and immunizations for children's growth and development as part of our EPSDT program. • Community center child and adult obesity education and awareness tied to WW program support for qualifying Members.

We identify Members for health education programs in several ways, including through Member completion of an HRS, our internal ID stratification tool, and referrals from various sources, including the Member, PCPs, and internal referral sources from UM and care management. Once a Member who will benefit from our health education programs is identified, we will connect with them based on their preferred communication style. We will also use our CBOs as an extension of the care management team to wrap important community-based services around the Member.

E.3.b Rationale for Selecting Areas of Focus

Our health education programs focus on areas where our Members need the most help. To identify those areas, such as those identified above for Mississippi, ***we analyze internal and external qualitative and quantitative data to identify the health education programs we will develop for MississippiCAN and CHIP Members***. This data drives the focus for our sample of health educational programs noted above that directly support the identified needs of our membership. The data we use comes from sources such as CDC Chronic Disease Indicators; CDC National Environment Public Health Tracking; the US Census Bureau; American Community Survey; US Department of Agriculture Food Environment Atlas; the American Academy of Pediatrics; State and local public health data, such as the Mississippi Primary Care Needs Assessment published by MSDH; localized community needs assessments like those performed by the University of Mississippi's Evers-Williams Institute; internal sources, such as claims, pharmacy, and utilization data; and our yearly community health needs assessment.

We believe we will empower Members to actively participate in healthcare and quality of life decisions important to them and their families by offering effective, Member-centric health education programs. Specific to Mississippi, we believe effective health education programs can:

- Reduce healthcare costs by removing social obstacles.
- Improve Member engagement and accountability.
- Drive better Member compliance for higher risk chronic conditions.
- Support better education of BH/SUD treatment to eliminate any stigma.

E.3.c Ensuring Materials Are at a Third-Grade Reading Level

We develop and design Member health education materials to address Members' varying degrees of literacy. All Member materials will be written using plain language and will comply with third-grade reading level requirements using several readability tools, including Spache, Dale-Chall, Flesch-Kincaid, and SMOG. Our materials use thoughtful word choice, sentence structure, layout, and visual aids to enhance readability. Sentences are short and simple with minimal use of compound or complex sentences. Words with one or two syllables are used as often as possible, with some exceptions (e.g., oxygen, glucometer). Our designs will make content easier to read and understand, using white space and breaking ideas into small, simple expressions with headlines, lists, and large font. Iconography will help readers understand the focus of each section (e.g., a medicine bottle icon next to the header "Medicines"). Materials will be illustrated and provide step-by-step instructions that walk Members through a particular care process or activity.

E.3.d Language Alternatives Available to Non-English Speakers/Readers

All printed and online Member materials will be provided in English, Spanish, and upon request, other common languages spoken in Mississippi, including Choctaw. As detailed in Proposal Section 4.2.2.1B.1.c, our Member services call center employees will be trained to support all Members, including those who are non-English speaking, hearing impaired, or visually impaired. Members will have access to 24/7/365 interpreter services available in more than 250 languages. Additional strategies to promote health education among non-English speakers include:

- **Partnership strategy with CBOs.** Many of the CBOs we've engaged to date and will partner with in the future have strong ties to Mississippi's ethnically diverse communities.
- **Model for culturally appropriate Member engagement.** We recognize and respect individuals' unique customs, values, health beliefs, and languages. We will require staff to attend annual cultural competency training focused on culturally and linguistically appropriate services standards. In creating Mississippi materials, we will consult our annual community and population needs assessment and engage our cultural competency work group to review materials for cultural appropriateness.

E.3.e Accommodating Members Who Are Visually and/or Hearing Impaired

Our Member handbook, website, Member portal, and Member mobile app will include information on how to use TTY/TDD relay services for those Members who are deaf or hard of hearing and trying to reach our Member services call center, Nurse Advice Line, or BH/SUD line. For the visually impaired, we will provide written materials in alternative formats such as braille, audio, or large print upon request and at no cost, including Member ID cards and our Member handbook. We will include taglines in the top 15 non-English languages and explain verbal and written interpretation options in large print using type no smaller than 12 points.

E.4 Creative Solutions to Encourage Participation in Member Outreach and Education Activities

Our local Mississippi emphasis will be designed to help the Division meet its population health management goals. We have already started working with CBO partners to develop targeted health education events. Our community engagement team, featuring regional representatives, will be in place upon go-live to spearhead these creative approaches to connect with all Members, educate them on self-care and preventive measures, and help them better manage existing chronic conditions. These efforts improve health outcomes for Members and have a ripple effect on the broader population, ensuring we help the State meet its goals.

Local Presence. We understand the importance of bringing education and Member outreach to the communities in which they live. We will feature regional events throughout Mississippi coordinated by our local community engagement team in partnership with our Provider representative, care management, CHW, and QM teams. This tailored outreach and education approach promotes health literacy, proactive well-care activities, healthy lifestyles, local SDOH support availability, an understanding of a Member's benefits and how to effectively use them, a connection to our resources and the introduction of Internet connectivity that fosters Member portal use, and specialized messaging as needed in areas like maternity health, tobacco cessation, and scholarship support programs.

Our national experience across affiliate health plans has taught us that education must be local and tailored to impact Member engagement and outcomes. Our local community engagement team will deliver creative educational outreach solutions to engage our Members, including:

- FQHC support days
- Mobile health program mobile resources and telehealth outlets
- Public housing authorities supported by local nursing schools
- Events at parks and playgrounds
- CBO- and faith-based partnership events

We believe that coordinating local education and messaging tailored to Members, their families, and especially our most vulnerable, children, is vital to enhancing Members' health. Our local support model will feature a community engagement team that delivers innovative health education and messaging to Members where they

live. Through our boots-on-the-ground learning in the State, we will continue developing innovative ways to bring localized education and support to the communities we serve by:

- **Using social media to enhance general health education** and program awareness through a future collaboration with local universities and influencers
- **Expanding locally available health education** through CHWs, who will coordinate care and services for higher risk Members on an individualized basis

E.5 Process for Maintaining Online and Print Provider Directories

We understand how important it is for our Members to have access to a thoughtful, well-organized, and easy-to-use Provider directory—both printed and online via our Member portal and mobile apps. For Mississippi, we will create two Provider directories: one for MississippiCAN and one for CHIP. Our process to develop and maintain the online and print Provider directories ensures our Members have access to the most current, real-time information they need. Our steps for maintaining online and print Provider directories include:

- **Updates during contracting.** Once we load our Providers' contract information into our Provider system, we update our online Provider directory within one business day. Our Provider contracting team audits the information in the system for newly contracted Providers within 30 days of the initial load.
- **Updates by Providers.** Our Provider online directory and Provider portal allow Providers to make demographic updates online. When Providers make demographic updates in real time online, our Provider system is updated automatically.
- **Updates through Members.** The Provider online directory allows Members to report Provider demographic changes. Our Provider data validation team contacts the Provider to ensure the change is valid before making the change to the Provider record and online directory, furthering our commitment to ensure Provider data accuracy to improve the Member and Provider experience.
- **Continued updates.** To ensure continued accuracy of Provider information, we automatically update Provider demographic information. This minimizes Provider burden while ensuring Members have access to up-to-date Provider information. We will bring the best practice of using an external Contractor to validate Provider directory data to ensure accuracy.
- **Paper directory updates.** Member services call center employees can print on-demand from the online directory on-site, which is updated nightly. A full paper directory is validated for accuracy, produced monthly, and mailed, if requested.

We will employ consistent Provider outreach and Provider data auditing activities to ensure the Provider directory complies with NCQA quality standards as well as MississippiCAN and CHIP requirements. Our online directory, which feeds our paper directory, is updated nightly. We will submit the Provider directory for Division approval 60 days before effective date. In addition, we will submit the Provider directory for approval if there are significant format changes.

Online and Print Provider Directory Capabilities

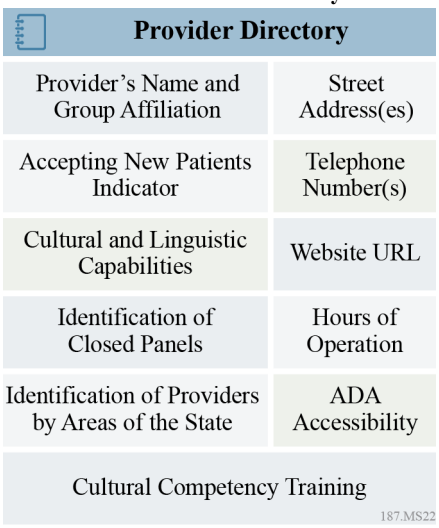
Flexible Search Capabilities. Our online Provider directory will be searchable from either the Member portal or our website. Both can be accessed via a desktop or mobile device in English or Spanish:

- Members will be able to select Providers and will be taken to a Provider-specific directory landing page.
- Every search will start with search filter parameters, including service area selection, city, State, zip code, and/or specialty type or Provider name. Members can search:
  - Across our network for a selected service area, such as medical care, hospital, urgent care, and walk-in clinics
  - By commonly searched categories, including primary care, BH, virtual care (that is, telehealth via a national telehealth Provider and Mississippi Providers offering telehealth services), urgent care, dental, vision, and hospitals
  - Specific languages, including Providers who speak languages other than English and are located near the Member
  - PCPs, PCMHs, and specialists that are or are not accepting new patients

Easy Category Search. Members select a specific Provider type, such as a cardiologist or internal medicine doctor, and can filter that search by Provider gender, patient rating, languages supported, affiliated hospitals and Providers, cultural training, and whether accepting new patients.

Intuitive Provider Profiles. After selecting a Provider for review, a Member is taken to a comprehensive Provider profile that features a photograph (if available) and the following subsections: Provider Highlights, Specialties and Expertise, Awards and Recognitions, Affiliated Facilities, Affiliated Doctors, and Location and Hours. These subsections include information such as whether the Provider is accepting new patients, star rating by Members, ADA access, and languages supported as shown in **Exhibit 7.**

Exhibit 7. Provider Directory. We offer Members comprehensive Provider profiles in the Provider directory.



Paper Provider Directory. Our printed directory format is easily searchable, with Provider profiles that are viewable by location and across an entire service area. Local views are alphabetized by Provider type. Global service area directories are:

- Ordered by Provider type, leading with primary care, followed by specialists, sub-sorted alphabetically by either city or Provider type
- Indexed and sorted alphabetically by Provider name across service area

Update Notification to Members. As updates are made to the Provider directories, Members will be notified through Member services call center employees, email announcements, the news feature on the Member portal, text messages, or push notifications from the Member mobile app. This helps Members close any gaps they may have in identifying a Provider in their area, with a specialty, or with staff that can support non-English speaking, hearing impaired, or visually impaired Members.

E.6. Proposed Policies, Procedures, and Processes Regarding Members' Rights

It is important for all Members to understand their Member rights and responsibilities to ensure they understand how to get the services and care they need. Member's rights and responsibilities will be communicated in the Member handbook and on our website, Member portal, and Member mobile app, and they will be posted in Provider offices across Mississippi. We will ensure all employees, affiliated Providers, and Subcontractors comply with any applicable Federal and State laws that pertain to Member rights as described in the Draft Contract § 5.10, Member Rights and Responsibilities.

Policies. We will have written policies and procedures in place that guarantee the following rights to Members in accordance with 42 CFR § 438.100:

- Receive information from plan
- Treated with respect
- Participate in decisions regarding healthcare
- Request and receive copy of medical records
- Receive information on available treatment options and alternatives
- Easily understandable language and format
- Free from any form of restraint or seclusion
- Free exercise of rights
- Receive healthcare services

Procedures. A written description of a Member's rights and responsibilities will be included in the Member handbook and on our website, Member portal, and Member mobile app. In addition, to ensure compliance of all employees, Providers, and Subcontractors, we will conduct a comprehensive training program and provide educational material on Member rights and responsibilities.

- **Member services call center employee training.** This will include topics such as Member rights, cultural competency, identification of emergency needs, and the specific populations they serve.
- **Provider orientation training.** This will include clear explanation of Provider responsibilities, access standards, Member rights, ADA requirements, cultural competency policies, and information on accessing interpretation services and sign language assistance. Further, we provide a copy of our policies and procedures (specific to Member rights) to all network Providers and any out-of-network Providers to whom Members may be referred.

- **Subcontractor training.** This will include initial and ongoing training and meetings to help Subcontractors understand the MississippiCAN and CHIP programs, unique populations, benefits, and cultural competencies, including specific Mississippi Member rights and responsibilities.

Processes. We will meet all NCQA accreditation requirements, which include monitoring of access to care, quality of care, and quality of services. We will consistently monitor for any signs that a Member is being limited in their rights across our organization, including employees, Providers, and Subcontractors. We conduct monitoring through our quality observation of Member calls as well as documented Member complaints, grievances, and appeals. We use those inputs to identify trends and any opportunities for improvement. We turn those insights into actionable steps and share them with our employees, Providers, and Subcontractors for immediate resolution, including Provider termination or other legal recourse.

E.7 Proposed Policies, Procedures, and Processes to Ensure Marketing Requirements Are Met

Our marketing efforts combine our decades of experience with local, grassroots, and community outreach programs across our affiliate health plans. The results are marketing materials, supported by our employees, Providers, and Subcontractors, that connect Members with their available services and benefits.

Policies. Our marketing department ensures quality, consistency, and compliance in all Member and potential Member content in accordance with 42 CFR § 438.104 for MississippiCAN and 42 CFR § 457.1224, cross-referencing 42 CFR § 438.104, for CHIP. All marketing materials will comply with all relevant Federal and State laws, including when applicable, HIPAA, Section 1557 of the Affordable Care Act, anti-kickback statutes, and civil monetary penalties for inducements to Members.

Procedures. Before developing a marketing plan, we will review all Contract requirements and identify additional Member needs that could be addressed in a thoughtful, planned marketing approach. We will develop a marketing plan based on those requirements and needs and share it each year with the Division. We will develop and submit all Member materials to the Division for review and approval 30 days before planned distribution. After receiving State approval, we will test our Member materials to measure their effectiveness with target populations and provide recommended adjustments. Any revisions to previously State-approved content results in resubmission for the Division's approval.

Processes. Our processes for marketing materials align with requirements from the Division and leverage our experience across other affiliate health plans.

- **Delivering work plan and updates.** We will develop and submit a work plan of planned, compliant marketing activities annually to the Division.
- **Leveraging best practices.** We will leverage our experience to produce materials that limit the amount of text, using photos or graphics to reinforce the message and fonts and layout designs that simplify the content. We also follow established Flesch-Kincaid index policies to use language that does not exceed the third-grade reading level.
- **Aligning to Member needs.** Based on usage and engagement metrics, we will prepare recommendations for adjustments to existing marketing materials or new materials that will meet the needs of Members.
- **Training for employees.** We will train and oversee our employees to ensure that they are well versed not only on the marketing rules, regulations, and Contract requirements, but also in ethical, transparent, and compliant business practices to discourage the possibility of inappropriate marketing behavior.
- **Monitoring and auditing of Providers and Subcontractors.** Our Providers and Subcontractors must attest that they have read and understand our code of conduct, which includes adhering to approved marketing practices and refraining from prohibited practices. In addition, they can readily access the marketing rules via the online Provider manual, code of conduct policy, or by consulting with our representatives.

Community Outreach

We will be actively involved in extensive community engagement across Mississippi with organizations that will assist in delivering our programs and enhancing our Member education initiatives. This two-pronged community engagement initiative consists of 1) impact to care and outcomes organizations, and 2) community and social connection organizations. We will submit all schedules, plans, and materials to the Division for events happening under this local outreach at least 30 days in advance

whenever possible. On a local level, our community engagement team, in collaboration with QM and other clinical areas, has already started developing programs, additional presentations, and new Member educational materials for Mississippi Members that will enhance education on preventive health services and benefits at new Member orientations.

Sample Marketing Materials

All MississippiCAN and CHIP Member marketing materials will be developed using plan language and a third-grade reading level, which we have found to be a best practice to ensure comprehension by our Members. At the end of this section, we provide two samples of our marketing materials for Members. The samples were developed for one of our affiliate health plans required to support a fourth-grade reading level and include 4.2.2.1 – Appendix 1: Member Open Enrollment Flyer and 4.2.2.1 – Appendix 2: Member Information Packet.

E.8 Approach to Inform Members About Covered Health Services

All Members will receive an information packet introducing their covered services based on their MississippiCAN or CHIP eligibility. Members can find additional information on primary and specialty care; BH/SUD; urgent/emergent care; care management; perinatal, neonatal, well-baby, and well-child care; EPSDT screenings; and chronic health conditions on our website, the Member portal, and our Member mobile app.

Keeping Members Informed

- **BH/SUD.** From the start, Members are assessed and guided toward the appropriate management of their care, whether they need physical health and/or BH/SUD support and treatment. Member services call center employees and care team participants are involved in each step of the process and will be the primary means of help and support in addition to direct BH/SUD self-referral options.
- **Perinatal/neonatal.** Our virtual maternal and pediatric care mobile app functionality enables Members to reach nurses 24/7/365, contact their Care Managers, or connect to lactation consultants for breastfeeding support. Our Member mobile app will provide content regarding well-child visits, early development, postpartum visits, and other educational content anchored to the baby's birth date.

- **Care management.** We will offer and communicate regularly with Members about our care management and disease management programs that focus on diseases that are chronic or very high cost. Through our care management program, our Care Managers engage regularly with Members and use assessments, guideposts, and action plans to surround the Member with person-centered care, including coaching programs designed to educate individuals on clinically effective methods for living with their chronic disease or condition.
- **Chronic health conditions.** Member education on the signs, treatment, risks, and daily health habits that may lead to onset of chronic conditions will be performed by every department through a variety of methods, including our Member services call center, our website, our Member mobile app, and home mailings.
- **EPSDT screenings.** We will educate and drive awareness with moms and family members about the importance of EPSDT screenings through their PCP and pediatrician and help connect Members with the right services for early detection and prevention.

E.9 Timely Process for Media Release, Public Announcement, or Public Disclosure

If a change affects benefits and services, we will follow a defined, compliant, and expedient process to communicate those changes. When a media release, public announcement, or public disclosure is deemed necessary, our process begins with the requesting team completing a press release request form for our media relations team at least two weeks prior to any target announcement date. During our internal review process, we will share and gain approval from the Division. Requested adjustments are reviewed and approved as well. Upon approval by all internal and Division parties, the release goes to our executive team before the preferred release date. If approved by the executive team, it is typically released the following week.

F. MEMBER SATISFACTION

CMS says that Member experience is not the same as Member satisfaction. To ensure we understand how well we are meeting the needs of our Members, we solicit feedback from them across every touch point and access point in their journey. We assess Member satisfaction levels, awareness and accessibility to services, Provider availability, and service quality. These four areas offer a 360-degree Voice of the Customer view and help us

refine and reshape service delivery through practical, measured quality initiatives that target a positive impact on critical service levels and our Members' health and quality of life.

F.1 Proposed Approach to Assess Member Satisfaction

Through formal surveys and ongoing Member feedback from interactions with our employees, Providers, and Subcontractors, we gain invaluable insight on opportunities for Member-centric improvements across our services and benefits. **Table 10** outlines many of our Member satisfaction assessment and feedback channels.

Table 10. Member Satisfaction Assessment and Feedback Channels Provide Invaluable Insight

Tools We Plan to Use	Tool Description	Frequency of Assessment	Responsible Party
CAHPS Survey	Formal survey conducted by an external vendor for a confidential random sample of Members. The CAHPS survey reports on the Members' experience with the health plan, healthcare, customer service, and coordination of care.	Annually	The quality department reviews survey results, identifies barriers, and develops action plans to increase Member satisfaction.
Voice of The Customer Survey	Quality initiative feedback survey or structured interview that is developed to gauge the Member experience with a specific quality initiative project or program in mind.	Before or during PIPs during the year (at least 4 to 6 times per year)	The quality department conducts Voice of the Customer surveys to get feedback about barriers to obtaining care or about programs.
Net Promoter Score	A single satisfaction question (How likely are you to recommend us to a friend or family member?) included at the conclusion of inbound and outbound Member services call center calls and Member mobile app interactions. Used to identify improvement opportunities.	During all inbound and outbound Member services call center calls and Member mobile app interactions during the year	The operations and quality departments will receive and summarize this input, identify opportunities for improvement, and present results to the QM committee.
Member Feedback	Member comments collected through the Member services call center, care management, and community engagement encounters passed via email to the appropriate team for outreach.	Part of ongoing interactions with different functional areas during the year	The operations, healthcare services, and community engagement departments will receive and summarize input, identify opportunities for improvement, and present results to the QM committee.
Care Management Survey	Member care management survey collected annually to obtain feedback from Members who participate in case management programs.	Annually, reported in first quarter of the following year	The healthcare services department will receive survey results, identify opportunities for improvement, and present results to the healthcare services committee.
Complex Care Management Discovery	Care management provides patient ID for Member services or via email to Member services for outreach on issues raised by Members.	During all inbound or outbound calls or through email throughout the year	The healthcare services department receives and summarizes input and presents it to the healthcare services committee.
Disenrollment Feedback	Disenrollment from the State eligibility file rollups citing a Member's reason for disenrollment reviewed for trends by our Member satisfaction work group.	During monthly enrollment file review	The operations department receives and summarizes input and presents it to the QM committee.
Member Advisory Committee Comments	Appropriate information from advisory committee forums passed via email by plan participants to Member services for follow-up inquiry or resolution.	During quarterly Member advisory committees or more frequently as directed by a State	The community engagement department receives and summarizes input and presents it to the QM committee.
Physical Health and BH/SUD Complaints	Complaints collected through the Member services call center, Provider services call center, or the community engagement team, and then forwarded to the grievances and appeals team for tracking and resolution.	During monthly aggregation of grievances and appeals data; quarterly review of reports by QM committee	The grievances and appeals department receives and summarizes data, identifies barriers, and presents reports to the QM committee.
Operating Area Feedback and Communication	• The Member services call center reports on feedback, as relayed during Member services call center telephone encounters. • The appeals and grievances team accepts, monitors, and reports on Member complaints and appeals, and identifies trends.	During inbound and outbound calls, and collection of data with quarterly summary	The operations, grievances and appeals, and care management functional areas receive and summarize data, identify barriers, and present reports to the QM Committee.

Tools We Plan to Use	Tool Description	Frequency of Assessment	Responsible Party
	• Care Managers report on clinical quality of care or administrative service issues. • The Nurse Advice Line identifies and reports service, Provider, or access to care issues.		
Social Media Campaign Responses	Hashtag responses to outreach and educational messaging along with service-specific trend identification passed to Member satisfaction work group within our QM structure.	Summarized each month for review	The operations functional area reviews these reports and presents them to the internal senior leadership team as needed.

Responsible Parties. Member satisfaction is the responsibility of every employee, Provider, and Subcontractor. But to effectively measure and impact change, all Member satisfaction and quality programs are the responsibility of our QM committee, supported by the QM team, which is responsible for the reporting and synthesis of our Member satisfaction, quality, and grievance and appeal data and the implementation, oversight, and ongoing monitoring of our QM program. For Mississippi, we will incorporate Member and Provider satisfaction work groups into our QM infrastructure, with the Member satisfaction work group focused on maintaining or improving satisfaction levels for CCO Program Members. Our Mississippi QM strategy begins with our Board of Directors, which delegates quality activities to health plan leadership, including the CEO, Medical Director, and Quality Director, who are responsible for development and implementation of the QM program work plan and evaluating QM system performance.

Role of the Member Satisfaction Work Group Within the QM Operating Structure. While our QM committee leads all QI initiatives, the Member satisfaction work group will focus wholly on issues affecting the Member experience. This work group will use the tools noted above to determine what is impacting Member satisfaction and facilitate cross-organization solutions. This singularly focused work group is derived from millions of Medicaid Member encounters that demonstrated resolution one issue may create others if a portion of the QM organization is not focused on the entirety of the Member experience.

Innovative Programs for Member Satisfaction

We recently implemented a new Member support program across our other affiliate health plans. Like our Provider program, our Member program focuses on listening. We proactively contact Members who frequently contact our Member services call center or submit frequent grievances or appeals. We use Member services call center data to identify appropriate interventions. We will continue to use feedback to drive improvements and support Members' overall navigation for better health outcomes.

G. MEMBER APPEALS

We are 100% committed to continuous improvement across all aspects of our business, especially our Member experience. Our end-to-end Member grievance and appeal process ensures Members feel confident their voices are heard throughout their healthcare journey. Our processes, tools, and staff allow us to respond swiftly and appropriately, and use grievances and appeals information throughout our organization to constantly evolve and improve. We will commit to timely resolution of Member concerns, as demonstrated in **Table 11** with our affiliated health plans' most recent performance:

Table 11. Grievances and Appeals Resolution Performance for 2021 Across Affiliate Health Plans Demonstrate Our Timely Resolution

Performance Metric	Measurement	Meets/Exceeds Division Goals
Grievances per 1,000 Members	2.88 per 1,000 Members	✓
Average Grievance Turnaround Time	4.25 calendar days	✓
Appeals per 1,000 Members	2.48 per 1,000 Members	✓
Average Appeal Turnaround Time	10.33 calendar days	✓

We will maintain high-quality standards in all aspects of services, including streamlined processes and integrated, rules-driven business management technology to effectively and efficiently address Member

grievances and appeals in compliance with State and Federal laws and regulations, NCQA standards, and Draft Contract § 5.11, Member Grievance and Appeal Process.

G.1 Proposed Member Grievance and Appeal Process

It is important for Members to understand their rights and how to easily file a grievance or appeal regarding their covered services (including physical health or BH/SUD), the support they receive, or the interactions they have they deem as not meeting their expectations. Upon enrollment, Members will receive a Member handbook that outlines our goals for Member experience, their rights, and a simple guide to grievances and appeals.

If a Member feels filing a grievance or appeal is the appropriate course of action, we will employ a Member-centric approach, offering a single point of contact who follows a Member's grievance or appeal from beginning to resolution. We will assist Members through each step of the process, ensuring they understand applicable time frames and available communication methods. We will begin by educating Members of their rights and steps for submission. We will reinforce the instructions through the Member handbook, orientation sessions at our community-based mobile health program mobile units and semi-permanent trailers, and the Member portal and Member mobile app.

Our policies and other Member materials clearly define Member rights regarding matters of dissatisfaction and quality of care, including disputing denial of coverage or payment. We also adhere to NCQA's rigorous accreditation requirements, ensuring each Member or their legally authorized representatives receive prompt, personalized attention. Member materials advise Members how to file a request for hearing (MississippiCAN) or independent external review (CHIP) with the Division. Complaints, grievances, or appeals may be filed through our Member services call center; via mail, fax, or email; or through referrals from other departments. A Member or legally authorized representative may also submit a grievance or appeal through our secure Member portal. Through verbal and written communications, we ensure Members understand that we are available to assist them through each step of the process.

In addition, at no cost to the Member, we will include 24/7/365 interpretation and written translation services for non-English-speaking Members; TTY/TDD and relay services for those who are deaf or hard of hearing; or braille, audio, and large-print formats for those with vision impairments or low vision. Our written materials that explain the grievance and appeal process will be available in Spanish and English or other local prevalent languages as requested and will include taglines in the top 15 non-English languages spoken, explaining oral and written interpretation availability and how to request such services. These services apply to all grievance and appeal information, including the Member handbook, Member portal, Member mobile app, and communications throughout the grievance and appeal process (e.g., denial letters).

Grievance Process

Members may submit a grievance via our Member services call center; in writing, fax, or email; or through our secure Member portal. Member services call center employees are the frontline for inquiries and complaints, and are trained to provide guidance. If a Member services call center employee resolves the grievance, the case is closed. If the case remains open, we route it to our grievances and appeals team. Our grievances and appeals team has real-time access to Member services call center data and directly contacts Members.

The Grievances and Appeals Team Coordinator ensures Members are notified and grievances are fully documented and investigated. The grievances and appeals team coordinates with other departments to resolve grievances as needed. For example, grievances related to a potential quality of care or service issue include our QI and Provider representative teams, respectively. Each department follows stringent written protocols, including Provider outreach, as appropriate. Grievances that involve medical necessity determinations or expedited resolution of clinical issues are reviewed by RNs and licensed physicians with appropriate clinical expertise and determined by a physician. Our UM department identifies potential quality of care, access to care, fraud, and safety issues, and reports them to our Provider representative and contracting teams for further investigation and outreach. We resolve grievances and provide written notice of decisions within 30 calendar days from the date the grievance was received.

Appeal Process

Members or legally authorized representatives may file an appeal orally or in writing within 60 calendar days of receiving a notice of denial. Each appeal is confirmed with the Member within 10 calendar days from receipt. A Grievances and Appeals Team Coordinator contacts the Member to explain the appeal and hearing or independent external review process (dependent on MississippiCAN or CHIP, respectively), gather pertinent information, and answer any questions. All standard appeals are processed quickly, no later than 30 calendar days from receipt. Expedited appeals are resolved within 72 hours of receipt.

If a decision is not in the Member's favor, a written communication explains a Member's right to request a State Fair Hearing. The Grievances and Appeals Team Specialist may assist and explain the process within 120 days of an adverse determination. Members may present evidence, examine their case notes, and receive copies of the documentation related to their appeal. Appeal decisions requiring a clinical review are made by RNs and licensed physicians with the appropriate clinical expertise in treating the Member's condition or disease.

We investigate claims and take action to ensure Members receive covered services without regard to race, color, national origin, sex, sexual orientation, gender identity, disability, creed, religion, age, ancestry, marital status, language, health status, disease or preexisting condition (including genetic information), anticipated need for healthcare, physical disability, or intellectual or developmental disabilities, except where medically indicated. We will submit complaint, grievance, and appeal reports to the Division monthly and quarterly.

Our Advanced Grievance and Appeal System

Our staff dedication, policies, and integrated technology systems allow us to consistently meet or exceed Member resolution time frames and support workforce efficiency and cost containment. While one owner maintains the case, our system offers static and dynamic routing, allowing stakeholders across the organization to stay informed. Our advanced grievance and appeal system and interactive dashboard allow for rapid and continuous improvement with the ability to:

- Automate standard processes, improving productivity, compliance, and quality
- Optimize workflow processes for simple and complex tasks
- Automate escalations to improve service-level agreement performance and ensure compliance
- Gain ongoing management control and transparency with visual dashboards and reports that allow real-time insight and immediate upstream routing for timely resolution
- Achieve unprecedented business agility and user flexibility

Our grievance and appeal system will integrate with core claims administration and Member services call center systems. The integrated system has built-in logic to calculate timelines between initiation and due dates, track turnaround times against service levels, and offer sorting capabilities to assist in case prioritization. We will employ daily monitoring to meet timeliness requirements, using automated key performance indicator reports that map plan service-level agreements. Our sophisticated system will provide near real-time data to support prompt decision-making and optimize response and resolution, as depicted in our interactive dashboards. We track grievance and appeal inventory by indicators such as age, type, Provider/Member, and reason with drill-down and workflow capabilities.

G.1.a Compliance with State Requirements

Our grievance and appeal process will comply with all State requirements as described in the Draft Contract § 5.11, Member Grievances and Appeals, and those specific to MississippiCAN and CHIP Members. We will comply with all specific population requirements for MississippiCAN Members as described in the Draft Contract § 5.11.2, and for CHIP Members as described in the Draft Contract § 5.11.3.

G.1.b Process for Expedited Review

All grievances and appeals will be triaged for clinical urgency, prioritized at time of intake, and processed appropriately. Upon receipt of expedited appeal requests, an RN will perform a clinical review. The purpose of the review is to determine if a standard appeal would jeopardize the Member's life; physical or mental health; ability to attain, maintain, or regain maximum function; or subject them to severe pain that cannot be adequately managed without appeal-related care or treatment. A Medical Director will review all expedited appeal requests

and render a decision to either maintain the expedited status or follow the standard appeal process. Grievances that do not fall under medical necessity are reviewed, and escalation is taken into consideration. As Member well-being is our priority, we will triage and prioritize clinically urgent appeals. We resolve each expedited appeal and provide notice expeditiously, no more than 72 hours from the date the request was received.

Expedited appeals may be filed verbally or in writing within 60 calendar days of a Member's receipt of denial and will be determined no later than 72 hours after we receive the appeal. If the grievance or appeal is expedited, we will contact the Member to communicate the next steps and time frames. We will also provide prompt notification of the resolution by phone, in person, or in writing. We will ensure no punitive action is taken against a Provider who either requests an expedited resolution or supports a request for an expedited appeal. Members may also file a grievance related to the denial to expedite an appeal request.

G.1.c. Involvement of Members and Their Families

Members, family members, and legally authorized representatives may file a complaint, grievance, or appeal verbally or in writing. While Providers cannot serve as a legally authorized representative for grievances, they may file an appeal on behalf of a Member. Except for an expedited appeal by a Member's Provider, a Member's written consent will be required for any legally authorized representative acting on their behalf. Our review process will provide Members and their family or legally authorized representative reasonable opportunity to present evidence and allegations of fact or law, in person or in writing, and to examine the Member's case file, including medical records, and any other appropriate documents and records. The Member, their family, legally authorized representative, or Provider (acting on behalf of the Member with the Member's written consent), or the legally authorized representative of a deceased Member's estate will be included as part of the appeal. The appeal process will provide an opportunity before and during the appeals process to examine the Member's case file, including medical records, and any other documents and records considered during the appeal process.

G.1.d How Grievances Are Tracked and Trended, and Using Data to Make Program Improvements

Complaint, grievance, and appeal data is used as part of our standard metrics and data analysis for measuring effectiveness and improvement in quality assurance program activities. Data is used internally for tracking and trending to identify opportunities for improvement and increase Member and Provider satisfaction as part of our outcomes-based model. Internally, we identify and categorize complaints, grievances, and appeals in accordance with NCQA. **Exhibit 8** illustrates the categories we use to identify opportunities for improvement.

Complaints and grievances are mapped to a first-level complaint category and include the reason for the Member's dissatisfaction. From there, a next-level category may be selected for a richer understanding of the complaint or grievance. This provides additional data to determine trends. Complaint and grievance data will be analyzed regularly, and formal analysis will be provided to the Division quarterly.

Exhibit 8. We track Member grievances and appeals based on five critical categories.

We establish goals and performance thresholds through this analysis. We compare these results from our advanced grievance and appeal system to previous metrics to inform quarterly discussions with Member and Provider satisfaction work groups and the QM committee, with oversight from our Board of Directors. Quality-of-care issues are immediately provided to the QM Director for review and corrective action. We will submit State-specific complaint, grievance, and appeals data in compliance with Division requirements.

Turning Insight into Program Improvement

Authorization Time Frame Appeal: Due to trending around home health aide cases for children at the Member appeal level, the Member appeals team worked with the UM team to make process changes for children with ongoing needs. The normal certification period was 60 days, but children were not in a position to

see change to their condition during that time period. To ease Member and Provider work to support these Members, an extended authorization time frame was given.

G.1.e How Grievances Are Addressed Prior to the Filing of a Member Appeal

The moment a Member expresses dissatisfaction, either verbally or in writing, Member services call center employees, Care Managers, or the grievances and appeals team will create a grievance in our client relationship management system. The Member's information and case will auto-populate our advanced grievance and appeal system with the call date and time stamps. This action establishes the earliest date of receipt. The Member services call center employee will confirm a grievance has been filed, verify the Member's best contact information, and outline the next steps and timeline for the process. The grievance and appeal system will flag all departments needed to support resolution, including the Provider representative team.

Our policies and technologies provide a seamless and improved Member experience and include:

- Ongoing management control and transparency with visual dashboards and reports that allow real-time insight and immediate upstream routing for timely resolution
- Integration with Member services call center systems, with logic to calculate timelines between initiation and due dates, track turnaround times, and offer sorting capabilities to assist in case prioritization
- Daily monitoring to meet timeliness requirements using automated key performance indicator reports that map plan service-level agreements
- Near real-time data to support prompt decision-making and optimize response and resolution

G.1.f Process to Review Overturned Decisions and Address Needed Changes

As part of our ongoing data analysis, we review both internal appeal decisions and hearing/independent external review decisions where the original decision was overturned. Our review process includes three phases of analyzing internal data: by grievances and appeals staff, medical affairs staff, and our operations team. These reviews identify type of service (e.g., MRI, braces, wheelchair), original reviewer (i.e., person who originally denied service), and appeal decisions to identify trends and determine if a change to process or criteria should be made. A decision to make a change is based on volume of overturned decisions, knowledge of Mississippi practice patterns, comparison to national clinical criteria, variances from our operational policies and procedures, and clinical expertise of our internal medical affairs staff. Ultimately, our goal is to review the appeal and hearing/independent external review data outcomes to address any areas where we can improve our Members' access to services or remove barriers to them receiving appropriate and needed care.

[END OF RESPONSE]

Image Placeholder

Get all Mississippi CHIP has to offer your child and more.

We are committed to making it easy for your child to stay healthy.

Mississippi CHIP from [MCO]. We've put members first for ## years. Visit [website] or call [toll-free number], TTY/TDD: 711 to learn more.

Choose [MCO] for all the extra ways we provide for your child to stay healthy:

- 24/7/365 virtual care
- Unlimited office visits
- Gift card rewards for taking your child to scheduled checkups, including:
  - $25 for infants up to 15 months
  - $25 for babies 15 - 30 months
  - $25 each year for children 3 - 18 years old
  - $25 for children with asthma who get primary care
- Fresh, nutritious vegetables from local farmer's markets
- $100 credit for frames or special lenses
- Gift card rewards for receiving scheduled immunizations, including:
  - $20 for infants up to 18 months
  - $20 each year for children 3 -18 years old
- A large network of doctors. Choose the one that's right for your child. For a listing, visit [website] or call [phone], TTY/TDD: 711.

And more!

Of course, [MCO] also provides all core Mississippi CHIP benefits for your child, including:

- Preventive care
- Dental services
- Personal Care Managers
- Smartphone app
- Behavioral and substance use disorder services
- 24/7 Nurse Advice Line

How do you enroll with [MCO]?

When it's time to pick your Mississippi CHIP plan, choose [MCO]. You can do this online at medicaid.ms.gov or visit your Regional Medicaid Office.

[MCO LOGO]

[MCO Website]

CHIP

Image Placeholder

Welcome to [MCO]!

MCO LOGO

Now you can get the care you need, close to home. Plus, value-added health programs—at no cost!
As a member of [MCO], you qualify for programs that can help you live your healthiest.

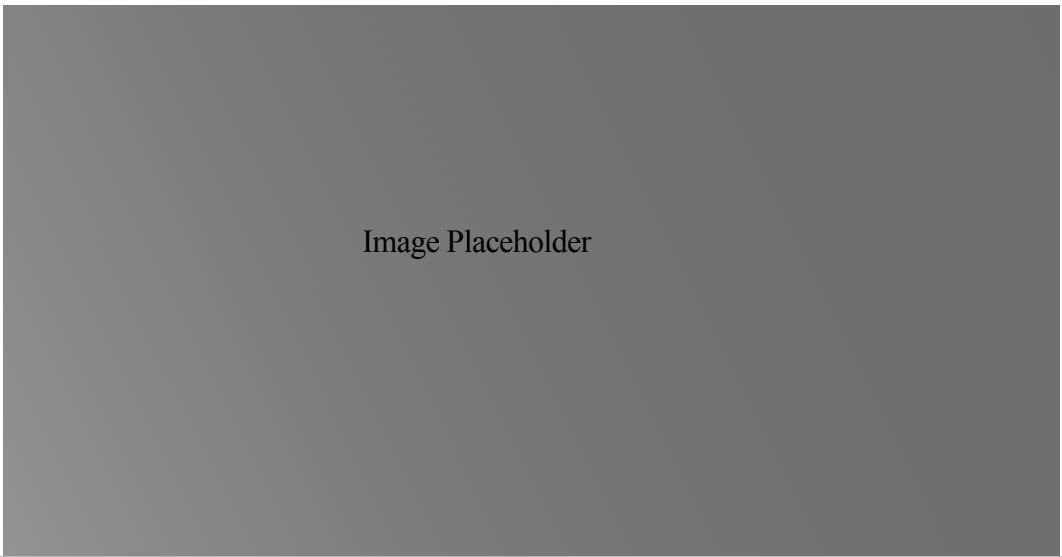
Case Management for children and adults with special needs to help you make the most of your coverage

Health maintenance programs like Weight Management and Stop Smoking Education

Disease management for chronic health issues, including Diabetes, Asthma, Congestive Heart Failure and Depression

For more information about your benefits and how to access them:

- Visit MCOHandbook.com/MS/CHIP
- Review the Member Handbook in this package



Make the most of your health plan.

- Learn all the benefits we cover at no cost to you. Review your benefits in the [MCO] Member Handbook:
  - Go to MCOHandbook.com/MS/CHIP
  - Visit [MCO Portal]
  - Use the [MCO] Mobile app from Google Play or the Apple App Store
- Provider Directory—All [MCO] doctors are board- certified and subject to quality review before they can join our network. To find one near you, go to MCOProviderDirectory.com/MS/CHIP
- Pharmacy Benefits—See the list of covered medications at MCODrugList.com/MS/CHIP
- For more details, please go online or call us.
  - Visit [MCO Website]/Members/MS
  - Call (Phone) (TTY/TDD: 711)

What does [MCO] do for you?

With [MCO], you get benefits like no-cost doctor visits, behavioral health, medication and hospital care when you need it. Plus, advantages like:

- Virtual Care—visit a doctor online 24/7, wherever you are
- Rides to medical appointments
- Health education
- Incentives for visiting your doctor
- 24-Hour Nurse Advice Line for answers to medical questions, day and night

Call us to learn more.
Details on page 11.

Image Placeholder

Tools to control your health care: [MCO] Mobile and MCO Portal].

Whether you prefer a desktop portal or mobile app, we got you covered. 24/7.

Download [MCO] Mobile:

- View, download and share your ID with your doctor
- Change doctors
- Update contact info
- And more

Scan this barcode to download [MCO] Mobile:

CHECK OUT OUR
NEW APP!

Prefer a desktop portal?
Visit [MCO Portal]

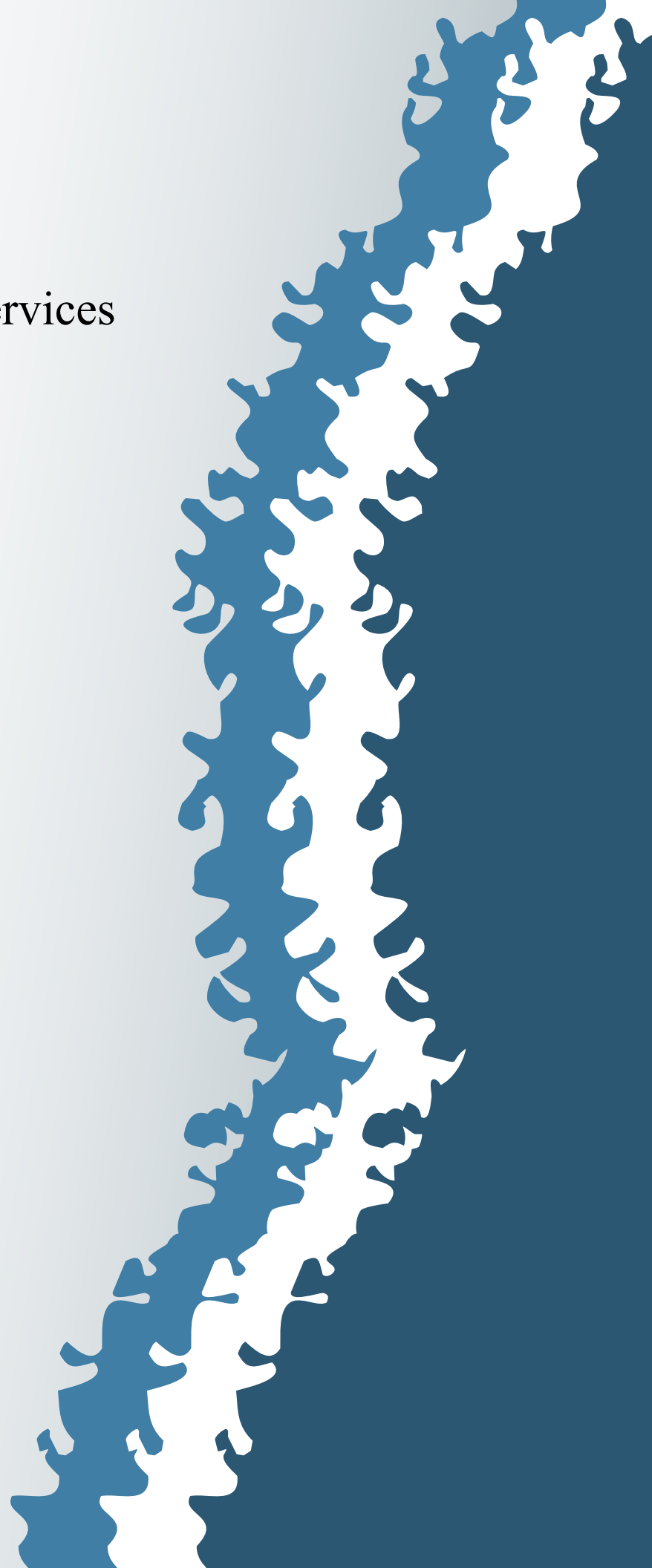
Image Placeholder

To sign up, just follow the instructions.

Questions?
Call Member Services:
[MCO Phone]
(TTY/TDD: 711)

4.2.2.2

Provider Network and Services



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4.2.2.2: PROVIDER NETWORK AND SERVICES

A. PROVIDER NETWORK

A.1. Plan to Develop a Comprehensive Provider Network That Meets Access and Availability

Our Value Proposition for Mississippi

- Contracts with traditional Medicaid Providers and health systems to align with existing care networks for Members
- Provider VBP models that transform service delivery and improve quality outcomes and access
- Practice transformation teams and Provider Representatives who establish trust and provide data and technical and clinical support to help Providers succeed
- Value-adds and Member incentives that physicians use to encourage their Members to engage actively in their healthcare journey

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As a leading national provider of managed Medicaid services, we offer almost 30 years of experience building and maintaining comprehensive, high-quality Provider networks to meet Medicaid and CHIP Members' diverse physical health, BH, and special healthcare needs. Our network strategy considers Provider and Member geographic locations, distance and travel times, and expected utilization of services, as well as Members' cultural, ethnicity, language, health disparity, and SDOH needs, to ensure access and availability of covered benefits for all Members.

Mississippi poses unique Provider network adequacy challenges due to its rural population, with more than 100 areas declared health professional shortage areas and a Provider-to-patient ratio that ranks 50th in the country. We are ready to meet the State's challenges to serve MississippiCAN and CHIP populations with a proven, comprehensive, and personalized approach to network development and maintenance.

To deliver and maintain a comprehensive network, we will engage a dedicated local team aided by proactive Provider engagement, innovative Provider incentives, and strong local partnerships to improve access and health outcomes. **We will deliver a fully contracted MississippiCAN and CHIP network that meets or exceeds the Division's access and availability requirements. Our approach includes:**

- Comprehensive, continuous assessment of access, availability, quality, and alignment with Members' needs.
- A Mississippi-tailored VBP program that rewards Providers based on performance and high-quality, cost-effective care, including our proposed collaborative Integrated Primary Care Model.
- Locally based, dedicated Provider Representatives as a consistent point of contact. Representatives specialize by four Provider types (PCP/PCMH/FQHC, BH, Specialists, and Hospitals), which ensures the capability to establish trust based on a deep understanding of Providers' specific needs.
- A Provider quality and practice transformation team that works closely with Provider Representatives to ensure Providers who are ready to participate in VBP arrangements or PCMH initiatives have the data and technical support to successfully improve outcomes and deliver care within a system that addresses SDOH.

We will work with major Providers who have built significant telehealth infrastructure, like the University of Mississippi Medical Center (UMMC), which will strengthen our ability to deliver the **full spectrum of MississippiCAN and CHIP covered services via telehealth capabilities**. We will collaborate with key telehealth Providers to **drive access for the State's more rural and access-challenged areas through a virtual continuum of care**. Access to telehealth services within our network will also allow us to connect mid-level Provider organizations with major health system partners for consultation and collaboration supported by their combined robust telehealth infrastructure.

We will contract with Providers focused on primary care and access to care beyond physician offices. This includes major FQHCs, some of which will be operating school-based clinics. The FQHCs are also in active contract negotiations with school districts throughout the State to provide school-based EPSDT services. We will contract with rural health clinics (RHCs) statewide and partner with the **Rural Health Association to improve access to communities throughout the State regardless of geography**.

We will foster cultural competence, diversity, and equity in our network. For example, we collect information about Provider backgrounds to assist Members in choosing Providers who meet their cultural preferences. We post the Provider's background on our Provider portal, including languages spoken and accessibility. Contracted Providers speak a wide variety of languages in addition to Spanish and English, including languages offered by the Division's language assistance program, such as Chinese, French, Arabic, Tagalog, German, and Hindi.

We understand and will fully comply with the Provider network requirements as detailed in the RFQ, including the Draft Contract, specifically § 6, Provider Network.

A.1.a. Recruitment Strategy

As a leading national provider of Medicaid managed care services, we have a wealth of experience in Medicaid/CHIP network development and Provider engagement that informs our recruitment activities. We will recruit high-quality Providers who demonstrate a commitment to serving MississippiCAN and CHIP Members, providing quality care, partnering to improve health outcomes, and working collaboratively to identify and implement access and care management solutions.

In Mississippi, we will implement our recruitment strategy through four process steps:

1. Identifying network gaps
2. Developing recruitment work plans
3. Implementing recruitment efforts
4. Processing and executing Provider contracts

Our MississippiCAN and CHIP network recruitment strategy and work plan will establish and maintain a statewide network of compassionate physical health and BH Providers to deliver all benefits. ***To maximize Member access and choice, our strategy is to add all qualified Providers willing to join our network,*** including PCPs and specialists (including specialists serving as PCPs, pediatricians, and pediatrician subspecialists); BH Providers; hospitals; urgent care centers and ancillary facilities; Indian Health Care Providers (IHCPs); school clinics/school-based Providers; home- and community-based healthcare services and supports; and Providers who are trained and qualified to serve individuals with special healthcare needs. We will deliver vision, dental, and NET for Members through long-standing relationships with superior Subcontractors.

Step 1: Identifying Network Gaps

The first step in our network recruitment strategy is identifying gaps in care based on an assessment of Member service needs compared to network Providers. We consider geography, health challenges, health disparities, and SDOH. We will analyze Provider and Member data to identify network gaps and inform our network development work plan, including:

- Division utilization data related to Providers who serve the MississippiCAN and CHIP populations, required benefits, and our value-adds
- Information gathered from Mississippi Providers, Provider associations, and Member advocate organizations
- Provider grievances
- Out-of-network utilization
- Member cultural and linguistic needs
- Disparities in access and health outcomes and SDOH
- Feedback from our staff, including Care Managers and CHWs
- Satisfaction feedback from Providers and Members

We will employ GeoAccess and report mapping solutions, customized to reflect MississippiCAN and CHIP requirements, to monitor network accessibility, identify gaps, and verify compliance with time and distance standards in each of the Division's five geographical regions—Pines, Hills, Capitol, Delta, and Coastal.

Step 2: Developing Recruitment Work Plans

We will leverage our Medicaid affiliates' wealth of experience in network development and Provider engagement to develop our Provider recruitment work plan. Our work plan to establish a high-quality, high-performing network will identify the steps and timelines necessary for each task and deliverable in accordance with the Draft Contract. The work plan will include milestones, critical path tasks that must be performed to avoid project delays, and personnel resources to be assigned to each task. The work plan will address network adequacy, including contracting targets, Provider

Recruiting PCMHs

Our network recruitment work plan will focus on recruiting Providers certified as PCMHs to increase medical home participation and meet Division goals. We will collaborate with the **Community Health Center Association of Mississippi and Rural Health Association and will contract with all 21 of Mississippi's FQHCs and with Mississippi's RHCs**.

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data configuration, training, and testing adequacy. The work plan will also identify the challenges and opportunities of each geographic region, such as rural access issues in the Delta, which we will address by contracting with key statewide health system Providers.

We will develop our recruitment work plan annually after completing our GeoAccess analysis. Network management staff, consisting of Provider Representatives and contracting staff, collaboratively draft the plan, focusing on specific needs identified by our network adequacy analysis to address any network gaps. We update the plan during the year in response to data indicating access challenges in geographic areas or Provider types. The network team shares the recruitment work plan with staff from quality.

Step 3: Implementing Recruitment Efforts

Under the direction of our Network/Contracting Manager, our network management team will build and maintain a fully contracted, high-quality MississippiCAN and CHIP network. We use experienced and quality national Subcontractors responsible for network development and recruitment activities for vision and NET.

Provider network management staff ensure we meet work plan deliverables and timelines for enhancing our comprehensive network and best serving the needs of Members. The team is comprised of contracting, Provider data configuration specialists, and Provider Representatives. Each team member will have a thorough understanding of MississippiCAN and CHIP requirements and Provider needs and expectations, and a commitment to ensuring each Provider has a successful experience working with us.

Our network recruitment strategy focuses on both adding and retaining quality Providers. Network recruitment activities include in-person on-site meetings with Providers, which we supplement with outreach by email and phone. Email communications include a network Provider agreement and related contact information. As additional support, and to encourage network participation, we will facilitate monthly joint operating committee meetings in collaboration with Provider Representatives to answer any questions network Providers have about contracting or other matters. Similar calls are regularly facilitated directly with prospective Providers to answer any questions they may have about working with our health plan.

Following and supporting ongoing network development, our Provider Relations Manager leads our Provider representative team and Provider relationship management efforts to foster open communications and trusting partnerships aimed at improving health outcomes and quality of life for Members.

Recruiting Providers to Address Provider Shortages

We will deliver a fully developed network targeted to address the needs of all Members, meet all network geographic access standards, and address health equity, disparities, and SDOH. We recognize the challenges Members may face in accessing Providers in rural and historically challenged areas due to Provider shortages. We will pursue the recruitment and network development strategies identified in **Table 1** to establish a systematic process for addressing access issues.

Table 1. Recruitment Strategies to Address Access Issues Caused by Provider Shortages

Provider Access Issues	Description of Recruitment Strategy
Shortages in Rural and Historically Challenged Areas	Recruit targeted Providers in adjacent counties and bordering States as enrollment grows and/or medical service needs indicate.
Service Delivery Challenges	Offer telehealth resources and reliable transportation vendors to ensure primary/specialty service delivery for Members in rural areas and augment service delivery to Members in urban areas.
Network Capacity Issues	Encourage Providers to employ physician assistants and certified nurse practitioners in primary care and some specialty offices to expand network capacity.
Health Disparities	Target strategies to strengthen the network and fulfill commitment to work with strategically located community Providers that serve low-income and minority populations.
Barriers to Accessing Clinics and Provider Offices	Add mobile units and semi-permanent trailers, and urgent care centers as PCMHs, and provide future scholarships to Northeast Mississippi Community College and CLIMB Community Development Corporation.
Primary Care Access	Create a mobile health program using mobile units to serve geographic areas experiencing access issues. Enhance partnerships with FQHCs and RHCs. Use flexible arrangements to recruit Providers who may not have traditionally accepted Medicaid.
Year-round Access to Care	Create options with public schools to maintain open clinics during the summer.

Provider Access Issues	Description of Recruitment Strategy
Workforce Shortages	Engage a large number of certified nurse Practitioners and continually reach out to new nurse practitioners entering the State. Contract with urgent care clinics to reduce the number of preventable ER visits.

Our recruitment activities will address specific regional challenges. For example, in the Mississippi Delta and border counties, we will review access, utilization patterns, and Mississippi program goals relative to Providers across the Mississippi border and determine the appropriate Provider network recruitment strategy. We will promote access and work to make the Delta healthier through initiatives such as specialty e-consults and pharmacists practicing at the top of their license.

Recruiting Indian Health Care Providers (IHCPs)

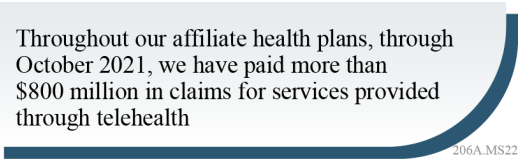
Recognizing their importance in the lives of American Indian Members, and in adherence with Draft Contract § 6.2.10, Indian Health Services Requirements, we will recruit and contract with the State's qualified IHCPs, including FQHCs and I/T/Us, to ensure timely Member access to services. Key to our strategy is that we impose no barriers to American Indian Members' direct access to all covered services provided by IHCPs. We will ensure these Members have a choice: they can access care either through IHCPs, where available, or through non-IHCPs as necessary.

We will leverage the national experience of our health plans working with IHCPs. We will respect each nation's own unique culture and structure and will use an inclusive approach to coordinate with Mississippi's IHCPs to offer American Indian-centric, flexible, and culturally relevant care management.

Recruiting School Clinics and School-based Providers

We understand the valuable role school clinics and school-based Providers play in providing care to Members. We will prioritize collaborating with these Providers to ensure we are providing the necessary support and resources for them to meet the needs of child and adolescent Members. In adherence with Draft Contract § 6.2.9, Provider Network Requirements, we will recruit and contract with qualified school clinics and school-based Providers to ensure timely access to services.

Expanding Access to Telehealth



Although not a replacement for the relationship a Member has with their PCP, telehealth provides a valuable option for Members who have challenges accessing non-emergency services due to Provider access issues, transportation barriers, or mobility issues. We will collaborate with local, leading telehealth Providers, such as UMMC, that provide advanced telehealth capabilities to expand access for Members, reduce unnecessary ER and inpatient utilization, and enhance overall health for Members. We will also support Provider capabilities through our national telehealth contract, which we have expanded in response to the COVID-19 pandemic and the easing of restrictions by States on the use of videoconferencing for medical care normally classified as urgent care. ***We will also employ mobile units and semi-permanent trailers to provide Members access to these telehealth resources***.

We will analyze telehealth utilization in Mississippi through network Providers augmented by our national telehealth Provider to identify usage trends by Member, location, and Provider. Our approach includes expanding the use of additional technologies to enhance the Member experience and stretch the Provider resources needed in underserved areas. We will encourage Providers to prioritize adding telehealth services to their own practices by incenting them through our pay-for-performance/VBP program. **Table 2** lists the recruitment activities we will employ to expand the use of telehealth in Mississippi to improve access to care.

Table 2. Telehealth Recruitment to Improve Access

Objective	Activity
Expand Access to Care	• Add direct links on our Member portal to our national telehealth Provider and network Provider telehealth sites • Include telehealth access for Member use via our mobile units and semi-permanent trailers
Reduce ER and Inpatient Utilization	• Educate Members on the value, use, and accessibility of Providers' telehealth services and our national telehealth Provider's urgent care services

Objective	Activity
	• Monitor usage and connect with Members and their PCP after telehealth visits to ensure continuity of care and Provider relationships
Enhance Overall Member Health	• Encourage and assist Member scheduling of post-discharge follow-up visits with their Provider • Coordinate with UMMC's Center for Telehealth Services to provide Member access to telehealth programs for chronic conditions such as congestive heart failure, diabetes, and asthma, particularly including prediabetes • Collaborate with UMMC's Center for Telehealth Services to enlist identified prenatal Members in their new program of prenatal virtual health services • Incorporate Provider programs for remote patient monitoring

Step 4: Processing and Executing Provider Contracts

Our experienced Provider network management staff seamlessly and simultaneously manage both Provider contracting and working with CVOs on credentialing, helping minimize barriers to enrollment and completion. Our Providers have a single point of contact to support them through the entire process. We value efficient, transparent processes that avoid claims denials, administrative burdens, unnecessary costs, and ensuing disputes, and we will partner with the Division on its new credentialing process designed to increase speed of completion, accuracy, and efficiency.

Our staff will load all information for contracted and credentialed Providers into our claims payment system within 21 days of Provider contract approval. Contracted Providers are effective in the network as of the date they received credentialing approval, and claims are paid for services delivered from that date.

A.1.b. Strategy for Retaining Specialists and Providing Access to Out-of-Network Specialists

We will target recruitment efforts to maintain as comprehensive a specialist network as possible and expand access to and availability of these specialists throughout the State. Critical to our specialist network and retention strategy is our commitment and successful approach to service excellence with comprehensive Provider relations and support. Provider Representatives, based in Mississippi, will know the local Providers and can meet with them face-to-face to build trust, provide ongoing education, foster open communication, and develop collaborative relationships. Our locally based Provider quality and practice transformation teams will support specialists with expert technical assistance to improve quality and health outcomes.

Excellent Provider Service

Exceeding Claims Payment Standards

In 2021, our affiliated health plans **processed and paid 99.53% of Medicaid claims within 30 days of receipt**.

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Our commitment to excellent Provider service reduces specialist turnover and helps Members build and sustain Provider relationships. Provider Representatives manage Provider issue resolution from beginning to end, coordinate with key health plan resources and departments, meet with Providers one-on-one to identify solutions, share best practices, and continuously refine our Provider issue resolution processes. We also expedite timely and accurate claims payment, quickly resolving issues and encouraging Provider feedback, which fosters trust and specialists' participation.

We will accommodate Provider changes whenever possible to retain specialists in the network. Changes are common in healthcare, from Provider demographic changes at the clinic level to high-level business changes in a healthcare system. In some instances, ownership changes to a facility or healthcare system can prompt the renegotiation of existing network Provider agreements or the need for new agreements in general. We provide every reasonable concession to be a good partner in accommodating these changes.

As an example, one of our affiliate's network Provider groups went through such changes in 2021, and a completely new network Provider agreement had to be negotiated. In the end, both parties made concessions in the contracting process to finalize the process as soon as possible, and our affiliate was able retain that Provider group (including applicable PCPs and specialists) in-network.

Access to Out-of-Network Specialists

In rare cases in which a Member requires the services of an out-of-network Provider, we execute a single case agreement with a qualified out-of-network Provider who is willing to provide services, but unwilling to sign a network participation agreement, to ensure the Member has adequate access. This ensures continuity of care and

allows our UM team to identify in-network Providers for potential transfer. These agreements also ensure out-of-network Providers follow the same requirements as network Providers for communication and coordination with the PCP and our Care Managers. To maintain the Member-Provider relationship, we also initiate discussions with the Provider to establish a full contract to join our network, as appropriate.

Comprehensive Closed-loop Provider Feedback Program for Specialist Feedback

We will also employ our proactive, nationwide Provider feedback loop in Mississippi to maintain high rates of Provider satisfaction and retain specialists in our network. Our Provider feedback loop is a targeted program to listen to specialists and other Providers that employs easy methods for offering feedback, including a postage-paid card that Provider Representatives make available during all office visits. A Provider information/feedback form is also made available at various Provider forums to allow Providers to document their feedback and share with us what they would like to see and how we can improve. These forums include Provider conferences, workshops, and Provider work groups. Two dedicated email inboxes (general inquiries and BH) and Provider satisfaction surveys are additional avenues for Providers to supply valuable feedback. Our Provider representative and specialized support teams gather feedback from advocacy groups and our Provider advisory council and QM committee. This offers a direct connection to share ideas with the goal of making it easier for specialists and other Providers to work with us and to enhance satisfaction. We meet with network Providers regularly to develop real-time solutions and share information with them on how to increase Member participation in improving their health outcomes. We also obtain feedback from specialists through:

- **Provider representative specialized support teams.** These teams serve specific specialty and other Provider types such as BH Providers, specialty care, FQHCs and RHCs, IHS, claims payments, and hospitals to manage Provider inquiries and feedback unique to that Provider type. Understanding their unique needs allows for rapid resolution of issues, which enhances Provider satisfaction.
- **Provider advisory council.** We will convene Provider groups to obtain direct feedback on topics of urgent need to specialists. We will use surveys to determine the most important topics for discussion during each council meeting. The council will convene quarterly and will include representation by specialty clinical leaders, as well as PCP and BH clinical leaders. Interventions will be developed and implemented based on the feedback from the council.
- **QM committee.** Specialists serving on the QM committee offer insight on proposed practice guidelines, preventive health standards, health management programs, QI study designs, and interventions to improve levels of care. Leveraging the committee's expertise, in 2020 we enhanced telehealth access for Providers and Members during the COVID-19 pandemic.
- **Healthcare services committee.** This committee involves network specialists and other Providers and reviews policies and procedures, including clinical practice guidelines, and solicits input and comments for changes and improvements in the areas of UM, care management, and BH.
- **Provider satisfaction surveys.** We conduct annual Provider satisfaction surveys and closely evaluate results to identify strengths and opportunities and make program and process changes accordingly.

Using Feedback to Execute Program Improvements

We act on the feedback collected through our comprehensive closed-loop Member and Provider feedback program to address Member-specific needs and make system improvements (see **Exhibit 1**). We will implement our "You Matter" and "At Your Service" programs in Mississippi to strengthen our relationships with Providers, as well as Members, community partners, and governmental agencies. The programs will also provide a vehicle to solicit feedback and identify opportunities for improvement. Using the information, reports, and dashboards developed as part of our Provider feedback loop, we execute program improvements.

Exhibit 1. Our Informed Feedback Loop Helps Identify and Execute Program Improvements

Program upgrades driven by feedback include an expanded **telehealth program, improved transportation protocols, improved communication and Member materials, and an enhanced Member mobile app. One of our affiliate health plans designed and launched new functionality for their Provider online directory and Provider portal to allow specialists and other Providers to make demographic updates online** in response to Provider feedback requesting a more efficient method to share real-time demographic updates. Our

affiliates have also added new functionality to the Provider online directory for Members to report Provider demographic changes. Our affiliate's Provider data validation team uses the information provided by Members to contact the Provider to ensure the change is valid before making the change to the Provider record and online directory. This furthered our commitment to ensure Provider data accuracy to improve the Member and Provider experience.

A.1.c. Subcontractor Network Development Coordination, Oversight, and Monitoring

We will coordinate the network development efforts of our vision and transportation Subcontractors with our overall recruitment strategy and provide oversight and monitoring of Subcontractor network development activities. Our vision and NET Subcontractors develop comprehensive networks, and we generate quarterly access reports to assess network adequacy for each of our Subcontractors. We also require Subcontractors to submit monthly network reports that include identification of any new Providers, terminated Providers, and Provider demographic changes, and attest to continued network adequacy or provide gap remediation.

Oversight and auditing of Subcontractors' network development activities is an extensive and integral part of our network development work plan. After comprehensive vetting and evaluation, we have partnered with Subcontractors with the demonstrated capabilities and overall responsiveness to improve services and complete all deliverables in a timely and efficient manner. We conduct on-site pre-delegation audits to review a Subcontractor's readiness, applicable licensure, and contract compliance. Our delegation oversight staff and Provider network leadership closely monitor each Subcontractor's network development and adequacy.

We will also perform ongoing review, assessments, and annual audits of the Subcontractor's performance of each delegated function. We determine if a Subcontractor is implementing delegated activities in accordance with Delegated Service Agreement terms by consistently monitoring reporting content and frequency, assessments, timely response to any corrective action plan (CAP), and Member grievance information. If we identify compliance issues, we may revoke the Subcontractor's right to perform delegated functions or require implementation of a CAP. Refer to our response to RFQ § 4.2.2.7, Subcontractual Relationships and Delegation, for more information on Subcontractor oversight.

A.1.d. Proposed Methods to Assess and Ensure Compliance with Network Standards

The Provider network team analyzes a variety of data each quarter to ensure compliance with contractual requirements, access to care, and quality of services. We will assess and ensure the network standards outlined in the Draft Contract are maintained for all Provider types and meet the diverse needs of Members by analyzing:

- GeoAccess Provider and Member location data
- Member-to-Provider ratios
- Claims and utilization data
- Out-of-network requests, single case agreements, and out-of-network utilization
- Member grievances about access, scheduling, wait times, and delays
- Grievances and appeals summaries
- Stakeholder and Provider feedback
- Cultural, linguistic, and demographic diversity of the network
- Expertise in evidence-based practices and other specialties aligned with Member needs
- Provider and Member satisfaction surveys
- Nurse advice line reports
- Monthly trends and individual Member usage of our national telehealth Provider and network Provider telehealth services
- Annual access study on appointment availability and after-hours access

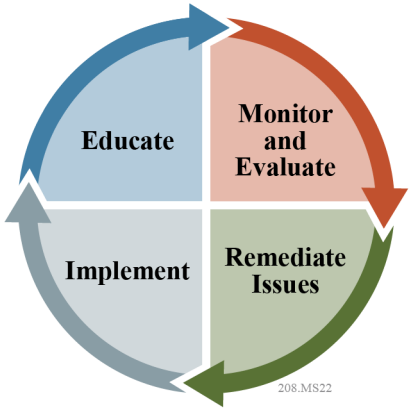
We will employ GeoAccess and report mapping solutions, customized to reflect MississippiCAN and CHIP requirements, to monitor network adequacy, identify gaps and deficiencies, and verify compliance with time and distance standards outlined in the Draft Contract. We will also monitor Member-to-Provider ratios and identify and contract with all hospital-based Provider groups to ensure participation of all Providers of service a Member may encounter during an episode of care.

Our Provider network leadership team, including Provider relations and Provider contracting, will meet weekly to review GeoAccess reports, measure our network against Contract access standards, and review and discuss network development activities and progress, credentialing and Provider data configuration status, Provider materials, Provider education, and claims testing results. Provider network staff will submit quarterly reports to our QM committee that measure our network against documented access standards, identify areas for improvement, and note progress made to remedy any deficiencies noted during the previous quarter.

A.1.e. Process for Continuous Network Improvement

Our continuous network improvement process involves an ongoing cycle of activities: monitor and evaluate, remediate issues, implement network improvements, and educate Providers and Members to improve access (see **Exhibit 2**). We continuously improve our network and Member access to quality services through ongoing monitoring and evaluation of Provider availability, appointment, and performance standards, analyzing data sources described in subsection A.1.d above.

Exhibit 2. Continuous Network Improvement Process



Compliance with Availability and Appointment Scheduling

At least every six months, we will conduct a review of the accessibility and availability of Providers and take corrective action against any Providers who do not meet the Division's accessibility and availability standards. We will conduct an appointment accessibility audit on a defined sample of PCPs, high-volume specialists, high-impact specialists, and BH Providers. We will include a health equity analysis in our assessment and report findings to the Division. Monitoring and evaluation will include a review of Member grievances related to accessibility, scheduling process, and delays, which will also be conducted on an ongoing basis. We will routinely measure performance against standards by reviewing:

- **Access.** We will review responses within the CAHPS Member Satisfaction Survey to assess Member perception of access to healthcare.
- **Grievances.** A QI Specialist will gather the grievance data from the call tracking module in our core administrative system for the Member grievance category "access/availability" and present the report to the Member and Provider satisfaction work group.

Using the access study results, we will maintain appointment access standards through ongoing Provider compliance monitoring, evaluation, and reporting that our QM committee reviews under oversight by our Medical Director. We monitor trends based on individual Providers, membership type, and geographical areas. Reports measure the network against program access standards, identify areas for network improvement, and monitor progress made to remedy any deficiencies identified in the previous quarter. Our Provider representative team will use town hall meetings, the Provider portal, the Provider manual, and periodic newsletters to educate Providers about mandated appointment and access standards.

A.1.f. Ensuring Appointment Access Standards Are Met if Members Cannot Access Care In-network

We will ensure appointment access standards are met when Members cannot access care within our Provider network by executing single case agreements. Out-of-network Providers are held to the same appointment access standards required by the Division for network Providers.

In the event a Member needs services from an out-of-network Provider, we will secure access to and execute single case agreements with a qualified Provider willing to provide services that meet Division requirements but unwilling to sign a network participation agreement. This provides continuity of care and allows our UM team to identify Providers for potential referral and appointment availability. These agreements also ensure out-of-network Providers follow the same requirements as network Providers for communication and coordination with the PCP and our Care Manager. Our Provider network team tracks and reviews monthly reports indicating utilization of services from out-of-network Providers, including Providers of emergency services, and identifies Providers for recruitment that would benefit Members.

We will also ensure Members have access to care if we lack an agreement with a key Provider type in each geographic area by connecting Members to telehealth resources and providing transportation to out-of-State or neighboring counties as needed to meet the Members' needs.

A.1.g. Provider Representatives Support Model

All Providers will have a locally based, dedicated Provider Representative as a consistent point of contact. This representative will be specialized in either primary care/FQHCs, specialty care, BH, or hospital services. This will ensure Providers have a representative who has a deep understanding of their specific needs and will help establish trust, which is a necessary element of successful health plan-Provider relationships. In addition, we are establishing Provider Representatives dedicated to claims payment and processing who will work internally to support the external representatives in managing any claims payment issues in an extremely timely manner. They will also manage our Provider-dedicated email inboxes to ensure requests are handled quickly. This allows our community-based Provider Representatives more time in the field engaging with Providers and enables increased responsiveness to Providers' needs.

We understand that Providers are at the heart of any innovations we make in the care delivered to Members; that's why we will establish a Provider quality and practice transformation team. This team will work closely with the Provider Representatives to ensure Providers who are ready to participate in VBP or PCMH initiatives have the support they need to be successful. The journey to practice transformation is different for each Provider, and this team will ensure a tailored experience depending on the Provider's individual needs and circumstances. To encourage practice transformation, we will launch our data for Providers program, which provides practice-specific data to help ease Provider administrative burdens and give them insightful, actionable data to help the Members they care for. The data for Providers program demonstrates how data informs practice transformation and is used to support the success of the health plan/Provider trusted relationship.

Our MississippiCAN and CHIP network strategy will focus on improving PCP accountability for improved care delivery and increasing PCMH adoption. For example, we will provide a report card to PCPs that includes gaps in care for their Members, in addition to giving Providers information about the Members' social and cultural competency needs based on SDOH, race and ethnicity, language, and geography. Our Provider quality and practice transformation team will then work with these PCPs to implement interventions to reduce gaps in care and potential disparities.

Role of Provider Representative and Provider Quality and Practice Transformation Teams

Provider Representatives are responsible for building trust with the Providers they are assigned to, with the expertise to understand challenges specific to the Provider's services delivery. Provider Representatives will assist Providers with claims, enrollment, credentialing, and all areas in which help is required. Provider Representatives are required to develop relationships with Providers located in their coverage areas through regular contact.

Key to our strategy of delivering better health outcomes, reducing Provider abrasion, and improving overall Provider satisfaction, we will hire a **dedicated Provider Quality and Practice Transformation Manager to manage a team of representatives who work directly with Providers outside of the role of traditional Provider relations to enhance HEDIS and quality gap closure, PCMH adoption, transparency, and sharing of best operational practices.** This position will improve communication, Provider satisfaction, and collaboration, and allow continuous feedback from our network Providers. The Provider Transformation Manager will also:

- Coordinate with our operational departments to develop and encourage fair, streamlined operational processes for Providers, including accurate and timely claims payment
- Provide locally based operational support for contracting and authorizations
- Coordinate with our operational departments to streamline and reduce administrative burdens
- Enhance coordination with our clinical staff for Members receiving care management
- Invite Providers to participate in key committees
- Provide easy access to data on Provider quality performance

- Liaise with our plan's Provider network management leadership and Providers to develop Provider bonuses/reimbursement for quality-driven, value-based performance

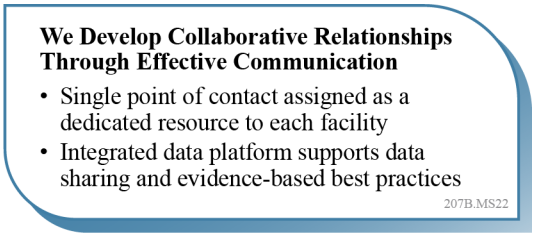
We anticipate this approach will minimize complaints, grievances, and appeals and will allow Providers to focus on innovative collaborations to improve healthcare outcomes, rather than being hindered by administrative duties.

Recruitment, Retention, and Training

We recruit Provider Representatives by targeting individuals who have previous Provider office/hospital administrative experience, former State employees, and those with managed care, and particularly managed Medicaid, expertise. We also target individuals with previous experience in Provider relations, customer services, claims, and Provider contracting.

Provider Representatives actively receive Medicaid Provider bulletins, "late breaking news" articles, updates regarding State plan amendments, and updates regarding changes to the Medicaid Administrative Code and the Provider billing handbook to ensure that up-to-date policies and procedures are shared and reinforced through the Provider Representatives to the Provider community.

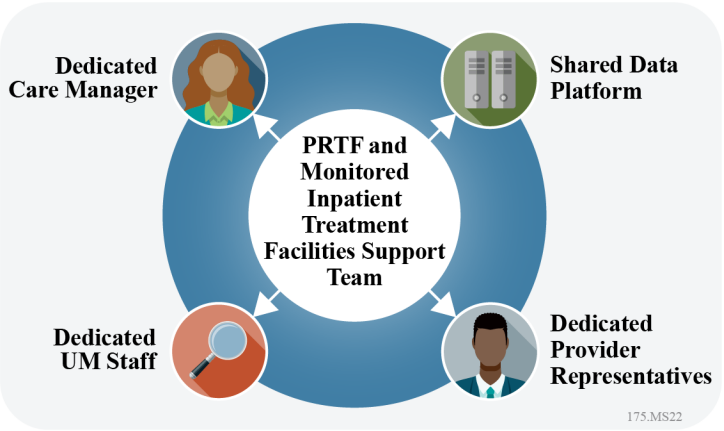
A.2. Developing and Maintaining Collaborative Relationships with Psychiatric Residential Treatment Facilities (PRTFs) and Monitored Inpatient Residential Treatment Facilities



Our affiliate Medicaid health plans have developed and maintained collaborative relationships with low-, medium-, and high-intensity PRTFs and medically monitored inpatient treatment facilities by employing effective communication strategies built on dedicated single points of contact and an integrated data-sharing platform. We will implement advanced data-sharing capabilities regarding facility quality and operations to support care management and discharge planning for Members as well as facility population-based data analytics and clinical systems improvement.

Efforts to address Mississippi's crisis in access to mental health resources, especially in rural areas, will include contracting with PRTFs and medically monitored inpatient treatment facilities. We will develop partnerships with facilities focused on nationally recognized and evidence-based programs specializing in services for children, with a track record for collaborative results-oriented operations.

Exhibit 3. Partner with collaborative results-oriented operations



Efficient, concise, and deliberate communication is key to developing strong relationships. We effectively streamline communications with PRTFs and monitor inpatient treatment facility Providers and facilities regardless of acuity level by assigning designated single points of contact. Our staff will include designated Care Managers, UM staff, and Provider Representatives experienced in working in and with BH facilities to serve as single points of contact, collaborating with facility staff to provide seamless support to PRTFs and monitored inpatient treatment facilities to improve Member outcomes. **Exhibit 3** illustrates the collaborative relationships we foster with PRTFs and monitored inpatient treatment facilities through dedicated resources: dedicated Care Managers, shared data platform, focused UM, and dedicated Provider Representatives, described below.

As the intensity level of treatment increases, so does our support and interaction to ensure Members receive the right care, the right resources, and appropriate reintegration support to return to the community or a lower level of care. We partner with each facility to make sure our resources and supports benefit Members in the most effective manner possible. For example, Care Managers will participate in daily rounds for Members in a monitored inpatient treatment facility or high-intensity PRTF, as these Members have the highest severity of behavioral, emotional, and medical needs.

Dedicated Care Manager for Each Facility

For each PRTF and monitored inpatient treatment facility, we will assign a Care Manager focused specifically on Members receiving treatment at that facility. As a result, the Care Manager develops a thorough understanding of the individual facility's programs, challenges, policies, and procedures and builds productive relationships with its staff. When appropriate and with facility permission, ***we will embed a Care Manager in a workspace within the facility to further strengthen the collaborative relationship.***

To fulfill our goals, our Care Manager will work closely with facility staff when assessing a Member for admission, during admission, and through discharge planning. They will collaborate with clinical staff to ensure a smooth transition from the acute care setting, which includes ensuring that the Member is discharged with prescription medications to bring to the facility. Once the Member has been transferred to the PRTF or monitored inpatient treatment facility, the Care Manager will attend all care management team meetings, all treatment team meetings, and all discharge planning meetings. The Care Manager will also recommend discharge planning options and ensure aftercare needs are in place. A follow-up appointment with a BH Provider is scheduled within seven days of discharge working with a Care Manager local to a Member's residence. The facility and the Care Manager will work collaboratively to ensure Members are discharged safely back into the community and SDOH and other needs are addressed to support stability in the home setting.

Shared Data Platform with Facilities

Our care management IT platform is an integrated system coordinating Member care, services, and outcomes at the individual and systemic levels. Our platform unites care management functions for increased productivity, efficiency, and accurate and timely reporting. It also enables sharing and integration of Member data and health information between PRTFs, monitored inpatient treatment facilities, and our health plan. Providers can access the platform through a secure connection to view health assessments, medication, and claims data, and enter key information such as care plan information, clinical documentation, and notes. The care management platform also helps facilities improve clinical care and care transition and achieve evidence-based best practices.

Dedicated UM Staff for Facilities

To support all levels of residential treatment facilities, we will have dedicated Care Managers and experienced UM staff who will focus on BH and SUD services. Like our assigned single points of contact, a dedicated UM staff member is assigned to each facility for each UM decision for Members being cared for in the PRTF or monitored inpatient treatment facility. This structure results in greater efficiency for the facility and our health plan, as both become experts in the other's capabilities, expectations, policies, and procedures, and help support a Member's path to recovery.

Dedicated BH and SUD Provider Representatives for Each Facility

Our BH and SUD network is supported by Provider Representatives with BH expertise to understand facility services and operations. A dedicated Provider Representative is assigned to each PRTF and monitored inpatient treatment facility to serve as a liaison, educator, and advocate within our health plan. This single point of contact offers facilities an in-depth understanding of contract terms, claims payments, and processing specifically for the services provided by the facility, which leads to increased overall efficiency of interactions.

The assigned Provider Representative schedules and holds regular joint operating committee meetings to discuss the status of operations such as claims payment, UM quality, claims submission, contract questions, and changes in the facility's demographic data. This ***level of Provider relations ensures open and effective communication***, creating a collaborative partnership focused on care for those receiving treatment and eliminating the potential for operational issues that often occur without such frequent interaction.

A.3. Process for Working with Providers and the CVO

We will work with Providers and the CVO to educate and assist Providers in completing the credentialing and recredentialing process with the CVO. We will support the Division's goal to simplify enrollment for Providers and improve efficiencies by reducing administrative burdens. Our Medicaid health plan affiliates are experienced in successfully transitioning credentialing and recredentialing activities to a CVO. We know from experience that CVOs save time by eliminating duplicative efforts and processes for Providers who credential separately with multiple MCOs, and that they reduce Provider and MCO administrative costs.

We also know this process can lead to questions from Providers, who may not initially understand the benefits or procedures. For example, when our affiliate's State Medicaid program transitioned to a CVO, our affiliate distributed an FAQ sheet that explained changes for Providers and that the contracting process remained the same—it consisted of agreements with each MCO individually. We will prioritize a similar education campaign for all Mississippi Providers.

We have established internal processes to make the transition as easy as possible for Providers. Our Provider Representatives will educate Providers on the new CVO policies, and we will also use our Provider website, Provider bulletins, and email blasts to keep Providers informed.

We will develop materials to be posted to our website and presented at Provider workshops and various Provider meetings. These materials will educate Providers on the Division's Centralized Credentialing Verification Program. These materials will also provide contact information for the Division's Fiscal Agent and CVO, information on how to complete the credentialing or recredentialing process, and an overview of the credentialing and recredentialing process and our enrollment process in general. This material will be shared with our Provider call center to equip our staff with the information to answer related Provider questions. Also, in instances when a Provider reaches out to health plan staff directly, personnel will direct them to the Fiscal Agent's website to complete the credentialing or recredentialing process.

We will comply with all requirements in Draft Contract § 6.5, Provider Credentialing and Qualifications, including the following:

- Designate one participant to serve on the Division's Credentialing Committee who meets the applicable qualifications.
- Refrain from conducting separate credentialing and recredentialing processes, will not require Providers to submit supplemental or additional information, and will accept the Credentialing Committee decisions.
- Only the Provider may appeal the CVO's credentialing decision to the Division.
- Coordinate with the Division's contracted Fiscal Agent to confirm the status of Providers who are requesting to enroll with us and to confirm recredentialing status.

A.4. Process for Timely Contracting of Providers Upon CVO Completion of Credentialing

We will complete Provider contracting within the Division's required 21 days of receiving information from the CVO that a Provider's credentialing is complete. In contracting any Provider, we will use standardized network Provider agreements to expedite the contracting process and exceed, whenever possible, the required contracting timelines. We also have predetermined alternative contract language and reimbursement levels that we may agree to, and established approval processes for when higher levels of internal approval may be required. We will work to finalize a network Provider agreement with Providers while credentialing is in process with the Division's Fiscal Agent or CVO. When a Provider and our health plan have not started the contracting process, and we are notified after credentialing that the Provider requested to enroll with our health plan, our systematic approach to contracting will ensure timely contracting within the Division's requirements.

A.5. Templates of Standard Provider Contracts

Templates of our standard Provider services agreement and hospital services agreement contracts are provided immediately following this section. Provider services agreements are generally used for Provider groups and other facilities, while the hospital services agreement is generally used with hospitals and health systems. Our standard Provider and hospital service agreement contracts for MississippiCAN and CHIP will meet all requirements set forth in Draft Contract § 6.6, Provider Agreements. Our standard single case agreements also comply with all applicable requirements for these contracts. Our standard Provider services agreement will address Provider obligations, the health plan's obligations, claims payments, term and termination, and general provisions, with attachments for the specific products included, compensation levels, specific State and Medicaid laws and requirements, and MississippiCAN and CHIP requirements.

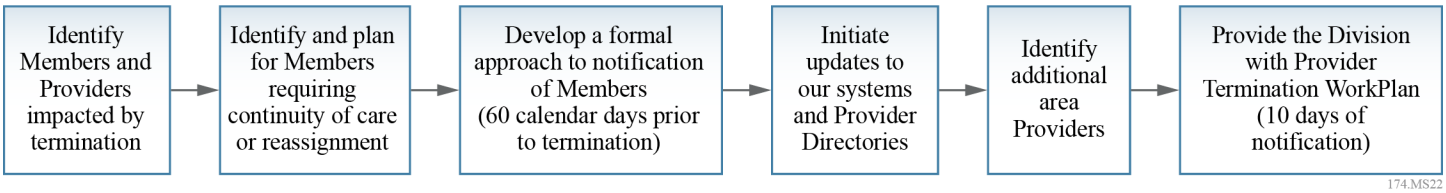
A.6. Policies and Procedures for Addressing a Large Provider Group or Health System Loss

Our policies and procedures employ extensive planning and care coordination activities to ensure a Member's seamless access to services despite any changes in the Provider network. Our strong Provider support systems

have enabled us to avoid losses of large Provider systems. In every case, we have successfully transitioned 100% of Members to new Providers without loss or interruption in access or care.

Upon notice of a termination or loss of a large Provider group, or a decision to terminate a Provider, a multidisciplinary team, which includes the leaders of our healthcare services, Member services call center employees, and Provider representative teams, initiates a recovery approach that promotes the best quality of care for the Member, supports seamless continuity of care, and minimizes disruption to the Member and Providers. This team immediately employs a set of policies and procedures, including a comprehensive work plan, as highlighted in **Exhibit 4.** These processes will comply with all Contract requirements for submittal, development, and implementation of a Provider termination work plan to the Division, as well as notification and Division approval.

Exhibit 4. Our Comprehensive Process Addresses Loss of a Provider Group and Ensures Member Access



Collaboration with the Division is essential to minimizing disruption of care for Members. Therefore, we will notify the Division within 48 hours of a Provider's notification of termination and follow up with the required Provider termination work plan and additional documentation within 10 days of the notification.

Once transition is complete, our team will conduct an interdepartmental follow-up meeting to assess the effectiveness of their actions and identify areas for improvement. The team will also assess whether any early indicators of Provider loss were present and if they were properly identified. We will incorporate any lessons learned from this process into the recovery plan.

A.6.a. System to Identify and Notify Members Affected by Provider Loss

We will use our core system application and our Member portal to identify and notify Members affected by a Provider loss. Our core admin system aggregates claims, membership, Provider, authorization, and other encounter data, which allows us to quickly identify which Members have regularly used the services of the terminating Provider. We will also use our systems to identify alternative Providers with available capacity near Members who may meet the Members' medical and cultural and language needs. In addition, we will post notices about the termination and how to select a new Provider on the Member portal.

We will send a Division-approved written notice within the later of either 30 days before termination or 15 days after notice of a Provider's termination to each Member who receives primary care from the Provider or is treated on a regular basis or is affected by the loss of the Provider for other reasons. We will prepare a notice in a Member's preferred language and send it via the Member's chosen method of communication to inform them about the Provider termination. The notice will contain:

- Information about how to select a new Provider
- Assurances that **current treatments are covered under our continuity of care commitment**
- Date that Members who receive an ongoing course of treatment must cease using their existing Provider
- List of available high-quality Providers in their local area identified by our system
- Contact information for the Member services call center
- Reminder that the Member can speak with a Member services call center employee or their Care Manager to select a new Provider

Each Care Manager and Member services call center employee is available to answer any questions and provide information about network Providers to help guide selection of a new Provider that meets specific Member needs, including medical and transportation needs and gender, language, and cultural preferences.

A.6.b. Automated Systems and Membership Supports to Assist Members with Transitions

Members can use the Member portal, mobile application, and call center to select a PCP, in addition to the list of available Providers included in Member notices of the termination. Our Member portal and mobile

application include an interactive search tool that allows Members to search for Providers based on location, services provided, languages spoken, and other data elements that promote a thoughtful Provider selection. Our Member call center employees are also available to help Members select new Providers.

In addition, our Care Managers conduct in-person and telephone outreach for Members who require relocation or are in active care, as well as to address any specific Member needs. The Care Manager visits with Members, their families, and their caregivers to discuss transitions of care and identify any preferences. A continuity of care plan of action is implemented to transition Members to alternative sites or Providers to alleviate potential disruptions in care, including transportation arrangements and appropriate transfer of all medications, medical equipment, and medical charts to the receiving facility or Provider.

Success Transitioning Members to New Provider

After the loss of a large Provider system in our affiliate health plan, the mother of a Member with autism asked for help finding new Providers. Though she could have switched to the large Provider system's insurance and Providers, she instead remained with our health plan.

She said the family felt well supported over the years and valued the ongoing check-ins by our care management team and in-home nurse practitioners.

Despite the network changes, the Member's CHW found a new prescriber and occupational therapist to meet the Member's needs. The family says they now feel very prepared for the change.

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Our processes will ensure Member continuity of care, minimize disruption, and result in a quick return to network access and adequacy compliance in the event of a Provider termination or loss. Processes also include:

- Conduct Care Manager outreach to Members within the first week following the Provider's termination to assist with the transition as well as selection of a new PCP in their area
- Prioritize Members based on their medical, safety, social, and BH needs, scheduling Care Manager-led meetings with Members, their families, and their caregivers to discuss transition of care and identify any preferences they may have
- Develop a specific continuity of care plan of action, including transportation arrangements, to transition Members to alternative sites or Providers to ensure no disruption in care occurs
- Transfer all appropriate medications, medical equipment, and medical charts to the receiving facility or Provider
- Establish on-site monitoring of the receiving facility or Provider to ensure it provides the appropriate quality of care
- Track availability of other facilities that better reflect the Member's wishes if they must temporarily be placed in a residential facility that is not their first choice

A.6.c. Systems and Policies to Maintain Continuity of Care

Unless a Provider is terminated for cause, we allow Members to continue an ongoing course of treatment for up to 60 calendar days from the date they are notified of a Provider's termination or pending termination or for up to 60 calendar days from the date of the termination, whichever is greater. We extend this continuity of care period when clinically appropriate. A Member who is pregnant may continue to receive care from the terminated Provider through completion of the Member's postpartum care.

We will secure single case agreements with out-of-network Providers to ensure access to care while we contract with the Provider. Our care management software is configured to support continuity of care requirements, including alerts to notify Care Managers of outstanding PCP assignment needs and alerts if regular appointments or lab tests are missed or maintenance prescriptions are not filled that may indicate a need for intervention.

For at-risk Members currently in inpatient care, we will employ our transition of care program to reduce avoidable readmission during the Provider transition process. Interventions will include assessment of health status, including BH issues and needs; medication management; follow-up care; coordination of post-discharge services; evaluation of housing/shelter to facilitate services if appropriate; and nutritional management.

A.6.d. Approach to Covering Membership Needs with Existing Network Resources

Following notice of a Provider termination, we use GeoAccess tools to determine network adequacy from both a quantity and quality perspective before the Provider leaves the network, to ensure we have Providers in place

to fill any resulting gaps. GeoAccess analyses will help us understand the impact on access and adequacy for Members based on time and distance standards and network capacity to accept new patients. If we determine a deficiency exists, we will identify recruitment targets and begin contracting efforts.

Our network also includes robust telehealth resources to address gaps, ensure primary/specialty service delivery, and augment service delivery to Members. We also expand existing network capacity by encouraging Providers to employ physician assistants, certified nurse practitioners, and other healthcare professionals in primary and specialty care offices.

A.7. Provider Incentive Programs to Improve Access and Quality of Care

Our recruiting efforts will offer Providers VBP models aligned with the Division's Value-Based Purchasing Work Plan designed to implement an innovative and collaborative statewide VBP program. We will offer Providers participation in VBP models that incorporate incentives designed to engage and meet Providers at appropriate levels of VBP adoption and integration. The fundamental components of our VBP strategy include:

- **Engage the Division, traditional and nontraditional Providers, health plan Provider advisory board, and QM committee**, to solicit feedback and input on VBP model design, including challenges, barriers, and improvement opportunities.
- **Address the State's goals and priorities** by assessing opportunities with other CCOs, Division subject matter experts (SMEs), Providers, Members, and other stakeholders to collaborate on VBP initiatives.
- **Align VBP models with our population health program** to drive cost-efficiency, improved quality and health outcomes, and enhanced Member wellness in a holistic way and adjust to address the clinical, cultural, and social drivers of Member health as these drivers change over time.
- **Enable Providers to succeed** by designing arrangements that match their capabilities and providing flexibility in financing, quality evaluation metrics, and opportunities to advance to more sophisticated VBP arrangements along the continuum of risk under the HCPLAN APM Framework.
- **Deploy VBP technical and clinical assistance tools, processes, and resources to support Provider success and improve Member outcomes,** including data analytics and reporting, IT systems, and dedicated training staff. These supports enable Providers to succeed under initial VBP arrangements while building the infrastructure and road map to advance along the APM Framework.

Considering the Division's vision for the CCO Program, the best potential for Provider adoption, and our experience with VBP for Providers serving similar populations nationwide, we will implement the programs described in more detail in our response to RFQ § 4.2.3.1, Value-Based Purchasing.

A.8. Maintenance of Provider Files to Support Provider Payments

We will coordinate with the CVO credentialing process, and aggregate Provider information within our system to support Provider payments, as part of maintaining reliable and up-to-date Provider files in compliance with program requirements. Our fully integrated claims processing system and subsystems enable us to maintain sufficient information on each Provider to support all applicable Provider operations, including payments. Our processes for maintaining our Provider file comply with all contract requirements, regulations, and laws. **Table 3** lists our core applications and how they support our process for maintaining Provider files.

Table 3. Core Systems and Their Role in Maintaining Provider File and Functions

Systems	Description of Features and Functionality
Credentialing Management Application	Our credentialing management application aggregates information received from the CVO and allows business users to define and store custom Provider attributes, including Provider licenses, certifications, NPI IDs, and education and malpractice information.
Core Admin System	Our core admin system provides access to a variety of information, including Provider data, which users can retrieve from a central location. It also provides a flexible, user-friendly interface.
Financial Management System	Our financial management system facilitates the flow of financial information and handles a wide range of other transactions to reflect complete financial activities. The system's enterprise resource planning modules help streamline reporting for Generally Accepted Accounting Principles (GAAP), taxes (including 1099s), and certain ad hoc uses of data.

Process to Maintain the Entity's Provider File

Provider credential and recredential data is stored within the credentialing management application, which allows users to define and store custom Provider attributes to maintain Provider licenses, certifications, and education and malpractice information. We aggregate all necessary Provider information required by the IRS and other regulatory entities, including a valid Provider ID number/service location and NPI/taxonomy/zip code. Our credentialing management system also tracks Drug Enforcement Administration, Clinical Laboratory Improvement Amendments (as applicable), and NPIs, and includes a security module to protect confidential information.

Provider demographic and payment terms and conditions feed into our core information system. We track all contracted and noncontracted Providers through the Provider module subsystem. For updates and modifications to Provider data, such as address or phone number changes, our Provider representative team submits requests to Provider data management to update the file. We also maintain data needed to comply with the Division's standards for accurate designation of each Provider.

A.8.a. Ability to Issue IRS 1099 Forms

Our process for maintaining Provider files sufficient to support issuing IRS 1099 forms involves integrating Provider file and claims payment information from our core admin system into our financial management system and uploading annual 1099 filings to the IRS from our financial management system.

Claims check payment data is integrated from our core admin system into our financial management system, which creates a single environment for combined reporting of claims and non-claims payment activities. Integrating data into our financial management system streamlines reporting for GAAP, tax (including 1099s), and certain ad hoc uses of data. We employ comprehensive internal control systems to verify completeness and accuracy of data integrated into the financial management system, which include formal approval processes, formal and routinely performed reconciliation processes, segregation of duties, and internal audit review.

All Providers are established and claims are paid in our core admin system. A TIN remediation team validates Provider TINs against the IRS's website. The team tracks all correspondence, W-9 collection, and data entry modifications, which are then updated in our core admin system. Provider address information, including any data updates, Provider parent affiliation, and Provider tax exempt status, is integrated daily into our financial management system. Payment information is integrated monthly to our financial management system general ledger. Annual electronic software updates are installed in the general ledger system to account for any new IRS regulations, required systems, or filing modifications. Further, our corporate tax department provides guidance on any new IRS regulations.

The TIN remediation team reviews and updates the Provider 1099 data stored in our financial management system on a quarterly basis. Original and corrected 1099s are consolidated based on like Provider TINs per each of our health plans and printed from our financial management system. IRS annual 1099 filing (i.e., magnetic media) is uploaded to the IRS site directly from our financial management system.

A.8.b. Ability to Meet All Federal and Division Reporting Requirements

Through our standard and customizable/ad hoc reporting capabilities, we will provide all reports in accordance with all reporting requirements established by the Division and outlined in the Draft Contract. Further, we will report information in compliance with all current and future State and Federal laws and regulations governing reporting and disclosure requirements.

Our financial management system includes a standard set of financial reports, such as balance sheets, income statements, and budget related reports, with budget variance, year-to-date, and period-to-date report capabilities, and can be used for all general ledger, accounts payable, and financial statement presentations in conformity with GAAP. The system also allows for the creation of user-defined reports. We have also developed a package of standardized reporting that accesses data from the back end of the system.

Our core admin system's finance manager module allows the creation of custom reports based on predefined financial templates. These templates allow the creation of comprehensive financial reports to monitor Member

utilization, claims payment, and overall financial performance on a timely basis. This critical module allows summary or detailed reporting, which is also used to integrate the financial data with the accounting system.

A.8.c. Ability to Cross-Reference to State/Federal Identification Numbers to Identify and Report Excluded Providers

We monitor Provider sanctions between recredential cycles for all Provider types and take appropriate action against Providers when we identify occurrences of poor quality. Our procedures for monitoring Provider sanctions and qualifications are described in the following paragraphs and are subject to Division review and approval, in accordance with Mississippi requirements. Upon Provider enrollment, reenrollment, and at least monthly thereafter, we verify the inclusion of Providers by checking all required databases. Once we identify an excluded Provider, our Compliance Officer will notify the State within 10 calendar days. All queries are documented and included in the Provider credentialing file.

Process for Ongoing Monitoring of Sanctions

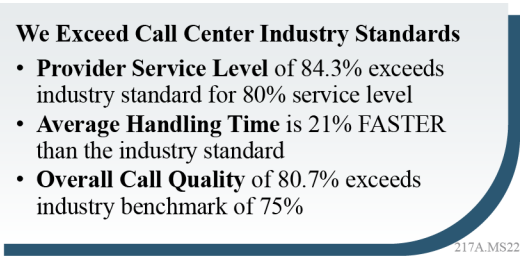
The United States Department of Health and Human Services (HHS) OIG Exclusions Program releases a monthly report of individuals and entities that have been excluded from Medicare and Medicaid programs. Within 30 calendar days of its release, we query every Provider in our core admin system against the updated exclusions report to identify any potential matches between sanctioned Providers and Providers in our system. If our network management department identifies a Provider on the exclusion report, they notify the following departments: claims, contracting, Member services, Provider information management, utilization management, pharmacy, compliance, and QI. The contracting department immediately terminates the Provider's contract effective the same date the sanction was implemented and sends an email notification to the network management department confirming the termination was completed.

We also ensure our core admin system is configured so no claims will ever pay to this Provider and no authorization can ever be generated to this Provider. The network management department maintains a log that indicates the date each OIG report was released, the date our organization reviewed the report, and if there were any matches found between the OIG report and our Provider network.

A similar process allows us to monitor for State Medicaid sanctions/exclusions/terminations through each State's specific program integrity unit (or equivalent). If excluded Providers are identified, we notify the appropriate departments, terminate the Providers' contracts, and configure our system so that claims are not paid to the Providers and no authorizations can ever be generated.

B. PROVIDER SERVICES CALL CENTER

Our Provider services call center will help drive Provider satisfaction by delivering efficient customized services through specially trained, culturally competent Mississippi-based staff who understand MississippiCAN and CHIP program requirements and the needs of our Provider network. Provider services call center employees help Providers access a full range of data, including Member eligibility, claims, authorizations, interpreter and TTY/TDD services, and contracting. Provider services call center employees focus on resolving Provider concerns on the first call and escalate issues to Provider Representatives as needed to resolve issues so that Providers can remain focused on offering high-quality, efficient service to Members.



B.1. Provider Services Call Center Operations

We will exceed State standards for call center operations as part of our commitment to provide consistency and ease of administrative burden for Providers by providing easy-to-use tools and exceptional service.

B.1.a. Hours of Operation

Our Provider services call center will be fully staffed and available Monday through Friday, 7:30 a.m. to 8:00 p.m. CST (our extended evening hours are beyond Draft Contract requirements), including State holidays, except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. Providers can access self-service options 24/7/365 through our HIPAA-compliant, automatic voice response phone system, including eligibility verification, claim status, and authorization status. Providers can also leave voice mail messages, which are returned the next business day. Our Nurse Advice Line is available 24/7/365 to Providers for referrals and other after-hours clinical support and to support emergency Provider issues.

Hours of Operation Exceed Requirements:

- Extended evening hours
- 24/7 assistance for Provider emergency issues
- Direct email and telephone access to Provider services call center employee
- Nurse Advice Line available 24/7/365 for referrals, clinical support, emergency issues

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We assist with emergency Provider issues on a 24/7/365 basis. Providers have access to Provider services call center employees via email and phone with contact information listed on the Provider portal. We will also create a map with our direct contact information for our Provider representative team and territory assignments, which will be emailed to Providers and distributed at on-site Provider meetings, conferences, workshops, and other Provider gatherings.

B.1.b. Ensuring Call Center Employees Have Cultural Competency

We are committed to exceptional service and culturally competent support for all Providers and Members. We ensure plan staff are well-versed in cultural factors that impact Member care by requiring computer-based trainings for all employees and new hires as part of onboarding. Provider services call center employees participate in mandatory company cultural diversity training and will receive monthly communications that promote an understanding of cultural perspectives and traditions specific to the Mississippi population. Our staff is equipped to direct Providers to resources that meet specific cultural and linguistic needs to care for Members in special population groups. Staff receive initial and periodic training and education in culturally and linguistically appropriate service delivery. All staff receive training about the significance of traditions and health practices of various cultural and ethnic groups, religious holidays, and other cultural topics.

We will also pursue NCQA Multicultural Health Care Distinction (soon to be Health Equity Accreditation) for our MississippiCAN and CHIP programs. Many of our affiliate health plans are in process and/or have already achieved the NCQA Multicultural Health Care Distinction, with many also achieving NCQA Health Plan Accreditation, NCQA Long Term Services and Supports (LTSS) Distinction, and/or star ratings in clinical quality, Member satisfaction, and accreditation survey results. These achievements demonstrate our commitment to quality and culturally competent service delivery.

B.1.c. Standards for Rates of Response

We will establish and comply with standards for rates of response identified in **Table 4**, which lists performance results for one of our affiliate health plans as an example. Provider services call center teams across our health plans enterprise-wide have met 100% of our target 2021 KPIs. We consistently meet or exceed program requirements, as demonstrated in our health plans' call center standards and results enterprise-wide for 2021.

Table 4. Our Affiliate Health Plans Meet Provider Services Call Center Standards and Performance Results for 2021

Performance Measure	Performance Standard	Performance Results
Service level percentage (live answer by Provider call center employee)	More than 80% of calls are answered within 30 seconds	82.3% answered within 15–20 seconds
Average monthly abandonment rate	No more than 4%	3.5%
Average monthly speed to answer	After initial automatic voice response, wait is 120 seconds or less	49 seconds
Average length of call	6 minutes 3 seconds (363 seconds)	286 seconds (21% faster than the industry standard and significantly exceeded industry benchmarks)

Performance Measure	Performance Standard	Performance Results
Call quality	75%–90%	80.7% (met or exceeded industry benchmark for overall call quality)

Measures to Ensure Standards are Met

We will meet or exceed all Contract performance standards, including maintaining the appropriate number of qualified staff on-site. We maintain a call center staffing-to-call ratio at one call center employee to 15,000 Members, based on call center sufficiency standards. Our Provider services call center will be located in Jackson, Mississippi, which emphasizes our investment in communities, human capital, and workforce in Mississippi. Although our call center capacity is highly scalable, during an emergency or overflow event, we can seamlessly route calls to multiple call center operations nationwide to continue serving our Providers. All Provider services call center employees are culturally competent and will be appropriately trained on MississippiCAN and CHIP benefits and services and the specific populations they serve as part of the program.

We will use data from our client relationship management platform, call tracking, and Intelligence Center software integrated with the call center phone system to track the call performance metrics identified in **Table 4** for both internal operational performance management and external reporting to the Division. We also monitor call volume, calls handled, and call quality on a system and/or call center employee level.

Call center management monitors performance daily, weekly, monthly, and quarterly to ensure compliance with performance standards. If standards are not met, we take corrective actions the next day to resolve the issue. We document and maintain all calls in our client relationship management platform and core information systems, which also enables us to monitor and report on warm transfers used to ensure Providers' questions are addressed as quickly as possible. We also assess Provider services call center employee performance weekly through monitoring side-by-side and remote calls and systems, checking for adherence to processes based on the type of call received, documenting all inquiries, and meeting quality audit criteria.

B.1.d. Training Program

Our Provider services call center employees, dedicated to answering calls from Providers, are trained to fulfill all call center functions before they have contact with Providers. Provider services call center employee training will encompass MississippiCAN and CHIP program information and include two weeks of classroom training as well as side-by-side mentor training to develop experience answering calls. We train Provider services call center employees to successfully connect BH/SUD Providers with required resources to meet Members' BH/SUD needs and proactively address challenges these Providers face in Mississippi. We will track and report monthly BH/SUD line calls received and processed by our call center and Nurse Advice Line.

Call Center Key Training Topics

- Cultural competency
- Member eligibility and current enrollment
- Prior authorizations and referrals
- Out-of-network Provider referrals
- Claims payment procedures, disputes, issues
- Medicaid Fee Schedule
- Division's Administrative Code
- Division's Rate Updates
- Billing for MississippiCAN and CHIP (modifiers recognized by the Division)
- Electronic claims submissions
- Complaints, grievances, and appeals
- Medical records transfers
- PCP panel lists and uses
- FWA hotline
- Covered services
- Out-of-network services
- Contracting and credentialing

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Our Provider services call center employees receive trainings at least quarterly. They also receive updates about all Medicaid changes and requirements, including "late breaking news" articles, Provider bulletins, State plan amendments and administrative code filings, and updates to the Provider billing handbook, MississippiCAN, and CHIP. Our Provider call center employees complete robust cultural competency training upon hire, and annually or as necessary, to ensure the consistent delivery of care that is culturally and linguistically appropriate.

We also train Provider services call center employees to provide PCPs a monthly list of Members who are under their care, including identification of new and deleted Members and an explanation guide detailing the use of the list. Provider services call center employees assist Providers in escalating issues to Provider Representatives and are trained in the types of issues appropriate for escalation and referral. We submit quarterly reports of trainings conducted, topics, and the number and positions of staff completing trainings.

B.1.e. Using Electronic Communication to Respond to Providers

Our HIPAA-compliant automatic voice response phone system allows Providers to access self-service options over the phone, including eligibility verification, claim status, and authorization status. The automatic voice response system is integrated with our core information management system, so data is exchanged in real time and accessible 24/7/365.

Our secure Provider portal allows Providers to search for other network Providers; submit and view authorization requests, conduct referral follow-up, and obtain real-time approvals; check claims receipt and status; generate a list of Member panels; and view HEDIS services reports. The portal is accessible to authorized users and Providers in accordance with HIPAA privacy and security guidelines and State laws. Providers can text or email Provider services call center employees for answers. We will also offer an integrated messaging feature from the claim status screen in the Provider portal, which is a faster, more effective platform for resolving simple queries about claims status.

B.2 Assessing the Quality and Efficiency of the Call Center

Plan staff audit Provider calls to assess the quality and efficiency of the call center. Our service quality assurance team will randomly select and record calls received and monitor no less than 3% of calls each month for compliance with customer care guidelines. The team will audit the calls and assign a score. We will report audit findings to the Division quarterly, make recordings available to the Division upon request within five business days, and maintain the recordings for at least 12 months.

The Provider services call center, in partnership with our workforce management team, will monitor and manage staffing levels and schedules to ensure performance meets or exceeds all key performance indicator standards, including the contractual requirement to ensure no more than 4% of Provider calls are abandoned.

We also review call trends to identify and resolve common issues among Providers. Our call trend report, which we will submit monthly to the Division, will document the most frequent categories of calls. We will compare categories monthly with the previous six months to remedy any reoccurring issues. We will also address any global issue identified by the Division in response to Provider communications. We organize call trend reports by categories based on performance expectations for Provider services call center employees.

We have developed training programs specific to COVID-19 issues identified through our call trend reports to equip our Provider services call center employees to assist Providers. Call center employees also work with care coordination staff, who assist Members with food access, transportation, testing, or other issues. Our call trend report tracks Provider calls related to COVID-19, including prescriptions, benefits, testing (cost, locations, eligibility), claims, Provider changes (due to appointment availability), temporary office closures, decline of PCP/home visits (Member refusing to go to PCP due to COVID-19), and access to care.

C. PROVIDER EDUCATION AND COMMUNICATION

Overview of Provider Education and Communication Approach

Nationally, our health plan views network Providers as key partners in improving health outcomes in States where we serve Medicaid Members. For Providers to succeed in helping to improve outcomes for Medicaid Members, they must thoroughly understand how the program operates, where to get questions answered, how to respond to programmatic changes and innovations, and how to help Members access covered services, care management, and community-based programs.

Our goal is to improve the Provider and Member experience, becoming the health plan of choice for Providers by delivering easy-to-use tools and exceptional service. We will support Mississippi Providers with comprehensive training (including individual training at Provider practice locations when requested) and easily accessible technical assistance. We will design our education and training program to address Providers' needs and offer education and training via multiple modalities to help reduce administrative burden, allowing Providers to focus on improving Member health. Following the guidance of our Health Equity and SDOH Manager, we will ensure our education and training program promotes health equity and includes implicit bias training.

C.1. Education of Network PCPs/PCMHs About Care Management

Provider representative team and care management staff will educate network PCPs/PCMHs about care management through a three-tiered program aligned with the Provider's needs and preferences:

- **First level.** Provider Representatives, with cross-training by care management teams, explain care management functions when meeting with Providers.
- **Second level.** Provider Representatives include Care Managers during meetings with Providers.
- **Third level.** Pilot places Care Managers in clinics that are interested in this opportunity.

We will establish trust with Providers by offering clinical and technical expertise with resources and tools to incorporate the Care Manager into clinic workflow. The Community Health Center Association for Mississippi (formerly the Primary Health Care Association) has expressed commitment to work with our health plan on identifying clinics and launching this program.

Education About Care Management Services and How to Connect with Care Management

The Provider representative team provides initial training to Providers within 30 days of contracting, which includes the role and responsibilities of the Care Managers for Members and the process for referral to care management. Providers will receive education on how to refer Members to care management telephonically on our live-staffed (during normal hours) care management telephone line and/or by faxing a referral form to our care management team. Providers can also fax directly to a Care Manager's email inbox that is managed by supervisors. Our Provider manual includes a description of the care management system and protocols and of the role of the PCP, including importance to the Member, legal guardian/caregiver, and care management team. Our care management welcome guide summarizes care management services in an easily accessible format and provides a process for referring Members to care management and collaborating with Care Managers.

Encouraging PCPs/PCMHs to Use Care Management

Provider representative team and care management staff will develop and submit to the Division our strategy to ensure PCPs are interacting as often as possible with care management, which will specify our methods for driving engagement, educating about the benefits of care management, and addressing health equity concerns; how PCPs can interact with care management, and best practices to ensure engagement. Our strategy will comply with the Division's Consolidated PCP Care Management Engagement Strategy.

To encourage Providers to use care management, we will inform PCPs/PCMHs of referrals made so that the Provider can document the referrals in their own records. We will also inform the Provider if the acuity level of the Member changes and transition Members who experience an increase in acuity levels from a PCP to a PCMH system, working with a PCP to enable the PCP to act as a PCMH, as appropriate.

We will also encourage PCMHs to coordinate their care coordination activities with our care management teams through our proposed Integrated Primary Care (IPC) VBP model. This model will be designed in collaboration with the Division to increase access to high-quality primary care, improve whole-person health outcomes, and address access and treatment barriers raised by SDOH and health disparities. Care management is necessary for PCMHs to deliver high-quality services and improve whole-person health outcomes under VBP arrangements. Care Managers assist Members in addressing treatment access and barriers, following physician recommendations, building personalized care plans, adhering to prescriptions, and other activities that help PCPs/PCMHs improve health outcomes and gain access to higher earnings under VBP arrangements.

Measuring Care Management Engagement and Addressing Underutilization of Care Managers

Health plan staff will measure care management activity by Providers by tracking care management engagement by Provider/Provider type using an active care management indicator in the Provider's Member panel report. We will target Providers with a lower-than-expected volume of Members in care management for outreach and education and then measure whether the number of Members active in care management increases. We will use all data we collect to strategically pinpoint expected Provider types who should have higher saturation of Members moving through care management. We will filter the data by highly utilized PCMHs, ERs and/or hospitals, women's health centers and OB/GYNs, and other types to identify commonalities, such as region, predominant ethnicity served, and HEDIS outcomes where care management services are underutilized.

Our Provider Representatives and Provider Quality and Practice Transformation Specialists will provide one-on-one technical and clinical expertise for Providers found to underutilize care management resources to address specific barriers. Provider Representatives will offer virtual focused training on care management, including services offered, eligibility criteria, referral process, and Provider consultation process. Joint operating committee meetings offer additional opportunities to address underutilization with specific PCPs. Our Provider training will also include detailed guidance to Providers regarding collaborating and communicating with care management, including the transitions of care team and UM departments, for care management referrals, care management performance, and our other population health programs.

C.2. Education of PCPs/PCMHs on Referral and Collaboration with BH/SUD Providers

As the first contact for Members, PCPs play a key role in identifying BH/SUD symptoms. A Member's cultural background may lead them to prefer to see a trusted PCP rather than a BH specialist. Our BH team supports and educates PCPs about BH/SUD conditions, including screening, treatment, referral opportunities, and collaboration with specialists, facilities, and CBOs. We encourage PCPs and BH/SUD Providers to integrate BH/SUD and primary care services to produce the best outcomes and support Members on their road to recovery.

Investments in PCP/PCMH Integrated BH Services

Working with I/T/U Providers, our affiliate is increasing BH services access and resources to support tribal care coordination and chronic disease management. The health plan recently awarded a substantial grant to a health center to help fund full-time American Indian peer support specialists; build secure, HIPAA-compliant telehealth infrastructure connecting Members to off-site psychiatric and addiction services; monitor chronic physical health/BH conditions; refer Care Coordinators for face-to-face meetings with Members; and leverage the Recovery-oriented Systems of Care model for treatment and intervention.

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Our educational program includes orientations for newly contracted Providers within 30 days of completing contracting. For new and current Providers, we offer training programs by telephone, face-to-face, via web conferencing, or in classroom settings. Trainings address core topics applicable to all network Providers and are supplemented with specialty topics. All Providers can also access ongoing training on Contract requirements, policy updates, and Members' special needs through scheduled in-person office visits, group training at public conference sites, or webinars. Our Provider manual also serves as an excellent resource for Provider reference.

Educating PCPs on BH/SUD Treatment Referrals

Absence of proper treatment referral can prevent Members from receiving timely and appropriate care, exacerbate other health issues, and increase cost of care. Our training and education program supports PCPs in treating BH and SUDs and identifying when a Member's disorder may be best served by a BH/SUD Provider.

Our BH team, led by our Medical Director, develops BH toolkits for PCPs and specialists. These toolkits are designed to help Providers assess and treat BH conditions in the primary care setting, as well as provide guidance regarding Member referrals to a BH/SUD Provider. Each toolkit includes screening tools, diagnostic criteria, clinical guidelines, interventions, and links to additional clinical resources. For example, the toolkit's clinical guidelines for Members with moderate risk of clinical depression promote medication review, and PCPs can also discuss Members with complex conditions with a health plan psychiatrist or SUD specialist.

Outcomes Promoted by our BH Toolkit: Clinical Guidelines for Members with Moderate Risk of Clinical Depression

- Medication review
- Evaluation of social supports
- Referral to our care management team
- Referral to a Provider
- Assistance with locating a Provider
- Scheduling, and coordination with the Provider

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We educate Providers on how to refer a Member when they determine medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals. We encourage PCPs to refer to the most appropriate level of care, which would include Mississippi's community mental health centers and PRTFs. We require PCPs and BH/SUD Providers to exchange information to coordinate and ensure continuity of Member care. Providers are required to document referrals in the Member's medical record, including the specialty, services requested, and referral diagnosis. To further facilitate the integration of care, Providers are required to refer Members to network BH/SUD Providers, except for emergency services. In addition to educating PCPs on referral processes, we provide tools, such as

our online Provider directory, to reduce administrative burden and simplify identification of available specialists for referral.

Health plan BH Care Managers are on call for contracted PCPs and PCMHs that have questions on how or when to refer a Member. For higher-acuity Members enrolled in our care management program, our staff often collaborate with a Member's Providers in the community to assess and secure resources needed to meet the Member's specific needs. Our Nurse Advice Line, which is staffed by RNs with BH training, is also available 24/7/365 to provide referrals, verify network Providers, and supply other needed clinical support.

Training PCPs to Collaborate with BH/SUD Providers and Systems

Training and toolkits emphasize effective collaboration between PCPs and BH/SUD Providers to minimize adverse medication interactions for Members taking medications for BH conditions, allowing for better management of treatment while improving follow-up for Members. We offer Provider training on our integrated model of care, including the roles of Care Managers, CHWs, and the Member and their family, as well as Providers (including the PCP and BH/SUD Providers) and social workers. We emphasize the importance of information sharing and data exchange. We include these topics in Provider orientation materials and sessions.

Key to encouraging PCP and BH/SUD Provider collaboration are incentives based on improved HEDIS measures. We will offer a pay-for-performance program targeting the seven-day follow-up after hospitalization HEDIS measure. Providers earn a bonus payment for completing follow-up visits with a target percentage of Members. We also make BH claims data available to network PCPs and BH Providers via our secure Provider portal to encourage Providers to work with Care Managers, schedule appointments and transportation, identify missed appointments, and share data to ensure their assigned Members receive follow-up care.

Additional Support for PCPs

Our model of care includes BH Care Managers supporting PCPs and ensuring collaboration among Providers, leading to greater efficiency and effectiveness of care delivery and better health outcomes. We train Care Managers to understand complex medical conditions and associated self-management interventions, and offer expert communication skills, community-based resource knowledge, and care management experience to our PCPs and other Providers. For example, Care Managers ensure their contact information is easily accessible when a PCP meets with a Member. If the PCP diagnoses a Member at high-risk for depression, the PCP knows to call the Care Manager to identify a BH Provider that can meet the Member's needs, immediately engage a BH specialist, and if needed, initiate visits with the Provider.

Our physical health/BH integrated care management model supports full integration of physical health, BH, and SDOH to eliminate fragmentation of care. Integration is achieved from the outset, when we assess our membership's needs and begin designing strategies to improve health outcomes, and continues all the way through evaluation of our effectiveness. Our healthcare services staff streamline interactions between internal teams, Providers, and other appropriate resources, promoting highly effective collaboration across disciplines that results in optimized Member care. Our streamlined processes establish one care management action, contact, or consultation to cover multiple health and social care needs to simplify process, reduce wasteful efforts, and improve Member outcomes:

- One set of physical health, BH, and SDOH criteria by care management risk level
- One assessment (HRS/CHA) for physical health, BH, and SDOH that triggers or prompts more comprehensive assessments
- One care plan, so the entire care team can be aware of the Member's holistic and personalized goals
- One care team for multidisciplinary consultations and comprehensive recommendations
- One primary case assignee who comanages with other assignees based on discipline and Member need

Our BH Care Manager will assist PCPs and other Providers by:

- Streamlining the UM processes: Working with Providers such as DME Providers, home- and community-based service Providers, public agencies, BH counselors, CBOs, and other identified service Providers to ensure necessary services and/or equipment are in place
- Connecting Providers with educational opportunities to enhance how they work with Members diagnosed with BH conditions, especially in a medical setting

- Facilitating and participating in interdisciplinary care team (ICT) and/or multidisciplinary team meetings and informal ICT collaboration on behalf of the Member to assist with their individual needs
- Assessing for barriers to care and providing care coordination and assistance to Members to address concerns to lessen the impact of SDOH and increase adherence to the Provider's treatment plan
- Supporting and strengthening Providers' efforts to give Members the information they need to improve health literacy and self-advocacy

To increase BH/SUD service access, we also encourage the use of telehealth by providing reimbursement incentives to Provider groups interested in establishing a telehealth platform or designating clinic space for Member consultation, in the form of a quarterly bonus to Providers serving four or more Members via telehealth. We have identified key health systems in Mississippi and neighboring States with robust telehealth programs for potential inclusion in our network to further expand access to BH and SUD services in rural and underserved areas and integrate these services into the primary care service environment.

C.3. Description of Provider Manual Development

The Provider manual is the foundational building block of our Provider education process and the primary reference source for our Providers. Health plan staff will develop distinct Provider manuals for those serving the MississippiCAN and CHIP populations, which will be reviewed by both health plan and corporate functional area SMEs for validation updates annually. Provider feedback informs the review process and contributes to the relevance and usefulness of the Provider manual. For example, we have added additional claims information in response to Provider requests for more detailed instructions on claims submission processes and available tools that enhance administrative simplicity. We will also collaborate with other CCOs to standardize the language in the Provider manuals, where appropriate, to assist Providers with coordinated and consistent information.

For ease of access for all participating Providers, the Provider manual is available on our website and through the Provider portal. To ensure changes to the Provider manual are transparent and visible to Providers, we also post a document alongside the manual that outlines important updates and send an email and/or fax blast communication notifying Providers when an important update has been made. We will submit the manuals to the Division for approval 90 calendar days prior to implementation and obtain approval before use.

MississippiCAN and CHIP Provider Manual Major Sections

Our health plan manuals will address all required topics, including those listed in **Table 5**.

Table 5. Description of Major Sections of MississippiCAN and CHIP Provider Manuals

Major Sections	Description of Topics
Health Plan Overview and Contact Information	• Introduction to MississippiCAN (or CHIP, as applicable), health plan structure, departments, and key contact information, including phone numbers, email addresses, websites, and fax numbers • Contact follow-up responsibilities for missed appointments • Explanation of the Division's requirements that the health plan may not require the Provider to agree to non-exclusivity requirements nor to participate in the health plan's other lines of business to participate in MississippiCAN
Care Management	• Description of the care management system and protocols • Roles and responsibilities of Care Managers and process for referrals to care management
Provider Responsibilities and Primary Care	• Description of the responsibilities of network Providers, including key policies, rules, and regulatory requirements • Description of the role of a PCP (including the PCP's importance to the care management team) and covered services, including excluded services, copayments, and benefit limitations • Description of PCMH role • Communication with the health plan on limitations on panel size and Member assignment to an alternate PCP/PCMH • Information about EPSDT screening requirements and services (well-baby/well-child for CHIP) • Provider responsibility to follow up with Members who are not in compliance with the EPSDT screening requirements and EPSDT services (well-baby/well-child for CHIP) • CVO credentialing processes, and health plan's coordination activities
Benefits and Covered Services	• ER utilization (appropriate and inappropriate use of the ER) • How Members can access specialists, including standing referrals and specialists as PCPs • A definition of "medically necessary" consistent with the Contract language • PA requirements, including minimum of a three-day emergency supply for drugs • UM: inpatient management, post-service review, open communication about treatment, and delegated UM functions • Communication and availability to Members and Providers • Out-of-network Providers and services

Major Sections	Description of Topics	
	• Coordination of care and services: continuity of care and transition of Members, reporting of suspected abuse/neglect, and health management • Services covered by the health plan and access to certain covered services: preventive care, well-child and EPSDT guidelines, emergency services, Nurse Advice Line, health education, and disease management • Telehealth services: telehealth toolkit, including regulations and infrastructure assistance options	
Cultural Competency and Linguistic Services	• Written translation and verbal interpretation services for Members with limited English proficiency, and alternate methods of communication available at no cost • Nondiscrimination in healthcare service delivery, cultural competency • Nurse Advice Line	
Member Rights and Responsibilities	• Member rights and responsibilities • Second opinions	
Enrollment, Eligibility, and Disenrollment	• Member enrollment, eligibility verification, and disenrollment • PCP dismissal, PCP assignment, PCP changes, and Missed appointments	
Claims Payment	• Billing instructions, including claims submission time frame requirements and manual or invoice pricing requirements • Claims submission, required elements, electronic submission, paper submission, and timely claim filing • General coding requirements: CPT® and HCPCS codes, modifiers, coding sources • Reimbursement guidance and payment guidelines • Hospital-acquired conditions present on admission • Coordination of benefits and third-party liability • Claims auditing, corrected claims, overpayment and incorrect payments, and claim reconsiderations and appeals • Balance billing and encounter data	
Provider and Member Disputes	• PA review and reconsideration; grievance, appeal, and State Administrative Hearing information • Member and Provider grievance, appeal, and State fair hearing procedures and time frames; Member's right to file grievances and appeals, assistance with filing, Member's right to request a continuation of benefits during a pending appeal (for MississippiCAN), and Member's right to an Independent External Review (for CHIP) • Expedited review process	
Quality	• Quality of care and patient safety program overview • Medical record documentation and medical record-keeping practices • Access to care: appointment access, office wait times, after hours, appointment scheduling, and women's health access • Quality of Provider office sites, including physical accessibility, physical appearance, and waiting room space • Advance directives	• EPSDT (for MississippiCAN) and well-baby/well-child (for CHIP) visits • Clinical practice and preventive health guidelines HEDIS and CAHPS • Patient safety program • QI activities and programs • Measurement of clinical and service quality • VBP programs • Health equity and population health programs
Compliance	• FWA • HIPAA, Member privacy and confidentiality requirements • Information security (cybersecurity)	
Technology Tools	• Description of information available through the Provider portal and process for accessing	
Delegation	• Delegation criteria and reporting requirements • Sanction monitoring, OIG Exclusion List	
Risk Adjustment	• Explanation of risk adjustment and importance • Your role as a Provider • Risk adjustment data validation audits	
Pharmacy	• Specialty pharmaceuticals, injectable and infusion services • Contact information for State PBA	

C.4. Developing Provider Trainings and Workshops

The Provider representative team will leverage our national best-in-class trainings and workshops for our Mississippi education and training plan and materials for network Providers and offer education and training to Providers and their staff regarding key requirements of this Contract. We will comply with all State requirements related to Provider training and education, including submittal of the Provider training manual and plan to the Division, submittal of training reports to the Division, deadlines for conducting initial education and training, and policies to monitor and ensure compliance of Providers with the requirements of this Contract.

The Provider representative team will comply with State requirements to conduct live hosted webinars with live Q&A sessions in coordination with other CCOs on a bimonthly basis. Webinar topics will be nonduplicative, include focused topics of interest to specific Provider types and general topics applicable to all Providers (e.g., proper billing), and be approved by the Division in advance. Health plan staff will facilitate all aspects of the webinars, track and share attendance with the Division, and record and post webinar content on the Division website for Providers who are unable to attend. We will also work collaboratively with the other CCOs in planning and executing the large format in-person conferences/workshops and webinars as required and approved by the State. We will provide the Division with detailed notes on training proceedings. We will keep a library of downloadable trainings and educational documents on our Provider website that Providers can easily access anytime.

Brief Description of Six Possible Training Topics and Technical Assistance

The Provider representative team will facilitate trainings and workshops via on-site facilitation and/or virtual training through web conferencing for new Provider orientations, refresher training, Provider townhall meetings, and to meet any personalized training needs at the Provider's request. The Provider representative team will also educate Providers during attendance at Provider conferences and workshops, and Division workshops/webinars. We will identify opportunities to collaborate with other CCOs—for example, to develop a video series focused on PCP/PCMH best practices for screening and management of chronic conditions and Member referral to address SDOH. In addition to State-required training, we propose developing training on the specific topics listed in **Table 6**.

Table 6. Description of Six Possible Training Topics

Training Topic	Description of Topic Scope
New Provider Orientation Training	Training for both general Provider audiences and specific Provider groups (e.g., BH Providers, with focus on SUD; and PRTFs, PCMHs, DME Providers, with focus unique to their populations)
Enhanced EPSDT (MississippiCAN) and Well-baby/Well-child Education (CHIP)	Training for EPSDT-certified Providers, PCPs, and pediatricians who render these services, with focus on correct coding and education regarding the examination schedule and HEDIS and performance measures
VBP Education	Training on VBP models and their components, coding guidance, data analytics, health plan support systems (including availability of technical and clinical assistance to help Providers meet quality and savings targets), and models to address health disparities and SDOH
Enhanced Claims Submission and Coding	Training to reduce claims denial errors, focused on common mistakes Providers make in filing claims
Cultural Competency and Disability Awareness Education	Training for general Provider audiences with a focus on cultural sensitivity, health disparities, and specific populations (seniors and Members with disabilities, LGBTQ+, immigrants and refugees)
Care Management and UM	Detailed guidance to Providers regarding collaborating and communicating with care management and UM departments for care management referrals, care management performance, and PA submissions and reviews

State-required Initial and Ongoing Training Topics

Our education and training plan and materials will address all State-required initial and ongoing training topics. We will also include topics, such as those described in **Table 7,** that offer expertise Providers need to provide high-quality services for Members. Training for Providers will include information about EPSDT services for those who treat MississippiCAN Members and well-baby and well-child services for those who treat CHIP Members. Each training topic will address the unique needs of each of these populations.

The Provider representative team will employ expert staff trained in trauma-informed care to conduct initial training on abuse/neglect, which includes abuse, neglect, and exploitation of adult Members and suspected brutality, abuse, or neglect of child Members. Training includes how to assess risk for abuse/neglect, how to identify abuse/neglect, and how to report abuse/neglect to MDCPS and our health plan staff. We will provide access to training on trauma-informed care and treatment modalities to address the impacts of abuse, neglect, exploitation, and brutality on Members. This training equips Providers with knowledge and expertise to create treatment environments for Members who have experienced trauma to avoid triggering trauma impacts.

Table 7. State-required Initial Training Topics

Initial Training Topics	Initial Training for Providers Taking Care of Children
Medicaid, CHIP, and coordinated care overviews	Social and emotional development
Member and Provider enrollment	Trauma-informed care
Service authorization requirements and processes	Valid developmental screening instruments
Care Manager roles and responsibilities	Identifying/referring developmental delays in young children
Service delivery: health equity, implicit bias, cultural competency	Required documentation for reimbursement of EPSDT services
Member service requirements (amount, frequency, duration, and scope)	Well-baby and well-child visits and screenings and related issues
Provider role and responsibilities	
Clean claims submittal	
BH Providers critical incident reporting and management	
Member and Provider grievances and appeals	
In-network referral processes	

Ongoing Training, Education, and Technical Assistance Topics

For at least 12 months following implementation in each county, the Provider representative team will conduct monthly education and training for Providers regarding Provider portal functionality, claims submission and payment processes, and common claims submission errors and how to avoid them. Our health plan operations team routinely monitors claim denial trends. When we see a spike in a denial reason or by a specific Provider type, we proactively create Provider trainings to address the issue. Our goal is to prevent Provider claims denials, and we routinely analyze our internal claims data to identify and help prevent trends from becoming widespread issues.

Our training plan and materials address ongoing Provider education, training, and technical assistance necessary for Contract compliance, including training and technical assistance in person-centered supports. We will provide training and technical assistance services for PCPs and BH Providers to assist them in participating in PCMH programs for Members who qualify for a PCMH. Our ongoing training also prepares Providers to proactively coordinate activities and improve relationships with other healthcare stakeholders.

Provider Training and Education Staffing and Expertise

We will retain a proportional number of Provider Representatives to assist Providers, as required by the State, which shall not be fewer than 30, including Subcontractors. ***Our Provider Representatives will specialize by four Provider types: PCP/PCMH/FQHC, BH, specialists, and hospitals.*** Our trained Provider Representatives will assist Providers with claims, enrollment, credentialing, and all areas required for assistance. Provider Representatives will develop relationships with Providers located in their coverage area through regular contact.

Our Provider Quality and Practice Transformation Specialists assist Providers in monitoring and improving performance on select adult and child quality measures, including performance on quality measures under the Provider's VBP arrangements. Specialists provide technical and clinical expertise to assist Providers in reducing avoidable utilization and decreasing unnecessary spend. Our specialists understand and communicate how our technology tools and web portal can be used to meet Provider clinical transformation goals.

C.5. Provider Education Concerning Cultural Competency, Health Equity, and Implicit Bias

The health plan will train all Providers on cultural literacy and ensure that Providers apply this training to meet culturally and linguistically appropriate services standards. Many of our affiliated Medicaid health plans have achieved NCQA's Multicultural Health Care Distinction, identifying them as market leaders ***in proactively addressing SDOH and confronting racial and ethnic health disparities through culturally and linguistically sensitive, evidence-based interventions***. To further this objective in Mississippi, we have designated a Health Equity and SDOH Manager, who will work with Mississippi's Office of Minority Health to ensure an ongoing focus on health equity and reducing disparities in healthcare.

Discrimination within the healthcare setting can present a barrier for people who are socially disadvantaged due to immigration status, race/ethnicity, or religion. This barrier manifests with Members of racial and ethnic groups who are less likely to receive routine medical care while also facing higher rates of morbidity and mortality. Our affiliate health plans recognize two keys to mitigating treatment disparity: strengthening the stability of Member-Provider relationships and promoting and educating on consistency and equity of care methods using evidence-based guidelines. In **Table 8,** we describe training, education, and network composition components we will apply to ensure Providers have the tools and resources to apply cultural competency, health equity, and implicit bias training.

Table 8. Training, Education, and Network Components to Ensure Providers Apply Training

Components	Description of Training, Education, and/or Network Component
Cultural Competency, Health Equity, and Implicit Bias Training	Provide initial orientation and ongoing training on cultural competency, health equity, and implicit bias, as well as targeted webinars, training materials, and one-on-one education to address issues specific to Mississippi and/or particular Providers. Incent completion of training through the Provider portal by offering options for continuing medical education credit.
Locally Based Approach (PCPs, PCMHs, Specialists, FQHCs, BH and SUD Providers)	Contract with Providers who are in the locations where Members live and/or work, as well as with local Providers who can support language diversity present in the Member population to eliminate language as a barrier. Identify Providers with a local presence and understanding and engage as many as are willing to contract to expand Member choice, including those taking few or no Medicaid patients.
Primary Care Emphasis	Incorporate and incent improvement in health equity, disparities, and implicit bias in the proposed IPC VBP model by stratifying health outcome measures by race, ethnicity, and geography; rewarding improvements; and establishing referral and feedback mechanisms for SDOH.
Culturally Sensitive Telehealth	Expand our already culturally sensitive telehealth partnerships, which include support in multiple languages.
CBO Engagement	Collaborate with CBOs to develop culturally and linguistically appropriate educational materials and approaches.
Ongoing Evaluation	Monitor Member satisfaction and grievances to identify trends and issues related to cultural competency and implicit bias that may indicate a need for additional training and education.

C.6. Approach to Assess Provider Satisfaction

Our affiliate health plans have a history of enhancing Provider satisfaction by emphasizing transparent communication to, and executing fair processes for, our Providers in our operational support. This approach addresses the needs of our Provider community while recognizing the importance of continually seeking feedback from our Provider partners. For example, our affiliates in five States have launched our successful comprehensive closed-loop Member and Provider feedback program that analyzes the Provider's call, claims, and appeals experience to identify opportunities to address Provider concerns and improve satisfaction with health plan services.

Targeted Provider Education Raised Satisfaction with Provider Network

Our affiliate health plan increased Member satisfaction with the health plan among Hispanic/Latino Members from 61% in 2017 to 72.1% in 2020. The plan closed the gap between Hispanics/Latinos and non-Hispanics/non-Latinos, and the rate of Hispanic/Latino Members' diabetic eye exams ultimately exceeded the rate of the overall population.

Our affiliate revised education approach to achieve this result. Through call campaigns and targeted cultural competency Provider training, the plan's health-equity-inspired initiative **increased the rate of diabetic eye exams among Hispanic/Latino Members from 55.5% to 61.14% between 2018 and 2020.**

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We will employ diverse approaches to assess Provider satisfaction and maintain a Provider advisory board in Mississippi that will provide feedback to indicate how well our health plan is managing Provider needs and identify potential areas for improvement that address care gaps and satisfaction. Internally, we will establish a multifunctional Provider satisfaction work group to facilitate continuous performance improvement with our participating Providers. The work group will meet quarterly to develop, review, implement, and analyze Provider satisfaction surveys as well as Provider feedback received through the tools outlined in **Table 9**. The work group will also develop action plans that address opportunities for improvement. Our QM committee will review all action plans, key drivers to improve satisfaction, and survey results to identify improvement opportunities. The work group will include staff members from the Provider representative team, network development, medical management, QM, and operations. A Provider Relations Manager will be accountable for Provider satisfaction.

Table 9. Tools, Frequency, and Responsible Parties—Provider Satisfaction

Tools	Frequency	Responsible Party
Provider Satisfaction Survey	Annually	Provider Representatives and QM
Provider Representative Visit Log	Quarterly	Provider Representatives
Provider Advisory Board	Quarterly	Provider Representatives
Provider Relations Feedback	Continuous	Provider Representatives
Provider Outreach Program	Continuous	Provider Representatives
Complaints, Grievances, Appeals	Quarterly	Provider complaints, grievances, and appeals
Performance Metrics	Quarterly	Provider Representatives

Annual Provider Satisfaction Survey

Our Provider representative team conducts an annual Provider satisfaction survey measuring satisfaction levels with numerous health plan functions and services, including the value and effectiveness of our Provider education and communication materials and how well we support Providers in delivering care. We contract with an external survey vendor to offer a confidential mechanism through which Providers report on their experience with our health plan. The survey asks Providers to rate our performance in several areas, including claims processing, providing timely authorizations, responsiveness of Provider Representatives, usefulness of communications, network adequacy for referrals, and coordination of care. The sample size is at least 1,500 Providers and includes all Provider types. The survey is administered through a mix of online surveys, multiple mailings, and phone calls.

We will submit our survey questions and methodology annually to the Division. Upon conclusion of the survey, the results and analysis, including industry benchmarks, comparisons to previous performance, statistical analysis and recommendations, and detailed data, will be reviewed by our Provider satisfaction work group, which then develops and implements appropriate action plans. We will file our survey results and subsequent action plans with the Division at least 90 calendar days following the completion of the survey and no later than December 1 for the current calendar year. We will also share the results with our Providers via newsletters, advisory meetings, our Provider portal, and site visits.

Provider Feedback Loop. We leverage our innovative Provider outreach program to inform training and educational strategies. Our comprehensive closed-loop Provider feedback program offers several easy ways for Providers to give feedback, including through a postage-paid card that Provider Representatives make available at Provider offices; sending an email to our Provider feedback loop inbox; during meetings and training sessions; and through a link on our Provider portal. At one of our affiliates, BH clinical leaders convened a summit of BH clinicians to discuss priority issues and how the health plan could better support Providers and Members. The agenda included a review of opioid use and feedback on resources needed to better treat the opioid epidemic. As a result, our affiliate developed resources and launched an opioid safety Provider education resources page with resources from the CDC and State initiatives. Content included care management Provider resources and videos on medication-assisted treatment best practices produced by our affiliate in partnership with the Medical Director for a local opioid treatment program and past president of the local ASAM chapter.

Provider Advisory Board

We will invite feedback from Providers through quarterly meetings of our Mississippi Provider advisory board. Meetings will provide a forum for open dialogue on issues related to the relationships and interactions among Providers and our staff, as well as to solicit Provider input and suggestions. The Provider advisory board will be facilitated by Provider Representatives and reflect network Providers' geographical distribution and diversity. We will include rural Providers on the board to reflect our commitment to making the Delta healthier.

Provider Representative Team Feedback

Provider Representatives meet face-to-face with network Providers on a regular basis, which allows them to discuss and address any questions, concerns, or issues. For large Provider groups and health systems, we conduct monthly joint operating committee meetings where they solicit feedback about any operational, claims, or UM challenges the Providers may be experiencing. Representatives respond to Provider inquiries with a final resolution or timeline for resolution in two business days or less and report issues and trends to our Provider satisfaction committee.

Provider Feedback Increases Efficiencies.

In a collaborative partnership with three hospital providers, our affiliate health plan's Provider advisory committee developed a concise 1-page request form for alternative levels of care clearly defining level of care and clinical information required to process the request.

The new form increased operational efficiencies for all parties and eliminated delays occurring due to "phone tag." The number of phone calls and turnaround times have decreased since the form was introduced.

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Our affiliate health plans have implemented improvements based on feedback received from Providers, including enhancements to Provider portals and eligibility documents. This includes:

- Creating additional training documents (Provider reference guides) based on Providers' feedback regarding additional education needed for claims, eligibility, and BH.
- Reorganizing the Provider website to make it easier for Providers to navigate.
- Merging the Provider representative team and Provider contracts role into one, with Provider Network Managers assigned by Provider types, which established one contact for all of a Provider's service and contract needs. This was in response to feedback from Providers indicating that they had too many handoffs and didn't know who their key contact was. This new approach instilled a new level of accountability for health plan teams to manage relationships.

Complaints, Grievances, and Appeals

We apply a formal Provider complaint, grievance, and appeal process providing timely, effective resolution of disputes between our health plan and our Providers. We track and download all complaints in our G&A platform in our core IT system, regardless of whether they are submitted by phone, email, fax, Provider Representative, meeting, or through the formal complaint, grievance, and appeal process. We can aggregate and trend issues and enable our representatives and the Provider satisfaction committee to take appropriate action to reduce or eliminate future occurrences.

Performance Metrics

Using our core IT system to aggregate data, we monitor diverse performance metrics daily, weekly, monthly, quarterly, and annually (as applicable), including claims payment, denials, and authorization timeliness. We share these metrics with the Provider satisfaction committee to identify areas for improvement and ensure an action plan is developed and implemented to meet the expectations of our network Providers.

C.7 Educating Providers Concerning EPSDT Services and Well-baby and Well-child Services

Our health plan ensures all appropriate Providers are trained and certified to perform EPSDT, well-baby, and well-child screening, referral, and follow-up services. We dedicate staff to educate Providers and assist with screening and referral follow-ups; provide foundational and best practice educational materials in easily accessible formats and venues; and invest in equipment Providers need to secure certification and perform screenings.

Approach for Improving Adolescent Screenings

We will initiate a program to combine EPSDT screenings with sports physicals to improve low screening rates for adolescents ages 12 to 18. We will convene a workgroup with CCOs and the Mississippi High School Activities Association to design and pilot a coordinated approach across all health plans.

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Staff Dedicated to EPSDT, Well-baby, and Well-child Provider Education

We will engage one EPSDT Coordinator for every 30,000 Members ages 0 to 17 in Mississippi. Our EPSDT Coordinators will customize Provider education to address the differing needs of Members by region, including SDOH and racial/ethnic disparities in access and health outcomes. Our Provider Representatives will lead relationships with Providers and coordinate educational activities with the Provider quality and practice transformation team, which will include our EPSDT Coordinators. We will assign a EPSDT Coordinator to school clinics to assist with EPSDT and well-child screenings. Our Care Managers assist Providers with service

delivery and educate Providers on the child or adolescent Member's learning development plan. Care Managers follow up with parents 30 days after a child's EPSDT/well-baby/well-child appointment to confirm attendance and answer any questions. Care Managers also engage CHWs to make in-person visits to parents when telephone contact is unsuccessful to encourage EPSDT/well-baby/well-child appointments.

Foundational and Best Practice Educational Materials

EPSDT, well-baby, and well-child services are addressed in Provider orientation materials, annual updates in Provider newsletters, EPSDT toolkits, and the Provider manual. Health plan staff will also coordinate with Provider associations and present on EPSDT screening best practices and related topics at the Mississippi School Nurse Association and Academy of Pediatrics educational meetings and conferences. We will also offer additional educational opportunities for school nurses, recognizing their role in performing screenings.

We will establish partnerships with the University of Mississippi School of Medicine to tailor educational materials on best practices for EPSDT, well-baby, and well-child services to the needs of Mississippi babies, children, and adolescents. This approach will inform our development of toolkits, videos, and practice guidelines, which we will publish after receiving feedback from Mississippi physician and nursing associations.

In addition to educating network Providers, we will partner with Mississippi family medicine residency programs to educate medical residents statewide on EPSDT, well-baby, and well-child services and equip these future physicians to provide these services.

We describe our approach to educating Providers on specific topics in **Table 10**.

Table 10. Approach for Educating Providers Concerning EPSDT, Well-baby, and Well-child Services

Topics	Educational Approach and Topics
Screening Instruments, Practices, and Schedules	• Educate Providers on the periodicity schedule established by the Division for EPSDT services • Follow AAP's more frequent EPSDT schedule for children in the foster care system • Send annual push care reminders to Providers via real-time electronic data-sharing platform • Leverage mobile units to provide EPSDT/well-baby/well-child screenings in underserved areas to improve access
Identification and Referral of Children with Developmental Delays	• Developmental milestones; monitoring and screening • Autism spectrum disorder, including applied behavior analysis • Stigmas of invisible disabilities • Mississippi developmental disabilities infrastructure • Referring children with developmental delays
Care Management to Facilitate Care of Children	• Assessments and screenings leading to diagnosis and treatment • Member referrals to treatment (upon diagnosis) • Tracking and following up on Member referrals • Overview of our childcare programs, prediabetes, weight management, asthma • Provider referral to care management process
Documentation for EPSDT Reimbursement	• EPSDT overview, certification, and guidelines • Coding and billing

Investment in Provider Equipment and Certification

We will leverage our experience in other States offering incentives for Providers to complete EPSDT education and certification by investing in grants for equipment. Certified screeners require specific equipment to complete EPSDT screenings, such as audiometers. ***Our grant program will increase the number of Providers capable of completing EPSDT screening and referrals, as well as well-baby and well-child exams.*** Our affiliates' experience in other States indicates this approach will help improve early identification of health issues for children and adolescents throughout the State.

In addition, Providers can earn additional payments for completing EPSDT, well-baby, and well-child screenings and referrals under our VBP arrangements. This incentive encourages Providers to invest in providing these services and improves quality outcomes for Members. Our Provider representative and Provider quality and practice transformation teams provide data and reporting tools to help Providers track their progress on completing screenings and referrals and earning VBP payments.

C.8. Educating Providers Regarding Members' Needs for Specific Conditions or Circumstances

Our Provider representative team will tap into the successful relationships our Medicaid affiliate health plans have developed nationally with network Providers to offer innovative training and educational approaches for Members with specific conditions or circumstances, including perinatal, BH, SUD, and chronic conditions, and for unique challenges experienced by children in foster care.

We will educate all Providers on health management tools available to assist with meeting Member needs, including care management resources. We will create a series of online written materials, videos, toolkits, and educational opportunities to offer best practices and address commonly asked questions. We will work with Mississippi universities and Provider associations to tailor education specifically for each topic area, including the Academy of Family Physicians, Community Health Center Association, Rural Health Association, Mississippi Chapter of American Academy of Pediatrics, Community Mental Health Centers, Mississippi Nurses' Association, Mississippi Public Health Association, and Mississippi State Medical Association.

We describe the unique approach we will employ to educating Providers about the needs of Members with specific conditions prevalent in Mississippi and the needs of children in the foster care system in **Table 11**.

Table 11. Educational Approach and Topics for Members with Specified Needs

Member Condition	Educational Approach and Topics About Member Needs
Perinatal	**Educational approach**: Educational self-led videos; Provider website with specific perinatal training slide deck and Provider reference guides; clinical care treatment planning tips, tools, and guidelines, available in the secure Provider portal; trifold brochures; Provider focus/feedback group Topics include: Perinatal overview; postpartum depression; impaired prenatal growth; insecure infant-mother attachments; breastfeeding; perinatal Member value-adds/incentives; and complementary perinatal care management programs (high-risk OB, NICU), including program referral process
BH	**Educational approach**: Educational self-led videos; BH tab with specific overview of BH training slide deck and Provider reference guides on the Provider website; MCGs in the secure Provider portal; trifold brochures; tabletop pop-up banners; Provider focus group; BH toolkit; mental health education platform Topics include: BH overview and screening tools; SUD; SDOH; chronic conditions; children in foster care; perinatal; screening; treatment options; coding; and clinical guidelines
SUD	**Educational approach**: Educational self-led videos; BH tab with specific SUD training slide deck and Provider reference guides on the Provider website; MCGs in the secure Provider portal; trifold brochures; tabletop pop-up banners; Provider focus group; BH toolkit; mental health education platform Topics include: SUD overview; addiction; screening; treatment options; coding; and clinical guidelines
Chronic Conditions	**Educational approach**: Educational self-led videos; Provider website with specific chronic conditions training slide deck and Provider reference guides; MCG clinical care treatment planning tips, tools, action plans, and guides, available on Provider portal; trifold brochures Topics include: Overview of chronic conditions, including asthma, diabetes, heart disease, hypertension, COPD, and prediabetes; weight management and nutritional consult; depression; tobacco cessation; chronic condition; Member value-adds/incentives; and Provider referral to health management programs process
Foster Children	**Educational approach**: Educational self-led videos; BH tab with specific foster care training slide deck and Provider reference guides on the Provider website; MCGs in the secure Provider portal; potential partnership with the Department of Mental Health; Provider focus group; BH toolkit; mental health education platform Topics include: Trauma-informed training, including impacts of trauma on children in foster care; evidence-based treatment modalities important to address the impact of trauma; foster care overview; abuse/neglect; domestic violence; human trafficking

Innovative forums through which we will offer the specialized Provider training identified in **Table 11** include the following:

- **Open mic forums.** We will bring open mic forums, which were recently launched by an affiliate, to Mississippi, specific to each of the topics listed. Held virtually and customized by Provider type, these forums will be used to educate Providers and their office staff, encourage questions via the chat box, and provide answers in real time.
- **Educational videos.** Based on trends, feedback from Providers, and Provider needs, we will develop short educational videos offering targeted training to our Mississippi Providers. For example, if there are new practice guidelines, we may make a short video with a physician introducing the new guidelines to Mississippi Providers to promote adoption.

D. COLLABORATION WITH PROVIDERS

As a national health plan experienced with Provider collaborations, we will leverage population health and quality of care strategies to assist PCPs/PCMHs to improve Member health outcomes, well-being, and use of SDOH services. We emphasize quality in collaboration with PCPs/PCMHs and provide innovative programs, tools, and supports to help them manage the care of Members with chronic illnesses, including diabetes, asthma, obesity, hypertension, and BH/SUD conditions.

Collaborations with Providers Improved Outcomes

- Our affiliate's statewide Provider engagement team helped Providers achieve better performance on **69% of quality measures** in 2019.
- Another affiliate's in-home postpartum care program partnered with nurse practitioners to achieve an 80% scheduled appointment completion rate and improved postpartum care rates by 6%.
- Our affiliate partnered with pediatric, primary care, specialists, and BH Providers to improve health outcomes for children through a pediatric transforming clinical practice initiative:
  - Achieved 7% improvement in well-child visit rates
  - Achieved 9% reduction in avoidable ER visits
  - Pediatric Providers scored 1.3-to-2.3 percentage points higher on average on all CAP measures compared to Providers not participating in the grant.

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Our goal to become the plan of choice for PCPs/PCMHs is centered on collaboration and innovation, providing easy-to-use tools, consistency, and ease of administrative burden. This approach is of particular importance for PCPs/PCMHs helping Members manage chronic illnesses.

D.1 Collaboration with PCPs/PCMHs on Member Care of Chronic Illnesses

PCPs/PCMHs play a central role in improving the health and lives of their patients, but their efforts are particularly critical for individuals with chronic conditions such as diabetes, asthma, and obesity. As described below, we will support PCPs/PCMHs to deliver high-quality, timely, well-coordinated care through:

- Formalized mechanism for ongoing collaboration
- Data and tools to support effective delivery and management of care
- Care management support
- Targeted programs to address chronic illnesses, including diabetes, asthma, and obesity
- VBP arrangements that provide incentives for improving health outcomes
- An innovative learning collaborative to promote testing, dissemination, and adoption of practice innovations

Joint Operating Committees Provide Formalized Mechanism for Engagement and Support

Our Provider services department facilitates joint operating committee meetings with PCPs/PCMHs and other Provider groups. These meetings include staff from Provider services and various departments within the health plan (UM, operations, care management, Chief Medical Officer) to aid the PCP/PCMH in receiving more expedient resolutions and fostering enhanced relationships with the Providers. Joint operating committee meetings also give Providers direct contact with health plan staff responsible for the most important areas with high Provider engagement.

Data and Tools

Providers can access data and tools to support their efforts and prioritize Member interventions through an easy-to-use Provider portal, with further consultative guidance from our Provider Quality and Practice Transformation Specialists and as-needed specialty support via our telehealth platform. ***We will streamline access to our Provider portal through single sign-on capability for ease of use and reduction in administrative burden.***

Provider Portal. Providers can use our Provider portal to electronically verify Member eligibility and paneled enrollment, submit electronic claims and query claims status, submit requests for claims reconsideration, and receive electronic notification of the outcome. Providers can also submit requests for prior authorizations, query the status of the request, and view HEDIS missed service alerts for their Members, helping to increase Member access to and use of appropriate healthcare services.

QI Tool. We share comprehensive quality and performance data with Providers to inform and empower their ability to provide the best care to Members. Through advanced analytics, our QI tool combines extensive disparate data sources (e.g., enrollment and demographic data, quality metrics, Member/patient experience, clinical outcomes, UM, and SDOH) and converts that data into insights needed to appropriately update Member

support and care needs for the best health outcomes. ***We share reporting/data and analysis at least monthly to inform actions.***

Our **locally based Provider Quality and Practice Transformation Specialists** use the QI tool to identify Providers with improvement opportunities. The specialists analyze Provider clinical outcomes using the tool and support Providers through education, insights, transformation, and partnership opportunities. They manage ongoing Provider action plans that capture and share performance data and track and monitor progress on all identified actions/interventions established to support performance outcomes, including overall impact of activities to performance goals.

Telehealth Platform. Our clinical support tools will include a local health system telehealth platform with a dedicated center for consultation, 24/7/365 urgent care services, remote patient monitoring, BH counseling, and prenatal care. In addition, we offer access to a national telehealth Provider: a HIPAA-compliant e-consult platform with over 120 specialties and sub-specialties, a guaranteed 12-business hour response time, and a mean response time of 4 business hours.

Care Management Support

Our care management team supports PCPs/PCMHs and collaborates with them to improve care and outcomes for Members with chronic conditions. Care Managers invite PCPs/PCMHs to participate in the assessment and care planning process through sharing assessment information and Member goals and requesting input on the care plan. They provide Member education on disease process and self-management strategies in alignment with the Provider's treatment plan. When the Member has a change in condition, the care management team contacts the Provider. They also alert the Provider of a Member's ER visit or inpatient admission or readmission and coordinate the PCP's/PCMH's follow-up care. The Care Manager also alerts the PCP/PCMH of care gaps to support the Provider's outreach to the Member and follows up with the Member to educate them on the importance of receiving the service and offer scheduling and transportation assistance.

Collaborative Programs to Address Chronic Illnesses

Our programs for chronic illnesses, including diabetes, asthma, and obesity, are designed to improve outcomes by promoting the PCP/PCMH and Member relationship using evidence-based best practices in chronic condition management. We describe our collaborative approaches with PCPs/PCMHs for each of these programs as follows. We also propose an IPC VBP program, which we are prepared to develop collaboratively with the Division to reward high-quality PCMHs that improve health outcomes with regard to diabetes, asthma, obesity, and other chronic illnesses impacting Members.

Diabetes: Continuous Glucose Monitoring Collaboration

The continuous glucose monitoring program enables Members to collaborate with their PCP/PCMH to take charge of their diabetes, reduce their HbA1c values, and live healthier lives. The program will provide participants with a continuous glucose monitoring device to check their blood glucose in the home. The program will target adult MississippiCAN Members who have been diagnosed with type 1 diabetes and meet the program eligibility criteria. The initial pilot program will last for four months with plans to expand statewide. We will also provide Member participants with educational materials and tools to successfully use the device. Members will be able to share data concerning the glucose readings on their continuous glucose monitoring device with their PCP/PCMH by using their computer or smartphone, depending on the type of monitoring device. Members will demonstrate their understanding by applying or inserting the continuous glucose monitoring sensor to the designated area while at the clinic as instructed during the training.

PCP/PCMH Collaboration. Our QM team will provide continuous glucose monitoring devices to participating PCPs/PCMHs for eligible Members and inform them of criteria and Member eligibility for use. The PCP/PCMH will identify which Members can participate based on health plan criteria and submit a continuous glucose monitoring PA/prescription. PCP/PCMH staff will train eligible Members on the use of the device as well as provide Division-approved educational materials on diabetes, physical activity, nutrition, and diabetes management. PCPs/PCMHs will use continuous glucose monitoring data to monitor glucose trends and patterns to determine when/if treatment adjustments are needed and will administer at least one HbA1c test during the four-month pilot program.

Program Evaluation. In collaboration with PCPs/PCMHs, we will monitor HEDIS measures using health plan executive dashboards and discuss progress and barriers during joint operating committee meetings. We will complete a pre- and post-survey of Members' HbA1c levels, glucose control, medication regime, physical activity, and nutrition.

Asthma: Asthma Pilot Project Collaboration
We will work closely with PCPs/PCMHs throughout Mississippi to ensure Members are educated about asthma medications, aware of asthma triggers, and have the necessary educational material to manage their condition. We will initiate an innovative collaboration with PCPs/PCMHs to better inform Members on properly using an inhaler, which will benefit them and their family, caregivers, and school educators. The Asthma Pilot Project will serve as an adjunct to asthma PIPs required by the Division of Medicaid.

PCP/PCMH Collaboration. Our QM staff will provide an asthma education toolkit to PCPs/PCMHs, which they can use to teach patients with asthma and their families on the signs and symptoms of an impending asthma attack versus an actual attack, and on known triggers. The toolkit will also explain proper use of an asthma inhaler, including a 30–60 second video of a nurse/physician demonstrating with a patient the correct way to use an inhaler. Our Medical Director will lead the video segment. Providers will also share the video with Members and family through their clinic televisions as they await their appointments. We will also make the video and toolkit materials accessible on our health plan website and the Provider portal. We will collaborate with the American Lung Association and the Mississippi School Nurse Association to share this educational segment with school nurses as an educational tool.

Program Evaluation. We will monitor Member asthma medication compliance, PCP attestations that asthma videos are being played, pre- and post-surveys of Member/family knowledge of the difference and benefit of the use of control medication versus use of inhaler (quick-relief or rescue medicines), asthma admission rates, and asthma-related ER visits. We will analyze and review monitoring results during joint operating committee meetings with Providers.

Obesity: Weight Assessment and Counseling Collaborative Initiative
We will collaborate with and support PCPs/PCMHs to improve body mass index and rates of weight assessment and counseling for nutrition and physical activities.

To reinforce Provider efforts, this program will be complemented by our educational obesity project, which targets younger Members (ages 12–17), encouraging them to schedule their annual wellness exam and providing education on and incentives for healthier lifestyles. We will provide materials on physical activity, nutrition, healthy snack choices, fast food, and annual wellness exams/checkups via mailings, community events, health fairs, and QM staff during Provider outreach visits and health-related educational activities and events.

PCP/PCMH Collaboration. PCPs/PCMHs will be responsible for improving completion rates of the weight assessment and counseling for nutrition and physical activity during annual wellness visits for Members ages 12–17 and submitting appropriate CPT and Z codes on claims. To support these responsibilities, QM staff will share our Provider toolkit that contains HEDIS tip sheets on the importance of conducting weight assessment and counseling for BMI, nutrition, and physical activity during the wellness exam. It also includes information on the appropriate CPT and Z codes for claims submissions.

Our QM team will collaborate with PCPs to encourage Members who are noncompliant to attend wellness visits at their offices to close those gaps in care. PCPs/PCMHs will also arrange for special days during which we can schedule Members for appointments. Our QM staff will set up a table inside the PCP office with educational materials and give Members/parents/caregivers the opportunity to ask questions and obtain referrals to SDOH community resources. We provide a Member incentive for completing their wellness visit on that day. QM staff also participate in PCP/clinic-sponsored in-office and community events to provide education and healthy snacks.

Program Evaluation. We will monitor completion rates of the weight assessment and counseling for nutrition and physical activity and appropriate CPT and Z codes. We will discuss progress and address barriers with the Provider during joint operating committee meetings.

CCO/Provider Learning Collaborative to Address Chronic Conditions

Our CCO/Provider learning collaborative will provide a platform for participating PCPs/PCMHs and clinical staff to test and measure practice innovations and then share their experiences to accelerate learning and widespread implementation of successful change concepts and ideas. This systematic approach to healthcare QI promotes team-based care and maximizes the use of electronic health records to address chronic conditions such as high blood pressure, coronary artery disease, and diabetes mellitus among patients.

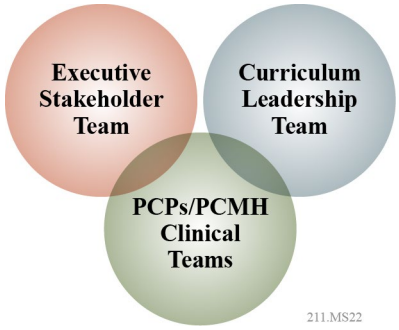
The learning collaborative structure is based on the Institute for Healthcare Improvement's (IHI) Breakthrough Series Learning Collaborative, which involves the Chronic Care Model and uses the Model for Improvement (Plan-Do-Study-Act [PDSA] method), for organizational QI. We also plan to use this collaborative to prepare Providers/clinics for PCMH accreditation.

Collaborative Participants

Participants will include (see **Exhibit 5**):

- **Executive stakeholder team.** Our health plan leadership and other CCOs, the Division , Community Health Center Association of Mississippi (formerly the Mississippi Primary Health Care Association), Mississippi Rural Health Association
- **Curriculum leadership team.** Experts from CCOs, health education consultants, and IT/data consultants
- **PCP/PCMH clinical teams.** Selected PCPs/PCMH teams that include Senior Leader, Physician Champion, Clinical/Technical Expert, Technical Support or Data Analyst, and Pharmacist or CHW

Exhibit 5. Collaborative Participants



Benefits to PCPs/PCMH of Collaboration

Participation in the learning collaborative presents an opportunity for PCP/PCMH practices to improve the care provided to individuals with chronic conditions. Ultimately, the PCP/PCMH teams become more efficient and create better health outcomes for their patients. Participating PCP/PCMHs will learn and benefit from:

- Techniques to improve patient education and self-management skills
- Strategies and methods to improve care coordination between PCPs and CHWs, pharmacists, and health educators
- The role of the practice "team" in improving care
- Evidence-based guidelines and data to improve chronic illness management, such as high blood pressure and diabetes care
- Support from SMEs in QI and health IT
- Complimentary continuing education credits
- Training to become better situated for VBP reform, attest to meaningful use, and apply for PCMH recognition/renewal
- Improved outcome measures for Physician Quality Reporting System, HEDIS, and Uniform Data System

D.2 Collaboration with PCPs/PCMHs to Reduce Preterm Births and Improve Perinatal Care

We welcome the opportunity to collaborate with PCPs, PCMHs, Members, key community-based organizations, and the Division to reduce preterm births, improve perinatal care, and reduce preterm deaths in Mississippi. We will implement a culturally diverse, appropriate, and comprehensive Maternal and Infant Health Model of Care that addresses the physical health, BH, and social service needs of pregnant Members. This approach will fully support the PCPs/PCMHs in Mississippi who are taking care of Members. Our strategy strongly aligns with the Division's Comprehensive Quality Strategy, where it states that "DOM has been long concerned about the rate of preterm births in Mississippi. Studies show the rate of preterm births as well as maternal mortality among Black mothers continues to be twice that of white women."

Maternal and Infant Health Model of Care Supports PCPs/PCMHs

Our Maternal and Infant Health Model of Care supports the Division's goals to make care safer by reducing harm caused in care delivery and is designed to ensure maternal safety and appropriate care during and after childbirth. Model components support high-quality care by PCPs/PCMHs and include the following:

Our Affiliate's Successful Model

Our affiliate health plan identified a higher rate of low birth weight infants born to Black women compared to other racial and ethnic groups. To address this issue, the plan implemented focused care management and care coordination to support their network Providers, **reducing the disparity in the rate of Black women who received timely prenatal care visits from 9 percentage points to less than 2 percentage points compared to other racial and ethnic groups**.

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- Support Providers with historical Member data through enrollment, claims and encounters data, health risk assessments, immunization data, pharmacy data, Nurse Advice Line data, referrals to community organizations, and risk stratification
- Support PCPs/PCMHs through sophisticated data reporting, which provides gaps in care reports and identification of Member SDOH, physical health, and BH needs, as appropriate
- Embed Care Managers and into PCP or PCMH offices and within the community to facilitate perinatal care for improving access and reducing disparities
- Provide resources to all pregnant Members, including Care Managers, who will monitor and facilitate care coordination; health education; SDOH support; and pregnancy-related referrals to key community resources, like WIC, SDOH-supportive organizations, and childbirth and parenting classes
- Assign Members with identified risks to experienced high-risk OB/GYN Care Managers who establish focused OB care treatment plans. These treatment plans, which are shared with PCPs/PCMHs, include Member goals, identification of risks related to hypertension, prior preterm births, BH/SUD conditions, and SDOH needs and guide the Care Manager, Member, and PCP/PCMH through the high-risk OB care management activities during Member pregnancies
- Motivate Members through incentives and value-adds that encourage timely and appropriate perinatal care
- Distribute reminders to Members who need prenatal and postpartum care
- Hire from within communities and supplement engagement of community resources
- Benefit from a systematic evaluation process where a cross-functional and multidisciplinary collaborative team implements the IHI Model of Improvement and PDSA cycles that test changes in real-world settings. IHI's model is an evidence-based, nationally recognized QM methodology designed to promote rapid cycles of improvement

Key Success Indicators of the Collaborative Maternal and Infant Health Model of Care

We will select, measure, and reevaluate key indicators for success. As available, key metric sub-analysis will include racial and ethnic groups, geographic region, and age to identify and reduce potential disparities in health. These metrics include:

- Early engagement at notification of pregnancy to support increases in prenatal care visits
- Timeliness of prenatal care HEDIS measure: By June 30 of the reporting year, the percentage of prenatal visits will increase in the first trimester among pregnant Members who have a live birth
- Postpartum care HEDIS measure: By June 30 of the reporting year, postpartum visits will increase on or between 7 and 84 days after delivery
- NICU admissions
- Low birth weight or very low birth weight babies
- Rate of C-sections

D.3 Collaboration with Providers to Develop Improved Care on Other Conditions

We will collaborate with Providers to develop improved care on other conditions that will include hypertension and BH, which are leading causes of poor health for MississippiCAN and CHIP Members. We will also be working with local Providers and CBOs to provide services to Members and the communities where we will deploy our mobile units. We will also work with university systems such as the University of Mississippi School of Nursing nurse practitioner program.

Hypertension: Self-measured Blood Pressure Monitor Program

Our blood pressure monitoring program will provide Members with a loaner device to check their blood pressure in the home. Members will take blood pressure measurements twice each morning and twice each evening at home with the loaner device and phone in the results to the PCP/PCMH office weekly after starting the program. The initial pilot program will last for four months with plans to expand the program throughout the State at the conclusion of the pilot. We will also provide Members with educational materials to assist them with this process.

PCP/PCMH Collaboration. Our QM department will help Members manage hypertension in their homes and improve their health by providing validated loaner blood pressure monitoring devices to participating PCP/PCMHs for eligible Members. We will train PCP/PCMH staff on program requirements and accurate measurement procedures using the American Heart Association and American Medical Association approved standardized education training video on the correct method of taking and recording self-measured blood pressure.

PCP/PCMH staff will discuss the self-measured blood pressure loaner program and expectations with eligible Members, refer Members eligible to participate, and educate and train Members on the use of the loaner device. Trained PCP/PCMH staff will also test the accuracy of the device with the Member prior to distribution. Members will demonstrate their ability to accurately use the device immediately after being trained.

The PCP/PCMH staff will use the weekly Member calls as an opportunity to provide education on high blood pressure, nutrition, and physical activity; address any issues with self-measured blood pressure measurements; follow up on adherence to medication regimen if prescribed; and offer recommendations as needed. They will also discuss the treatment plan as necessary and confirm agreement/understanding with the Member. Staff may also schedule Members for in-person office appointments to follow up on self-measured blood pressure readings as necessary.

After the self-measured blood pressure program period is completed, the PCP/PCMH will schedule a follow-up appointment and reminder call with the Member. If a Member's blood pressure remains uncontrolled at the end of the initial six-week period, Providers may extend the Member's participation for another six weeks. Members who successfully complete the self-measured blood pressure program may keep the blood pressure monitoring device for continued use at home.

Behavioral Health

We will design, collaborate, and implement a Performance Improvement Project with BH Providers and facilities to reduce BH readmissions statewide by 10% over 3 years. Together we will encourage Members to enroll and actively engage in care management services.

Interventions may include improving hospital discharge planning and transition processes; bettering medication practices; enriching transitions of care; coordinating more effectively between care settings, including the use of closed-loop referrals; and promoting the recovery-oriented practice model that uses enhanced coaching, education, and support for Member self-management as well as support for caregivers. Additionally, we will collaborate with hospitals on effective discharge planning to ensure continuous and coordinated quality BH healthcare treatment for Members following discharge from acute care facilities.

E. PROVIDER PAYMENT

Our health plan will consistently deliver exceptional services for Providers, paying claims accurately and timely to earn Provider satisfaction. We will exceed claims payment standards, ensure non-participating Providers are paid timely for emergency services, pay all Providers from the date of credentialing, and hold Subcontractors accountable for meeting these same high standards. We ensure that each Provider, participating or non-participating, receives education and easy-to-use tools to submit clean claims, which improves timely claims payment.

Our health plan will employ a rigorous claims auditing process to promote accuracy and timeliness of claims payments, including auditing Subcontractors to ensure they meet the same high standards.

Exceeding Claims Payment Standards

In 2021, our affiliated health plans **processed and paid 99.53% of Medicaid claims within 30 days of receipt**.

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E.1. Timely Payment of Non-participating Provider Emergency Services

Our process for ensuring that non-participating Providers are paid timely for emergency services includes quality control audits and procedures that eliminate barriers to timely payments. We also pay claims for emergency medical services provided by a non-participating Provider at the applicable Medicaid fee-for-service (FFS) payment rate. This approach promotes predictable payment amounts, reliable reimbursement methodology, and consistency of claims processing, as well as Member access to necessary services on an emergency basis. We pay participating and non-participating Providers for treatment when the Member has an emergency medical condition and seeks emergency services and/or when their PCP has instructed the Member to seek emergency services.

Quality Control Processes for Accurate and Timely Claims Payment

Auditors perform daily, weekly, and monthly audit reviews of the claims processed by claims resolution staff, including claims for emergency services by non-participating Providers. The auditors review claims in pre-payment and post-payment status for accuracy in processing as well as appropriate billing and payment. Additionally, auditors identify issues, work closely with business analysts to resolve issues, and report all findings to management. Audit findings may result in additional training for claims staff, modifications to claims processing procedures, or enhancements to claims edits.

Processes to Eliminate Barriers to Timely Payment

We will eliminate barriers to timely payment of emergency services delivered by non-participating Providers, as well as all claims, through processes that include the following:

- Distributing information and providing education on the criteria for emergency services for all non-participating facilities providing emergency medical services, including those practicing outside of State lines
- Not requiring notice of emergency care provided by either participating or non-participating Providers
- Paying for emergency services even when the services are included in a claim for a non-covered inpatient stay
- Providing instructions regarding claims submission timeframes and guidelines in our Provider manual
- Providing instructions and claims tips in training resources on the public section of our Provider website
- Providing information on the Member's ID card and the Provider portal about where and how to submit claims electronically, on paper, or through the portal
- Providing monthly billing guides for non-participating Providers in response to claims denial reports
- Not subjecting non-participating Provider claims to any unique or additional claims edits or reviews
- Providing instructions on the Provider's remittance advice in the event the submitted claim is not clean
- Assisting all Providers, including non-participating Providers, with any claims questions and procedures either on-site or through the Provider services call center from 7:30 a.m. through our extended hours of 8:00 p.m. CST

Health plan staff will also review and analyze data to identify opportunities for continuous improvement in claims payment processes. If needed, we will conduct Provider/Member education, direct engagement with Providers, or other corrective actions to minimize delivery of emergency services by non-participating Providers. Our Provider contracting team will reach out to non-participating Providers with high claims denials every month to encourage them to join our network. Our Provider representative team will also reach out to these Providers to educate them on the steps to decrease the amount of claims denials. We contract with a comprehensive network of emergency service Providers, including tertiary care and trauma, which minimizes the use of non-participating Providers for emergency services.

E.2. Willingness to Pay Claims Immediately Upon Credentialing

We pay claims with dates of services on and after the date of credentialing regardless of the date the credentialed Provider is loaded into our claims processing system. When a newly credentialed Provider is loaded with a retrospective effective date, Provider data management staff run a claims impact report to identify claims that processed as of the effective date. This report is sent to appropriate staff for claims reprocessing.

Our Subcontractors follow and comply with the same requirements by paying claims based on the date their network Provider is credentialed and not by the date the Provider was loaded into their claims processing

systems. Our delegation oversight team ensures and validates the Subcontractor's compliance via claims audits, which compares claims rejected based on service dates with dates for credentialing. Delegation oversight also validates the Subcontractor's internal auditing systems and processes used to confirm compliance. Subcontractors who do not pay claims because of the credentialing date instead of the date the credentialed Provider was loaded into the claims processing system are issued corrective actions to remediate any deficiencies and noncompliance.

E.3. Claims Payments by Subcontractors

We contract with experienced, qualified Subcontractors to manage provision of dental, vision, and NET services and ensure these Subcontractors meet all requirements for timely claims payments. In **Table 12**, we describe our business relationships with these Subcontractors.

Table 12. Business Relationships with Subcontractors Responsible for Processing and Paying Claims

Subcontractor Services	Business Relationship
Dental Services	We have collaborated with our dental Subcontractor since 2017 across multiple lines of business, including Medicaid and Medicare-Medicaid Plans (MMPs), for nearly 600,000 Members. Our Subcontractor will be responsible for claims processing and payment, UM, Member and Provider services call centers, and credentialing.
Vision Services	Our vision Subcontractor has grown with us as a partner since 2001, providing vision services for our affiliate health plans in multiple States. Our Subcontractor is responsible for network development and management, claims processing and payment, Member call center, and credentialing.
NET Services	Our NET Subcontractor, who we have worked with since 2020, will offer a network of experienced Providers throughout Mississippi and will be responsible for network development and management, claims processing and payment, Member call center, and driver validation and credentialing.

System Diagram of Subcontractor Claims Payment Process

Proactive Oversight Ensures Compliance

Due to our proactive oversight processes and collaborative relationships with Providers, we have experienced no issues with claims payments by our Subcontractors.

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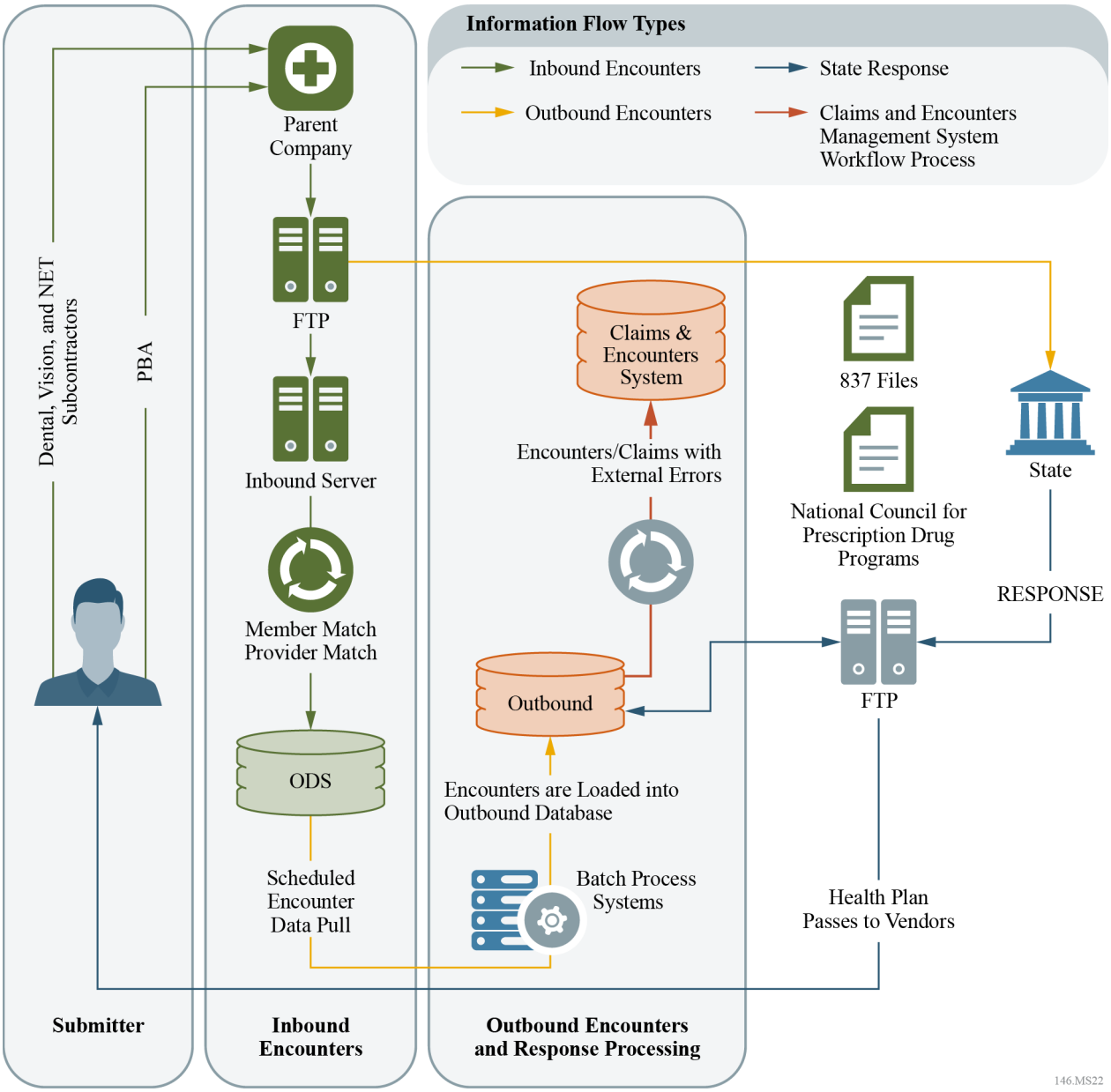
We hold our Subcontractors responsible for effective, efficient, and streamlined claims payment processes to reduce Providers' administrative burdens and meet and exceed all applicable claims payment requirements. Our approach to Subcontractor oversight relies on adequate controls and contingency plans to ensure compliance with requirements and avoidance or mitigation of risks and issues. We require Subcontractors to submit encounter data, which we use to audit claims payments and other compliance.

The systems diagram in **Exhibit 6** illustrates our encounter data submission and audit process to ensure that claims payments by each Subcontractor meet State requirements. The process steps follow the exhibit.

Exhibit 6. System Diagram of Subcontractor Claims Payment Process



1. Subcontractors submit their adjudicated claims to the health plan via Secure File Transfer Protocol (SFTP).
2. Plan staff access the files from SFTP and validate for file format, HIPAA-level edits, and Member and Provider match edits. The health plan sends files that do not pass validation to Subcontractors to correct and resubmit.
3. The data is then loaded into the Operational Data Store (ODS).
4. The health plan batches encounters into outbound databases and our claims and encounters management system.
5. In parallel to steps 1–4, the encounter file is submitted to the State for processing.
6. Once the State submits the response files, they are sent to the Subcontractor to remediate any errors.
7. The encounters are then loaded into their own queue for Subcontractors' visibility.
8. The health plan also loads the response files into the ODS, outbound systems, and our claims & encounters system.
9. From our claims & encounters system, plan staff have visibility of encounters submitted and those with responses for reconciliation.

Health plan staff meet regularly with Subcontractors to review remediation of both inbound rejected files and the responses from the State. We direct Subcontractors on error prioritization and discuss interventions to prevent errors. We will address Subcontractors that are not compliant using CAPs.

Annual Delegation Audit Processes

Our delegation oversight committee, which is accountable to both the QM and compliance committees, requires annual delegation audits of all Subcontractors responsible for claims payments. Our State-specific delegation oversight staff oversees the auditing and the performance monitoring plan for each Subcontractor, which includes performance requirements for all delegated functions, including claims payment timeliness and accuracy; required reporting and interfaces; review of the financial operation and amounts paid for covered services, if applicable; and review of contract compliance, logged complaints, and functional performance measurements. If we identify deficiencies or areas for improvement, we follow up by taking corrective actions (up to termination) as necessary and appropriate.

Depending on the severity of an issue, remediation measures would include changes to reporting, increasing meeting frequency or adding content, focused performance reviews, more frequent and focused auditing, and/or CAPs. Joint operating committee meetings are held quarterly to monitor Subcontractor performance activity and discuss future strategies regarding Subcontractors. The joint operating committee for each Subcontractor includes the responsible business owner, delegation oversight, staff from network and contracting, compliance, and operations, and Subcontractor participants to ensure multidisciplinary discussions and actions.

F. PROVIDER GRIEVANCES AND APPEALS

Our Provider grievance and appeal process employs collaborative best practices and innovative processes to achieve consistency, ease administrative burdens on Providers, and ensure Members' access to care. Our goal is always to be the plan of choice by offering Providers easy-to-use tools and support and ensuring exceptional service and partnerships.

Provider satisfaction can be closely linked to Member satisfaction and overall perception of health plan performance. Providers are partners in the Member experience, and our goal is to prevent issues that give rise to Provider grievances and appeals. When we are made aware of these grievances and appeals, we operate effective, efficient, and compliant processes to address them with Providers.

Example of Our Commitment to Timeliness and Compliance

Our affiliate health plan with a similar population and size as Mississippi completed 100% of appeals within the State timeliness standard in every month of 2020.

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Our innovative, comprehensive closed-loop Provider feedback program has improved process efficiency, Provider satisfaction, and Member quality of care. Our affiliate health plan reduced calls from Providers engaged in the feedback program by 20% and achieved a decrease of 28,000 calls (February/March 2021 data compared to October/November 2021 data). The program creates cross-functional teams responsible for collaborative resolution of issues to assist Providers. Identifying trends by Provider type helps these teams identify issues and key Provider education opportunities.

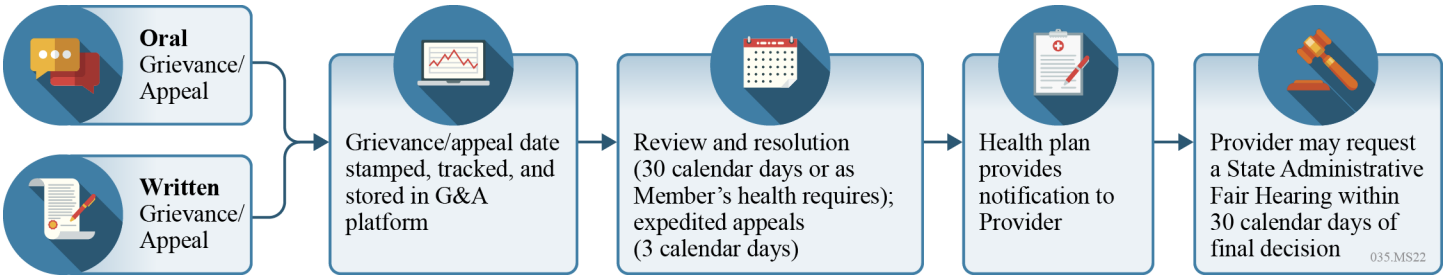
As an organization with a multitude of NCQA accreditations, our Provider grievance and appeal processes have been audited and determined to meet or exceed industry standards. Our Provider G&A platform provides for timely and effective resolution of any disputes between our health plan and Providers. All grievances and appeals are systematically downloaded and stored in our G&A platform in our core administrative system, which allows for aggregation of and identification of trends in issues to enable us to respond with prompt, appropriate action and plan improvements to reduce or eliminate future occurrences.

F. 1 Provider Grievance and Appeal Process

Under our grievance and appeal process, Providers may file a grievance, orally or in writing, within 30 calendar days from the date of the event causing the Provider's dissatisfaction. Grievances may come to our attention by phone, email, or fax, as well as by Provider communications directly to Provider Representatives, or in Provider meetings. Providers may consolidate grievances of multiple claims involving the same or similar payment or coverage issues, regardless of the number of individual Members or claims included in the bundled grievance.

The grievances and appeals team is creating a dedicated mailbox specifically to address Provider questions, as well as secure messaging and appeals submittal options through our Provider portal. Providers are encouraged to submit grievances and appeals through the Provider portal and may check the status of grievances and appeals on the portal. We accept appeals through the portal, by fax, and by mail. **Exhibit 7** depicts our Provider grievance and appeal workflow.

Exhibit 7. Provider Grievance and Appeals Workflow



Regardless of how we receive them, we record all grievances and appeals in our G&A platform for tracking and trending identification purposes. We configure the G&A platform to capture all critical information needed for timely review and effective resolution within all applicable contractual and statutory requirements and time frames, including the process and timelines in Draft Contract, § 6.10 and Table 6.3, Summary of Provider Grievance and Appeals Requirements. This platform interfaces daily with our core administrative system, which maintains all Provider demographic information, performs claims adjudication, and is the source data for all claims inquiries. Grievances and appeals are initially recorded in our core IT system, similar to disputes expressed verbally, and then uploaded to the G&A platform.

Grievance Process Time Frame

A grievance, once received, remains open in our core IT system until the Provider has been notified of the outcome. We assist Providers with any issues related to Members and/or services and make every reasonable effort to resolve complaints immediately upon notice and no later than within one calendar day of receiving notice. We confirm receipt of Provider grievances and provide an expected date of resolution within 5 calendar days of receipt and resolve grievances within 30 calendar days of receipt. We may extend the time frame for resolution by up to 14 calendar days in accordance with Federal requirements. All documents and activities related to the grievance are retained in our G&A platform.

Appeal Process Time Frame

Providers may also file an appeal to our health plan to review a Provider-related Adverse Benefit Determination, such as denial of a PA. Providers must file a written appeal within 30 calendar days of receiving our notice of an Adverse Benefit Determination. We confirm receipt of the appeal within 10 calendar days of receipt and provide an expected date of resolution. All appeals are resolved within 30 calendar days of receipt of the appeal, or sooner as the Member's health condition requires, and within 3 calendar days after receipt of a request for an expedited resolution of the appeal. We may extend the time frame for standard or expedited resolution of the administrative review by up to 14 calendar days in accordance with Federal requirements. If the time frame is extended, we share a written notice of the delay reason with the Provider.

Grievance and Appeals Platform

The G&A platform tracks all aspects of the grievance and appeal process to ensure all regulatory timelines are met. Each grievance or appeal created in the G&A platform lists due dates for an acknowledgment letter, grievance or appeal resolution, and resolution letter. In the G&A platform, the Provider grievances and appeals team has access to view their individual queues and run dashboard reports that list the receipt and due dates of each step of the grievance and appeal process.

Grievance and Appeal Staff Process

Our assignment process ensures that disputes are reviewed by Provider grievances and appeals staff with the appropriate expertise and experience based on the Provider type and/or the nature of the dispute. For example, cases related to CPT and HCPCS coding are reviewed by certified coders, while hospital and professional claims are reviewed by claim examiners familiar with Medicaid benefits and contract interpretations for the

respective Provider type. Grievances and appeals staff consider all supporting documentation submitted with the requests and conduct research of all available health plan databases (e.g., prior claims, calls to the health plan, and prior complaints) to ensure that all relevant information is included in the review.

When a review requires input from another health plan department, the request is routed through our G&A platform. For example, if the request is related to a post-service authorization denial, the disputed claim is routed to our healthcare services department for clinical review by our Medical Director or, if the request relates to a denial for Member ineligibility, the disputed claim goes to our enrollment department for review. Departments involved in review of a case then route their determinations back to grievances and appeals staff who ensure the decision is executed and the case is resolved.

When the case decision requires a G&A platform update (e.g., updated authorization, eligibility update) grievances and appeals staff engage the appropriate department to execute the update and ensure prompt and accurate resolution is submitted to the Provider. Once resolved, we update the G&A platform to reflect resolution. We also review updates to confirm and ensure all required steps and provisions were considered and appropriately applied prior to closing the case in the G&A platform, including applicable statutory and regulatory time frames and contractual provisions.

To ensure that grievances and appeals are created, researched, and resolved quickly, the Provider grievances and appeals team has an internal grievances and appeals quality assurance program that reviews Provider grievances and appeals team member's cases. These internal audits are conducted by a separate quality audit team. The goal of the grievances and appeals quality assurance program and the quality audit team is to maintain and improve the quality of work, documentation, and outcomes of resolved appeals, grievances, disputes, and cases worked by grievances and appeals team members. Ultimately, the goal is to maintain and improve the Provider experience, while meeting State, Federal, and accreditation requirements.

F.1.a. Compliance with State Requirements

In compliance with Draft Contract § 6.10, we will submit our grievance and appeal policies and procedures to the Division at least annually for review and approval and will amend as needed. Our policies and procedures will align with the State's Quality Strategy and meet all Contract requirements. Once approved, they will be included in our Provider manual. We will further disseminate these policies and procedures to out-of-network Providers with remittance advice of the processed claim. We will submit all required grievances- and appeals-related reports within prescribed content parameters and time frames as stated in Draft Contract §16.2.9.

Our Provider manual gives comprehensive information to Providers to facilitate full compliance with all applicable contractual, regulatory, and statutory requirements, including our submission and resolution processes for Provider grievances and appeals. We advise Providers of their right to file a request for a State Administrative Hearing, after exhausting all of our plan-level appeal procedures.

Our Provider training program will meet State requirements. Provider Representatives conduct initial orientation, which includes education on grievance and appeal processes, with newly contracted Providers and their staff in the Provider's office, our offices, or via teleconference. Ongoing Provider education on grievances and appeals is included in annual Provider workshops, joint operating committee meetings, information on remittance advice, and claims fact sheets.

F.1.b. Elevating Grievances

When a decision is favorable to a Provider, the grievances and appeals team and the claims department collaborate to ensure an adjustment is processed in accordance with the decision and required time frames. In instances where a dispute approaches our internally established 25-day deadline for resolution, the claims adjustment is escalated to a high priority level to ensure it is processed quickly. This escalation process will also be used for all Division-received disputes and final orders issued by an independent review entity. Once the final review is complete, grievances and appeals staff generate a determination letter, which is mailed to the Provider within two business days of the final decision.

Any Provider exhausting our grievance and appeal process may file a State Administrative Hearing request within 30 calendar days of our final decision. We will provide all requested documentation to the Division and

participate at its discretion. If the Division reverses an Adverse Benefit Determination, we will bear all associated hearing costs.

F.1.c. Identifying, Tracking, and Trending Grievances

All grievances and appeals are date-stamped, documented, tracked, and stored in the G&A platform, which will allow for the aggregation of and identification of trends in issues as well as the capability to share data with the Division monthly. In addition, we will generate a quarterly summary report that includes this information. Ad hoc reports will also be provided upon the Division's request.

- Enhanced data analytics enable us to identify opportunities for plan improvement and establish goals and performance thresholds, which ultimately lead to a reduction in grievances and appeals and an increase in Provider satisfaction. We review the analysis and results in quarterly Provider advisory committee, QM committee, and Provider satisfaction committee meetings. The Provider dashboard includes appeals, trends, and analyses, and appeals data is an element of the Provider scorecard.

Data Analytics Addresses Provider Claims Issues

Our affiliate health plan identified a billing issue for a rural health clinic (RHC) when their claims denial rate spiked from 4% to 90% in 1 month, but their grievances were all upheld. The affiliate's grievances and appeals work group identified the cause, and the provider network team educated the RHC on how to correct the issue, which was billing with an incorrect NPI.

The RHC was paid more than $100,000 when the RHC rebilled all their previously denied claims with the correct NPI. The RHC informed our affiliate that they were the only health plan to bring the issue to their attention, even though they had the same issue with other payers.

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We also conduct root-cause analysis and barrier assessments to enable insight into issues that may have contributed to issues and performance gaps in achieving established goals, while opportunities for improvement are developed and implemented by the appropriate department within our health plan. All resolutions and improvements are shared with the Provider. For example, in January 2021, our Medicaid health plan affiliate established a Provider grievances and appeals work group to assess root-cause trends of Provider grievances and appeals, identify key Providers with the largest volume, and implement a plan of action to reduce future submissions. The work group meets every two months and consists of the Regional Operating Officer; VP, Operations; Manager, Health Plan Configuration; Director, Provider Network; and Manager, Provider Grievances. The meeting addresses:

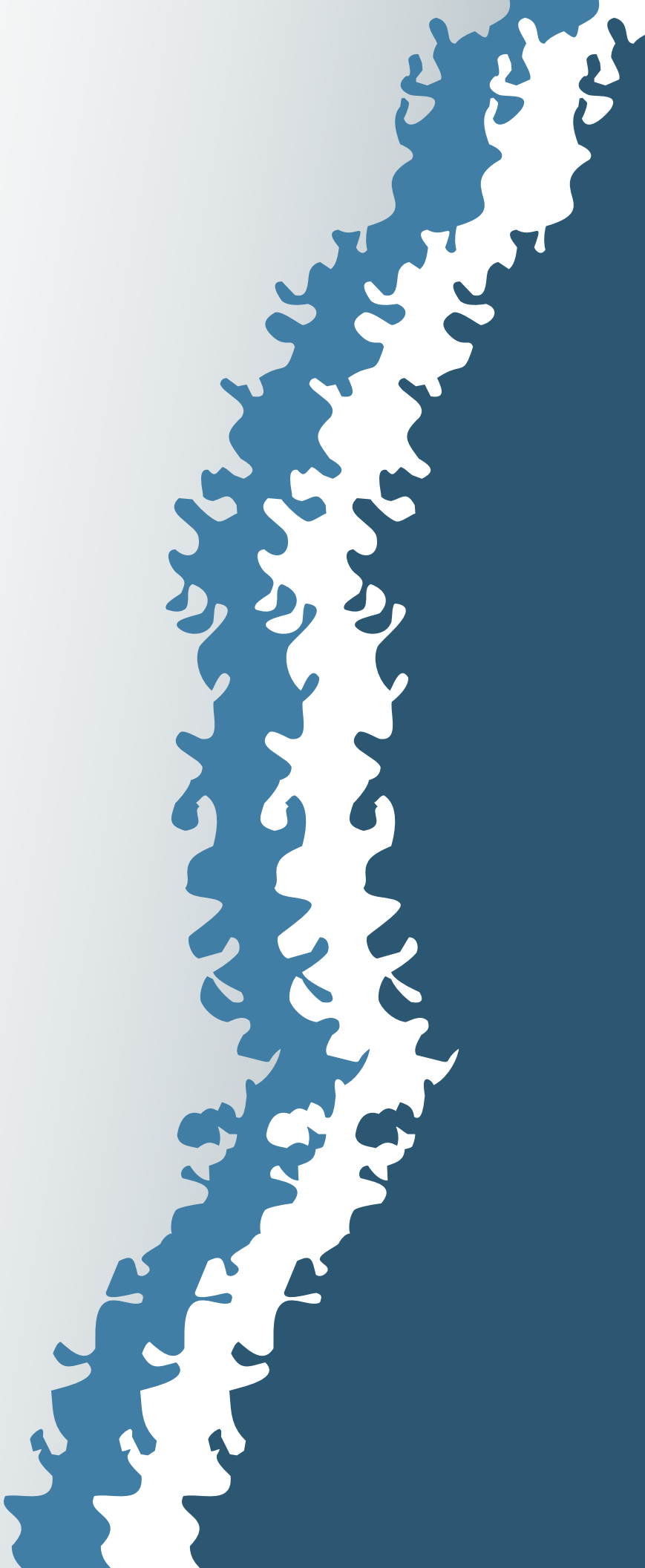
- Provider grievances and appeals submitted and overturned, meaning the health plan paid the claim after a second review. Our affiliate digs deeply to understand what, internally, was the root cause for not processing the grievance or appeal appropriately the first time and develops an action plan for how to prevent the mistake from occurring going forward.
- Provider grievances and appeals submitted that were upheld, meaning the health plan agreed with their original determination when processing the claim. In these cases, our affiliate analyzes opportunities for additional Provider education for the claims to process correctly and be paid.

Our national, comprehensive closed-loop Provider feedback program creates cross-functional teams with oversight of Provider challenges and the opportunity to collaboratively brainstorm and resolve issues to assist Providers. This proactive approach has improved process efficiency, Provider satisfaction, and Member quality of care. Program teams meet weekly to assist Providers and drive internal operational process improvements. The teams review claim denial appeals and call center data; identify Providers with the highest numbers of calls/denials; and engage these Providers with additional in-person or virtual conference calls, check-ins, and emails for support. Ensuring claims, call center, Provider services, Provider grievances and appeals, and operations leadership are all discussing the Provider experience builds a partnership approach to enhancing our Providers' satisfaction and improving administrative processes. We look forward to bringing this best practice to Mississippi.

[END OF RESPONSE]

4.2.2.3

Care Management



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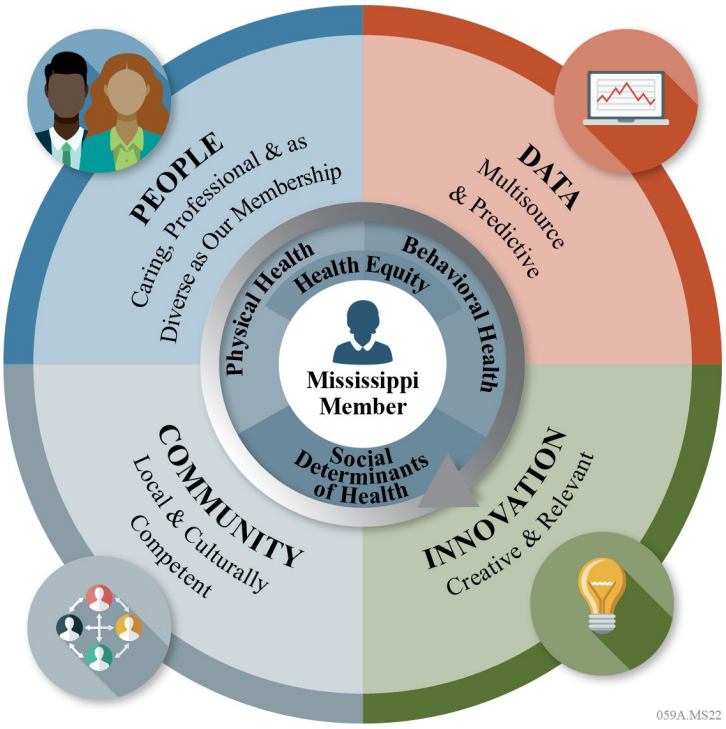
4.2.2.3: CARE MANAGEMENT

A. CARE MANAGEMENT PROPOSAL

A.1 Our Proposed Care Management Strategy

The overarching goal of our Care Management Strategy is to improve MississippiCAN and CHIP Members' health and quality of life by using an integrated, team-based, person-centered approach informed by best practices and lessons learned from our affiliate health plans. Members, their families, and caregivers are the center of our integrated care management model that addresses the unique physical health and behavioral health needs of Members as well as the functional and social support services appropriate to each Member's level of need and acuity. We always remember that each Member is an individual with specific needs, goals, and desires.

Exhibit 1. Care Management Strategy Elements. Every element of our Care Management Strategy is focused on improving the quality of life for Mississippians.



Comprehensive care management requires a team effort. Our Mississippi Medical Director will guide our population health and care management programs. He will collaborate with our Behavioral Health Director, Perinatal Health Director, and others across our Mississippi based population health, care management, and quality management teams to ensure continuous quality improvement and an approach that evolves with and is responsive to the needs of our Members. Our Medical Director will ensure that the elements that comprise our care management strategy, as shown in **Exhibit 1** and detailed below, work together seamlessly to support our Members.

People: Our Local Staff Come from the Communities We Will Serve. Our staff will reflect the diversity of our membership and will be recruited from and located in the communities where Members live, work, and play. This ensures they will understand challenges unique to each region of the State.

Data: Data Informs Our Care Management Strategy. Our care management program is continuously informed by healthcare and social data gathered from multiple sources, including qualitative and quantitative demographic and clinical data from members, providers, healthcare stakeholders (like State agencies and Providers), community-based organizations (CBOs), and third parties (like the CDC, American Survey, and others). Our national experience drives our data collection, analysis, and data-sharing approach designed to improve collaboration with Members and their care teams. We use best-in-class tools and technology to derive actionable intelligence to identify Members in need of care management based on clinical risk, impactable opportunities, and social determinants of health. Data measures the impact and success of our programs, and we are agile in adjusting to changing needs.

Community: We Are Community-focused. Across Mississippi, each region and county has its own unique challenges. Our community focus means we can serve all Members effectively, regardless of where they live, through an approach that combines on-the-ground staff—like community health workers (CHWs) who help find and engage hard-to-reach Members, [redacted] ith tools like our social determinants of health (SDOH) closed-loop referral system, which links Members to curated local supports to meet their needs. Our community engagement specialists are also on the ground to coordinate and collaborate with CBOs to find and close gaps in the social safety net, to understand their challenges and encourage them to include their services in the referral system.

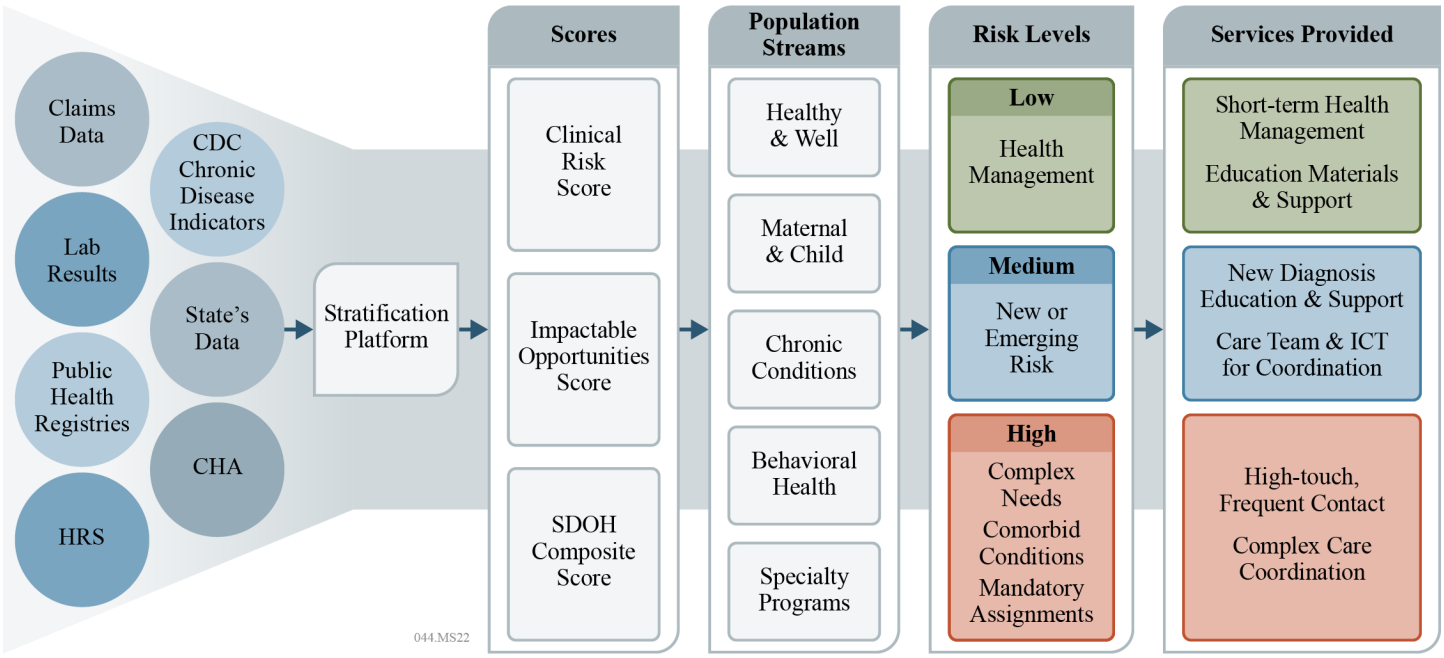
Innovation: Our Strategies Are Innovative. We will bring to bear our local teams, data and analytics, and community focus to tailor solutions that are effective in engaging Members in their healthcare. Drawing on our national experience, and specifically in states similar to Mississippi, we will innovate to serve Members whether they are managing a single chronic condition or have complex health needs, no matter where they live. For example, in one of our affiliates, more than 50% of the population served lives in a rural area. Through ongoing evaluation of the population health and care management efforts supporting this population, we have gained deep understanding of how rural living impacts access, social risk, and health equity. ***We will leverage this knowledge to develop rural-focused programs to solve healthcare challenges, like our food insecurity program, which will bring together Hearty Helpings Food Pantry, Food Corp, and others to promote nutrition and access to healthy foods in the Delta.***

Our Care Management Strategy: Process

Our care management process uses health risk screenings, assessments, predictive modeling, and risk stratification for timely identification of Member risks and changing needs. Timely identification supports the alignment of our care management efforts, interventions, and ongoing monitoring to ensure every Member gets the appropriate level of services. Understanding cultural competency, health equity, and SDOH needs underpin care management processes. Recognizing the member's viewpoint and barriers, treating the member with respect and compassion, and understanding the member's readiness for change are essential for the success of the care management process. As detailed below, our process for care management process includes identification, outreach and engagement, assessment, person-centered care planning, and ongoing care management monitoring and evaluation.

Identification. Our risk stratification and predictive modeling platform enables early identification of Members' risks and changing needs. The stratification platform views Members holistically and identifies their physical health, BH, pharmacy, and SDOH risks to help prioritize services. Based on the initial segmentation and stratification, our care management team uses relevant data, such as Member claims history and Member assessments, to assess impactable opportunities (e.g., medication adherence) and social vulnerability variables. Through our risk stratification process, as described in more detail within this section, we derive further insights around inpatient and outpatient utilization, Member safety and outcomes, health risk and the burden of illness, episodes, and total cost of care, which ultimately helps us refine risk level and case assignment. **Exhibit 2** summarizes our risk stratification process.

Exhibit 2. Risk Stratification Process. Our stratification platform uses myriad data sources to score Members for clinical risk, impactable opportunities, and population/engagement opportunities, which help us understand Members' holistic risk profiles.



Our approach to identification is not solely based on predictive analytics. We use health risk screenings and referrals from staff, providers, and community partners to identify members who may benefit from care management support. Our integrated care management team is staffed with licensed clinicians, health coaches, and CHWs. Members are matched to a care management team member with an assignment system that honors Member preference and choice, such as language, culture, and gender, as well as the staff member's area of expertise and credentials to support the Member's primary diagnosis or concern. For example, Members with diabetes will be supported by a Certified Diabetes Care and Education Specialist who has completed a specialized course of study to provide diabetes-tailored, evidence-based care coordination.

Outreach and Engagement. We meet Members where they are in their health journey. All Members are educated about care management and their options in receiving support to meet their care coordination needs. For Members stratified at medium and high risk, Care Managers deploy a high-touch model, which includes meeting and engaging Members face-to-face in a setting of their choice, including the Member's home, school, or place of employment; at our mobile unit; or in a community-based setting (e.g., homeless shelter, or residential placement) or other location where the Member feels comfortable.

Assessment. Using the Health Risk Screening (HRS) or the Comprehensive Health Assessment (CHA), care management staff assess Members' holistic, integrated needs and strengths to develop an understanding of their chronic conditions, presence of comorbidities, demographic information, SDOH barriers and other potential health disparities, current Providers and treatment plans, and prescribed medications and medication adherence.

Person-Centered Care Planning to Address Member Needs. Care managers help members create an individualized care plan identifying what is most important to them. They serve as the member's advocate in helping to address care and social support needs. Using motivational interviewing and activation techniques, we help Members articulate meaningful Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goals that reflect personal priorities. Care management staff coordinate care planning activities with the Member's Providers and others via an interdisciplinary care team (ICT), who support the Member's care, such as caregivers, guardians, peer supports, traditional and non-traditional Providers, counselors, school personnel, State agencies, and CBOs.

Ongoing Care Management and Evaluation. We support Members as long as required to meet the individual goals. Based on the monthly stratification platform scoring, a Member's acute event or transition in or out of a treatment facility, change in health risk, psychosocial needs, or reassessment, we adjust the intensity of care management. Care management staff respond agilely to emergent or urgent needs. Ongoing, care management staff assist all Members in navigating covered benefits and services, linking them to community resources, and coordinating value-adds, including Member incentives. We provide linguistically appropriate education to improve health literacy and help Members self-manage their conditions for better outcomes. We engage medium- and high-risk Members for comprehensive coaching, resolving care gaps, closing the loop on SDOH referrals, and continued monitoring toward care plan goals.

Our Care Management Strategy: Criteria

Our nationwide experience has allowed us to hone our care management strategy, including the criteria used to best stratify our members as their care needs evolve. Monthly, our stratification platform analyzes Member data and applies a composite score based on the criteria summarized in **Exhibit 3.**

Exhibit 3. Our Proprietary Risk Stratification and Predictive Modeling Platform Scorable Criteria Summary.
Advanced analytics measure Member criteria to produce a composite risk score.

Clinical Risk Factors	Impactable Opportunities	Population/Engagement Opportunities
• Historical and Predicted Utilization: – Inpatient – Readmission – ER admission • Physical Health and BH: – High-risk medical conditions per RFQ § 7.4.3.3.1 – Multiple chronic conditions – SUD/opioid use disorder – Mental health condition • Other: – Historical and predicted high cost – Polypharmacy (10+)	• Physical Health: – High ambulatory utilization – 4+ ER visits in the past 6 months – No specialist consult when indicated – Frailty – New diabetes diagnosis • Pharmacy: – Care opportunities: medication adherence (1+) – Not on appropriate medications – Treatment noncompliance concerns • BH: – Opioid use disorder/overdose/4+ pharmacies/providers and not medication-assisted treatment – Nonadherence to antidepressants or antipsychotics • SDOH: – High Social Vulnerability Index – High risk for housing, food, economic, or transportation insecurity – High risk for social isolation	• High-risk Populations (high-risk and <21-year old pregnant women, foster children, individuals with intellectual/ developmental disabilities, SPMI, SUD) • Health Ownership Index: – Level of Member engagement with their own health regardless of health status (healthy or chronic) • Propensity to Engage—Care Management: – Likelihood a Member would participate in a care management program • Propensity to Engage—Inbound Call: – Likelihood a Member would engage with our health plan by telephone

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Performance Measures Used to Assess Achievement of Quality Outcomes

To determine the success of the care management program and quality outcomes, we track and monitor several performance measures, including contractually required key performance indicators as described in Appendix A, Draft Contract § 7.4.3.4. These performance measures also include:

Care Management Participation Increases Member Preventive Care

92% of Members enrolled in care management have had at least 1 or more PCP visits for general health and for general health and preventive care within 6 months of care management enrollment

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- Clinical indicators, metrics, and outcomes, such as provider preventable events
- Quality measures (HEDIS®, National Quality Forum and Agency for Healthcare Research and Quality Prevention Quality Indicators™)
- Utilization and cost of care indicators (ER visits, admission and readmission rates, length of stay data)
- Member experience, such as quality of life, satisfaction, grievances and appeals, and CAHPS survey results
- Identified SDOH referrals, gaps resolved and closed, number of housing placements, and meals served
- Provider-level performance tracking and evaluation of effectiveness of value-based purchasing (VBP) arrangements compared to national benchmarks
- Health inequities and disparities, comparing health outcomes data from the same geography across racial or ethnic populations

A.1.a. Challenges Unique to MississippiCAN and CHIP Populations

We consider maternal and infant health, SDOH and social risk factors, and preventive care and chronic condition management as the three most pressing challenges we see in Mississippi that will drive our Care Management Strategy. Using geomapping and advanced population health analytics, we combine what we know about individual Members with population data at the community and county level to understand regional differences and compare Member data to the overall population. We layer advanced analytics with Provider and CBO testimonials to understand local challenges and pain points from their perspective. We will use Mississippi-provided data, Contract requirements, known engagement rates, and the experience of our staff and partners to provide on-the-ground insights.

How We Will Address Maternal & Infant Health Challenges in Mississippi

- High-risk OB program
- Maternal monitoring
- Maternity support platform for Black women
- Electric breast pump program
- Virtual maternal and pediatric care platform
- NICU program
- Health disparities initiatives

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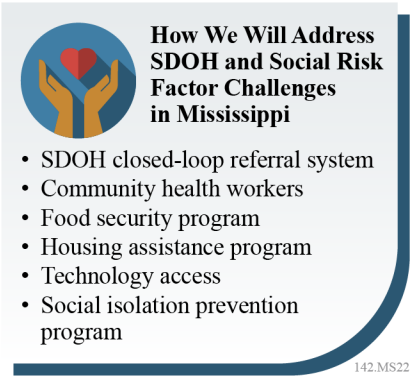
Maternal and Infant Health. Mississippi's infant mortality rate stands at 8.8 deaths per 1,000 live births, compared to 6.0 deaths per 1,000 live births for the US overall. The State has the highest rate of low birth weight in the US (11.6% vs. 8% average). Deep racial disparities also exist. Black

mothers are 49% more likely to give birth prematurely, twice as likely to have a pregnancy complication, and three times more likely to have a pregnancy-related death.[1] These outcomes result from lack of prenatal care, access issues, unmanaged chronic conditions, and the absence of culturally competent, patient-centered care. For details about our approach to maternal and infant health, see our response to RFQ §§ 4.2.2.1.A.1 and 4.2.2.1.A.3.



SDOH and Social Risk Factors. Food insecurity, lack of education, inadequate transportation, and unemployment are the top four SDOH challenges facing Mississippians. According to Feeding America, 550,370 Mississippians face daily hunger, which means one in five individuals are not sure where their next meal will come from. Members who live in food deserts must travel an average of 30 miles to find healthy food.[2] Chronic underfunding has resulted in Mississippi's public education system being ranked last, year after year, which affects Members' health literacy and ability to navigate healthcare and services. For our approach to addressing SDOH, see our response to RFQ § 4.2.3.3.

Preventive Care and Management of Chronic Conditions. Preventive care is critical to keeping Members healthy and halting the progression of chronic conditions, but often individuals see no reason to seek the care of a physician when they are not feeling sick. Lack of access to care also has an impact: Approximately 50% of Mississippians live in underserved counties with greater than 2,000 persons per PCP.[3] For details about our approach to supporting Members with chronic conditions, see our response to RFQ § 4.2.2.1.A.4.

A.1.b. How We Ensure Closed-loop Referrals and Warm Handoffs Are Executed and Tracked

Our Community-based Referral System. Our closed-loop referral system offers access to vetted social programs by zip code that address SDOH issues in Mississippi communities. The platform is available 24/7/365 and can be accessed by care management staff, Providers, and Members. Each service offered on the platform includes the program name, CBO name, phone/address, miles from zip code, hours of operation, services offered, website link, social media link, and target audience. Our community engagement team and Community Liaison are feet on the street, making personal connections to CBOs across Mississippi to build referral system functionality and close gaps in the social safety net by identifying need categories where we do not have a large range of services. Our community engagement team will work with CBOs around the State to get formal agreements in place and incentivize timely response to Members and maximize closed-loop referral rates.

Linking Members to Services. Care management staff will access programs through our referral system. We will log the Member's need in the system and connect them to the organization, preferably through a warm transfer, but we will respect and honor Member choice and use their preferred referral method. When Members are referred, the CBO will "claim" the case in the system and close it out when Members receive services.

Tracking and Follow-up. When referred by a Care Manager, the Care Manager will follow up with the Member within 7 days (or 48 hours if the Member is referred through the transitions of care program). During this follow-up, our staff gauge Member satisfaction with the service and assess if further action is needed on the referral, whether redirecting to another CBO, providing additional referral for distinct needs, or addressing other barriers to complete the referral, such as arranging for transportation or reaching out to the CBO on the Member's behalf. For Provider or Member-initiated referrals, our local CHWs monitor the referral system and follow up within 7 days to make sure needs are met. For highest-risk Members with co-occurring SDOH and clinical needs, the Care Manager and CHW comanage all referrals and care plan completion.

[1] America's Health Rankings, Mississippi 2020.
[2] Ibid
[3] Ibid

Provider Referrals. We encourage Providers to take an active role in supporting Members with SDOH needs. Our provider representative team will train Providers on how to use our referral system to support their patients. In Mississippi, we will incentivize Providers to use Z codes as part of our value-based agreements and will incorporate SDOH in our quality payments.

A Safe Place to Sleep for Amy's Newborn Child

Amy, a 33-year-old pregnant Member at our affiliate, was enrolled in their high-risk OB program. During clinical assessment, the Care Manager discovered that Amy had no safe place for the baby to sleep. The Care Manager contacted a CBO to refer Amy for a home-delivered crib. When Amy delivered her baby early, our affiliate's Care Manager coordinated with the CBO to deliver the crib to Amy's hospital room. Amy received a demonstration on crib setup and safety, and education on safe sleep and SIDS prevention. Amy expressed gratitude for this assistance, and she was able bring the baby home to a safe space to sleep.

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Building the Community Social Safety Net. Our community engagement team, led by the Director, Community Engagement, will work with CBOs to incentivize closed-loop referrals. We will give CBOs access to our closed-loop referral system at no cost and will provide training if needed. For CBOs that use their own referral system, we will assist them to establish system interoperability to facilitate closed-loop referrals while complying with privacy requirements. We will have formal agreements with CBOs to reward them when they track Members' needs and meet needs timely. This robust process enables us to use our data and analytics to understand the impact of SDOH interventions on health outcomes as part of our broader population health and quality strategies.

A.1.c. Ensuring Care Management is a Tool to Address Health Equity Concerns

Health equity is integrated at every level, from how we hire diverse staff who understand the community and the challenges Members face, to how we train our care management staff in cultural competency, cultural humility, and learning strategies to push back on implicit and unconscious bias. We will include the voices of marginalized communities in decision-making within our Member advisory committees and surveys, and will design our programs with Mississippi's unique challenges in mind to inform our outreach and engagement.

Care Management Staff Training. Through training and education, we equip our care management staff to understand health equity, how disparities impact health and wellness, and how to recognize and address when a Member is experiencing health inequity. Specifically, our staff will be trained in the disparities experienced by Mississippians and CCO Program populations, and how to leverage the person-centered care plan, benefits, and community-based resources to address them. All staff are provided tools, techniques, and resources to ensure cultural competency and recognition of implicit bias Members may experience. Care Managers take a learner's stance when engaging Members in ways that build trust, including leveraging faith-based organizations.

Data Analytics to Identify Areas for Intervention. We use our stratification platform to identify subsets of the population experiencing health inequities or disparities for care management intervention. ***Our health equity dashboard, part of our care management tool, provides enhanced data mining and analytics capabilities to drill down on subgroups to identify racial, ethnic, and SDOH disparities at the county and Member level.*** Data presented in dashboards allow Care Managers to stratify key performance indicators for each population and individual Members and combine criteria to understand where to target resources. We combine race and ethnicity information provided on State enrollment files, Member-reported information, data from national sources such as the US Census Bureau, and claims, encounters, and other utilization data, including lab and pharmacy data, to score for risk. At the Member level, we use specific questions on the HRS and CHA to ask Members about their demographics and SDOH risks. HRS/CHA data is fed into our stratification platform to further identify and refine risk scores and population disparities and inequities.

Our annual care management assessment includes findings by race, ethnicity, language, and disability, and points us to opportunities for improved health outcomes. This drives the design and build of our care management programs. We will offer specialty programs, such as high-risk OB, opioid use disorder/SUD, pre-diabetes, and more, targeted to specific subpopulations, based on findings in the assessment. Building on what we know about Mississippi in each population health stream, we will overlay and align cross-system partnerships, and the population-level health disparities data, to tailor specific care management programs, interventions, and Member engagement to each community.

Monitoring Goals for Reducing Disparities. From our analysis, we identify specific goals for reducing identified health disparities and monitor them as part of continuous improvement of our care management programs. We analyze available information to inform and adjust existing programs, interventions, and engagement strategies and develop new approaches as the population's needs evolve over time. For example, we will monitor the effectiveness of our initiatives for a healthy Delta in meeting our goals by evaluating health disparities in relation to preventive care appointments, low birth weight, and premature births, drilling down by county, zip code, or neighborhood and overlaying this with race, ethnicity, language, and disability data.

Care Management Programs. We engage identified Members in our care management programs, which offer person-centered, culturally competent information. [redacted] We verify the Member's comfort level with their Providers relevant to the identified disparity, for example, identifying a PCP who speaks the Member's preferred language, or meeting other Member preferences such as for a Provider of the same gender or race. Our Care Managers offer health literacy support targeted at areas of identified disparities. We connect Members to specific SDOH resources related to disparities to overcome barriers to treatment or healthcare.

Provider Engagement. We work with Providers to facilitate understanding of the effects of healthcare disparities on Members. Our Care Managers engage Providers on behalf of specific Members to address equity barriers and to apply implicit bias strategies when necessary. We equip the Member with tips on how to effectively advocate for themselves and how to ensure successful Provider visits, such as crafting questions for the Provider prior to the appointment or taking notes during the visit. We provide broader Provider education on health equity and disparities, implicit bias, and cultural competency, and information on care management initiatives and goals related to disparities we have identified in the Member population.

A.1.d. Methods to Engage Difficult-to-Reach Populations or Members Who Are Unresponsive

We combine the use of trusted health partners and feet on the street with technology and tools to engage difficult-to-reach Members and those who are unresponsive to outreach. We will combine strategies to act as a force multiplier to reach and engage Members who often cross groups, such as those experiencing homelessness, BH conditions, and high ER use. Our outreach methods for difficult-to-reach members include:

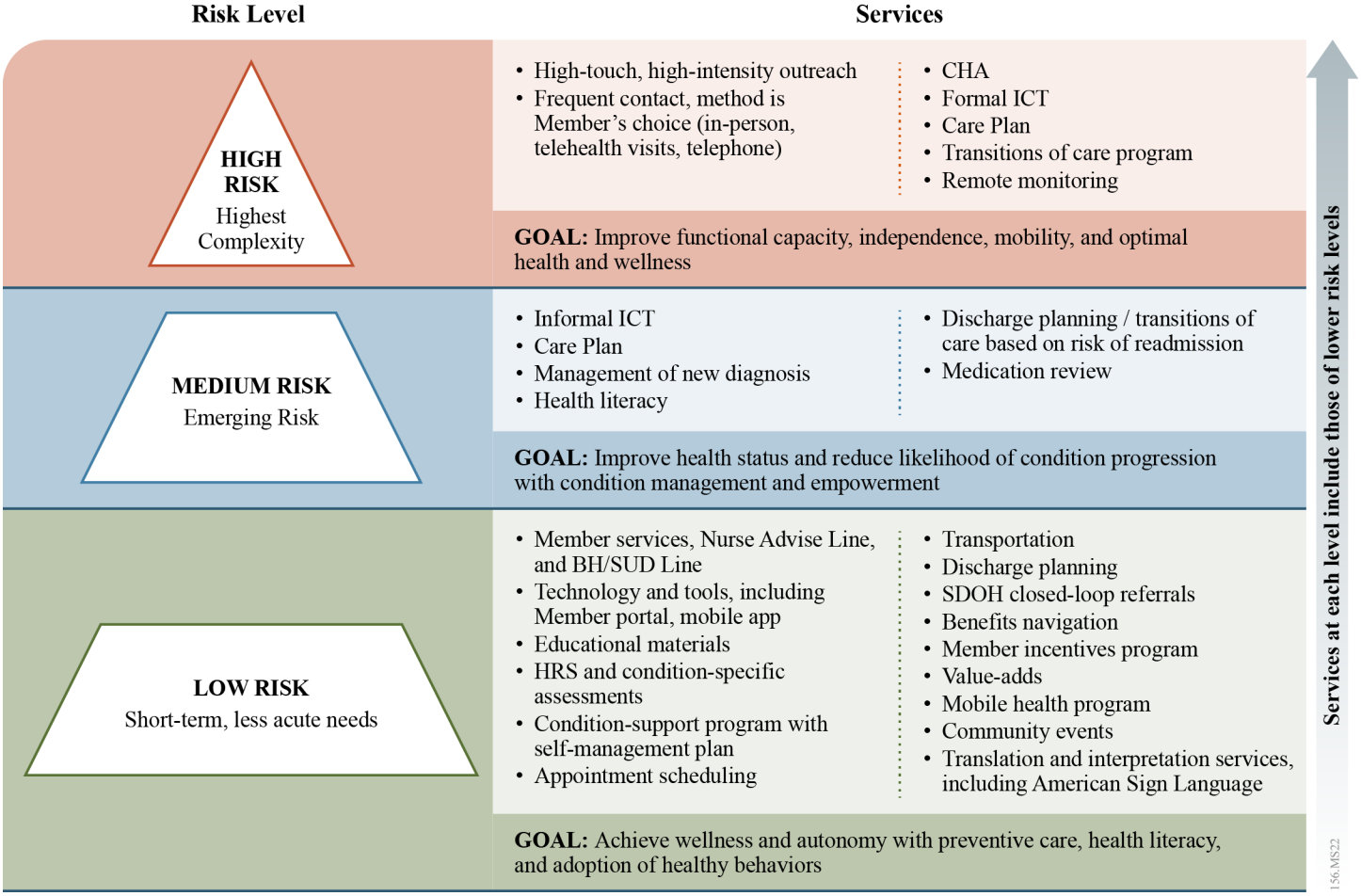
- **Welcome visits.** Nurse practitioners visit high-risk Members ***in their home*** within 30 days of enrollment and complete the HRS, assessing needs, scheduling appointments and arranging necessary transportation.

- **Mobile health program.** Mobile units and semi-permanent trailers are deployed to underserved communities for community-level access to healthcare services and for Members to engage with the health plan.
- **Point-of-care outreach.** Admission, discharge, and transfer (ADT) alerts or hospital census notify us of Members needing immediate outreach. We will assign Care Managers to larger Mississippi facilities to work closely with Members and engage them in their treatment.
- **Member choice in contact.** We reach out to Members in the way they prefer. We will offer various communication modes, including telephone, in-person, or mail, and are expanding communication platforms to offer electronic push notifications (i.e., email, text, mobile app, or telehealth visit).
- **Meeting the Member where they are.** Care management staff make visits to homes, community locations, churches, Provider offices, and wherever the Member is willing to engage, following appropriate COVID-19 safety protocols. Our staff use motivational interviewing to activate Member empowerment in their wellness.
- **In-community resources.** CHWs reach difficult to contact Members by visiting their last known address or churches, shopping centers, barber shops, or community centers. Our affiliate used this strategy to ***improve the rate of finding hard-to-reach Members by 12% and reduced the rate by 24% in 3 months.***
- **Alternate contact information/location.** We mine data for contact information using internal and public databases, Provider health information exchange (HIE), credit bureaus, white pages, claims, and reaching out to Providers, pharmacies, and CBOs (such as emergency shelters the Member has previously accessed).
- **Methods to stay in contact.** We help Members keep in contact through our value-add service providing a no-cost phone, data plan, and mobile hotspot—pre-loaded with their Care Manager's contact information, the Member mobile app, and an image of their Member ID card. We also train Members on how to use our tools.

A.1.e. Care Management Services by Risk Level

Exhibit 4 summarizes services available for each level of care management.

Exhibit 4. Care Management Services for Each Level of Risk. Services build in intensity as Member's risk increases.



All Members in our plan—no matter the risk level, but in alignment with their needs, cultural and linguistic preferences, and personal goals—will have access to appropriate person-centered services and the myriad initiatives we will bring to Mississippi. For every Member, we will provide disease management programs such as weight management and management of chronic conditions; access to community engagement events; and connection to our community partners through our SDOH referral system to address social service needs. We will provide educational opportunities to increase health literacy across the spectrum of the Members we serve. Members will receive care management services based on their assessed risk level. These risk levels are not static: Members will be leveled up or down as risk or needs change.

B. STRATIFICATION AND ASSIGNMENT

B.1. Proposed Initial HRS for New Members

Promptly identifying and connecting newly enrolled Members with clinical and social needs to our care management program will help members address urgent health care needs, which reduces imminent and future health risk, preventable health events, and exacerbations of conditions. The initial HRS is a valuable tool used to begin building a complete picture of the Member, including their immediate and ongoing needs, in order to properly connect them to care. We've designed the HRS to be intuitive, using branch tree logic to gather detailed information from the Member as they respond to each question. We use HRS information to actively engage Members in their own care and to meet their whole-person needs. Understanding Members' immediate needs, including the impact of health inequities and SDOH identified by the HRS, helps us develop holistic and personalized solutions for each Member and family we serve.

We use a number of methods to engage our Members to respond to the HRS, and it is our goal for all Members to respond to an HRS within 30 days of enrollment. For the CCO Program, we will implement an innovative method for gathering Member HRS information. ***We are developing a bidirectional data-sharing capability that allows a provider's electronic health record (EHR) to "talk" with the HRS, pulling answers from the EHR to pre-populate the HRS.*** We will leverage what Providers are already asking their patients (e.g., do you smoke, do you have any chronic conditions) to populate the Member's HRS through the EHR, reducing the time to collect this information. By gathering this information early in the Member's enrollment, we gain valuable insight into the Member's needs so that we can target and connect our members to the most impactful programs. We will partner with several Mississippi facilities to improve interoperability and data sharing.

Questions on the HRS

The HRS is comprised of 10 questions with a branch-tree logic extending to a maximum of 28 questions, depending on the Member's responses. Our HRS asks questions in four domains—general demographics and preferences, BH, general health, and SDOH—which together give a holistic view of all aspects of the Member's health and wellness. These questions have positive predictive value that feeds our risk stratification and predictive modeling platform, supporting early identification and segmentation of members who are at greater risk. Please see **Mississippi HRS** following this response.

Methods of Seeking HRS Answers

We make responding to the HRS convenient, recognizing that every interaction with Members is an opportunity to complete the screening. Members can choose the most convenient method for responding to the HRS, including by phone with a Member services call center employee or their Care Manager; using an automatic voice response option; using an online version on either the Member portal or our website; or using a paper version. We will use solutions we have implemented successfully across our organization to increase the rate of completion, such as reminders by text or email with a link to the online HRS and instructions for other methods Members may prefer. These include but are not limited to:

- **Member information packet.** Includes a prepaid-postage return envelope and instructions for completing it online or over the phone, and for accessing in-person support based on Member preference.
- **Welcome call**. HRS will be attempted during the welcome call in the first 30 days of enrollment.
- **Member website.** Includes link for Members to complete the HRS online.
- **Call center.** Member services call center employees will attempt to conduct the HRS when the Member's personal health record indicates no completed HRS or offer additional methods available to the Member.
- **Self-service.** Members can self-administer the HRS using convenient modalities of their choice available in English or Spanish, including the Member mobile app and the Member portal.
- **In-person assistance.** We will provide multiple options to assist Members to complete the HRS, including through their Provider or Care Manager, a nurse practitioner, a CHW, or our mobile units.
- **Providers.** As stated, we will leverage a bidirectional data-sharing capability to allow a provider's electronic health record (EHR) to "talk" with the HRS, pulling answers from the EHR to pre-populate the HRS.
- **CBOs.** While receiving community services, Members will be educated on the importance of the HRS and encouraged to engage with the plan to complete the screening.
- **Alternate formats.** Available in Spanish and Braille; translated into any language at the Member's request.

How HRS Answers Are Used for Stratifying Members Based on Acuity Level

The HRS score is one of many data points we use to understand the needs of Members, including identification of immediate clinical, functional, or social service needs that require an urgent response. The preliminary score is used to determine if a Member has emerging risk or already has high acuity warranting urgent follow-up with a comprehensive health assessment (CHA). The HRS will identify immediate needs, such as if the Member is unsafe or in crisis, and applies hierarchy leveling logic to quickly route the Member to the appropriate care management staff for support.

Our care management team conducts further stratification through application of clinical or professional judgment based upon their findings with other accessible data (e.g., claims, prescriptions, authorizations), including conversations with the Member, family, caregiver, and treating Providers. Information gathered

through the HRS process is quickly synthesized to identify and draw conclusions about Members' priority care and social needs to prepare and inform the person-centered care planning process. To enhance our understanding of Member risk, our system continuously feeds assessment responses back into the Member's personal health record and combines this with claims, authorizations, and referrals to further refine and derive insights on Member risk level and risk prediction over both the short and long terms.

How HRS Answers Are Used for Care Management

Identify Urgent Needs for Immediate Outreach. A response on the HRS indicating urgent needs, such as not having access to food, transportation, or an inability to perform activities of daily living, will result in immediate Member outreach and include coordination with the Member's Provider. Care management staff will work with the Member, provider, and utilization management (UM) team to get medically necessary services authorized quickly.

Comprehensively Assess Risk to Determine Appropriate Level. Answers on the HRS are fed back into our proprietary risk stratification and predictive modeling platform to refine the risk score and predict future risk. The more we understand about a Member, the better we can meet the Member's needs effectively by aligning them to the appropriate care management program according to their acuity level. The HRS uses leveling logic that aligns with clinical criteria for each risk level: Members with a diagnosed condition but low emergency room (ER) usage and a moderate level of impactability are scored **low risk** and will be triaged to our disease management program. Members identified as ***medium or high risk*** *or* ***high need*****,** having a potentially high-risk condition or any BH condition, or pregnant upon enrollment, ***are assigned a Care Manager immediately*** to outreach for a prioritized CHA assessment within 30 days from HRS completion. Care Managers assigned for this outreach have ***expertise and experience reflective of the Member's primary health concern or condition***. For example, Members with a primary physical health condition like diabetes would be matched with an RN Care Manager who is a Certified Diabetes Care and Education Specialist. Members with a primary BH diagnosis will be matched with a BH clinician. Our care management team has experience across many focus areas, including pediatric, critical care, OB, behavioral health, and SUD.

Care Management Assignment. Member information is fed into our stratification platform, offering scores and insights as the data moves through key thresholds and criteria to align risk and acuity with a care management program level. Then, the Member is queued based on their clinical risk and impactability, including SDOH propensities, displaying their primary diagnosis or condition for ease and appropriateness of case assignment. We review each routed case to identify correct case assignment using our personalized assignment process. Regardless of risk, we always consider primary condition, language, location, and Member preference in our assignment process. Members are matched to a Care Manager, CHW, Transitions of Care Coordinator, or Health Coach who is culturally and linguistically appropriate and has the clinical expertise and experience to coordinate care effectively to meet the unique needs of the Member. For example, Members who are pregnant will be assigned to a high-risk OB team for outreach; Members who are inpatient to our transitions of care team; and so on. Through this process, Member choice is always honored, and they may request to change their assigned Care Manager at any time.

To Inform Clinical Decision-making. We will provide Member's HRS responses and score to Providers and the Member's selected interdisciplinary care team (ICT) within the secure Provider portal or by mail. Sharing this information provides care team participants with a holistic view of drivers impacting the Member's health and helps Providers identify emerging and changed risks within their patient panel.

B.2. Methods for the Comprehensive Health Assessment of Members

The integrated CHA is the main tool for developing the Member's personalized care plan. Our person-centered approach to administering the CHA engages Members and supports active participation in developing, implementing, and monitoring the care plan. Care managers are trained in evidence-based practices, including motivational interviewing, which emphasizes empathy and compassion. Through this process, the care manager will better identify and recognize challenges and risks facing the Member. Our process and CHA include open-ended questions, affirmation, reflection, and summarization with a goal of supporting Members to identify their goals and needs.

Questions on the CHA

To reduce Member abrasion and focus valuable time with Members, the CHA pre-populates the Member's prior HRS responses and only asks questions relevant to the Member. This reduces the risk of assessment fatigue. CHA questions are directly tied to previous positive responses to gain a deeper understanding of the severity of Member's conditions, clinical history, and current functioning. Branching logic sends Members and the care managers to secondary assessments to dive deeper into their personal, holistic needs and confirm prior assessments. Please see **Initial CHA Summary** and **Comprehensive Health Assessment** following this response for samples of our CHA we use with Members.

Methods for Seeking CHA Answers

Our Care Managers engage Members through their preferred method of communication (e.g., face-to-face, through the phone) to seek CHA answers, making it has convenient as possible. Using motivational interviewing, the teach-back method, and activation techniques, our Care Managers engage the Member to help them feel comfortable and confident in articulating meaningful CHA answers. Our Care Managers are trained in culturally competent, trauma-informed care, and how to listen to Members, instead of jumping in with their own assumptions in order to secure a true reflection of the Member's current health status and needs.

How CHA Answers Are Used to Stratify Members Based on Acuity Level

CHA gives us a deeper dive into the Member's specific conditions, how well they are managing their current status, and their clinical and social support needs. Responses help the Care Manager facilitate development of a comprehensive person-centered care plan. As we assess and probe deeper with the Member, family and/or caregiver, we assist the member in refining and personalizing the care plan and its milestones, goals, interventions, outcomes, and barriers.

How CHA Answers Are Used for Care Management

To Give Us a Holistic View of the Member. The comprehensive assessment tool holistically assesses physical health, BH, and social support needs, providing necessary information to the Care Manager for identification and connection to appropriate services and supports. The tool uses branching logic to guide all Care Managers to conduct additional customized assessments, medication review, and condition-specific screening as needed, such as the CANS, SBIRT, LOCUS, CAGE-AID, PHQ-9, AD8, PRAPARE®, and Trauma Symptom Checklist.

To Develop a Meaningful, Person-centered Care Plan. Care managers use the care plan as a framework for discussion with the Member. The care plan is designed to help Members define their personal goals and interventions. Using motivational interviewing and principles of trauma-informed care, Care Managers engage Members in the care planning process and assist Members in articulating their priorities into meaningful goals that follow the SMART framework. Members are guided in documenting realistic steps to help them achieve their health goals and meet care plan milestones. A care plan also includes resources to resolve identified SDOH or equity barriers. Care Managers will use our SDOH closed-loop referral system to help Members identify available resources to meet their needs. Their knowledge of the community helps to ensure Members are connected to available resources and services to meet their needs and to resolve identified barriers.

To Facilitate Care Collaboration. With Member consent, Care Managers will share assessment results with the interdisciplinary care team and others the Member chooses to inform. The assessment is documented in the Member's profile and shared via the Provider portal.

B.3. Methods for Reassessment of Members

Members needs are continuously evolving, requiring consideration of Member's progress, successes and barriers. Reassessment helps us to reevaluate the Member's health, social needs, and to identify changes following the most recent assessment to determine new or ongoing needs. We employ several methods to reassess members, including:

Risk Stratification and Predictive Modeling. We are always monitoring our full membership for fluctuations in acuity, disease prevalence, and SDOH by race and ethnicity through our stratification platform. Our transitions of care readmission risk scores refresh semi-monthly, which ensures we proactively catch Members' acute crisis so we can intervene or predict likely acute crisis events and divert them. Monitoring our membership using ongoing advanced analytics drives improved population health outcomes, enhancing

Member experience of care, reducing the cost of healthcare by avoiding preventable hospitalizations and disease progression including healthcare disparities.

Health Risk Reassessment for All Members. We recognize that the best means of identifying member needs are through the Member's voice. We continuously seek to reassess Members for any external referrals or if a Member has a change in condition. To make the HRS easy and convenient for Members, we use various methods for reaching out to Members, including live agent calls; using our staff with telephonic, in-person, and telehealth engagement; and Member self-service platforms (portal, mobile app, text, email, mail, and an automatic voice response option).

CHA for Members in Care Management. CHAs are conducted by the Care Manager using the Member's preferred method (telephonic, in-person, or telehealth visit) to understand the evolving holistic needs of the Member. Regular reassessment with CHA is based on the Member's level of need with ad hoc reassessments based on Member or caregiver request; Provider request; clinical judgment of care management staff; or change in condition, new diagnosis, or significant health event. ***Members who are continuously enrolled without a trigger for reassessment are given an annual CHA reassessment on their enrollment anniversary.*** Our focus for Member CHA reassessment is the Member's primary health concern to support the Member with timely and relevant health and social needs.

B.4. Other Methods to Identify Member Acuity Levels for Assignment and Care Management

While our primary method to understand Member acuity for assignment and alignment to the appropriate level of care management intensity is through the data analytics capabilities of our stratification platform, we also analyze incoming data to identify shifts in acuity and risk composition. Additional sources for Member acuity come to us in the following ways:

- Referrals from PCP/PCMHs, specialists, CBOs, counselors, or others who provide services to Members, typically as part of a referral to our care management program
- Referrals from home health agencies and other agencies that serve the Member
- Notification of a Member's pregnancy directly from a Provider or through our maternity analytics platform through a daily report that prioritizes urgent cases
- New diagnosis or change in condition
- Hospital census reports, which can indicate a change in the Member's condition
- Readmissions risk score for Members transitioning from an inpatient setting
- Member's care management enrollment with a previous CCO, Member's care plan and progress notes
- Internal departments, including the Nurse Advice Line; Behavioral Health/Substance Use Disorder (BH/SUD) line; UM team; and Care Management, BH, and Medical Directors
- Member, guardian, or caregivers
- Secondary assessments, including transitions-of-care and condition-specific assessments, and SDOH, caregiver, and Member self-assessments

Practice Transformation and Technology Enablement Initiatives

We look forward to partnering with **Jackson-Hinds Comprehensive Health Center, Hattiesburg Clinic, Peace Children's Clinic, Magnolia Regional Health Center, and North MS Health Services (NMMC)** to implement bidirectional data sharing with Providers to pull from EHRs to alert us to changes to a Member's condition or new diagnosis with the goal of having seamless communication with network Providers.

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Our care management approach is flexible and agile, allowing care management staff to promptly identify and address member's evolving needs. When we receive acuity data, if the Member is already in medium or high care management, the assigned Care Manager will continue to be the primary point-of-contact and reach out to the Member using their preferred contact method to administer a reassessment. If the Member is not in care management, care management staff will contact the Member telephonically to administer an HRS assessment and engage and enroll the Member into care management.

B.5. Integrating SDOH, Health Equity Evaluations, and Nonmedical Risk Factors into the HRS and CHA

Our HRS and CHA are fully integrated tools that assess the major domains within all aspects of health and social services. This includes Member demographic and preferences, BH, general health, including medication

management and functional needs, and a robust SDOH domain, including identifying housing, food, and transportation needs. ***Our CHA process adheres to all NCQA complex case management initial assessment standards and elements.*** The assessments provide a complete picture of challenges the Member is facing, including disparities (ethnic and racial, gender, geographic, and patterns of inequity in access and outcomes), and SDOH barriers (food insecurity, housing, financial insecurity, and more) to facilitate targeting Members for early and frequent preemptive outreach. Our stratification platform also assists our care management program by capturing potentially preventable events, such as admissions, readmissions, complications, and ER visits, and providing that information within the member's personal health record.

SDOH. Both the HRS and CHA contain questions designed to offer insights into how SDOH affects our Members. Our dynamic predictive model will continuously monitor and identify Member's risk levels as new HRS data is incorporated and integrated with identified SDOH needs. We will identify Member SDOH needs upon enrollment and continuously throughout their tenure, understanding that SDOH needs often change among this population and affect presence and acuity of clinical needs. SDOH questions within the HRS and CHA include housing, food, transportation, utilities, clothing, finances, and safety. Further, if the Member responds positively to these questions, it will prompt the assessor to complete a detailed SDOH assessment using the evidence-based PRAPARE tool which dives deeper into the individual Member's SDOH needs.

Health Equity Evaluations. As part of our assessments, we will ask for Members' race, ethnicity, and cultural and language preferences and assess for technology access and geographic, race/ethnic, and other disparities based on what we know about the overall population and Mississippi communities. We will also modify or add questions to the HRS/CHA as needed based on our evaluation of the trending health equity issues and disparities within the population. This will help us identify and proactively provide relevant support to Members who share characteristics with identified subsets of the population experiencing health equity issues or disparities.

Other Nonmedical Risk Factors. Our assessments will also ask about Members' functional needs, such as activities of daily living, their feelings of safety, if they participate in risky behaviors, or if they have fall risk. We will also ask if Members have a caregiver or informal supports and the ability of those supports to assist the Member effectively.

C. CARE MANAGEMENT SERVICES

C.1. Outreach to Ensure Members Receive Preventive and Follow-up Treatment and Medications

Policies, Procedures, and Processes to Conduct Outreach

Our policies, procedures, and processes for conducting outreach ensure that Members receive preventive care, follow-up treatment, and medications timely and in accordance with their PCP/PCMH's recommendations. Engaging members, family, and caregivers is essential to the success of the care management process. From the beginning when Members are enrolled in care management programs, we are proactive in providing education about the importance of these services to their overall health and treatment goals.

Our policies, procedures, and processes for engaging Members define high-touch, multifaceted strategies that meet Members where they are and honor their preferences for interacting with the health plan. ***Our model for outreach brings together critical elements for ensuring relevant, convenient, and culturally and linguistically appropriate coordination for Members through local staff, data to inform outreach, community partners who know the neighborhood, and innovative methods*** that have been successful in our affiliate plans and tailored for Mississippi's unique needs. **Table 1** describes some of the ways we conduct outreach.

Table 1. Member Outreach for Preventive and Follow-up Care and Medication Adherence. When Members receive scheduled care and adhere to prescribed medications, they can better manage their conditions, maintain their health, and improve their treatment outcomes.

Preventive Outreach
• Member education about the benefits of preventive care throughout the Member's enrollment using various methods, including the welcome call, welcome visit, Member information packet, Member website, and the hold message on our Member services line • Member texts or email reminders about preventive care coming due • Texts or emails with information about our mobile health program coming to their community • Care planning activities to promote and assist with preventive care coordination • Member PCP/PCMH selection

- Appointment scheduling support
- Member services representative reminders when Member record indicates they are due for preventive care
- CHW in-person outreach in the community (parks, shelters, churches, food banks) for Members with high risk or care gaps
- Mobile health program to help close preventive care gaps
- Clinic days at Provider offices where we assist Providers with block scheduling appointments
- Periodicity schedule for EPSDT exams that's easy to find on our website
- Member outreach training for Providers to promote active Member engagement

Follow-up Treatment Outreach

- Follow-up treatment scheduled and documented for the Member at discharge from any inpatient stay
- Reminder texts and emails for upcoming follow-up
- Care management outreach directly to the Member
- Care plan documentation of provider's treatment plan(s) and follow-up instructions
- Community resources through closed-loop referral platform to solve barriers to care
- EPSDT periodicity schedule on our website

Medication Outreach

- Collaboration with the treating Providers, trusted CBOs (such as peer supports and faith-based organizations)
- Lock-in program
- Care management care plan and monitoring
- Collaboration with the PBA to identify Members for priority outreach

Notifying Members When Follow-up Is Due

We use individualized and direct Member engagement and Provider-centric quality management strategies to notify Members when follow-up care is due. Our multimodal appointment reminders give us many options for contacting Members via their preferred method, including phone, email, or text, reminding them of their appointments and assisting with rescheduling, if needed. Additionally, our Members may elect to receive text messages or Member mobile app reminders.

Appointment Reminder Campaign Results

In 2020, our affiliated health plan conducted a multimodal, data-driven outreach to assist Members in making and keeping appointments through a variety of avenues. **More than 57% of Members who were contacted self-reported making healthcare appointments**.

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When our staff reach out over the phone or in person, they will assist the Member with addressing barriers to keeping an appointment, such as arranging for transportation to and from the scheduled appointment, scheduling interpretation services, and solving for SDOH needs, such as childcare.

Notifying Providers When Follow-Up Is Due

Providers play a vital role in reaching out to and educating Members about the importance of follow-up care. Our locally based teams train Providers on best practices for encouraging Members to complete their appointments and adhere to treatment plans. Our care management, quality management, and provider service representatives will work collaboratively within provider practices to coordinate follow-up care and missed services. Our provider services representatives will share tips for managing Member follow-up after an admission and post-discharge to meet the seven-day follow-up metric.

Our representatives will assist Providers in accessing and understanding the available data about their Members. Through ***bidirectional data sharing systems***, ***we will provide comprehensive, actionable data to promote timely care for their patients, with notifications identifying Members who need follow-up treatment.*** Our Provider portal also facilitates information access. Through the portal, Providers can view HEDIS scores to compare against national benchmarks and quickly identify attributed Members who have completed or are missing specific HEDIS measures (e.g., well-child visits 3–6 years, childhood immunizations), reports on Members who need preventive and follow-up services, and periodicity schedules.

Clinic Days Help Providers Successfully Close Care Gaps

In partnership with local health department offices or Provider clinics, our staff will assist Providers in scheduling multiple patients for the same day in a four- to six-hour block exclusively set aside for appointments with Members to close care gaps. We will incentivize Providers to participate with no risk to them if the Member is a no-show. **To minimize no-shows, we will reach out to Members prior to the event to remove barriers, like arranging transportation or interpretation services, and make reminder calls**.

Because clinic days are so successful, Providers continue to request them for their practices. In one affiliate, **we resolved 89 care gaps with 14 clinic day events**. Even with the decrease in the number of patients seeking care due to COVID-19, the Provider closed an additional 712 care gaps in 2020.

167.MS22

For Members engaged in care management, Care Managers act as a single-point-of-contact to coordinate care with Providers. We contact Providers about Member care gaps and communicate to these interdisciplinary care team members through the Provider portal. ***We will push care gaps to the Provider workflow using EHRs to alert Providers when Members need additional follow-up for acute events or when a Member experiences a change in their condition.*** We also reach out directly to inform them when a Member has been admitted to the hospital. In Mississippi, we commit to assigning designated Care Managers to support larger clinics or inpatient settings to facilitate discharge and follow-up at the point of care. They will be collocated at the facility for in-person assistance to the Member with making appointments, arranging for transportation, and resolving barriers to keeping follow-up appointments.

C.1.a. Facilitation and Monitoring of Member Compliance with Treatment Plans

For those members without a PCP/PCMH or who require specialty services, we help them to select providers, encouraging the Member to foster relationships with them, assisting with appointments and filling prescriptions, as applicable. We include Members' providers in the assessment and care planning processes, ensuring alignment of the Member's care plan with providers' treatment plans.

Facilitation of the Member's Treatment Plan. We will implement interoperable data sharing capabilities to allow the Member's treatment plan to be available in the Member's record. Providers are responsible for facilitating the treatment plan; however, we will incorporate the Member's treatment goals into the care plan and have an open and honest conversation with the Member about their health status and adherence to the treatment plan. Using evidence-based motivational interviewing and activation techniques, the Care Manager guides the Member in articulating personal goals, identifying strengths and resilience to build on, and planning a path that is realistic and achievable. Care Managers use the teach-back method to ensure that Members understand their treatment plans and how to manage their chronic conditions. They will address Members' barriers to adherence by assessing SDOH needs and link Members to community resources using our closed-loop referral system. They will provide a warm handoff to those services and follow up within seven days to ensure the Member has completed the service. If referrals are part of a discharge plan, the Care Manager will follow up within 48 hours.

Monitoring the Treatment Plan. For Members enrolled in care management, Care Managers will contact the Member monthly, at minimum, using the communication method preferred by the Member to monitor Member progress in meeting the treatment plan goals documented in their care plan. The Care Manager updates the care plan monthly for Members to ensure alignment to provider treatment plans and tracks progress to Member identified goals, using coaching, health promotion and motivational interviewing techniques with the Member to encourage adherence. Throughout this process, information is continuously shared with the Provider and other care team participants through the Provider portal and data sharing arrangements. Additional ways Care Managers monitor Members' progress include:

- Coaching and supporting Members with scheduling, arranging transportation, and attending appointments
- Monitoring or reassessing the Member's condition at every Member contact, including identifying upcoming preventive and wellness care
- Reviewing claims, medication refills, and medication management with the Member

Care Managers maintain contact with the Member and their caregiver and Providers on a continuous and ongoing basis by using the tasking function in our care management platform, which can be used to maintain regular care plan meetings and review the Member's progress toward care goals at critical milestones.

C.1.b. Partnerships with CBOs and State Agencies

Partnering with CBOs. Our affiliate plans successfully build trusting, fruitful relationships with local organizations to provide additional resources to Members that support their health and wellness and act as a force multiplier in reaching more Members. We partner with organizations to provide education to Members about the importance of preventive care (e.g., vaccinations), making healthy choices, taking their medications as prescribed, and following their PCP's instructions. We partner with

Investing in the Communities We Serve

We invest in the communities we serve by providing funds to CBOs that have proven success in strengthening the social safety net and increasing access to care in their communities.

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faith-based organizations, cultural centers, community centers, and others to hold health events that bring Members out for preventive care, like vaccinations and mammograms. In Mississippi, we will bring these community partners together in the following ways.

- **Mobile Health Program.** We will locate our mobile health program in underserved areas to bring preventive care directly to Members' communities. Our community engagement team will coordinate with community partner participants to inform families when the mobile units will be coming to their neighborhoods. We will invite multiple organizations to participate to bring awareness to the services they can offer Members, such as nutrition supports that include food box distribution, health education, and assistance with applying for SNAP and WIC benefits.

- **Mississippi Food Network.** We will partner with Emergency Food Program partners— including food pantries, soup kitchens, homeless shelters, churches, and other charities — to connect individuals with nutritious food.
- **Mississippi Health Department COVID Vaccine Collaboration.** We will partner with Mississippi Health Departments to bring COVID Vaccines to Mississippi's underserved communities. Faith-based organizations offer a trusted source to encourage and promote vaccination. [redacted] We will partner with community clinics and station our nurse practitioners onsite to provide these services, expanding access and supporting community clinics with limited workforce availability.

- **Healthy Lifestyle Community Events.** In partnership with Statewide County Public Housing Authorities, we will hold family-oriented events in local parks for everyone in the community. These events will provide health screenings, vaccinations, EPSDT check-ups, and health education. CBOs will be invited to participate to provide social services to attendees and connect them to nutrition, financial security information, addiction help, prenatal nutrition and healthy lifestyles information, parenting classes, and more. For example, one of our affiliate health plans sponsored back-to-school events that provided backpacks and school supplies to children in attendance.

Partnering with State Agencies. Our work with State agencies ensures that Members who are eligible to receive services provided by those agencies are receiving those services timely and in coordination with their Providers treatment plans and the care plan. Across our health plan, we will work closely to coordinate care, provide advocacy, and follow up with Members to close care gaps and support them in receiving medically necessary care on schedule. The following scenario illustrates how we work with State agencies: When a Member is identified at risk for homelessness, our CHW will work in collaboration with the Member and our Housing Specialist to identify appropriate housing for the Member's needs, such as housing for families or high-risk Members. The CHW will educate the Member about housing options available to them, including emergency housing, temporary shelters, and permanent housing through Section 8. We will assist the Member with filling out housing applications, identifying necessary supporting documents, and submitting their applications. We will keep Members informed throughout the process with frequent follow-up with both the agency and the Member. Once the Member is housed, we will continue to provide supports, such as education about how to be a good tenant and working with their landlord.

C.1.c. Coordination with Other Providers

Close collaboration and coordination with Providers ensure that Members receive timely preventive care, follow-up treatment, and medications. The Care Manager acts as a convener for the Member's ICT, supporting alignment of the care plan to Providers' treatment plans as well as managing cross-coordination between Providers, including communication and coordination between physical and behavioral health Providers, with our Member's approval. For example, the Care Manager may identify new prescriptions that the Member has received and will advise all appropriate Providers in order to ensure patient safety. We also educate PCPs/PCMHs on their roles in coordinating services for the Member. Our practice quality and transformation team will educate Providers about these initiatives and assist them with assessing their capabilities and implementing these standards in their practices. Below, we detail other ways we coordinate with Providers.

Bidirectional Data Sharing. We maximize opportunities for communication and relevant information sharing between key stakeholders in a Member's health by extending to contracted Providers—including nonclinical community service Providers—the ability to access our care management platform for Members under their care. This not only enables Providers to collaborate with one another in the care of Members within the region, but it also allows for close coordination of the care of Members if they move between regions. Providers will have access to their Member-specific information regarding current status, care gaps, and service needs. They can view when a referral to a specialist has been made and by whom and when a Member is inpatient or has been discharged. Additional information for the Provider will also display medication red flag alerts to facilitate clinical decision-making prior to prescribing. Providers are notified when Members are due for follow-up or preventive care and screenings and when medications have been refilled.

Notification Directly from Our Staff. Our staff reach out to Providers directly—over the phone, in person, and via email and fax—to coordinate Members' preventive care, follow-up treatment, and medications. We work with Providers through the care team to bring together the Member, caregivers, and other participants (e.g., the pharmacist) as needed. Coordination can also occur informally with a series of phone calls or other kinds of contacts. We follow-up with the Member on referrals to ensure they complete the necessary service.

Telehealth. We will deploy multiple strategies to expand telehealth to promote cross-collaboration among Providers. One way we will do this is through remote patient monitoring in collaboration with UMMC's Center for Telehealth, a program giving the PCP/PCMH and treating specialist daily insight into the Member's care. Another way is to expand cross-collaboration is through our specialty e-consult solution. This solution enhances primary care services by providing PCPs access to top specialists in a variety of fields. Using text-based conversations, PCPs will receive feedback on diagnoses or care plans, input to support those waiting for specialist appointments, or help interpreting labs/diagnostic tests. This will empower PCPs to make informed clinical decisions and enable access to specialty care, regardless of where Members live.

C.2. Coordination of Care Across the Care Continuum for Members with Special Healthcare Needs

Coordination of Care Across the Care Continuum and with State Agencies

Care Managers coordinate across the continuum of care for Members with special healthcare needs with specialty programs led by dedicated staff with condition-specific expertise. We will ensure that Members receive recommended condition-specific assessments and will connect Members to these specialty programs, such as the high-risk OB program, while also supporting their primary condition needs.

Members in mandatory populations identified in RFQ § 7.4.3.3.1, as well as others who have complex needs or high risk, will be assigned a Care Manager who will work in collaboration with CHWs with specialized experience in employment, food security, SUD, and OB to connect Members to community supports and non-covered benefits. Members who are in foster care will be supported by the Foster Care Manager, who will work directly with Members and their guardians. When Members are eligible for a waiver program or need redetermination, Care Managers will help to coordinate the application process, often with a very hands-on approach to ensure Members do not lose coverage.

We use a wraparound model to ensure Members with special health care needs have comprehensive supports at all times with intensity and contact frequency increasing during transitions of care or changes to the Member's condition. The Care Manager serves as the single-point-of-contact, inviting all involved Providers, including agencies that serve the Member, to participate on the care team; sharing care and treatment plans (with the Member's consent) with the PCP/PCMH and specialists; facilitating Provider communications; sharing monitoring information (such as notifying Providers of an ER visit or inpatient admission); and assisting Providers, as requested, to help Members with referrals, compliance, education, and more. We use various methods to share data bidirectionally among the care team, including via EHRs, the Provider portal, telephone, fax, and letters.

Coordination with State Agencies

Our Care Managers drive continuous communication and coordination with State agencies involved in the Member's care, ensuring that supports and interventions are in place to address the complexity of the Member's individualized needs. Below, we highlight care coordination activities proposed with Mississippi agencies.

MDCPS. Our dedicated foster care team and Foster Care Manager will provide frequent outreach to MDCPS for coordination of Member care across the care continuum. We will reach out to and follow up with county department of human services agencies to assure they are notified when eligible Members under their supervision are due for EPSDT screens and follow-up treatment. We will work closely with MDCPS to make sure our Members in foster care receive the services they need at all times, with intensive support (i.e., more frequent contact and assessments) during changes in placement, health status, and behavioral issues to ensure continuity of care. Upon identification of new foster care children and adolescents, we will send the MDCPS case worker a welcome letter that includes the Care Manager's contact information, materials about our care management program, and information about our reports. We will work to improve care coordination for Members, coordinate urgent screening and assessment, improve outcomes, and reduce system fragmentation and duplication of services.

DMH. We will participate in monthly State-level care review meetings to address the needs of Mississippi children and adolescents with serious emotional disturbances referred by Providers, MDCPS, or the Division. During these meetings, our Mississippi-based care management leadership will collaborate in the development of transition plans and resources for youth with special health care needs and their families. In addition, we will work closely with DMH to establish adequate BH network capabilities and strategize on building BH infrastructure for all Mississippians.

Specialized Planning, Options to Transition Team (SPOTT). We will participate in biweekly meetings facilitated by Arc of Mississippi to support the needs of our Members, including those referred by Providers and family members via the DMH Helpline or Office of Consumer Support. During these care plan meetings, our Care Managers will be well-prepared to discuss the coordination plan and collaborative efforts for Members with a BH condition and multiple inpatient and/or State hospital stays.

Perinatal High Risk Management/Infant Services System (PHRM/ISS). We will educate eligible Members on PHRM/ISS, a multidisciplinary case management program for pregnant women, postpartum women, and infants. We will refer Members that express a desire to participate in a PHRM/ISS case management program in addition to or in lieu of our care management program. When Members are enrolled in our care management program and a PHRM/ISS program, our Care Managers will share successful methods of contact with the PHRM/ISS case manager. Our care management leadership will participate in collaborative meetings with PHRM/ISS to ensure that we address maternal and infant health outcomes, with a focus on reducing the rate of low-birth-weight newborns and infant mortality.

Identifying and Gaining Access to Community Resources, Including Non-covered Benefits

For Members with special health care needs, community-based organizations can provide critical resources and services, including non-covered benefits, such as home modifications, caregiver supports and education, peer supports, supportive and temporary housing, and advocacy groups. Care Managers will work with Members to identify community resources that may help address barriers facing the Member reaching their goals, including non-covered benefits. Care managers are skilled at aligning Member's care and service needs, including complex care coordination across multiple providers, and creating a comprehensive care plan with the Member at the center.

Community resources providing non-covered services play a key role in the care planning process. Our Care Managers will be familiar with resources in their communities and will incorporate their services into the care plan as identified by the Member. Our SDOH closed-loop referral system is our validated community resource directory offered at no cost to Members, Providers, and CBOs. Care Managers, Providers and CBOs use the platform to send and receive referrals, making it easier for us and Providers to collaborate, close the referral loop, and ensure every person gets the help they need. The system follows national and State privacy regulations to fulfill social service referrals. When Members are referred to services in the system, they will be documented in the care plan or Member record. We look forward to partnering with CBOs across Mississippi providing services to Members with special health care needs, including March of Dimes, Special Olympics, Association of People Supporting Employment (APSE), Disability Rights of Mississippi, the ARC of Mississippi, Families as Allies, LIFE of Mississippi, Youth Villages, Family 2 Family, and the Coalition for

Children with Disabilities. Our SDOH referral system highlights our value-adds in the database, so Members with special health care needs know what is available to them.

Our Care Managers, CHWs, nurse practitioners, and Transitions of Care Coordinators will warm handoff Members to community resources to ensure they can complete the referral. When the referral is part of inpatient discharge, our staff will reach out to the Member directly within 48 hours to follow up on the referral. For non-discharge-related referrals, we will follow up within seven days. Our CHWs also play a valuable role in helping to connect Members to community resources providing non-covered services as they are our "feet in the street." They have deep knowledge of their communities and are familiar with the challenges and barriers that Members face as well as local culture, language, and norms. They are available to collaborate with Providers to help Members with special health care needs successfully access community resources. ***Specialized CHWs in SUD, food, employment, and OB will provide their expertise to Members*** with needs specific to these areas.

C.3. Communication with Providers and Members' PCP/PCMH

We ensure appropriate communication with Providers, follow-up communication with the Member's PCP/PCMH, and follow-up care for the Member through consistent, regular communication with the Provider and education to the Provider about how to interpret Member data for the benefit of patient outcomes.

Communication begins with the PCP/PCMH assignment to the Provider. Providers can view their entire health plan patient roster use the Provider portal. This information is provided in a flexible format that allows Providers to drill down on individual Members or sort according to their preference. For example, Providers can identify Member events, such as an ER visit or gaps in care, by manipulating criteria in the dashboard. Providers can view discharge notifications, care gaps, physician referrals, and whether the Member is currently inpatient. Providers can initiate a Medical Director consult if they have questions about a Member's case. In addition to individualized member data, our quality team also reports valuable data to the Provider, including population health evaluations, patient panel outcomes, HEDIS outcomes, VBP outcomes, and more.

Providers with patients participating in our care management program will be invited to participate in the formal ICT and will receive notification that the Member has enrolled in care management. Providers and the plan will share data bidirectionally; the frequency of these updates will depend on the Member's needs. The Care Manager will share information online through the Provider portal, such as the Member's progress on treatment goals, whether the Member has an inpatient admission or discharge, assessment results, the care plan, services, prescribed medications, and other treatment Providers.

We use a variety of methods to communicate with Providers, including via telephone, fax, online through the Provider portal, mobile app, mail, and in person.

Our Role in the Provider Communication Process

As a CCO, we are ultimately accountable for cross-communicating with Providers and providing tools, resources, and staff to help Providers' engage and support Members' timely follow-up care. Member outreach and engagement begins at the point of enrollment and continues across the continuum of care until the Member disenrolls from the plan. Our role in ensuring appropriate communication with the Provider to connect Members with follow-up care happens at all levels of the organization. **Table 2** summarizes the many ways our team will interact with Providers

Table 2. Provider Supports. At every level of the health plan, we communicate and support Providers' connections to Members for follow-up care.

CCO Role	Provider Communication Responsibilities
Medical Directors	Collaborating on Member care through joint operating meetings to understand Member's root cause for readmission; supporting medical-director-to-medical-director consultations to improve Member's physical health, BH, and social care; and leading ICT discussions and recommendations when meetings are held with other treating Providers
Network Team	Supporting a Member's continuity of care for medically necessary follow-up by communicating with out-of-network Providers, offering them contract and/or single-case agreement opportunities
Member Services	Educating and connecting Members to PCPs/PCMHs; communicating with Members about opportunities to support appointment scheduling, transportation arrangement, and medical follow-up reminders; and emphasizing the importance of the PCP/PCMH relationship and establishment

CCO Role	Provider Communication Responsibilities
Quality	Establishing and communicating PCP/PCMH and other Provider patient panels, including VBP arrangements; ensuring Provider access to their patients' HEDIS outcomes; evaluating and sharing health outcomes, including behavioral and social outcomes by patient panel; and training, supporting, and coaching to improve Provider capabilities, data sharing, and Member engagement
Provider Representatives	Training Providers on best practices, such as appointment reminders for their Members; training on how to understand Member-specific data to identify need for follow-up; continuous and ongoing support and coaching to enhance and transform Providers' practices
UM	Ensuring Members receive quality services in the right setting of care at the right time by a quality Provider, reviewing Provider service requests timely, deciding all service requests as appropriate based on clinical criteria available, notifying Providers of service request decisions, and providing a safety net to highest risk Members by performing warm transfers to care management team
Care Managers	Supporting Members with Provider coordination and communication on follow-up care and referrals; keeping Members and care team Providers informed of Member progress, changes of condition/care setting, and any other new health or social concerns; and ensuring Provider communication and collaboration throughout the continuum of care
CHWs	Communicating and coordinating with CBOs and other local resources to resolve Members' SDOH needs and barriers to follow-up care, sharing information with Providers when Members have a barrier to care, and supporting closure of any communication gaps between Members and Providers
Transitions of Care Staff	A specialized discipline within the care management team, transitions of care staff have a targeted focus on communicating care transitions to Providers, facilitating care team consultations in multiple ways, and monitoring Member communication with treating Providers to ensure discharge safety and adherence to targeted interventions, including but not limited to: treatment plan, follow-up appointments, and medications

PCP/PCMH Role in the Communication Process

The PCP/PCMH is the main driver of clinical care in facilitating the treatment plan and is responsible for communicating and collaborating with other treating Providers about Members' treatment and follow-up care. Our Provider education promotes a concept of PCP/PCMH ownership of the Member relationship and communication with other Providers about clinical decision-making with the goal of delivering comprehensive, integrated care to help the Member achieve optimal outcomes. PCPs/PCMHs are responsible for communicating Members' barriers to care to care management staff for additional community-level supports to resolve these barriers. Using information received through our exchange protocols, Providers will request interventions from specialists and the Care Manager, issue appropriate referrals for physical health and BH needs, and connect with other Providers through consultation and treatment plan staffing.

C.3.b. Examples of Information We Provide to Providers

We will keep our Providers apprised of Member follow-up care and progress on treatment goals through a robust data-sharing program and self-service tools that help Providers manage their patient panel efficiently and effectively. We offer Providers the following:

- **Provider portal.** A suite of data that gives Providers access to ***actionable Member-level data to help them track a Member's follow-up care and treatment progress***. Providers will see the care plan; completed assessments; other treating physicians; and physical health, BH, and SDOH referrals.
- **Secure notification platform.** ***Used to push actionable, clinically relevant information directly into the Provider's workflow within the EHR***. This capability supports better patient care and coordination, reduces readmission, helps track and share information about high-risk patients, and allows clinical reminders—such as (but not limited) to EPSDT, immunizations, preventive and chronic condition care needs, prescription fill needs, and overall wellness visits—as a support partner in ensuring our Members' best care and health outcomes.
- **The Provider Profile.** A monthly scorecard measuring performance on key clinical measures, including comparison of performance in the current year versus last year and current performance on HEDIS measures, such as meeting follow-up after hospitalization timeframes.
- **Reports.** ***Highlights Members who are likely to benefit from Provider outreach*** and more active engagement, including HEDIS Gaps in Care, which shows Members who have missed a needed follow-up service.

- **Data for Providers.** Additional information supporting Provider engagement with their patient panel, including education about how to bring Members back to their practice to close care gaps and ***how to use the supports of the care management staff and practice transformation and quality teams*** to ensure Members receive follow-up care and keep their follow-up appointments.

C.3.c. Interaction Between Care Manager and Members, Members' PCP/PCMH, Family, Other Physicians, and Other Relevant Parties

Care Managers coordinate Member follow-up care with Providers and other care team participants using various methods, including:

- Consultation phone calls with Member, their Providers, and others who provide services to the Member, such as case managers from State agencies, social workers, or peer supports
- Internal calls to our UM team, Medical Directors, and pharmacy
- Meetings of the formal ICT that might include family members, caregivers, school nurse, or others chosen by the Member

Care Managers proactively interact with Members, caregivers, Providers, and others of the Member's choosing with the method and timeframes for interaction based on Member preference and the Provider's recommended schedule for follow-up. Care Managers have frequent, regular contact with Members using multiple methods, such as over the phone, face-to-face, telehealth visits, portal, or mail, with the Member's preference and need driving the primary method. Reminders for follow-up and treatment are reviewed at each contact.

C.3.d. Transition Planning for Members Receiving Covered Services from Out-of-Network Providers

Transition planning for new or existing Members is all about ensuring continuity of care for the Member. Out-of-network Providers will be included in the Member's care team. Our care management staff will provide out-of-network Providers contact information for the health plan, and how to contact us when follow-up care is needed.

If the Member is enrolled from another CCO, we will work with the previous CCO to receive historical information on the Member prior to enrollment. We will honor the Member's PCP/PCMH selection and assign them to the same PCP/PCMH. If the Member is receiving active treatment, we will send a letter to the Provider and Member explaining that their services are still approved and to plan to continue the plan of treatment. A Care Manager will be assigned to handle the continuity of care and will reach out the Member as well, to connect them to services and assess for additional needs. Our network team reaches out to Providers who are not contracted with us to authorize continuity of care protections for up to 90 days and through the course of the Member's treatment. For treatment beyond the 90 days, such as for Members who are pregnant, are receiving chemotherapy, or dialysis, we will honor those authorizations beyond the 90 days to ensure continuity of care. During the 90-day transition period, we will work to locate an in-network Provider.

When we don't receive historical information from the previous CCO, we attempt to capture Member's current, active treatment through the HRS. Our UM team will also request PAs from the previous CCO and will log this as a continuity of care request. UM will reach out to the Provider for information about the Member's current treatment plan. They will refer the Member to Care management to coordinate care with the out-of-network Provider and the Member. UM will alert our network team to initiate a single-case agreement for the Provider.

For existing Members, when medically necessary services are not available within the contracted network or do not meet the access standards, we allow a referral to an out-of-network physician or Provider after review by the health plan. Our goal is to ensure that the Member gets the services they need as quickly as possible. Our contracting team works collaboratively with Providers to resolve issues as quickly as possible through a single-case agreement or secure a contract with the Provider to close network gaps. Initially, we approve non-contracted Providers for up to three visits and/or an episode of care based on the clinical condition being treated and/or the course of treatment recommended. Additional visits and/or services beyond the initially approved services may be approved as necessary based on the Member's progress or response to the current plan of care. We coordinate payment with out-of-network Providers and ensure that services are provided at no cost to the Member.

C.3.e. Care Management Processes and Specific Communication Steps with Hospital Inpatient Providers

Transitions of Care Coordinators work collaboratively with contracted and non-contracted hospitals to ensure quality Member care. They work closely with the Member's onsite clinicians; the Member's PCP/PCMH, BH Providers and staff; and other key Providers to ensure development of a comprehensive treatment plan and review potential readmissions by diagnosis. The Coordinator communicates with the hospital discharge planner by phone or face-to-face, as needed, during the Member's inpatient stay to address any gaps or perceived barriers.

Our UM Review Nurses will be strategically assigned by hospital to enhance relationship building and collaboration with the facility's discharge planners. They will communicate with the physician to ensure all Member and family needs are met and all PAs are approved prior to discharge. They regularly meet with Transitions of Care Coordinators to ensure coordination of services for Members prior to and post discharge.

Our Medical Director will initiate discussion with the hospital's attending physician and leadership to determine the root cause for the Member's admission/readmission. Our Medical Director meets regularly through established joint operating committee meetings with key facilities and local attending physicians.

When the Member is scheduled for discharge, the Transitions of Care Coordinator reviews pre-admission information regarding living arrangements, home equipment, and medications. The Coordinator ensures the Member has all referrals and follow-up appointments scheduled prior to discharge (within seven days for a BH discharge and 14 days for a medical discharge). We follow up with Members within 48 hours of the referral for BH and medical appointments. Once the Member is home, the Coordinator will call the Member with a post-discharge survey to ensure that all home health, durable medical equipment (DME), and prescriptions are in place and received and will resolve issues immediately.

D. TRANSITIONS OF CARE

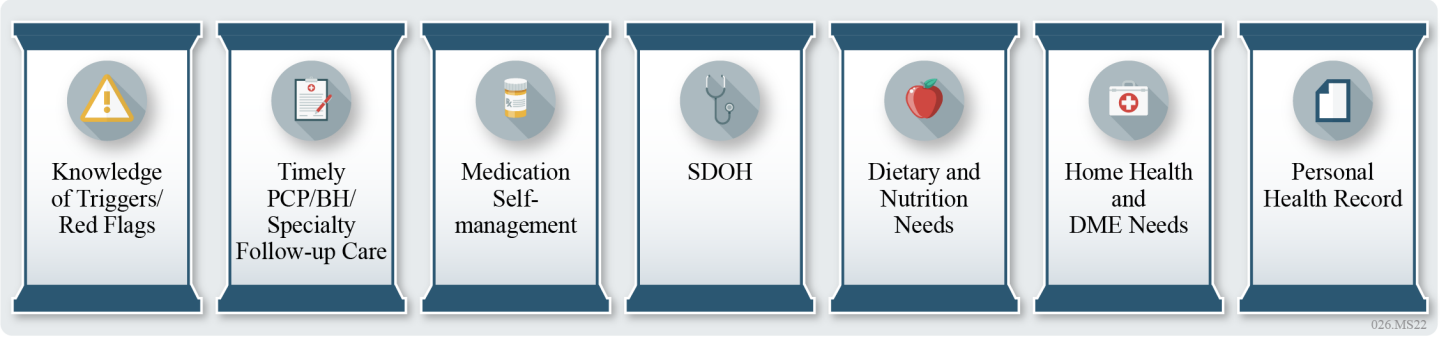
D.1 Overall Approach to Transitions of Care

Our transitions of care program, ***a Coleman-based model***, is an integrated, comprehensive care model ensuring Members have continuity of care across healthcare settings. Our program leverages industry best practices and our experience serving Medicaid Members to coordinate medical and behavioral care and social supports to improve Member's health outcomes and avoid preventable readmissions. Our program provides Members a high-touch, person-centered approach; tools and supports to promote health literacy; self-management; and informed decision-making to ensure Members are supported in all aspects of their health for a safe return to the community. Our program intentionally addresses SDOH and social risk factors because they often increase risk of readmission, adverse health outcomes, and increased utilization.

Our transitions of care program uses a multidisciplinary team approach with Transitions of Care Coordinators, UM Review Nurses, and Care Managers providing comprehensive care coordination and support to Members when they are most vulnerable for readmission. As part of our larger care management team, the transitions of care staff will be located in Mississippi.

Our program is a focused, 30-day program post-discharge for Members who have been inpatient in a hospital or other treatment facility, such as a long-term acute care hospital or psychiatric residential treatment facility (PRTF). We engage Members prior to discharge to help them understand their triggers for admission and how to stay out of the hospital and to prepare them for a successful transition to home. ***We start the transitions of care process early to promote Member participation in their own care, which results in higher engagement rates and better outcomes***. The program objectives are to improve Member capacity for self-management through pre- and post-discharge coaching and education in the seven domains shown in **Exhibit 5** and detailed in the transitions of care process section below.

Exhibit 5. The Seven Domains of Our Transitions of Care Program. The seven domains ensure Members have comprehensive, integrated care coordination, education, and engagement, to support a safe transition back home without risk of readmission.



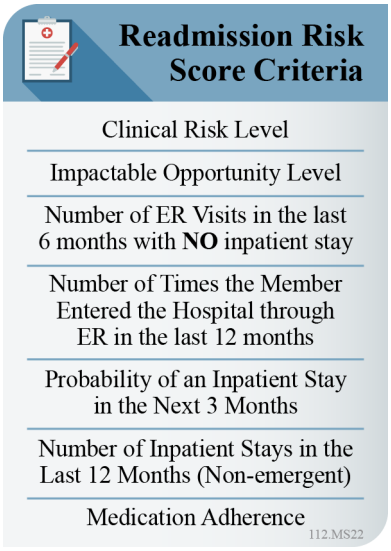
We deploy the transitions of care program in various ways: telephonically, face-to-face, or telehealth visits with staff embedded in the facility setting or through field-based staff, such as our Care Managers or nurse practitioners. ***We will work with larger facilities, like UMMC, to collocate clinical staff who can have real-time, face-to-face contact with inpatient Members to assist in discharge planning.*** Our staff will request space to use a few days a week and will attend care coordination and interdisciplinary team meetings on-site, assist with administration of Members, and reach out to inpatient Members and their families.

Transitions of Care Criteria

Members will be identified for transitions of care through hospital census reports and admission, discharge, and transfer (ADT) reports. Members will also be identified through our predictive risk and stratification platform using an established algorithm that produces a readmission risk score for Members. We prioritize Member outreach for engagement in the transitions of care program based on risk score. For example, Members with a risk score of 16 or greater (high or very high risk) are prioritized and contacted before Members with a low risk score. See **Exhibit 6** for how readmission scores align to risk level.

All Members in the health plan are assigned a readmission risk score, which is available to all staff and found on our inpatient census. The readmission risk score is generated based on seven clinical criteria that score and weight results based on Member acuity and utilization trends. The model criteria and weighting were developed through statistical analysis, readmission prevalence comparisons, and machine learning/artificial intelligence capabilities. **Exhibit 7** shows the readmission risk score criteria, which provide directional guidance to determine staff assignments, prioritization, and methods for outreach. The readmission risk scores refresh as more data is available on the Member and published in the inpatient daily census report.

Exhibit 6. Readmission Risk Score Data Attributes. Our stratification platform analyzes readmission criteria to assign risk of hospital readmission within 30 days of discharge.



Transitions of Care Process

Assigning Appropriate Staff. All Members referred to the transitions of care program are reviewed by care management team members to determine appropriate level of support. We match Members to the appropriate care management program and staff with experience and expertise to support their case. For example, Members participating in care management at the time of admission have their transition of care coordinated by their assigned Care Manager, who works with the facility discharge planning nurses and ensures Members receive care and services post-discharge. Members being discharged from a PRTF are assigned to a care manager with BH experience.

Additionally, Members with BH illness or SMI or who are at risk of institutionalization are assigned a Care Manager or Transitions of Care Coordinator (Coordinator) specializing in BH. Effective management of transitions after a BH or SUD inpatient discharge is essential to ensure that the Member has a follow-up outpatient appointment within seven days after hospitalization to reduce the likelihood of an avoidable readmission. We assist in identifying the optimal post-discharge level of care, placement options, barriers to placement, and the supports and services, such as prescriptions, required to achieve a successful discharge while

also preventing duplication of services. The program promotes integration of physical health and BH, so the Member's holistic needs are met.

For all other high-/very high-risk Members, the assigned Coordinator acts as a single-point-of-contact for the Member and works with them, their caregiver, and the care team to understand the reason for admission and to coordinate follow-up care to ensure the Member can safely discharge home without readmission.

Outreach and Engagement. Initial outreach to the Member is attempted while they are inpatient. In Mississippi, as part of our community-focused care model, we will embed Coordinators in larger facilities that see many plan Members to reach out to them during their inpatient admission or ER visit.

The Coordinator reaches out to coordinate with the facility to monitor the Member's condition and plan for discharge. Coordinators connect in-house teams, including pharmacy, UM, and others to ensure Members' needs are met when returning to the community. If the Member is not returning home, the Coordinator communicates information about the next care setting to the PCP/PCMH.

Exhibit 7. Readmission Risk Scores. The Member's readmission score aligns with level of risk and prioritized outreach.

Grouping	Score Range
Very High	18 and Above
High	16 to 17
Moderate	13 to 15
Low	10 to 12
Lowest	0 to 9

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Members Who Agree to Participate in the Transitions of Care Program Will Be Supported for 30 Days Post-discharge. We make a phone call or home visit within 48 hours of discharge notification and will follow up weekly with the Member. Members who agree to participate complete the transition of care assessment. The Coordinator works with the Member to develop an individualized care plan. Weekly, at minimum, the Coordinator contacts the Member to monitor their progress and ensure their discharge needs are met. Members have a choice in how often they are contacted, and we will honor their preferences, which may adjust the contact frequency. Members remain in the program for the full 30 days, unless the Member opts out. The 30-day interval is the time frame where risk of readmission is the greatest.

Member engagement centers around the seven domains shown in **Exhibit 5** to support improved health outcomes and improve clinical care through Member self-management and Provider engagement, as well as connecting the Member to resources in the community. The Coordinator works collaboratively with the Member, using motivational interviewing and teach-back techniques to develop an individualized care plan to facilitate Member treatment and prevent a readmission or exacerbation of their condition.

Knowledge of Triggers/Red Flags. The Coordinator works with the Member to help them understand the reason for their hospitalization. They educate the Member about their condition, how to identify early signs and symptoms, and what action to take, including when to call the doctor, consult the Nurse Advice Line or BH/SUD line, and when to seek emergent care. The Coordinator also helps the Member and their caregiver understand how to avoid progression of the condition. These discussions are reinforced with easy-to-understand, linguistically appropriate educational materials and use of teach-back techniques to engage the Member in their care and increase their level of health literacy.

Timely Follow-up Care. The Coordinator emphasizes the importance of follow-up with their PCP or specialist after discharge within seven days and will assist with scheduling the appointment prior to their discharge from the hospital, arrange for transformation, and follow up with an appointment reminder using the method the Member chooses (phone call, text message, email, or app alert). In addition, the Coordinator assists the Member and caregiver prepare for the follow-up PCP/specialist appointment by helping them prepare a list of questions and concerns to discuss with the Provider.

Medication Self-management. The Coordinator ensures the Member and caregiver are knowledgeable about prescribed medications and assists them with obtaining their medications. The Coordinator reviews medications, including over-the-counter or herbal remedies, to create a comprehensive list of all medications the Member is taking. They educate the Member on the importance of medication adherence and report any troubling medication side effects to their PCP to avoid interruption in their medication schedule. The Member is encouraged to share the list of medications and discharge paperwork indicating any new, discontinued, or changed medications with their PCP at the follow-up appointment for reconciliation with the Provider.

SDOH. As part of the transitions of care assessment, the Coordinator assesses the Member for SDOH needs and documents them in the Member's care plan. When Members have an identified need for food, housing, transportation, or something else, they will be referred to community resources using our closed-loop referral system. Transportation issues may impact the Member's ability to complete important follow-up care and are addressed by the Coordinator. If the Member assesses for unstable housing, which impacts their ability to safely manage their care post-discharge, the Coordinator will work with our local CHWs to secure housing for the Member. ***We will follow up on all referrals within 48 hours to ensure Members were able to complete them.***

Dietary Needs. The Coordinator works with the Member and caregiver to ensure they understand the role of good nutrition and its impact on health. The Coordinator assesses the Member's current understanding of any identified dietary requirements and supports the Member in their ability to self-manage. Nutritional education is reinforced with educational materials and referrals to additional nutritional supports in the Member's community, such as WIC, or to resources offered through our food security program, including home-delivered meals.

Home Health/DME. The Coordinator evaluates the Member's need for additional home services or DME to ensure the Member's safe and effective transition to home and that services and equipment ordered during discharge are in place. The Coordinator provides education to the Member and caregiver on the use of DME, as ordered. If the Member is not yet capable to fully take care of themself independently, the Coordinator prompts them to identify informal caregivers.

Maintaining a Personal Health Record. The Member and caregiver are educated on the importance of maintaining a personal health record (i.e., notebook) including PCP/specialists information, health reminders, medication, and other important contacts to be reviewed at future PCP/specialist visits.

Additional Support. Members who complete the 30-day transitions of care program and require additional support beyond the 30 days will be referred to the care management team.

Performance Measures Used to Assess the Transitions of Care Process

We will monitor and evaluate performance measures to assess, monitor and evaluate the success of our transitions of care program and identify opportunities for improvement. Our Health Equity and SDOH manager will support the review of performance measures by race/ethnicity, geography, and age to measure the impact of our program on health equity and disparities. Our process will monitor these performance measures:

- Reduction of preventable post-discharge readmissions and ER visits
- Standardized metrics that demonstrate performance monitored by health plan leadership including:
  - Monthly dashboards that measure and report leading indicators
  - Quarterly and annual clinical outcome measures
- Operational reporting monthly, at minimum, and separately for MississippiCAN and CHIP, including number of Members identified for transitions of care; attempted for outreach; reached, enrolled, and engaged; currently enrolled in the program; and referred into longitudinal care management, as well as the number of contacts per case and the average length of stay in the programs
- Quarterly and annual Member outcomes reporting, including number of Members enrolled in high-risk transitions of care, readmission rates measured at 60 days post program completion, preventable ER visits measured at 60 days post program graduation, medication and treatment adherence, and Members reporting meeting and/or exceeding self-identified goals
- Quality measures, including HEDIS Follow-Up After Hospitalization for Mental Illness 7-day and 30-day follow-up rates
- Provider outcomes, including readmission rate by facility and Provider, with Member detail

D.2.a. Scheduling Outpatient Follow-up and/or Continuing Treatment Prior to Discharge for Members Receiving Inpatient Services

When the Member is ready for discharge, the Transitions of Care Coordinator works closely with them to schedule appropriate follow-up appointments. The Coordinator identifies and addresses barriers to completing the follow-up appointment, assisting the Member to schedule the appointment and will follow up with the Member using appointment reminders to ensure they remember to attend the appointment. Member engagement

includes education about the importance of following up with the PCP or specialist, arranging transportation, home health, and DME. At the time of discharge, all Members receive a discharge letter that includes helpful information about their follow-up care with their PCP/PCMH, filling their prescriptions, taking their medications as prescribed, arranging for transportation, and accessing 24/7/365 support through the Nurse Advice Line and BH/SUD line.

Innovations to Promote Member Engagement in Their Follow-up Care. In Mississippi, we will expand telehealth to reduce readmissions and relapse. ***In collaboration with UMMC's Center for Telehealth, we will implement remote patient monitoring for Members who demonstrate an underlying chronic condition during discharge planning, such a hypertension, congestive heart failure, asthma, or diabetes, that puts them at increased risk of readmission.*** We will work with Members to ensure they are engaged in post-discharge care by **scheduling a follow-up telehealth appointment with their treating physician**. This will be especially effective for Members who lack transportation or are reluctant to attend a follow-up.

Our Coordinators assist Members from the point of admission to identify and address any barriers that impact the Member's ability to engage in outpatient care and continue their treatment. In Mississippi, we will take the following steps to promote continued treatment after discharge:

- Connecting the Member to additional Providers, based on knowledge of a Provider's specific strengths and factors such as geography and appointment access
- Conducting a post-discharge survey to ensure all post-discharge services have been started, equipment has been delivered, and the Member and caregiver understand how to use the equipment
- Assisting with scheduling follow-up appointments that best fit the Member's schedule and meeting the standard of seven days for a BH discharge or medical discharge
- Arranging transportation to get the Member to and from follow-up appointments or therapies
- Scheduling telehealth or alternative treatment options if the Member is unable to find convenient appointment times or faces other barriers to attending appointments in person
- Reassessing the Member's holistic needs and updating the care plan with them to include discharge planning activities
- Sharing the updated care plan with Member's Providers

D.2.b. Coordinating with Hospital Discharge Planners, PCPs/PCMHs, and BH Staff

Transitions of care staff coordinate directly with contracted and noncontracted hospitals, and we work closely with Member's onsite clinicians, the Member's PCP/PCMH, BH Providers, and staff, and other key Providers. This involves coordination of the discharge plan created by the facility, treatment plans created by the Providers, and the Member's comprehensive care plan, which is created with the Member and shared with all parties. Everyone involved has a shared goal for quality care and a safe discharge, and alignment of these plans is critical. The transitions of care team coordinate with the hospital discharge planner by phone or face-to-face, as needed, during the Member's inpatient stay to address any gaps or perceived barriers. In Mississippi, other ways we will collaborate include:

- Our UM Review nurse will be strategically assigned to hospitals to enhance relationship building and collaboration with facility discharge planners.
- Our Medical Director will initiate discussion with hospital attending physicians and leadership to determine the root cause of Member admissions.
- Our Medical Director will meet regularly through established joint operating committee meetings with key facilities and local attending physicians.
- Transitions of care staff will review preadmission information regarding living arrangements, home equipment, and medications.
- UM will communicate with the treating physician to ensure all Member and family needs are met, and all PAs are approved prior to discharge.
- UM will create authorizations for all services post-discharge. Transitions of care staff will review and confirm all required Member services are in place such as home health, DME, prescriptions, and more prior to discharge and post-discharge through a telephonic survey with the Member.

- Transitions of care staff will review referrals and schedule follow-up appointments prior to discharge (seven days for a BH discharge or medical discharge). We will follow up with Members within 48 hours of the referral for BH and medical appointments and community services.

Along with these collaboration points, we also recognize the shortage of BH Providers and the need to closely coordinate with the BH staff to help the Member identify Providers that will best meet their needs and to help schedule follow-up appointments post-discharge. If we identify a need, but are unable to find a suitable BH Provider in the Member's community, we will use our available telehealth program to increase access to BH services through local telehealth resources, such as a UMMC's Project ECHO; and other certified telehealth Providers, such as our national telehealth Provider and our specialty e-consult solution, which will offer telehealth and on-demand, virtual access to board-certified physicians.

D.2.c. Arranging for the Delivery of Appropriate Home-based Support and Services in a Timely Manner

Arranging for the delivery of home-based support and services is a key part of the transitions of care program. Prior to discharge, our UM team works with the discharge planner and transitions of care coordinator to identify and ensure authorization of requested services and notifies the Member's PCP/PCMH of hospital admission. This includes coordination with facility personnel to ensure all medication and DME requests are filled and that Members have their post-discharge instructions in hand. We inform the Member about the services they will receive once they are discharged home and educate them on medication adherence. The Transitions of Care Coordinator coordinates referrals and ensure post-discharge orders are in place for home based support and services, such as home health and DME, and refers to community programs to address SDOH needs in collaboration with additional care management staff, such as a CHW with deep knowledge of the Member's local community resources and experienced in housing. We use the post-discharge survey to follow up with the Member to ensure all services have been received and the Member has no further post-discharge barriers.

D.2.d. Implementing Medication Reconciliation in Concert with the PCP/PCMH, BH Provider, and Network Pharmacist to Ensure Continuation of Needed Therapy

Our Coordinators conduct a ***medication review*** in concert with the Member's PCP/PCMH, BH Provider, and network pharmacy to ensure continuation of needed therapy and avoid medication errors or duplication. Members also are offered the opportunity for a pharmacy consultation with our own pharmacy team when they have questions or concerns about medications. The review includes any applicable discharge medications, ensure timely pharmacy fill, identify refill barriers, refer medication issues requiring intervention to the appropriate Provider, and provide detailed guidance to the Member and caregiver on appropriate self-management of their medication regimen. Identified discrepancies or inconsistencies are documented in our care management platform and referred to the appropriate Provider and pharmacy team for further review.

As part of discharge, the Coordinator educates Members on the importance of medication adherence, including taking their medication as prescribed, and to report any adverse side effects to their physician. We educate Members to bring their discharge instructions to their follow-up appointments, along with all prescribed and over-the-counter medications they are taking, so their PCP/PCMH and BH provider can conduct a ***medication reconciliation*** in agreement with the inpatient Provider's treatment plan. The Coordinator informs the Provider if the Member is experiencing any issues in filling or adhering to their medication, including any observed adverse effects. Our transitions of care program also includes electronic notifications through the Provider portal to alert Providers when their Member is discharging from an inpatient setting. We also send Providers a post-discharge letter in the mail.

D.3 Proposed Transition Plan and Policies for Ensuring Continuity of Care for Members Who Are Currently Receiving Covered Services from Noncontracted Out-of-Network Providers at the Time of Contract Implementation

Our transition plan and policies ensure continuity of care for Members as they transition to our health plan during Contract implementation.

Transition Plan. When a Member enrolls with or is auto-assigned to our plan, we will work collaboratively with the former CCO to import the Member's information and, when possible, participate in a warm handoff to review the Member's case. Our Care Manager, or other care management staff, will educate the Member and their Provider of the transition to our health plan while reassuring them that the Member will continue to access current authorized care and medications until the care and treatment plans are updated with the Provider. Care management will review all care plans and care management notes to understand the Member's current care coordination activities prior to transition. Throughout the Member's transition period, we will pursue contracts with nonparticipating Providers or, if they decide not to join our network, help the Member find a suitable in-network Provider. Concurrently, our Care Managers will integrate existing services into the Member's care plan.

We will participate in data sharing with other CCOs. Our UM team will review historical files, State-supplied data, and preapprovals to determine what covered services the Member needs from a noncontracted Provider during the transition period. When we receive a claim from a noncontracted Provider, we will execute a single case agreement for the Member's covered service, and our network management department begins efforts to recruit the Provider into our network. We will accept all eligible Providers who meet the CVO's credentialing requirements. If a Provider does not wish to join our network, our team will work with the Member to identify in-network Providers who best fit the Member's physical health, BH, cultural, and linguistic needs.

Policies. Our policies will ensure continuity of care for Members with noncontracted Providers for up to 90 days after Contract implementation as they transition to our health plan. During this period, we will honor service authorizations and coordinate previously ordered DME, prescriptions, and supplies. We will approve exceptions beyond the 90-day transition period when continuity of care outside our network is essential to ensuring optimal outcomes (e.g., chemotherapy, transplants, pregnancy, ongoing BH crisis). We will pay Providers, whether contracted or noncontracted, at the rate of the current Medicaid fee schedule and in accordance with State payment timeliness standards throughout the continuity of care period.

E. STAFF

E.1.a. Education and Training Required for Care Managers

The value of our care management staff cannot be overstated. They are often the face of our health plan for Members and will be 20% of our workforce located in Mississippi. Successful care management programs are built to be responsive to the specific needs of the Member. This is made possible through the establishment of a trusting relationship with a Care Manager. We seek care management staff who are not only professionally qualified through education, licensing, and experience, but who are a cultural fit, reflective of our company's mission, vision, and values. We hire individuals with a deep, demonstrated passion for improving outcomes among underserved individuals. This will ensure a workforce committed to Mississippi's vision and goals for its MississippiCAN and CHIP populations.

Required and Preferred Care Manager Qualifications. We require all Care Managers to have at minimum, an undergraduate or graduate degree in social work or a related field or to be licensed as an RN, Licensed Practical Nurse, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Professional Counselor, or Licensed Marriage and Family Therapist. We require a minimum of three years' experience in care management. Preferred experience includes a minimum of three years in a clinical, acute care, managed care, or community setting; experience working with vulnerable populations with chronic or complex conditions; and a certification in care management. We provide a hiring salary pay differential for care management staff who are certified bilingual.

E.1.b. Our Care Manager Hiring Process

Our hiring process promotes a diverse care management workforce that reflects Member demographics and regional differences. Diversity, equity, and inclusion policies and processes impact the design of our interview and hiring process to be as free from implicit bias as possible. Hiring managers are trained to understand the impact of implicit bias in selecting and interviewing candidates and on the use of best practices to ensure every qualified candidate is fairly considered.

We will make sure all areas of Mississippi are adequately staffed based on the needs of the membership and in compliance with the Draft Contract § 7.3. We will hire a Care Manager with special training and knowledge of care management practices relevant to the State's American Indian community.

Recruitment. We recruit from the communities we serve and will hire locally to build a Mississippi care management team as diverse as our membership. ***We recruit and hire care management staff with diversity, equity, and inclusion top of mind to promote diverse talent acquisition*** of internal and external candidates. Our organization will also use qualified internal healthcare recruiters and external staffing agencies. We are active on the standard job sites for the workforce at large and will use local Mississippi workforce resources such as the Mississippi Nursing Association to advertise for open care management positions. We will host employment fairs in each region of the State to connect to talent in the communities we serve.

Employee Referrals. We recognize that one of the best ways to attract talent is to tap into the extensive network of talent already at our disposal: ***employee referrals***. Through our employee referral program, an employee can receive up to $3,000 if we hire a referred candidate. It is a testament to our faith in our employees, and likewise to our employees' understanding of our culture.

Retention and Employee Satisfaction

We will **strive to be the preferred CCO employer in Mississippi** through our focus on key factors in employee satisfaction such as engagement, career and growth opportunities, emotional support, and a suite of employee benefits. We offer Care Managers a ***competitive compensation package*** as well as ***nontraditional benefits*** such as flexible work schedules and work-from-home arrangements, a casual dress code, leadership participation on various boards and councils, and a career path using job families for future growth. We have implemented several benefits to motivate and support Care Managers and improve employee satisfaction, including a kudos program to reward extraordinary achievements; a program for discounted gift cards, store coupons, and cashback opportunities; dependent care and homework assistance; a health and wellness program; and paid volunteer time off. ***In 2020, our national retention rate was 90% for our care management staff, with an average tenure of four and a half years.***

In response to COVID-19, we provided a stipend toward internet cost and office supplies for our staff while they worked remotely. We support professional development with our education reimbursement programs and free continuing education units. We reimburse for licensure and certificate renewal costs. In response to the pandemic, we implemented time off for employees to receive their COVID-19 vaccinations and an extra bank of COVID-19 time off for use by employees who are ill or need to care for others.

E.1.c. How We Will Ensure Care Managers Are Culturally Competent and Aware of Implicit Biases

We ***ensure care management staff complete initial and annual training on cultural competency, implicit bias in healthcare, and health equity.*** Training topics include implicit bias; cultural humility; health impacts of structural racism and poverty, national Culturally and Linguistically Appropriate Services standards, language, and communication assistance requirements; trauma; and how culture includes characteristics such as disability; LGBTQ+ identity; and homelessness. The training helps staff understand how to identify barriers that may impede a Member's ability to achieve their healthcare goals. It helps staff understand cultural beliefs that impact dietary choices, family structure, decision making, and healthcare decisions to ensure that we meet Members where they are and craft person-centered care plans.

Our Health Equity and SDOH Manager works collaboratively across the company with other teams to enhance how we implement policies and operations that promote health equity, including development of training materials. The Director oversees development of the annual cultural competency plan, leads health disparities initiatives through data analysis and stakeholder engagement, and supports cross-functional design of culturally appropriate interventions. Our annual assessment informs our selection of topics for inclusion.

We were an early adopter of practices that promote cultural competency among our staff. NCQA has awarded ***the majority of our affiliated health plans Multicultural Health Care Distinction,*** identifying them as market leaders in proactively addressing SDOH and confronting racial and ethnic health disparities through culturally and linguistically sensitive, evidence-based interventions. We mitigate disparities using national standards for

Culturally and Linguistically Appropriate Services and integrate equity strategies into existing systems rather than creating separate programs.

E.1.d. Overview of Our Continuing Education and Training Plan for Care Managers

Our training consists of new employee education, role-specific education for Care Managers, State-specific modules related to culture, and training to engage with Members of different acuity levels. Our training is informed by our experience serving Medicaid populations nationwide, industry best practices and clinical practice guidelines, the State's population health needs, and CCO Program Contract requirements. Our training program ensures our Care Managers are properly trained in accordance with the requirements in Draft Contract, § 7.3.

Care Manager Training

- New employee orientation within 30 days of hire
- Mentorship to complete skills-based training within 45 days of hire
- Ongoing monthly educational opportunities
- Self-paced training enhancements through our internal training platform and an online educational platform
- Annual training
- Continuous learning and professional development
- Specialty training: cultural competency and motivational interviewing
- Ad hoc training

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Our learning and development team designs our training program in collaboration with subject matter experts. Our Medical Director and Behavioral Health Medical Director review and approve training curriculum prior to dissemination to our staff.

Training Modalities. Each learner has a unique learning style, and we deliver training in various ways and modalities to reinforce learning, including online, independent study, hands-on, face-to-face, and additional training opportunities through our educational portal. We provide on-going education at staff regional team meetings and quarterly town halls, based on staff suggestions and trends discovered from care management case audits.

Care Managers receive more than 120 training hours prior to Member contact and a minimum of 22 hours of continued training annually.

Training Plan

The Clinical Training Program. This role-specific training curriculum is designed to ensure care management staff acquire the necessary job-related knowledge, skills, and competencies to assist them in performing their job in alignment with the goals of the organization and the CCO Program Contract. The training curriculum, summarized in Table 1, is based on established policies, workflows and job aids; utilization of those resources is frequently modeled throughout the training to encourage habits in daily work.

Behavioral Health *Coffee Break*

The Coffee Break is a weekly internal communication to clinical and non-clinical staff on BH-related updates, including program/system enhancements, training opportunities, and mood-boosting activities to increase morale among staff.

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Our training life cycle begins with ***new employee orientation,*** which includes standardized training across the enterprise to ensure staff are prepared to perform their job duties consistent with our care management programs and the State Contract, and in adherence to standard policies and procedures, contractual requirements, and CMS and NCQA standards. Required to be completed within the first weeks of hire, new employee orientation consists of company and healthcare principles training: HIPAA compliance, FWA, cultural competency and implicit bias, and human resources personnel-related topics. Care Managers then receive ***role-specific instruction***, including deep-dive training on the care management system, mobile tablet and all inter-related systems, how to use the SDOH closed-loop referral system, the importance of warm-handoffs, care planning, motivational interviewing and activation techniques, and Mississippi-specific training, such as prevalent health conditions and disparities.

Hands-on practical application exercises and competency-based assessments or "knowledge checks" that align with behavioral learning objectives help us see how the learner is progressing and ensure staff are ready to get to work at the completion of their training.

Continuous Learning and Professional Development. We provide ongoing educational opportunities to enhance clinical knowledge of staff around clinical programs, initiatives, and product solutions. Learning continues and skills are reinforced as staff transition from the classroom into their new roles, where they are mentored by subject matter experts who support learning transfer. We use a learning management system to manage training content and student activities such as course completion, test scores, student feedback,

attendance, and compliance reporting. It ensures staff have access to learning resources on demand to supplement instructor-led training and strengthen knowledge. For all clinical staff, we pay a clinical continuing education vendor to support existing licensure and certifications and promote growth and development of staff to continue their educational endeavors as well as keeping them abreast of evidence-based practices. We also provide access to an online educational platform to support staff development and satisfaction.

On-the-Job Reinforcement of Learning Objectives. Care management staff participate in a preceptor program, which provides opportunity for the Care Manager to shadow an experienced Care Manager. The program completes the Care Manager's skills-based training within 45 days of hire. Care Managers listen to calls to Members and participate in ride-alongs to observe in-person visits. The program ensures Care Managers are consistent, objective, and effective as they apply care management tools and procedures. The Care Manager has access to on-demand resources to reference, such as Healthwise or other nationally recognized evidence-based clinical guidelines/guideposts. All leaders are responsible to ensure their direct reports complete required training.

Ongoing Training. Care Managers continue training throughout their tenure with a variety of learning opportunities, including training online and through independent study, hands-on instruction, classroom instruction, and our educational portal (see **Table 3**). We will also provide education at staff regional team meetings and quarterly town halls, based on staff suggestions and emerging needs in Mississippi communities. We will use subject matter experts for education (e.g., disease-specific education), including the Medical Director, the Division staff (when appropriate), and speakers who serve Members (e.g., area DME Providers, regional food banks).

Table 3. Summary of Care Manager Training Curriculum

General New Hire Training	
• MississippiCAN and CHIP Programs Overview • Complex Care Management Functions and the Responsibilities of the Care Manager • Clinical Conditions of Our Members • Service Authorization and Delivery • Behavioral Health Support and Coordination • Conducting Assessments, Including Protocols for Different Modes (e.g., in-person, telehealth) • Member Changes in Condition, Transitions of Care, and Conducting Reassessments • Member Safety and Crisis Identification and Management, Including Critical Incidents and Neglect • Person-centered Care Plan Development • Person-centered Practices/Approaches	• Motivational Interviewing • Cultural Competency and Implicit Bias Health Equity and Disparities • Trauma-informed Care and Approaches • Adverse Determinations • Complaints and Appeals Process Overview • FWA and Exploitation • Time Management and Clinical Competencies for Care Managers • Documentation Systems for Care Management Platform and Electronic Visit Verification • Identification of Risk and Mitigation Techniques • Advance Directives and End-of-Life Planning Support • HIPAA and Other Privacy Laws • Disaster Planning • Successful Provider Relationships
Mississippi-Specific Topics	
• Overview of Mississippi CCO Contract • Mississippi Regulatory Requirements • MississippiCAN and CHIP Plan Eligibility Categories • MississippiCAN and CHIP Covered Benefits • Risk Stratification Level Framework Tiers and Related Interventions • Mississippi and Community-level Health Profile and Prevalent Conditions • Mississippi's Child Welfare and Juvenile Justice Systems	• Addressing SDOH and Coordinating with Mississippi CBOs on Delivery of Community-based Services • Prevalent Disparities • School-based Services and Individualized Education Program Process • Cultural and Disabilities Competency, Including Serving Rural, Underserved, and American Indian Communities • The Role of Mississippi State Agencies

Training Program Monitoring and Evaluation. We verify staff training through attendance logs for in-person training and attestation forms. Web-based training systems house competencies and individualized development plans and automatically document and store completion certificates. Completed training is recorded in personnel files. Retention of training content is confirmed through skills demonstration tests or knowledge checks within training content and with end-of-course evaluations, auditing, and oversight. Our supervisors and quality improvement managers review care management documentation, workflow processes, and telephone skills and work closely with Care Managers to improve skills where needed. Supervisors audit Care Managers' Member records and grade for adherence to standard processes as pass or fail, with a goal of 100% compliance. Managers observe Care Managers' motivational interviewing interactions with Members and provide feedback.

Those who do not meet job function or competency requirements will be provided retraining tailored to their individual needs, with a goal of measurable improvement.

Annual Performance Reviews. Care management staff set annual goals. They participate in a mid-year check-in to evaluate progress and drive achievement of goals. Managers rate staff's performance goals and company/role-based core competencies, and overall ratings result in merit increases for the next pay year if staff are meeting and exceeding goals.

E.1.e. Expected Wages to Be Paid to Care Managers (Hourly/Salary and What Amounts)

Our expected hourly salary range for Care Managers is minimum $21.60, mid $30.86, and maximum $40.12.

F. HYPOTHETICALS

F.1.a. Member who had been stratified as low risk has had four (4) emergency department visits in the previous five (5) months;

MEMBER PROFILE

Name: Terrie

Age: 32

Residence: Outside of Sebastopol (Scott County)

Health overview: Hypertension, regular medical care, headaches

SDOH challenges: Food, isolation, transportation, childcare, low health literacy

Terrie is a 32-year-old single mother who works as a housekeeper for a motel in Sebastopol.

083A.MS22

IDENTIFICATION

- While at work one day, Terrie has a horrible headache and is rushed to the Laird Hospital ER, where physicians discover she has elevated blood pressure and give her a "pain shot" for her headaches. They prescribe metoprolol for her blood pressure, but she does not get this prescription filled.
- Over the next few months, Terrie returns to the ER three more times for "another shot to help her headache."
- Terrie's multiple ER visits in quick succession are revealed through our **ER utilization report** and predictive analytics. We begin focused interventions with Terrie through our **ER diversion program**. Her case is assigned to a Care Manager, Shelia, who immediately begins outreach to bring her into care management.

OUTREACH AND ASSESSMENT

- When she reaches Terrie, Shelia conducts assessments, including the HRS, the CHA, which includes questions on mental disorders and depression, along with PRAPARE for her SDOH needs. She also assesses her for hypertension.
- Shelia uses **motivational interviewing and coaching** to coach Terrie on ER diversion. Terrie comes to understand that getting shots at the ER is not appropriately managing her headaches or fixing her high blood pressure. Shelia stresses the importance of the **PCP/PCMH relationship** for Terrie as well as her children. Shelia also gives Terrie information on the 24/7/365 Nurse Advice Line, the BH/SUD line, and urgent cares with evening and weekend hours.
- They talk about **Terrie's goals,** which include feeling better physically, finding and cooking healthier food, reducing her anxiety and depression, and finding more reliable childcare for her kids. Shelia says she will help Terrie develop a personalized care plan as a road map to improved health.

TARGETED INTERVENTIONS

- Support establishment of East Central Mississippi Health Care (ECMHC) as PCMH and schedule first appointments
- Identify pharmacy close to home and educate on requesting refills via text message
- Provide reliable daycare options and applications for financial waivers
- Refer to SNAP and WIC, and confirm the children are on MississippiCAN.
- Refer to food pantry.
- Provide health education materials on hypertension and depression.

083B.MS22

CARE TEAM

Member: Terrie

PCMH: PCP and BH

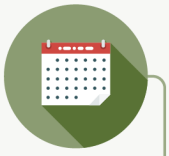
Care Manager: Shelia

Community Health Worker: Jocelyn

Pharmacy

083C.MS22

TERRIE'S SIX-MONTH JOURNEY



Shelia helps Terrie prepare for her first appointment by making a list of her health concerns to share with the doctor.

PCP writes a blood pressure monitoring and treatment plan, an order for a blood pressure monitor, and a refill for metoprolol. Shelia reviews the Provider's treatment plan with Terrie after the visit.

Terrie fills her prescriptions at the pharmacy and picks up the blood pressure monitor.

Terrie also schedules a visit with a BH Provider at ECMHC. Shelia supports Terrie with scheduling appointments for her children's well-child checks for the same day as Terrie's BH appointment.

Shelia assigns a community health worker (CHW), Jocelyn, to the case. Jocelyn helps identify local daycare providers, and Terrie enrolls her kids in Conehatta Early Childhood Center three days a week.

Jocelyn provides Terrie with healthy reduced-sodium meal recipes and connects Terrie with a church food pantry, a farmer's market, and SNAP.

As Terrie achieves her major care plan milestones, Shelia keeps in touch by sending her tools and tips such as a "brighter days" diary that Terrie can use to document and track how she feels each day.

Terrie graduates from care management after six months. Shelia reminds her about the Member services call center, care management, the Nurse Advice Line, and BH/SUD lines for 24/7/365 support.

MEMBER OUTCOMES

Short-term

- Goes to PCMH (ECMHC) routinely and has not used the ER in more than six months. Went to our semi-permanent trailer in Sebastopol to get tested for COVID-19.
- Checks blood pressure daily, and blood pressure is now 120/60 and stable. Manages headaches with over-the-counter medication.
- Receiving SNAP benefits, has learned healthier eating habits, and is finding and cooking healthy foods.

Long-term

- Takes children to well-child checks, dental and vision screenings on schedule.
- Meets with her BH provider as needed for anxiety and mild depression.
- Kids in daycare for full week as Terrie's cleaning jobs become more stable.
- Plans to attend one of our upcoming community events and has offered to speak with the public about her personal experience.

083D.MS22

F.1.b. Member with diabetes and ADHD 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.

MEMBER PROFILE

Name: Elijah

Age: 13

Residence: Jackson, MS (Hinds County)

Health overview: Type 1 diabetes, ADHD

SDOH challenges: Housing, healthy food, transportation

Elijah is a 13-year-old boy living in Jackson, MS. Has diagnosis of ADHD, newly diagnosed type 1 diabetes, and identified as homeless, stratifying member as high risk.

042A.MS22

IDENTIFICATION

- Elijah is a newly enrolled Member, and we attempt initial outreach within the first few days of his enrollment. Our teams commence welcome campaigns (Member service efforts/outreaches), which will include administering the HRS, leveraging available contact information from his enrollment record.
- Elijah's Mom responds to text message and completes HRS. Intuitive logic within the HRS responses automatically routes Elijah to high-risk care management—complex care management level—upon identification of his homelessness.
- Elijah is assigned to a Care Manager experienced with children and equipped to address his type 1 diabetes, ADHD diagnosis, and SDOH needs resulting from homelessness in an integrated manner.
- Care Manager Ava performs a pre-call review and begins outreach but receives no response. Ava calls two more times on different days and times, mining internal data for any current claims and utilization activity. Elijah is identified as "difficult to engage" after the third attempt.

DIFFICULT-TO-ENGAGE/HARD-TO-FIND STRATEGIES

1. Care manager mines internal data for updated or alternate contact information.
2. Care Manager calls recent providers, pharmacy, clinics for additional contact information on record with known Providers.
3. Care Manager deploys CHW.
4. CHW searches publicly available sources of information to locate Member.
5. CHW shares findings with Care Manager.
6. Care Manager continues outreach calls and mining of internal data, and discovers that family picked up insulin at pharmacy within the last week. Care Manager calls pharmacy, which provides contact info.
7. Care Manager calls using new contact info., and successfully connects with Mom.

042B.MS22

OUTREACH AND ASSESSMENT

- Ava calls Elijah's Mom to schedule a telehealth visit with Ava to complete the CHA and other assessments. Ava learns that Elijah's family recently moved in with his Grandma after losing their housing.
- During the telehealth visit, Ava administers the CHA, our pediatric diabetes condition-specific assessment, and PRAPARE, an evidence-based SDOH assessment.
- Findings for Elijah:
  - Newly diagnosed with Type 1 diabetes
  - Has been diagnosed with ADHD but prescription is with a different pharmacy and is not being picked up
  - Elijah uses a continuous glucose monitor, using a sliding scale; however, Elijah's glucose is not being checked as directed by his PCMH
  - Living with Grandma is not ideal; she has a small apartment
  - They have a lack of reliable transportation to PCMH, Elijah's endocrinologist, and pharmacy
  - Elijah is hyperactive and loses focus while at school
- Our person-centered approach helps Elijah and his mother identify milestones and goals, combining care plan elements to ensure appropriate outpatient care, medication compliance, housing stability, SDOH closure to improve his health and social outcomes. Ava discusses goals with Elijah, his Mom and Grandma, including physical health, housing, reliable transportation, and assistance for ADHD at school.

042C.MS22

COMPLEX CARE TEAM

Member: Elijah

Member's Family: Mom and Grandma

PCMH Pediatrician

Endocrinologist

Care Manager: Ava

Housing Support Specialist

Certified Diabetes Care and Education Specialist

Other Providers

042D.MS22

TARGETED INTERVENTIONS

- Ava educates Elijah, Mom and Grandma on importance of checking **continuous glucose monitor** regularly as directed by Elijah's PCMH
- Ava reinforces and confirms Elijah's, Mom's, and Grandma's understanding of **medications** (filling on time and taking as directed). She coordinates both insulin and ADHD medications at best pharmacy for Mom, close to Grandma's
- Ava educates Mom on **transportation** benefit and how to arrange for transportation to PCMH, endocrinologist and pharmacy
- Ava recommends adding our Housing Support Specialist and Certified Diabetes Care and Education Specialist as members of Elijah's **interdisciplinary care team**. Elijah agrees to include both as well as his mother, grandmother, endocrinologist and PCMH
- **Housing Support Specialist** educates Mom on services, and connects Mom with housing authority, contacts housing authority to prioritize family for Section 8, and connects Mom with CBO services to prepare for permanent housing (dishes, linens, furniture and more)
- **Certified Diabetes Care and Education Specialist** educates on diabetes care, diet and healthy foods, and teenage diabetes social media forums
- Care Manager works with school to establish an **individualized education plan (IEP)** with accommodations for Elijah's ADHD and school nurse's assistance with medication and glucose monitoring

MEMBER OUTCOMES

- Elijah, his Mom, and Grandma are staying in constant contact with Ava
- Adhering to glucose checking and monitoring. Elijah begins to understand his own glucose readings and signs when his glucose is too high or low
- Pediatrician did med review, discussed family concerns, identified alternative ADHD med (Daytrana long-acting Ritalin patch)
- All meds are with centralized pharmacy; Elijah stays compliant with medications
- Mom is using transportation benefit to PCMH, pharmacy, and endocrinologist
- At school, Elijah has an integrated IEP and support to monitor glucose and medication needs. His ADHD patch helps him stay focused, and attendance and homework compliance increases
- Elijah is connecting with peers on social media and exchanging diabetes tips and stories
- The family is eating better and has identified alternative foods they can use for treats or snacks
- Mom is on wait list for housing, identifying preferred neighborhoods close to PCMH, pharmacy and school; Mom is educated on available housing support services and who to contact when ready

042E.MS22

F.1.c. The Offeror's Care Management System identifies that a 14-year-old Member with BH needs was admitted last night to a local inpatient facility after presenting with an asthma attack.

MEMBER PROFILE

Name: Olivia

Age: 14

Residence: Greenville, MS (Washington Co.)

Health overview: Poorly controlled asthma, history of trauma and anxiety, overweight

SDOH challenges: None

Olivia is a 14-year-old girl living in Greenville, Mississippi, with her mother and brother. Olivia has a history of persistent mild asthma, trauma and anxiety, and obesity.

075A.MS22

IDENTIFICATION

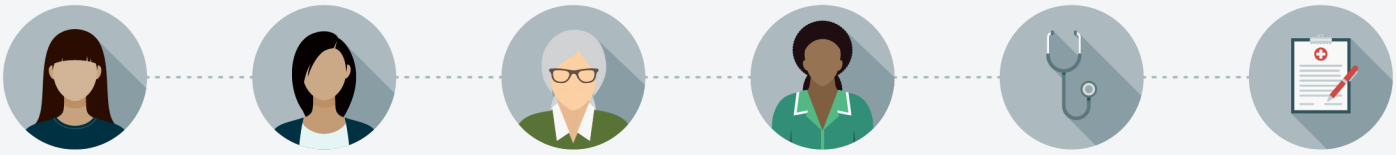
- Olivia is identified as a **candidate for care management** as well as our kids diabetes prevention program following her completion of the HRS, which fed data into our predictive analytics engine and identified risk factors associated with her physical and BH needs. Olivia is identified as obese and has a history of trauma and anxiety as well as asthma.
- Olivia's case is assigned to Colleen, a Care Manager with **experience supporting adolescents** with behavioral and clinical needs.
- Colleen reviews internal data and sees that the pediatrician has prescribed daily inhaled corticosteroids to control the asthma and a short-acting beta agonist inhaler for asthma exacerbation. The prescription for daily inhaled corticosteroids has not been filled.
- As Colleen begins outreach and engagement efforts, Olivia is **admitted to the hospital** following an asthma attack We are alerted of Olivia's inpatient admission through our daily census report, and Care Manager Colleen pivots from outreach to supporting Olivia's safe discharge.

OUTREACH AND ASSESSMENT

- Colleen engages with Olivia and her mother during the inpatient stay and will continue to support them through post-discharge following our **transition of care program protocols**.
- Through her **assessments**, she learns:
  - Olivia is not currently taking her daily inhaled corticosteroids for asthma
  - Olivia is sedentary indoors after school playing video games, with little exercise. Her diet primarily consists of fast foods and high-carbohydrate snacks.
  - Olivia lives in a two-family dwelling that is known to have had infestations of cockroaches and mice.
- Colleen works with the hospital discharge planner, Olivia's mother, and Olivia's PCP to ensure a **safe discharge home**. She ensures authorizations are in place for home visit and environmental assessment by a visiting nurse within 24 hours of discharge, then for weekly visits for three weeks.
- Olivia and her mother agree to enroll in care management. Olivia and her mother identifies milestones and goals that are important to them. Colleen helps them identify strategies and interventions to help achieve these **milestones and goals** on Olivia's health journey.

075B.MS22

COMPLEX CARE TEAM



Member: Olivia

Member's Family: Olivia's mother

Care Manager: Colleen

Home Visiting Nurse

Primary Care Physician

BH Provider

075C.MS22

TARGETED INTERVENTIONS

- With Olivia's mother's permission, our Care Manager speaks with Olivia and her mother weekly to assess Olivia's transition to home.
- Care Manager Colleen connects Olivia with **new female PCP** (focused on adolescents) to manage her asthma and get preventive EPSDT, dental, and vision screenings completed.
- Olivia and her mother are **educated and coached** about asthma, exercise, managing anxiety, and obesity. The Care Manager works with Olivia, her mother, and the PCP to create a safe outdoor mild exercise regimen for Olivia to reduce her risk of developing type 2 diabetes and to improve her lung capacity.
- During home visit, nurse identifies **asthma triggers** in the home and develops plan to address vermin infestation. Colleen authorizes home infestation treatment for 3 months.
- Asthma plan provided to **school nurse**
- Referral made to our **nutritional counselor** for dietary review and support with future referral to Kurbo by WW (free weight loss program for adolescents) as needed.
- In addition to CM education Olivia is referred to the **mobile health program mobile unit** in her area – Olivia and her mother receive in-person preventive care and asthma education and discuss stress reduction strategies.
- To address BH, Olivia is referred to a CMHC to begin trauma-focused **cognitive behavior therapy**.

075D.MS22

MEMBER OUTCOMES

Olivia returns home to her family and begins taking an active role in identifying and mitigating the asthma triggers in her home. She learns inhaler use and other strategies. She meets with a new behavioral health Provider to work through her past trauma experience. While difficult at times, Olivia understands more about events causing her current physical conditions and begins using strategies shared by her Providers to lessen her stress and anxiety.

- ✓ Asthma triggers reduced in the home.
- ✓ Member completes nutritional counseling and enrolls in Kurbo by WW to reinforce ongoing healthy eating tips.
- ✓ Member makes progress working through trauma history through cognitive behavioral therapy.
- ✓ Member learns strategies for managing anxiety, including meditation and exercise
- ✓ Ongoing health education.
- ✓ Reduction in ER and Inpatient utilization.
- ✓ Reduction in missed school days.

075E.MS22

F.1.d. Member with BH needs is taking multiple psychotropic medications and will be discharged from an acute psychiatric hospital and returning to his home next week.

MEMBER PROFILE

Name: Nathan

Age: 24

Residence: Picayune, MS (Pearl River Co.)

Health overview: High risk, transition of care program, schizophrenia

SDOH challenges: Transportation, unstable housing

Nathan is a 24-year-old male diagnosed with schizophrenia. He has recently been hospitalized in an acute psychiatric hospital and is being discharged with prescriptions for multiple psychotropic medications. 077A.MS22

IDENTIFICATION

- We are informed of Nathan's inpatient admission through our daily census report, and Care Manager Darius engages with Nathan and with the discharge planner at the hospital as part of the transitions of care protocol.
- The protocol includes assisting with the hospital discharge planning and process, outreach to any caregivers within 48 hours of discharge, and completion of an HRS and other assessments as indicated.

OUTREACH AND ASSESSMENT

- Darius indicates he will help Nathan safely discharge by ensuring access to medications and scheduled follow-up appointments.
- Nathan indicates that he had been seeing his PCP for his symptoms sporadically, and this is who initially provided the diagnosis of schizophrenia. Nathan does not have a psychiatrist or outpatient Providers managing his medications and has not taken any medications since an ice storm in February 2021 caused him to relocate and miss many doctor's appointments. He has struggled with medication compliance since that time.
- Darius enrolls Nathan into the serious mental illness (SMI)/serious emotional disturbance care model and begins the care plan development process prior to Nathan's discharge. This care model provides extra support and assistance that Members with SMI or serious emotional disturbance may need in order engage in care and improve health outcomes, address SDOH needs, identify functional impairments, and address improvement of functional capacity as related to the Member's goals. Risks are proactively identified, and routine screening is completed for suicide risk.

077B.MS22

COMPLEX CARE TEAM

Member: Nathan

Care Manager: Darius

Primary Care Physician

Partial Hospitalization Program for outpatient BH care

077C.MS22

TARGETED INTERVENTIONS

- Darius knows the **pharmacy** would typically reject prescriptions for more than two brand name psychotropic medications, so he pre-emptively sends the form to the pharmacy to override denial because Nathan is taking three psychotropics. He coordinates delivery of medications to Nathan's home so there will be no interruption in his care.
- Darius **educates** Nathan on the importance of taking his medications, the symptoms they help to address, and potential side effects or concerns he should escalate to his psychiatrist.
- He coordinates referral and regular transportation to the **partial hospitalization program** where Nathan will attend five days a week and participate in groups to learn medication management and receive education on diagnosis.
- Darius connects Nathan with **CMHC** services, including family psychoeducation, which will be pivotal to his continued recovery once he discharges from the partial hospitalization program.
- He connects Nathan with a new **PCP** for yearly wellness visits and preventive care.
- Through our **mobile device access program**, he gets Nathan a smartphone to assist with transportation and appointments. Darius also helps Nathan download specific apps to help him track and elevate his mood, and to set his own reminders for medications.
- He works with Nathan to develop a **crisis safety plan** that he can use independently in the event of a BH crisis or distress.
- Darius will continue to contact Nathan at least weekly and begin to implement the specific interventions related to SMI/serious emotional disturbance as he participates in a partial hospitalization program and moves to outpatient services at the CMHC. The weekly contacts will change to two contacts per month when Nathan begins to demonstrate progress and capacity to manage his treatment schedule, take his medication consistently, and follow his crisis safety plan independently.

077D.MS22

MEMBER OUTCOMES

- Member enrolled in SMI/serious emotional disturbance care model.
- Member receives ongoing health education about medication compliance and management of symptoms.
- Member able to see BH Provider on outpatient basis, avoids future hospitalizations
- Member receives consultation to receive long-acting injectables, receives them, and symptom stabilization is noted.
- Member able to independently use crisis safety plan to notice BH warning signs, and independently reach out to his social and Provider supports and use outpatient services to prevent the need for assistance from emergency medical services and hospitalization
- Member successfully reaches goals identified in his care plan and one specific goal most important to him—developing and maintaining at least one friendship with an individual he meets in the partial hospitalization program.

077E.MS22

F.1.e. Hospital staff are resistant to having you assist with coordinating discharge and transitions of care activities for a Member.

MEMBER PROFILE

Name: Justin

Age: 2

Residence: Athens (Monroe County)

Health overview: History of failure to thrive, resulting in developmental delays, Pneumonia, febrile seizure

SDOH challenges: None

Justin was born prematurely and has a history of failure to thrive, which has resulted in developmental delays in speech and motor skill development.

078A.MS22

IDENTIFICATION

- We learn about Justin's inpatient admission from our daily census report. He has recently been admitted to the hospital with a 103-degree fever after suffering a seizure in his parents' car en route to the hospital. He is being treated for pneumonia. Justin was born prematurely and has a history of failure to thrive and receives physical therapy and speech therapy at home three times a week from a local home health agency.

OUTREACH AND ASSESSMENT

- As his discharge approaches, our UM Review Nurse Carol is having difficulty coordinating discharge and services with the facility discharge planner. Our UM Review nurses work to enhance relationships with hospitals and provide a single point of contact. Carol normally has a great working relationship with the hospital, but the facility discharge planner is out on leave, and the per-diem facility discharge planner is not answering or returning calls.
- While conducting admission and concurrent reviews for Justin's hospitalization, our UM Review Nurse Carol identifies additional discharge planning needs for Justin due to his special healthcare needs. To ensure coordination of care upon discharge, Carol refers this case to our Transitions of Care Coordinator, James.

078B.MS22

COMPLEX CARE TEAM

Member's Family: Mom and Dad

PCP/ Pediatrician

Attending Physician/ Pediatrician

Facility Discharge Planner

UM Review Nurse: Carol

Transitions of Care Coordinator: James

CHW

Home Health physical therapy and speech therapy

078C.MS22

TARGETED INTERVENTIONS

- UM Review Nurse Carol presents Justin's case during **weekly UM rounds** with her director, the Transitions of Care Coordinator James, and Medical Director Dr. Rick. Carol explains that she has identified a barrier in coordinating services and discharge for Justin and his family and uses rounds to discuss next steps. Carol explains she has made numerous calls to the hospital discharge planner with no response.
- Dr. Rick schedules a **peer-to-peer conversation** with Dr. Stan at the facility to collaborate on the situation and assures Carol he will follow up with her by the end of the day to ensure a timely and safe discharge for Justin
- Dr. Rick and Dr. Stan discuss the situation, and the hospital discharge planner supervisor calls Carol for follow-up. Carol instructs her on the availability of the **Provider portal** to submit the requests for home health services.
- Justin will **return home** with physical therapy and speech therapy services reinstated quickly, minimizing impact to his speech and motor skill progression.
- Our Transitions of Care Coordinator James will follow up with the family post-discharge to complete a **transitions of care assessment**, assess SDOH needs, ensure prescriptions for any new medications have been filled, educate on the importance of a 7-day follow-up appt with Justin's pediatrician, and ensure home health services have been restarted.
- James provides Justin's mother with information about after-hours and urgent care facilities and the 24/7/365 Nurse Advice Line.
- Our Medical Director Dr. Rick and our Provider network rep present the case at the **quarterly joint operating committee meeting** with the facility to discuss what continual improvements can be made to current processes to mitigate issues with discharge planning.

078D.MS22

ADDRESSING PERVASIVE AND SYSTEMIC BARRIERS

Our Medical Director initiates discussion with hospital attending and leadership to determine the root cause.

Our UM team communicates with the treating physician to ensure that all Member and family needs are met and all prior authorizations are approved before discharge.

A representative of our healthcare services department attends Provider discussions or forms a joint operating committee with hospital leadership.

We provide State reporting on any issues regarding hospitals' failure or reluctance to provide us access to coordinate Members' care. This is also tracked through our QI process as well as within our program integrity department.

Multidisciplinary team rounds are conducted to discuss Members in an acute care setting with complex discharge needs. Participants may include UM and care management staff, MD, pharmacy, and treating Physicians. Use Data for Providers initiative to share data with team on Member patterns.

078E.MS22

MEMBER AND PROVIDER OUTCOMES

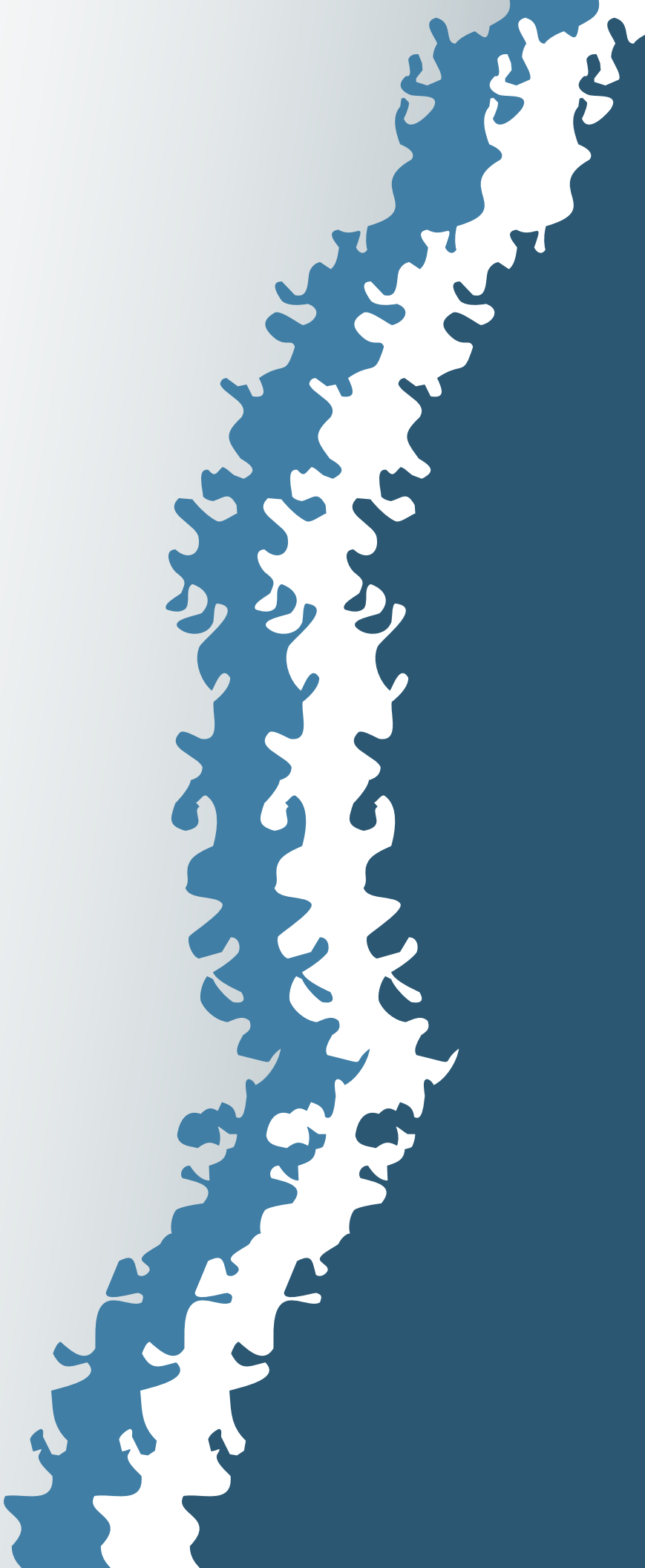
- James and Justin's mother agree to a follow-up call next week to make sure services start and no additional needs arise.
- Our Medical Director and Dr. Stan, the attending physician, and the director of discharge planning at the hospital discuss and implement a new escalation process for any barriers in discharge
- The hospital discharge planner is aware of and begins the use of the Provider portal to streamline the authorization process
- James follows up with Justin's mother and validates that Justin saw his pediatrician, his physical therapy and speech therapy resumed, and Justin has resumed his normal activities
- James provides Justin's mother with information on some local and online support groups for mothers of children with special needs, as she mentioned sometimes feeling disconnected from others with similar experiences
- James closes out the transitions of care case and provides Justin's mother with the name, phone number, and extension of her CHW, who is always available to her and Justin to help navigate the healthcare system, act as an advocate, or provide any resource information needed
- The CHW completes a follow-up call with Justin's mother a few weeks later to ensure she has connected with all resources and that all needs have been met

078F.MS22

[END OF RESPONSE]

4.2.2.4

Quality Management



UNMARKED

4.2.2.4: QUALITY MANAGEMENT

A. QUALITY MANAGEMENT PROGRAM

A.1 Our Proposed Quality Management Program

Successful QM Initiative

One of our health plans implemented a data-driven, rapid-cycle improvement activity with large hospital systems to improve BH care and reduce disparities. As part of the initiative, Members are quickly transferred to the next appropriate level of care. In 2019, the health plan reached the 75th percentile for the Follow-Up After Hospitalization for Mental Illness HEDIS rate.

212.MS22

We are experienced in designing and implementing QM programs that are tailored to each State's demographics, health and service priorities, and Contract requirements. Our QM program provides the structure and key processes that enable us to carry out our commitment to the ongoing improvement of care provision, service delivery, and Members' health. ***Our quality infrastructure and approach support and inform every element of our Medicaid programs and encompass all aspects of our health plan operations.*** Our ongoing program and strategic approach are structured to continuously respond to the evolving and holistic needs of our Members, Providers, regulators, and other program stakeholders, and are aligned to nationally recognized standards. Our proposed QM program has been created to align with Mississippi's Comprehensive Quality Strategy and ensures our administration of care and services is *anchored in core values of accountability, consistency, and respect.* We apply this same excellence to our programs and ensure quality is woven throughout the organization.

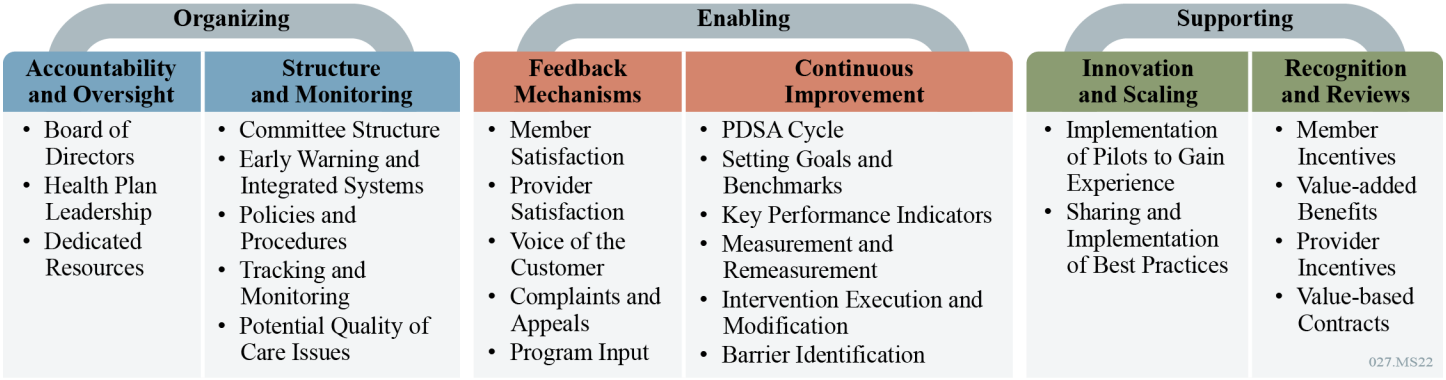
Many of our affiliate health plans have achieved NCQA accreditation and NCQA's Multicultural Health Care Distinction for their focus on improving culturally and linguistically appropriate services and reducing healthcare disparities. Some of our affiliates have also attained NCQA's Long Term Services and Supports (LTSS) Distinction. ***We require that every service provided to Members meets or exceeds these nationally recognized quality standards, and we will do the same in Mississippi.*** Our ongoing success in NCQA accreditation reflects this dedication and commitment to improving health outcomes. Well-established policies and procedures are in place to align to NCQA standards and documented processes focused on clinical quality and improving culturally and linguistically appropriate services. Health equity accreditation is of paramount importance to us. We look forward to continuing our journey to advance health equity with NCQA Health Equity Accreditation and Health Equity Accreditation Plus.

Our health plan leadership fosters and creates an ongoing and dynamic culture of innovation, continuous Quality Improvement (QI), and healthcare excellence through the QM program. This is achieved through our experienced QM staff with deep subject matter expertise, integrated local committee structure, advanced data and analytics capabilities, innovative Member strategies, Provider collaboration, and NCQA accreditation. Our QM system, which is highlighted in **Exhibit 1,** focuses on three key components:

- Organizing to ensure accountability and effective oversight, structure, and monitoring
- Enabling improvement through continuous improvement and feedback
- Supporting Members and Providers through innovation, recognition, and reward

Our QM program incorporates our experience and lessons learned in State Medicaid programs and is a critical element of our population health program, delivering data-driven, evidence-based strategies and innovative approaches that combine best practices, affiliate successes, and community-informed interventions.

Exhibit 1. Health Plan QM Program. Our QM program incorporates our experience and lessons learned in State Medicaid programs and directly aligns with Mississippi's goals for the CCO Program.



A.1.a. Our QM Infrastructure

Our QM program provides the infrastructure and framework that will enable us to fulfill our commitment to quality and the Division. Key program infrastructure components include:

- Robust QM structures, processes, plans, and strategies, so we are aligned to and can meet or exceed State, Federal, and internal program requirements, including NCQA
- Specialized staff with diverse backgrounds, training, and experience—including experience in public health, lactation support, community engagement, and epidemiology—to offer support to Members and Providers in their communities
- Mechanisms to solicit and incorporate insight and feedback from Members, caregivers, Providers, and CBOs
- Detailed goals and objectives that are created, reviewed, and modified at least annually and more frequently if needed
- Advanced data platform and analytics that support priority focus areas, including identification of opportunities for improvement
- Causal analysis of issues, problems, or concerns discovered during QM program activities and evaluation
- Contracts with credentialed PCPs, facilities, institutions, and subcontractors to deliver healthcare and services to Members, including value-based care
- Corporate QM support structure with expertise in data, analytics, and program design

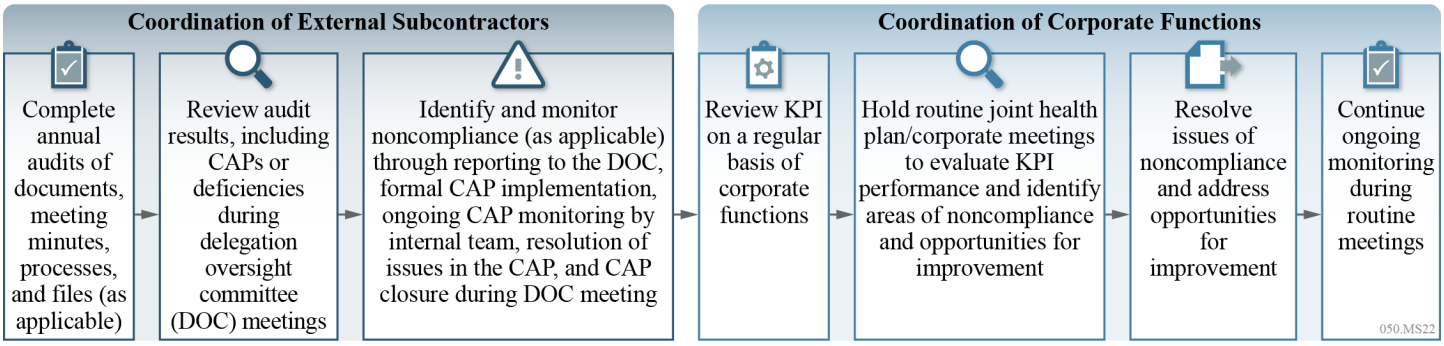
Coordination with Subcontractors and Corporate Entities

We contract with, coordinate, and oversee Providers, facilities, institutions, Subcontractors, and corporate entities to ensure delivery of adequate, timely, and culturally sensitive healthcare and services. We monitor ongoing compliance through monthly reports, annual on-site assessments, evaluation of appointment scheduling and Provider network composition, comparison of performance against established benchmarks, review of potential over- and underutilization, and other QM program activities.

Communication between corporate entities is conducted through touch-base meetings, monthly and quarterly meetings, and feedback sessions. We evaluate issues, problems, or concerns discovered through causal analysis of QM program activities. We develop action plans to correct any identified barriers and implement modified interventions. We reevaluate plans and review interventions to determine effectiveness.

Exhibit 2 demonstrates how we coordinate with Subcontractors and corporate entities.

Exhibit 2. Coordination with Subcontractors and Corporate Entities. As part of our holistic approach to oversight, we coordinate with Subcontractors and corporate entities to ensure ongoing quality service delivery, which is a critical part of our QM infrastructure and framework.



A.1.b. Lines of Accountability

Our QM program provides defined lines of accountability, enabling us to achieve and maintain excellence. Accountability for the QM program rests within the program oversight and monitoring structure and begins at the top, with the health plan Board of Directors and QM committee. The QM committee designates authority of the QM program to our Medical Director, who oversees the QM program in partnership with our QM Director. Our corporate teams will also work collaboratively with our Mississippi QM staff to support local operations with best practices, training and education, and data and analytics expertise.

The dedicated Mississippi staff described in **Table 1** are accountable for and will support the goals of improving the QM program.

Table 1. Dedicated Quality Staff. Our QM program provides defined lines of accountability with our dedicated local Mississippi QM staff, and corporate teams work together to achieve quality goals.

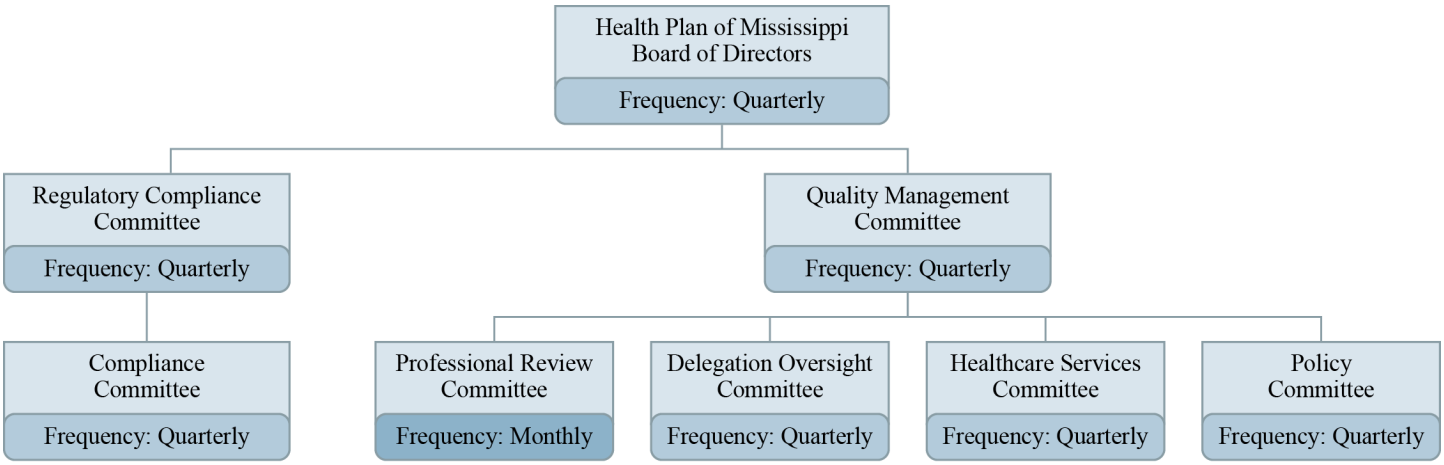
Medical Director	Responsible for oversight of all quality and UM activities and cochairs the QM committee. Directs the development, implementation, and evaluation of all QM activities. Monitors quality of care. Supports joint operating committee meetings.
QM Director	Oversees QM program and activities with a focus on population health, health equity, and reducing health disparities.
QM Manager	Oversees development and execution of QM interventions. Maintains Member and Provider interventions collaboratively with the other members of the quality team.
Health Equity and SDOH Manager	Reports to the QM Director and Medical Director. Will provide leadership, coordination, and project management to help define, implement, and evaluate the health plan's strategies to achieve its mission of equitable access and to reduce disparities in clinical care and quality outcomes for Members. Will support the cross-coordination of innovative programs to address SDOH.
Provider Quality and Practice Transformation Team Manager	Reports to the QM Director and will oversee the Provider quality and practice transformation team and manage all the elements of practice transformation.
[redacted]	[redacted]
EPSDT Coordinators	Reports to the QM Director and will be staffed at a ratio of 1:30,000 children 0–17, focused on increasing EPSDT and well-child visits for MississippiCAN and CHIP populations.
Access to Care Specialists	Responsible for assessing gaps in Member access to care and ensuring Member access to care regardless of Provider network status. Recruits and contracts Providers to address gaps.
Quality Specialists	Develops and maintains action plans for QM initiatives, tracking results and associated barriers.
Mobile Health Program Team	Three FTEs will report to the QM Director, managing the activities of our mobile units and semi-permanent trailers.

Using Our QM Committee to Provide Infrastructure Support and Monitoring

Our local QM committee is responsible for the implementation, oversight, and ongoing monitoring of the QM program. The QM committee reports to the Board of Directors. The board delegates authority to the QM committee as shown in **Exhibit 3**. The CEO has overall accountability to the Board for the QM program and delegates day-to-day operations for QM to the Medical Director and QM Director, who are responsible for guiding the development and implementation of the QM program work plan and evaluating QM program system performance.

The QM committee ensures alignment of our QM program with the Mississippi Comprehensive Quality Strategy and that all functional areas and resources support the QM program goals and activities. The QM program will establish a broad infrastructure across the organization, with critical responsibility for quality in every department and integration of quality, population health, and Provider engagement staff and activities, such as practice transformation and value-based contract implementation. The QM committee recommends policy decisions, analyzes and evaluates the progress and outcomes of all QI activities, institutes needed action, and ensures follow-up. The QM committee also supports our population health programs, including UM, care management, and Member and Provider engagement. Our corporate teams work collaboratively with the health plan to support local operations.

Exhibit 3. QM Committee Structure and Meeting Frequency. Our QM committee aligns our QM program with the Mississippi Comprehensive Quality Strategy, and our greater committee structure is designed to provide forums for addressing quality processes and practices.



Subcommittees reporting to the QM committee continuously monitor data, identify areas for improvement, track interventions and performance, and review PIP results. Community physical health and BH Providers also actively participate and contribute to the committees by reviewing Member care. We seek practicing network Provider committee members with specialties relevant to our population, focusing on pediatrics, primary, and OB care Providers. Through committee activity, participating Providers review and provide feedback on proposed practice guidelines, performance measure results, clinical protocols, QM study designs and interventions, and plans to improve levels of care and service.

As part of the QM committee structure, we will also seek Member involvement in our QM process and initiatives through the Member advisory committee. Member representatives from both MississippiCAN and CHIP programs will participate and provide formal input and feedback about the QM program.

In addition to our quality leadership, our Providers, CCOs, and other representatives will participate in the Mississippi Coordinated Care Quality Workgroup (MCCQW) to assist the Division with their healthcare strategies and determining how improved delivery models can promote more equitable care. The MCCQW meetings are the central forum for communication and collaboration between the Division and the CCOs for

quality strategies, past initiative evaluations, and opportunities to develop systematic, integrated, and innovative approaches to quality activities.

A.1.c. Process for Selecting Areas of Focus

We identify key focus areas that are aligned to important national programs, the Division's Quality Strategy, MSDH, and our QM program initiatives.

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Selecting areas of focus for opportunities to improve health outcomes and reduce disparities is an ongoing process that begins with a comprehensive assessment of data to understand the unique health conditions facing Mississippi Members. We use evidence-based practices and guidelines to monitor quality and service performance and analyze data, establishing and monitoring performance against regional and national goals and benchmarks. We then focus strategies toward high-priority areas, such as obesity, prenatal and postpartum care, and BH readmissions. We will also leverage geomapping tools to identify Members in the same geographic area who are facing access or social barriers that negatively impact health outcomes in these key areas of focus.

We understand that a key factor in our selection is feedback from our delivery system partners. We will collaborate with our State partners, such as the Division and local CBOs, to understand barriers negatively impacting health outcomes and to address and align with the Division's Managed Care Quality Strategy. Community health needs assessments are also a crucial part of our assessment and selection process to identify gaps in SDOH. We will build upon this stakeholder and community-level feedback and data with our Member population-level data, including clinical outcomes (e.g., HEDIS and performance measure data); SDOH data (e.g., Z codes and CBO referrals); and satisfaction data (i.e., CAHPS). We will assess the combined data against rates and trends in performance compared to statewide and national benchmarks to identify potential areas of focus for improvement opportunities.

Data sources we will leverage to select Mississippi areas of focus include:

- State and national health trends. We will compare rates to statewide and national benchmarks to identify potential improvement opportunities. For example, Mississippi's 2021 America's Health Ranking is 50th for low birth weight.
- Community-level assessments, such as the 2021 UMMC Adult Hospitals Community Health Needs Assessment or upcoming 2022 needs assessments from Baptist Community Health and North Mississippi Medical Center.
- Member and Provider surveys.
- Direct input from Providers received during committee discussions and Provider engagement visits.
- Grievance and appeal data.
- State and local CBO feedback, including results of previous CCO PIPs and initiatives.
- Members' clinical outcomes (e.g., HEDIS and performance measure data).
- External quality review audit results. In accordance with 42 CFR § 438.350, we fully cooperate with evaluations and assessments of our performance and address any feedback or deficiencies.

Exhibit 4. Regionally Aligned QM Pod. With a hyperlocal focus, our cross-functional "pod" collaborates within the local community to foster deep insights into each region's quality needs.

Dedicated to Regional Solutions

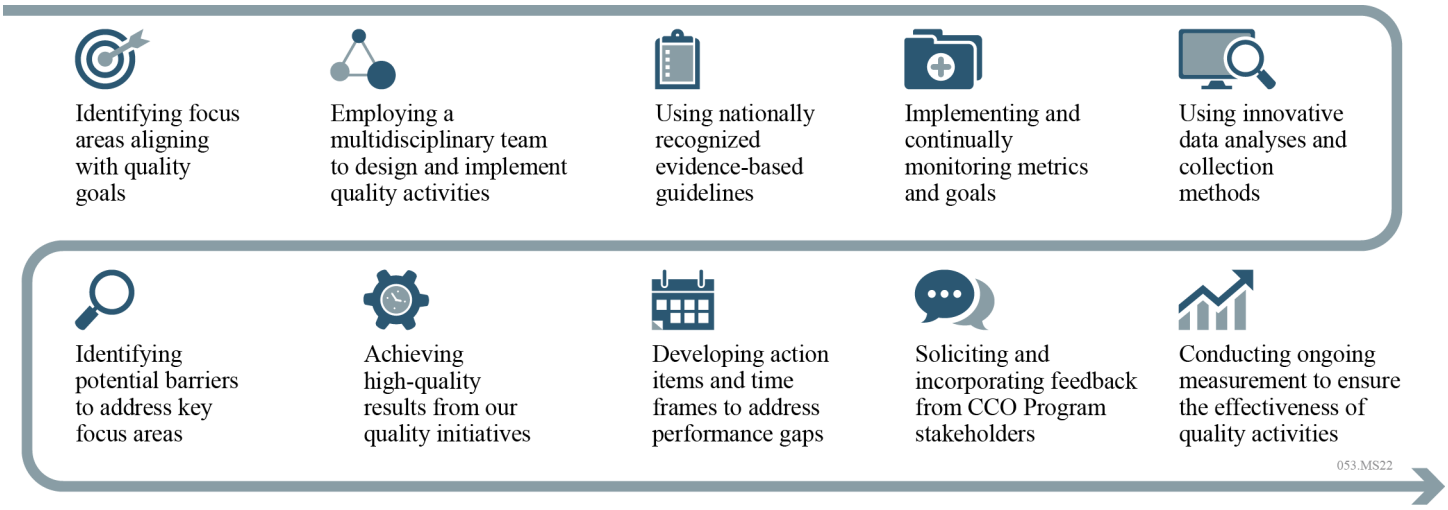
To gain further insight into the voice of our community partners and local Providers, we will align our regionally assigned Mississippi Quality Specialists, as shown in **Exhibit 4,** to partner in a cross-functional "pod" with community-based Provider Quality and Practice Transformation and Community Engagement Representatives to ensure that our QM improvement initiatives are focused on relevant areas within the community and infused with an understanding of local and regional resources and needs. A Quality Specialist will be assigned to each Mississippi region (Northern,

Southern, Central, and the Delta) and will cultivate a deep understanding of regional data trends, including understanding Member demographics, culture, public health statistics, and concerns. These integrated QM teams will collaborate on quality interventions, such as community outreach and clinic days through our mobile units, and address selected areas of focus. They will evaluate defined performance measures, including clinical outcomes, health disparities, and Member and Provider satisfaction, to evaluate impact and program success. This multidisciplinary team will recommend and design PIPs specific to identified areas of focus, informed by community health and access needs. The QM committee will provide ongoing oversight and input as the PIP is implemented, incorporating feedback from committee Providers and additional data inputs, evolving our interventions as we gain more experience and data.

A.1.d. Process for Using Evidence-based Practices

Evidence-based practices and QI are inherently complementary. Both are used to drive optimal quality of service and health outcomes for Members, as shown in **Exhibit 5**. Evidence-based practices are accepted best practices for clinical decision-making. The QI team uses performance auditing and monitoring, measurement, and outcomes assessment to help Providers incorporate evidence-based practices into their care and service deliver. Our national QM committee adopts, monitors, and updates evidence-based clinical practice and preventive health guidelines that are relevant to our populations, such as those related to asthma, ADHD, depression, obesity, and pregnancy management. These guidelines are based on valid and reliable clinical evidence, review of medical literature, or a consensus of healthcare professionals in the relevant field. Our QM team reviews guidelines monthly to identify potential updates and ensure they reflect the most recent clinical evidence and best practices.

Exhibit 5. Evidence-based Guideline Adoption, Implementation, and Evaluation of Performance. We adopt, monitor, and update evidence-based clinical practice and preventive health guidelines that are relevant to the populations we serve.



A.1.e. Complying with and Supporting the Mississippi Managed Care Quality Strategy

Our QM program goals will comply with and fully align with the Mississippi Medicaid Managed Care Quality Strategy. Our program goals are also consistent with the CMS Quality Strategy. Our approach to quality fully aligns with the Division's Comprehensive Quality Strategy and priority focus areas to ensure Members receive accessible, cost-effective, and high-quality physical health and BH care across the care continuum. Our QM program will provide excellence through continuous improvement, teamwork, and application across all functional areas. Our QM program structure is supported by internal and external goals, which in turn support Mississippi priority focus areas of maternal and infant health, mental health and SUD, obesity, and other chronic conditions. As illustrated in **Exhibit 6**, the areas of focus we have identified align directly with the Mississippi Quality Goals.

Exhibit 6. Quality Focus Alignment with Mississippi Goals. Our QM program goals will comply with and fully support the Mississippi Medicaid Managed Care Quality Strategy, providing excellence through continuous improvement, teamwork, and application across all functional areas.

Mississippi Quality Goals	Our Focus
Make Care Affordable	• Incentivize innovation by advancing VBP arrangements • Minimize wasteful spending by reducing low-value care • Maintain compliance with State and Federal regulatory requirements
Work with Communities to Promote Best Practices of Healthy Living	• Partner with communities to improve population health and address health disparities • Foster solutions to eliminate barriers to health equity and access
Promote Effective Prevention & Treatment of Chronic Disease	• Ensure timely and proximate access to primary and specialty care • Improve chronic disease management and control • Improve quality of mental health and SUD care • Prevent obesity and address physical activity and nutrition in children and adults
Make Care Safer by Reducing Harm Caused in the Delivery of Care	• Ensure maternal safety and appropriate care during childbirth and postpartum • Reduce medication errors and improve adherence to medication regimen
Strengthen Person & Family Engagement as Partners in their Care	• Engage and partner with Members to improve Member experience and outcomes
Promote Effective Communication & Coordination of Care	• Ensure appropriate follow-up after ER visits and hospitalizations through effective care coordination and care management • Achieve an interoperable health information technology system that keeps health information secure but readily accessible to Members and other authorized parties

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A.1.f. Use of Data to Design, Implement, and Evaluate Program Effectiveness

Through our continuous QM PDSA cycle, we are experienced in collecting and using data to design (plan), implement (do), and evaluate (study) program effectiveness, and (act) we report data on a wide range of topics, taking action where appropriate. We use this data, systematically collected from various data sources, to identify potential gaps and key focus areas for improvement and to evaluate the efficacy of our QM program.

Using Data to Design Our QM Program

We recognize the value of stratifying measures by demographic and geographic characteristics to identify disparities and target improvement activities to specific populations. For example, we report Child Core Set measures stratified by race, ethnicity, gender, and geography. Data sources used to design, implement, and evaluate program effectiveness include:

- Claims and encounters data
- Survey feedback from Members, Providers, and Care Managers
- Care management, care plan, and outcomes data
- Utilization trends, including PA data
- Trends from call center inquiries
- Grievance and appeal data
- PIP results and findings

Using Data to Implement Our QM Program

The quality measures we track span the entire healthcare continuum, allowing us to direct our resources to key areas of focus for Mississippi. We present data and reports to our QM committee, where we instill rapid-cycle process improvements based on Member outcomes and use of services. Committees and senior leadership develop a course of action based on those recommendations. We use fishbone and key driver diagrams to consider barriers faced by Members in obtaining services and achieving ideal health outcomes, and interventions that can address those barriers.

Using Data to Evaluate Our QM Program

We identify Member barriers through focus groups, Member advisory committees, Member and Provider feedback, and analysis of SDOH in our annual community health needs assessments. Based on our data findings, we partner with CBOs, when possible, and apply appropriate interventions through our QM structure,

testing changes on a small scale and refining interventions to implement broader changes. Additionally, we incorporate feedback and responses from network Providers and Members into our interventions and then apply them with the collaboration of the QM committees. Modifications to address potential performance gaps may include:

- Development, modification, or updates to policies and procedures
- Changes to staffing patterns, personnel, or training needs
- Changes in network Providers or scope of services, materials, and systems needed to support Providers and address Member needs
- Deployment of new or modified systems
- Communication of results, changes, and updates to internal staff and external Providers

Effective PIPs

We propose to collaborate with the Division, other CCOs, and Providers to ensure PIPs are effective in addressing identified focus areas and improving outcomes and quality of care for MississippiCAN and CHIP Members. We will use an array of analytic tools to mine various data sets for identification of performance improvement opportunities. Once we identify an improvement opportunity, we will work to ensure Members receive the benefits of preventive care, early detection, tools to facilitate self-management, and dedicated care coordination. Interventions will then be developed to deliver the highest possible quality of care and improve health outcomes.

Our PIPs will follow CMS protocols and meet all United Nations Office for the Coordination of Humanitarian Affairs requirements designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction in accordance with Draft Contract § 8.11, Performance Improvement Projects. Our strategy will focus on the Division's mission and vision, as well as program goals, to drive sustainable improvements for Members. We value CCO collaboration as an opportunity to standardize PIPs for both scalability and measurement while easing Provider administrative burden. Our QM team will design our PIPs to reduce health disparities, focusing on Members with the greatest needs or those at risk for adverse outcomes.

Identifying and Proposing PIP Focus Areas

In collaboration with the Division, the State's External Quality Review Organization, and other CCOs, we will review available data to identify physical health, BH, clinical, and nonclinical PIP focus areas. To support all our PIP areas, our CHWs, in collaboration with our care management team, will implement interventions that promote health and wellness for Members. These support staff will collaborate with CBOs to address any unmet health needs, such as SDOH barriers to care.

We will fully comply with the Division's minimum requirement of five clinical or nonclinical PIPs for each line of business each year. We have identified the following four PIPs that we will detail in our response to RFQ § 4.2.3.5, Performance Improvement Projects:

- Obesity in MississippiCAN and CHIP populations
- BH readmission
- Prenatal and postpartum care
- Cross-CCO Provider learning collaborative

Designing PIPs for Success

Established measurable goals and tracked progress are part of the PIP development process. We design project goals or performance thresholds based on evidence-based clinical guidelines and professional literature, as well as practical experience, industry standards, and available national benchmarks. Project evaluation includes an assessment of goals or performance thresholds. Specific sources used to identify goals or performance thresholds include NCQA Quality Compass and National Benchmarks, our performance thresholds and goals, and regulatory standards and requirements.

Implementation

When we identify an opportunity, we develop targeted interventions based on key barriers and drivers identified by the QI department or the responsible functional area in collaboration with the designated QM committees. This structure and linkage ensure interdepartmental expertise and accountability for the interventions and

outcome. Our team completes the intervention, documents the findings—both quantitative and qualitative—to determine the results, and captures the data needed for analysis.

Evaluating PIPs for Effectiveness

Each PIP sets forth the metrics used to measure the PIP's impact, such as related HEDIS scores or CAHPS or other Member satisfaction survey data, in accordance with the PIP's SMART goals. Following rapid-cycle protocols, the PIP's assigned QM specialists review those PIP measures monthly, using run charts or other tools to identify month-over-month improvement and compare it to the previous year's performance.

Shared with the PIP team, the monthly report documents progress and informs the PIP team's evaluation of the PIP's effectiveness, including identification of successful and unsuccessful interventions, so that we can adapt our PIP interventions as the PIP proceeds. Improvement is evidenced in repeated measurements of the indicators specified for each PIP and involves comparing initial measurement against benchmarks and improvement from the baseline. Sustained improvement is the goal. If the measures do not show improvement, interventions are revised or replaced. We continue our participation in a PIP until demonstration of significant improvement and sustainability of the improvement for more than one year.

The QM Specialist delivers PIP progress reports to the QM committee at least quarterly to gather their feedback to strengthen results. The PIP team and the QM committee provide ongoing recommendations, driven by the PIP's results data, about opportunities to enhance results through new or modified interventions. We will also tailor our reporting to reflect the Division's approved format. In addition, we will work with the external quality review organization as appropriate, sharing progress and participating in audits to verify the integrity of our PIP methodology. Working collaboratively, we will share PIP best practices with other CCOs as we team up on regional or statewide collaborative PIPs. PIP outcomes and measures will be reported to the State quarterly and annually.

A.1.g. Assurance of Separation of Responsibilities Between UM and Quality Assurance Staff

We ensure a clear division of responsibilities between UM and quality assurance staff. This is achieved through separate functional responsibilities and oversight, staffing mechanisms, role-based permissions for accessing information, and written policies and procedures.

UM, along with claim payment and grievances and appeals, is kept separate from QM activities and committees, delegated instead to Provider groups or eligible health delivery organizations. We conduct on-site assessments to determine ongoing compliance with regulatory and accrediting requirements. In addition, the QM team monitors key performance indicators and conducts ongoing audits to ensure compliance with NCQA standards. This additional oversight helps to ensure that UM maintains a separate compliant process outside of QM.

A.1.h. Addressing Health Access and Equity in Our QM Program

Every person deserves to live a healthy life. Our aim for healthcare access and equity is the same as the State's Health Equity Mission: reducing inequalities and disparities in health status based on race, ethnicity, and linguistic ability to improve the quality of health for all State residents.

We strive to ensure everyone has access to affordable and culturally competent healthcare. By analyzing utilization and performance data by race, ethnicity, and language, we can identify disparities and target Member and Provider interventions. We can also reduce or correct disparities by developing community-based strategies to reach minority Members.

A thorough review of MSDH's Office of Health Disparity Elimination Annual Health Disparities and Inequalities Report provides a virtual roadmap for us to assess the health disparities Mississippians face based on race and ethnicity.

The December 2018 report indicated significant health disparities in Mississippi based on race and ethnicity. Mississippi's Black population had the highest mortality rates due to heart disease, hypertension, stroke, diabetes, renal disease, cancer, and homicide. At 14.2%, the mortality rate for Black infants was more than twice as high as the rate for White infants. This is almost a 2% jump from the 2015 report. This population has the highest prevalence of obesity, the highest prevalence of adults with permanent teeth extractions, and the

highest teenage pregnancy rate. Mississippi's Black population also has the highest total invasive cancer incidence as well as the highest HIV incidence rate.

To support the State Health Equity Initiative's focus areas, we have aligned our program components when developing policies, procedures, services, and plans with the aim of reducing inequity. The components of our health access and equity program are:

- Health equity and cultural competency plan
- Clinical planning for diverse populations
- Provider training on health access and equity
- Community engagement and partnerships focused on health equity
- Data analysis

Community Baby Shower Success Story

Our affiliate's QM team partnered with a children's clinic and its healthcare personnel to conduct a community baby shower. **Using their quality performance tool dashboard, our affiliate compiled a list of prenatal and postpartum Members from current residents in counties bordering the area where the event was being hosted and invited them**. Vendors offered information, resources, and support to mothers and expectant parents who participated, and our affiliate provided door prizes, raffles, food, games, and speakers. Of the perinatal attendees, about 37% spoke only Spanish. One of the health plan's Spanish-speaking quality staff was on hand to translate, ensuring all attendees could understand the information being presented and participate in the activities.

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Health Equity and Cultural Competency Plan

Our health equity and cultural competency plan is comprehensive and coordinated to ensure that we meet the individual, culturally and linguistically diverse, and equitable needs of all Members, including individuals with limited English proficiency and those with physical or cognitive disabilities. Our health equity and cultural competency plan reflects the US Department of Health and Human Services (HHS) National Standards for Culturally and Linguistically Appropriate Services standards and is an integrated part of our QM program.

In Mississippi, the limited English proficient population accounts for almost 36,000 individuals, with some areas of the State more concentrated than others. The top ranked English language learners in Mississippi are those who speak Spanish, Vietnamese, Arabic, Chinese, Gujarati, and Choctaw. We recognize that limited English proficiency can affect access to care, so we provide all materials (e.g., Member handbooks, Provider directories, program letters) to Members in their preferred language. If a preferred language is not available, we provide information on how the Member can receive translation services in all communications they receive.

This plan is incorporated into our QM program, and we ensure that our staff, Provider network, Subcontractors, organizational systems, infrastructure, operating policies and procedures, and governance support the needs of our diverse membership. Our health equity and cultural competency plan will help us focus on Member needs and ensure Members have access to culturally and linguistically appropriate services. ***We also will offer medical terminology training for our Member services call center, and Member-facing staff*** who are proficient in Spanish receive pay differentials once they have passed the proficiency exam. The medical terminology class will offer these staff members additional experience in understanding Spanish medical terms.

Mississippi has one of the highest illiteracy rates in the nation, at 21%, and ranked 35th in the nation for K–12 achievement in 2021. To address Members' health literacy, our staff uses a software program add-in for all Member materials to calculate reading level and review words that may not be understood by Members. We follow plain language guidelines to develop content at a third-grade reading level.

We also accommodate our Members who are visually impaired by providing materials, such as a Member information packet, instructional materials, and booklets, in alternate formats when requested. Members may ask to receive auxiliary aids and services by contacting the Member services call center.

Clinical Planning for Diverse Populations

Creating a network of diverse Providers is fundamental to effective clinical planning that includes targeted interventions. Through collaboration with this diverse network, we can develop strategies to help mitigate health disparities in diverse populations. We analyze the diversity of the network annually, identifying any potential gaps and developing remediation plans. Provider directories include information about languages spoken and any cultural competency training completed by each Provider listed.

Annual needs assessments and collaboration with our Provider advisory committee help us develop clinical intervention strategies for reducing disparities in healthcare for program Members. We will ensure that PCPs and specialty Providers are sufficiently available to Members in all racial and ethnic communities throughout Mississippi. We will track the health status and outcomes of our racial and ethnic communities and provide supplemental resources to address identified disparities.

Addressing SDOH Barriers To Improve Member Access To Care And Health Outcomes

To address SDOH barriers to transportation, we will assist Members with scheduling assistance for their required medical appointments. Care Managers or Member services call center employees can make appointments on the Member's behalf, but Members will be encouraged to create the appointments independently, which inspires ownership.

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We offer community-based clinic days by organizing mini wellness fairs at Provider offices, through our mobile health program, or at FQHCs to encourage Members to complete well-care visits, immunizations, and other preventive services. During the events, we provide education on the importance of healthy eating, physical activity, and preventive care. We hold these events over weekends or at times when Members may have better access availability, which also benefits Providers by enabling them to see scheduled Members concurrently. Additionally, we will leverage our telehealth resources and network to reach those community Members who lack access to brick-and-mortar health facilities.

Provider Training on Health Access and Equity

Our diverse leadership and workforce focus on training all Providers in cultural literacy. We aim to meet the culturally and linguistically appropriate services standards to meet the needs of racial and ethnic groups. This work has resulted in many of our affiliated Medicaid health plans earning NCQA's Multicultural Health Care Distinction, identifying them as market leaders in proactively addressing SDOH and confronting racial and ethnic health disparities though culturally and linguistically sensitive, evidence-based interventions. We expect to bring the Mississippi health plan this distinction.

To further this objective, ***we have designated a Health Equity and SDOH Manager for enhanced local support***. Reporting to the QM Director, the Health Equity and SDOH Manager actively works to ensure the ongoing and proper focus on minority and ethnic health equality. We provide continuing education and training on health access and equity topics, such as "Introduction to Cultural Competency," "Health Disparities," and "Special Population Focus: Immigrants/Refugees." Providers receive incentives for completing the training.

Community Engagement and Partnerships Focused on Health Equity

Our experience and long-standing relationships foster solutions to eliminate inequities. These can vary widely by region and culture but will be tailored to each of Mississippi's community-specific needs, reflecting the community's demographic and socioeconomic composition, cultural values, existing infrastructure, and supports. We intentionally seek and enter agreements with CBOs and social service organizations that engage the broader public through community-based activities and programs.

Almost 40% of Mississippi's adults are obese or overweight, with 48% of Black Mississippians reported as overweight or obese. Mississippi also has the highest rate of food insecurity in the nation, something that is linked to a higher risk of chronic conditions and overall poor mental and physical health. Research also shows a higher utilization of ER services among food insecure populations. With more than half of the State's households located in rural areas, access to decent, healthful food is limited, which leads to further health disparities, as Mississippi's mortality rates resulting from diabetes, hypertension, congestive heart failure, and asthma climb. We will partner with additional CBOs to focus on food security by hosting farmers market events and distributing locally grown vegetables to Members.

One of Mississippi's top areas for improvement is preventive care for children. In efforts to address childhood and adolescent obesity in Members ages 12–17, we will offer our fitness-in-education program with a goal to influence behavior and develop healthy habits for a lifetime. Members who are interested in participating will receive a call from a Quality Specialist and will be mailed a fitness-in-education program Member information packet, which includes a watch that tracks physical activity, a journal and pen, and flyers and brochures on exercise and healthy food choices.

We will collaborate with March of Dimes on improving maternity outcomes with culturally sensitive strategies. We will collaborate with the Myrlie Evers Institute for the Elimination of Health Disparities and the MSDH Office of Health Disparity Elimination to implement Mississippi-specific strategies to reduce impacts of health disparities.

Obesity and Well-child Success Story

During a recent courtesy call, a child enrolled in the fitness-in-education program asked to speak directly to our affliate's Quality Specialist to share her update. The child stated that she journals every day and uses her fitness watch to track her sleep and daily steps. The Member stated, **"Writing what I eat in my journal has been helpful; when I read over what I have written, it reminds me that I need to eat more fruits and veggies if I haven't had any that day. I plan to keep doing this even after the program is over."** The Quality Specialist commended the Member for taking charge of her health and encouraged her to continue making positive changes.

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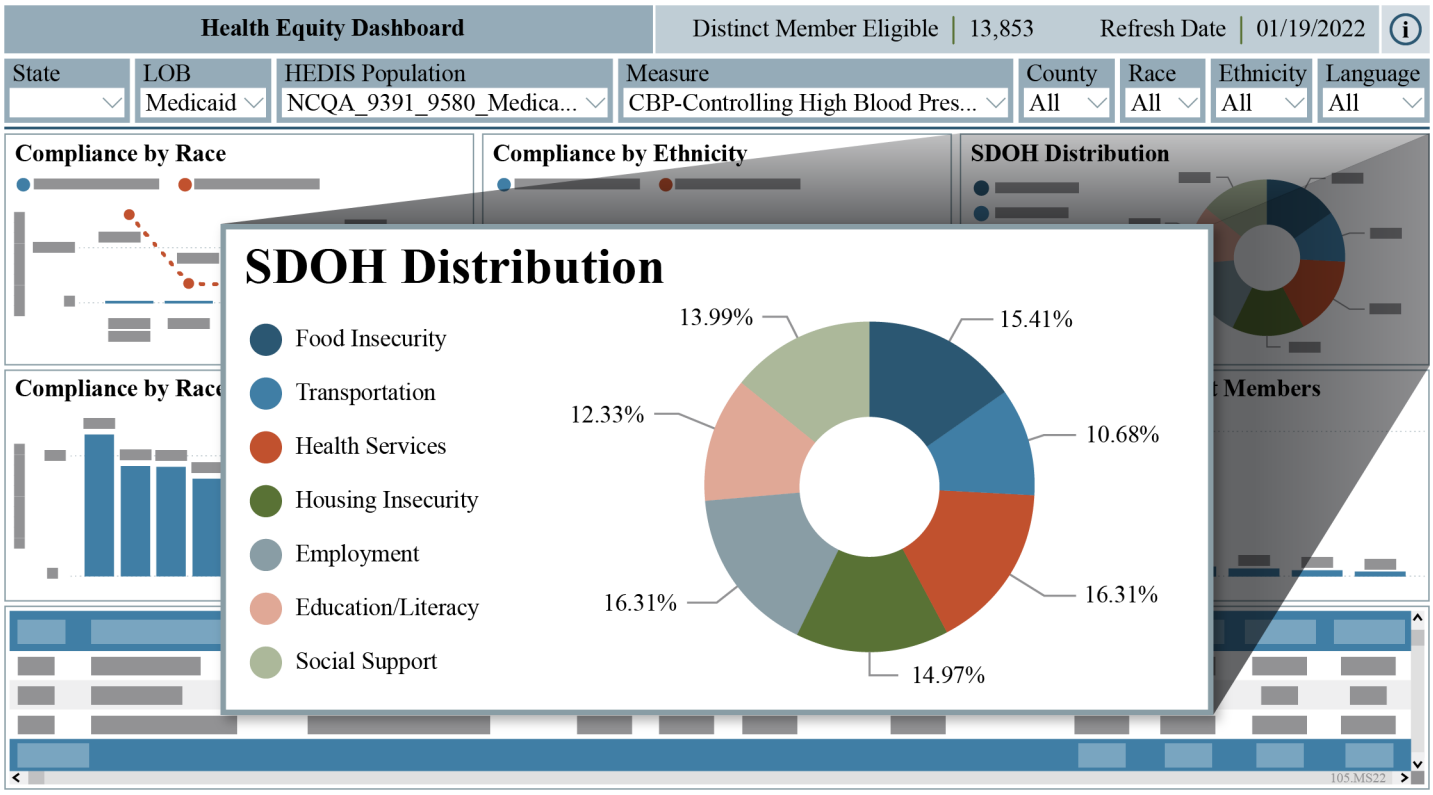
Data Analysis

We will implement an innovative approach for Mississippi to identify and analyze potential disparities in care for the Medicaid population. ***Our health equity dashboard provides insight into the effects of ethnicity, literacy, language, and geography on Members and identifies Members as high or medium risk for prioritized outreach.*** The risk stratification and predictive modeling platform uses interactive data analysis and goes beyond cost and utilization data. This data is presented within dynamic dashboards, as shown in **Exhibit 7**, allowing us to stratify key performance indicators for each population and combine criteria to understand where we can target resources to address greatest needs.

Exhibit 7. Health Equity Dashboard. Powered by our advanced business intelligence technology, we leverage our health equity dashboard to provide data-driven insights and measure the success of our QM program strategies.



Health Equity Outcomes Success Story

Our affiliate health plan identified a disparity among Hispanic/Latino Members with diabetes, noting they were less likely to receive a diabetic eye exam compared to the overall diabetic population. Through Provider incentives and outreach, which featured call campaigns and targeted cultural competency Provider training, ***this health-equity-inspired initiative increased the rate of diabetic eye exams among Hispanic/Latino Members from 55.5% to 61.14% between 2018 and 2020.*** This difference represents a closing of the gap between Hispanics/Latinos and non-Hispanics/non-Latinos, and the rate of Hispanic/Latino Members' diabetic eye exams ultimately exceeded the rate of the overall population. At the same time, satisfaction with the health plan (CAHPS Rating of Health Plan measure, Child Survey) among Hispanic/Latino Members increased from 61% in 2017 to 72.1% in 2020.

A.2. Models of QM Documents

We employ innovative, integrated QM approaches targeting the highest-priority health needs of Members, ensuring consistent health plan performance improvement. Our QM documentation outlines our infrastructure, program goals, and the activities we use to continuously identify and measure improvement opportunities directly related to important elements of care and service delivery. For example, the use of HEDIS measures and CAHPS, complex and care management, and Provider satisfaction survey results, provide a means to evaluate the care and services administered by our health plan.

The following documents drive our QM program activities (see 4.2.2.4 Appendix 1: Annual Program Evaluation and Annual Program Description/Work Plan).

Annual QM Program Description

Our QM program scope encompasses the quality and appropriateness of care, including service availability and accessibility, network quality, quality of services and supports, care planning and implementation, coordination and continuity of care, and Member safety. It also includes clinical quality performance measurement and improvement, disease management, medication management, Provider and Member engagement, removal of barriers, and improved access. Our QM program provides accessible, appropriate, cost-effective, and high-quality integrated healthcare and services for Mississippi Members throughout the entire range of care, with the primary goal of improving health outcomes and quality of life.

Our QM staff will work with the QM committee, subcommittees, and other work groups to plan, design, develop, and implement policies, procedures, and activities designed to improve quality outcomes. The QM program provides the organizational structure and supporting processes to fulfill our commitment to achieving clinical and operational excellence for the State of Mississippi.

Annual QM Program Work Plan

The QM committee develops our written QM work plan annually to accomplish QM program goals, objectives, accountabilities, and time frames. The plan contains details and requirements under our annual QM program evaluation, with descriptions of completed and ongoing QM activities, identified issues, and overall effectiveness of the program.

We will apply appropriate adjustments in Mississippi to account for seasonality, health risk or disease prevalence, geographic area, and data completion. The QM committee reviews and updates the QM work plan at least quarterly to assess progress toward program goals, address specific barriers, determine timelines for completion, and identify required changes.

Annual QM Program Evaluation

We use standard metrics and data analysis to continuously measure effectiveness and demonstrated improvement in our QM program goals and activities. Using a standardized evaluation template, we ensure consistency in our evaluations year over year. We evaluate the status and outcomes through a review of our work plan and produce an executive summary for committee and senior leadership, which demonstrates how well we met our program goals and objectives. Our summary focuses on quality and value; quality of clinical care; utilization of care; effectiveness of network-wide safety; adequacy of program resources; growth; customer experience; Provider participation and leadership involvement; committee structure; cultural, linguistic, and race/ethnicity programs; and areas of focus and recommendations for the coming year. We achieve overall effectiveness and demonstrate improvement through quantitative analysis of comparable data collected from internal and external normative and benchmark data and established thresholds and goals. If the program evaluation indicates performance is under or over the baseline threshold, we will perform root cause analysis and investigate underlying barriers to achieving the desired performance level. Through annual program evaluation and ongoing measurement and analysis, we identify priority areas and develop interventions.

B. CLINICAL GUIDELINES AND COMPLIANCE

We use clinical practice and preventive health guidelines to drive optimal quality of service and health outcomes for Members. Our national QM committee establishes, monitors, and updates guidelines that are

based on valid and reliable clinical evidence or a consensus of healthcare professionals in the relevant field. Our quality team reviews guidelines monthly to identify potential updates and ensure they reflect the most recent clinical evidence and best practices.

Our approach to QM focuses on ensuring access to high-quality care for Members through accountability, consistency, and respect. We will achieve these objectives by collaborating with Providers, other CCOs, State agencies, and community partners to promote the delivery of equitable quality healthcare services. Guidelines we adopt will define our expected standards of practice, and Provider compliance with these guidelines will be a key component of our successful QM program.

We will not adopt guidelines without input from Mississippi licensed and practice Providers. Our Mississippi QM committee, which will include Mississippi Providers, will review and approve the guidelines at least annually, and more frequently as evidence changes, assessing their relevance and appropriateness for MississippiCAN and CHIP populations. We will also engage our Provider advisory board to review and provide input and feedback on guidelines and recommended changes.

B.1. Proposed Process to Notify Providers of New Practice Guidelines and Monitoring Implementation

As clinical practice and preventive health guidelines define our expected standards of practice, it is critical to give our Providers access to, notification of, and performance feedback regarding their adherence to adopted guidelines and practice standards.

Our local, high-touch approach to partnering with Providers promotes adoption of guidelines at the practice level. Providers are notified of updates through various methods and are monitored through analysis of data statistics and quality-of-care data. In addition to recommending that network Providers use designated practice guidelines, we will disseminate guidelines to all appropriate Providers before the Contract start date through new Provider orientation, the Provider manual, and our Provider website. Newly contracted Providers will participate in Provider orientation within 30 days of being placed on active status. Facilitated by the Provider's assigned and locally based Provider Representative, orientation sessions will include practice guidelines topics as well as a host of other valuable information. After orientation, we will continue to encourage adoption of practice guidelines through a host of methods, activities, and required performance measures outlined in Draft Contract § 8.5, Performance Measures, including:

- **VBP work plan.** Our VBP arrangements reward Providers for meeting targets and quality measures consistent with guidelines, such as those for well-child visits and prenatal and postpartum care. For example, our maternity care VBP arrangement will offer a bundled payment for OB care, aligning incentives to apply evidenced-based practices in prenatal and postpartum practice, improving outcomes and reducing racial and ethnic disparities. Providers performance targets identified in the Mississippi Division of Medicaid Value-Based Payment Work Plan will align directly with practice guidelines. Performance data will be submitted annually to the Division.
- **HEDIS gaps-in-care reports and tip sheets.** We will supply Providers with monthly quality and risk gaps-in-care reports for assigned Members, viewable on the Provider portal, and a spreadsheet to view Member details—both of which deliver critical information Providers need to review alignment with preventive health practice guidelines. Included in the report is an additional patient population demographics summary. This summary provides a snapshot of the Provider's assigned membership, including SDOH indicators based on Z codes. We use this information to engage Providers and discuss opportunities to address SDOH and recommend best practices to improve quality outcomes. Tip sheets educate Providers on specific HEDIS measures, aligned to preventive health guidelines, including measure specifications, correct CPT coding, and tips to increase Member engagement and adherence. Providers can access these tip sheets through our Provider website and portal.
- **Focused QM priority area Provider toolkits.** Available on our Provider website, resources such as our BH toolkit and hypertension toolkit furnish Providers with practice guidelines, BH evidence-based practices and screening tools, diagnostic criteria, interventions, and guidance on referring Members to a specialist.
- **Notifying Providers of new guidelines.** We avoid surprises. We communicate any changes in guidelines in advance of making the change, aiming to publish all changes at least 30 days in advance. New guidelines, including changes and updates, are communicated to Providers through:

  - Written communications, such as letters, emails, faxes, and quarterly Provider newsletters
  - Provider Quality and Practice Transformation Specialists, who share tools and resources, including guidelines, during office visits with Providers
  - The Provider portal, which includes links to adopted guidelines
  - Meetings with Providers through events such as town halls
- **Ongoing education.** Every Provider will have a designated Provider Representative as their primary contact for training, education, and technical assistance, including adoption of practice guidelines. Providers will also receive support from our Provider Quality and Practice Transformation Specialists, who deliver quality and risk reports and support Providers in closing gaps in preventive and chronic care for Members. These personnel share practice guidelines with Providers during visits and support them by accessing and evaluating comprehensive cost, utilization, and quality data, and by identifying and proposing improvement opportunities and related resources.
- **Virtual medical education.** Evidence-based training on guidelines and best practices is available for physical health and BH Providers. Providers can access this training, which offers continuing medical education credits, 24/7/365 through our Provider portal. A variety of courses are available to Providers on topics such as addressing health disparities and cultural competency. We also offer access to a mental health education platform offering quality mental health and BH courses and information.
- **Provider manual, newsletters, bulletins, website, and videos.** We believe in transparency. Our clinical practice guidelines are published and available for Providers to reference at any time. We educate Providers on guidelines through our Provider manual and regular communications in our quarterly Provider newsletters and Provider bulletins, and through monthly joint operating committee meetings. Providers can access and review practice guidelines through our Provider portal. Providers can also watch short online educational videos that deliver timely communications in an engaging way.

Monitoring and Addressing Providers Who Are Not Compliant

We monitor, measure, and address Provider performance on practice guidelines, including denial rates, to look for patterns and for educational purposes to ensure Members receive optimal care and services for the best possible outcomes. We will provide a Mississippi-based QM team who will monitor compliance with guidelines using the resources described below.

Integrated Quality and Clinical Quality Performance Tool Dashboard. We use this one-stop resource for our quality and clinical teams to review, track, and trend Provider and Member compliance with evidence-based guidelines. This tool combines various data elements, including enrollment and demographic data, quality metrics (HEDIS and HEDIS-like), Member experience, clinical outcomes, UM, SDOH, and Member race/ethnicity. Using this resource, we can view real-time insights, benchmarked against nationally recognized standards, allowing us to implement appropriate and targeted interventions.

Our regionally based Provider Quality and Practice Transformation Specialists use the integrated quality and clinical dashboard to identify Providers with improvement opportunities at the group, practice, and NPI level. They share quality performance data and collaborate with Providers to identify barriers and discuss improvement opportunities. To further support Providers, the team also shares guidelines, screening tools, and other best practices tailored to each clinical measure.

QM Audits. To measure Providers' compliance, our QM team will annually design, conduct, and audit at least two preventive health guidelines and four clinical practice guidelines, including BH. Our audits are based on quality measure rates obtained from claims, encounters, and pharmacy and lab data (as applicable). They include a review of quality measure rates and potential over- and underutilization and compare them to national benchmarks. Following QM protocols, if adherence to practice guidelines falls below the target, our QM team conducts a root cause analysis to identify barriers and design solutions to drive improvement. Results from the audits will be shared with the Mississippi QM committee to discuss successes; solicit input and feedback on areas of noncompliance, including root causes; and discuss improvement opportunities.

Complementing our work to improve guideline buy-in and adherence, we identify barriers Members face in obtaining needed tests and exams. This feedback allows us and our network Providers to improve guideline compliance. We will use our affiliates' best practices to improve quality of care and service and to achieve

health outcomes consistent with the goals and objectives outlined in the Division's Comprehensive Quality Strategy (September 2021).

How We Address Providers Who Are Not Compliant. When our monitoring activities (Provider profiling, QM audits, and QM monitoring) and subsequent analysis indicate noncompliance, our first step is to contact the Provider, relay our findings, and discuss potential contributory factors. We work collaboratively with them to address barriers and improve identified deficiencies. If a Provider is not complying with practice guidelines, our Medical Director educates them on the guidelines and addresses any barriers preventing adherence. Corrective measures range from phone calls or visits to formal plans of correction. If a Provider's behavior does not improve, disciplinary action is imposed, up to and including termination from our Provider network.

B.2. BH/SUD Clinical Guidelines and Monitoring Provider Adherence

We know that BH/SUD is a focus area for Mississippi. As stated in the Division's Quality Strategy, in State fiscal year 2020, nearly 20% of the potentially preventable hospital returns among Medicaid beneficiaries were attributed to adult mental health. To address this area of health disparity, PCPs and other allied health workers engage in a wide range of clinical preventive practices, intervening early with the aim of preventing disease and promoting health. Addressing the social determinants within BH/SUD practice entails starting earlier for identification and broadening the scope of interventions to make entire families and Mississippi communities healthier. We pair Providers with care management staff to work collaboratively and help empower Members through education and identification of resources necessary to control and manage their conditions. We will partner with Providers to keep them current on the most up-to-date guidelines used to support this population and to improve the lives of Mississippi citizens so they can lead the most productive and healthiest lives possible. Our local QM committee provides Mississippi BH/SUD Providers opportunities for participation.

We collect, analyze, and report on a comprehensive set of performance metrics to measure program success. The adoption of evidence-based practice guidelines and BH/SUD utilization trends are identified through ongoing reporting and review of data, such as ER utilization, HEDIS outcomes, top diagnosis reports, readmission reports, and prevalence reports. Under the direction of our Mississippi and national Medical Directors, we will determine the areas of focused review for clinical practice guidelines. Our committees review top Member BH/SUD trends and high-priority areas, research clinical evidence and evidence-based recommendations, and align with guidelines published by national organizations.

Board-certified BH and SUD Provider participants on our QM committee review these trends and the suggested clinical practice guidelines, which involves identifying whether there are any updates from a nationally recognized review body, such as SAMHSA. For example, our QM committee may consider if a clinical practice guideline advising on the treatment of BH/SUD for adolescents could be beneficial. Our QM committee uses a variety of criteria to help determine whether a guideline should be adopted: high cost, high utilization, inconsistency in use of a procedure, identified quality issues, review of top diagnosis and prevalence reports, and more. For this scenario, we would consider the Screening and Assessing Adolescents for BH/SUD Protocol published by SAMHSA, which provides the following:

- General guidelines for evaluating, developing, and administering screenings and assessment instruments and processes for Providers who screen and assess adolescents for BH/SUD
- Information to inform a wide range of people whose work brings them in contact with adolescents (teachers, police, coaches, and others) about the tools available to screen for potential BH/SUD concerns
- Evidence-based strategies that can be used to detect related problems in an adolescent's life, including problems with family and peers and psychiatric concerns

Our QM committee would review and discuss this guideline and solicit the recommendations and opinions of board-certified Providers from appropriate specialties to determine if the guideline should be adopted or if we need to develop our own clinical guideline. **Table 2** provides a list of our BH/SUD clinical guidelines that we intend to promote.

Table 2. BH/SUD Guidelines. Our committees review BH/SUD trends and high-priority areas, research clinical evidence and evidence-based recommendations, and align with guidelines published by national organizations.

Condition	BH/SUD Guideline
Acute Stress and Post-traumatic Stress Disorder	**Title:** VA/DOD Clinical Practice Guideline for the Management of Post-traumatic Stress Disorder and Acute Stress Disorder **Source/Date:** Department of Veterans Affairs and Department of Defense, June 2017
Anxiety/Panic Disorder	**Title:** Practice Guideline for the Treatment of Patients with Panic Disorder **Source/Date:** American Psychiatric Association, January 2009
ADHD	**Title:** ADHD: Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit Hyperactivity Disorder in Children and Adolescents **Source/Date:** AAP, October 2019
Autism	**Title:** Identification, Evaluation, and Management of Children With Autism Spectrum Disorder **Source/Date:** AAP, January 2020
Bipolar Disorder	**Title:** Bipolar Disorder: Children & Adolescents **Source/Date:** American Academy of Child and Adolescent Psychiatry, 2005
Depression	**Title:** Treatment of Patients with Major Depressive Disorder **Source/Date:** American Psychiatric Association, October 2010, 3rd edition
Homelessness—Special Healthcare Needs	**Title:** Adapting Your General Recommendations for the Care of Homeless Patients **Source/Date:** National Health Care for the Homeless Council, 2010
Opioid Management	**Title:** Use of Medications in the Treatment of Addiction Involving Opioid Use **Source/Date:** American Society of Addiction Medicine, June 2015 **Title:** CDC Guideline for Prescribing Opioids for Chronic Pain **Source/Date:** CDC, March 2016
Schizophrenia	**Title:** Treatment of Patients with Schizophrenia and Guideline Watch **Source/Date:** American Psychiatric Association, 2004 and 2009
Substance Abuse Treatment	**Title:** Detoxification and Substance Abuse Treatment Guideline **Source/Date:** SAMHSA, October 2015
Suicide Risk	**Title:** Assessment and Management of Patients at Risk for Suicide **Source/Date:** Department of Veterans Affairs and Department of Defense, May 2019
Trauma-informed Primary Care	**Title:** Fostering Resilience and Recovery: A Change Package for Advancing Trauma-Informed Primary Care **Source/Date:** The National Council for Mental Wellbeing, November 2019

Monitoring Provider Adherence to BH/SUD Clinical Guidelines

Adherence to BH/SUD clinical guidelines leads to better overall Member outcomes. ***Across our affiliate plans, we maintain a deep roster of experienced health plan psychiatrists who offer expertise in their areas of specialty and serve as peer reviewers.*** For clinical decision-making, we use evidence-based level-of-care guidelines. Contracting with a national specialty review vendor with experienced physical health and BH/SUD specialists provides valuable assistance in authorization decisions that require additional levels of clinical specialization.

To ensure adherence on an ongoing basis, we detect, monitor, and evaluate under- and overutilization as well as inappropriate service utilization. We also use HEDIS data to monitor adherence to the guidelines and continuously monitor Provider performance for utilization and potential opportunities for improvement. For BH/SUD, we measure the "Effectiveness of Care" measures ranging from antidepressant medication management to screening for people with schizophrenia or bipolar disorder. For BH/SUD, we track Follow-up After High-Intensity Care for Substance Use Disorder, the percentage of acute inpatient hospitalizations, and residential treatment or detoxification visits for a diagnosis of BH/SUD.

Because routine BH/SUD services do not require PA, we also encourage completion of outlier audits. These compare Provider-specific utilization data (e.g., hospital and ER utilization or prescription medication utilization) to average Provider utilization in the same category to flag outliers. To compare data, we pull information from resources including:

- Historic data to ascertain utilization patterns and thresholds

- Historic data from affiliate plans for similar geographies, populations, and Provider types
- NCQA Quality Compass
- State Medicaid results
- Other regional quality-reporting initiatives
- Comparative data from companies that provide utilization review guidelines
- Comparative data, thresholds, and benchmarks provided by professional associations
- Evidence-based utilization standards from medical literature

Comparisons of individual Provider utilization data to data for larger groups allow us to identify utilization patterns that are outside the norm. The UM committee works with the pharmacy and therapeutics committee to evaluate utilization trends, identify anomalies, investigate specific details, and initiate actions to address identified issues.

Depending on the circumstances, the committees might recommend Provider education to review Contract requirements and resolve issues. This education would be conducted by the Provider representative team.

B.3. Compliance with the SUPPORT Act

The SUPPORT Act requires education for Providers who specialize in addiction medicine, addresses barriers to treatment access and recovery support, and emphasizes care coordination. The Act helps reduce opioid misuse through prevention, treatment, and leveraging data to better target efforts. Our comprehensive DUR board's clinical pharmacy program is focused on preventing fraud and abuse of controlled substances and supporting compliance with the SUPPORT Act. Our program educates prescribers and pharmacies about ways to improve the quality of patient care by increasing awareness of therapeutic issues and reviewing the efficacy of drug management operations. We will investigate pharmacy utilization patterns that require either immediate intervention or detailed investigation and analysis to improve Member safety. We will monitor prescribing patterns and usage for several pharmacy measures, including reporting for children who are prescribed an antipsychotic, polypharmacy for two or more opioids or antipsychotics, concurrent utilization of opioids and benzodiazepines, and more.

Our parent company's national pharmacy and therapeutics committee is the clinical authority governing the implementation and monitoring of SUPPORT Act requirements and processes. We will leverage our national DUR board and pharmacy and therapeutics committee to provide data and insight to the State's DUR and pharmacy and therapeutics committees as well as the PBA. Our DUR program is a structured, continuous program that reviews, analyzes, and interprets medication use against established medical standards and criteria. This data-driven program offers services designed to identify and address inappropriate prescribing practices as well as Member overuse or misuse of pharmacy services.

DUR Programs Used to Implement SUPPORT Act Requirements

Our DUR program provides multiple targeted solutions for retrospective monitoring that helps identify, investigate, and intervene when potential indicators of opioid misuse or antipsychotic high-risk utilization are present. This approach provides levels of safety reviews to implement SUPPORT Act requirements. Our DUR board conducts quarterly reviews of retrospective DUR data based on drug claims to identify problematic utilization patterns and recommends edits in the claims processing system to prevent inappropriate utilization. Our retrospective DUR programs will evaluate physician prescribing practices, drug use by individual Members, and dispensing practices of pharmacies, and will use drug claims data and other records to monitor for the following:

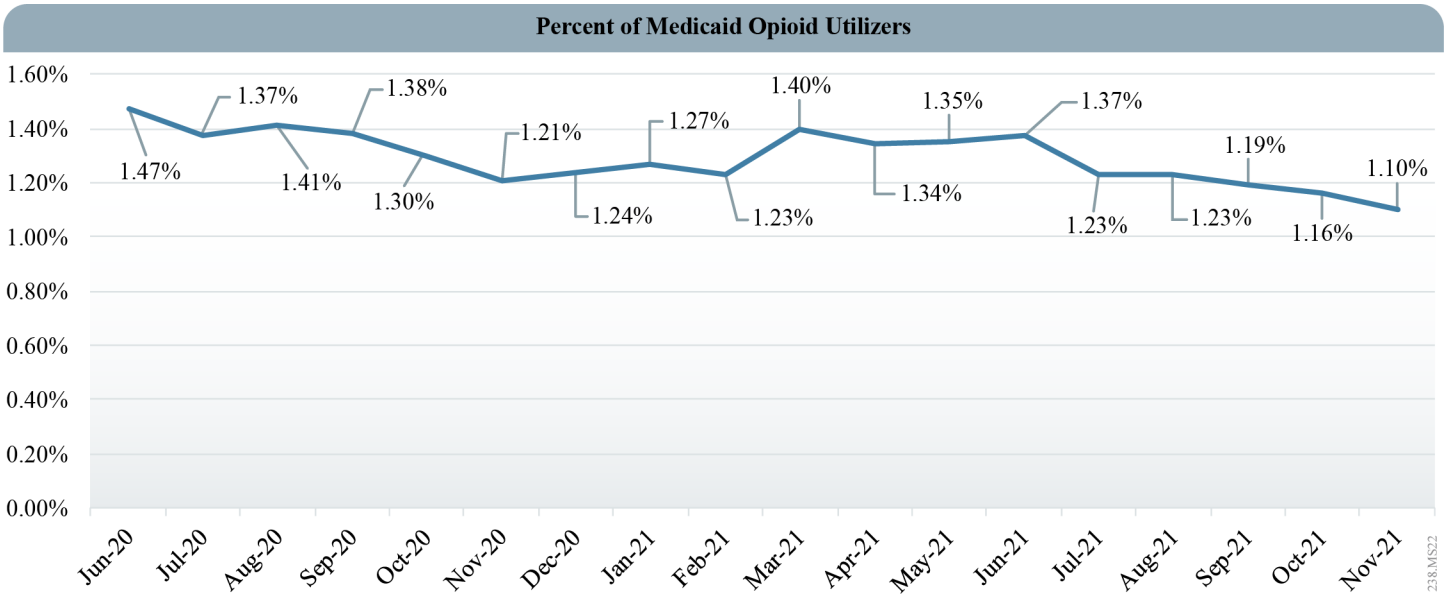
- Fraud
- Underutilization
- Drug disease contraindication
- Drug-drug interactions
- Therapeutic appropriateness
- Therapeutic duplication
- Clinical abuse or misuse
- Incorrect duration of drug therapy
- Overutilization
- Appropriate use of generic products
- Incorrect drug dosage

We will perform retrospective monitoring for opioids and other medications and identify and investigate controlled substances for potential misuse/overuse, including anabolic steroids, anxiety medications, sleep medications, opioids, muscle relaxants, and stimulant drugs. Our safety and monitoring solutions program will

identify potential fraud concerning controlled substances by the Member, the prescriber, or the pharmacy. This program will help to determine the extent to which Members are prescribed high amounts of opioids, identify those at risk for opioid misuse or overdose, and identify prescribers with questionable prescribing patterns. Clinical thresholds and prescription patterns will be established for triggering retrospective reports to identify Members who need further evaluation. Review of edits and threshold values will be done annually or as needed. At this time, the following criteria are reviewed: addition/deletion/modification of edits or threshold values, frequency of review or intervention, program inclusion and exclusion (screening) criteria, and patient risk score thresholds for clinical review.

Exhibit 8 provides an example of our SUPPORT Act opioid utilization report, which tracks the number of utilizers for opioids and can be used to show outliers. For example, this report highlights the trend of opioid utilizers (normalized for our Medicaid membership) decreasing significantly at the end of 2021. This would provide a starting point for investigation. We would use this data to monitor whether the trend continues to improve and to direct clinical programs and best practices.

Exhibit 8. Sample SUPPORT Act Opioid Utilization Report (Fourth Quarter 2021). Our SUPPORT Act opioid utilization report tracks the number of opioid utilizers and can be used to show outliers.



Example: Monitoring Appropriate Use of Antipsychotics in Children

Between 2008 and 2017, the incidence of antipsychotic use among children and adolescents increased from 2.1 to 3.8 per 1,000 individuals[1]. The use of antipsychotics in children comes with significant risks, including metabolic and neurological side effects, and the use of these agents "off-label" or as duplicative agents increases safety risks. We have taken steps to intervene in inappropriate prescribing of psychotropic medications using best practice guidelines and rigorous monitoring and oversight of prescribing practices. We will ensure our activities and monitoring of this population align with Mississippi's Metabolic Monitoring in Children Taking Antipsychotics requirements. Member access to safe and appropriate medications is our goal. We follow the Mississippi Psychotropic Medication Monitoring Plan for Children in Foster Care (see additional details regarding foster care in our response to RFQ § 4.2.2.1, Member Services and Benefits).

Our DUR board will facilitate the monitoring of child Members for potential drug therapy issues, including excessive dose and multiple-medication therapies. Through this monitoring, we will identify potential drug therapy issues and perform Provider outreach to inform them of the identified concern and reach resolution. Our DUR board will meet quarterly to review utilization of antipsychotic medication and opioids among children. The board will monitor trends around prospective safety edits and point-of-sale overrides in addition to retrospective outcomes.

[1] Varimo, Eveliina, et al., "New Users of Antipsychotics Among Children and Adolescents in 2008–2017: A Nationwide Register Study," *Frontiers in Psychiatry*, April 24, 2020.

Specifically, we will review pharmacy claims for the following:

- Members under 18 who are on psychotropic medication exceeding recommended dosage
- Members under 18 who are receiving two or more stimulants, antidepressants, antipsychotics, alpha agonists, and/or mood stabilizer medications
- Members under 18 who are prescribed psychotropic medication without a DSM-5 diagnosis
- Members age 4 or under who are prescribed psychotropic medications, polypharmacy, concomitant prescribing, or dose in excess of FDA guidelines

These criteria will trigger a review of the Member's clinical needs. Our pharmacy team will educate Providers and refer Members to care management for follow-up as indicated.

We will also evaluate those Members under 18 who are utilizing antipsychotic therapies and have not had the appropriate metabolic screening. Providers will be educated when Members at risk are identified.

Innovative, Proprietary Screening Tools

We have developed proprietary screening tools using nationally accepted clinical elements from ASAM (ASAM Screener and ASAM assessment, the National Institute for Drug and Alcohol Quick Screen, and CAGE-AID). These screening tools allow for Member-driven interventions and rapid coordination with Providers and community resources.

Our care management staff use these tools to capture as much information as possible about Members at risk for substance use and/or overuse. The ASAM Screener and ASAM assessment use six dimensions to identify immediate needs and potential barriers to treatment and recovery. From experience, we understand how vital the first contact with a Member is in predicting the course of successful contacts in future care management. Due to the nature of this complex population, we have learned to capitalize on the initial contact and ensure the most important needs are identified and addressed. The ASAM Screener allows Care Managers to quickly identify immediate needs that require intervention within a few hours to a few days, and also reduces assessment fatigue.

Through collaborative engagement between the Care Manager and Member, the Member will become more involved in their care and more confident in the care management services they receive.

Dedicated Care Managers Specializing in SUD

To best address the needs of Members with SUD, we propose dedicated, specialized Care Managers and support staff who have received highly specialized training in SUD treatment. When a Member is identified as having confirmed or suspected SUD or opioid use disorder, or their primary health concern is related to SUD, the case will be assigned to a dedicated Care Manager who will contact the Member within one day. ***Our BH/SUD team will consist of experienced full-time staff, including BH/SUD clinicians (licensed clinical social workers, licensed professional clinical counselors); RNs with core competencies in pain, addiction, and mental health; and paraprofessionals. This team is dedicated to BH/SUD cases and has received specialized training in key competencies such as SUD, mental health, and pain management.*** Care Managers use motivational interviewing techniques to determine the Member's perception of their health and assess their readiness for change. Based on the results of these assessments, the Care Manager works with the Member to develop targeted Member-centric goals and interventions.

Through a proposed partnership with the Office of Mississippi Physician Workforce, a specialized addiction medicine fellowship will be offered to selected Providers willing to partner with us and their peers across Mississippi to increase use of BH/SUD evidence based practices.

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Care Managers may receive assistance in contacting the Member from our CHWs specializing in SUD, hired for their local knowledge and connections. Our Care Managers are well-versed in coordinating the most appropriate care for Members, including traditional treatments for SUD or pain management, as well as nonpharmacological treatments for pain, such as acupuncture, mindfulness/meditation, and massage.

One of the challenges for all groups in treating SUD is unfamiliarity on the part of many healthcare workers. To address this knowledge gap, our care management program emphasizes general BH/SUD training and specialized fields. Our Care Managers will be Mississippi-based, clinically licensed staff with experience in addiction, mental health, and/or chronic pain. We will supplement their experiences with additional training on

specialized topics each year. In addition, we require training for our general (non-SUD) care management and UM staff as well as nonclinical staff who have contact with Members. Training is conducted live, online, and through self-paced videos. Topics include understanding BH, perinatal depression, crisis calls, verbal de-escalation, assessment and intervention, pediatrics and SUD, SDOH, neonatal abstinence syndrome, medication assisted treatment, pain and addiction, and trauma-informed care.

In addition to working with Care Managers, established Providers are encouraged to enhance their knowledge and skills and to increase evidence-based practices.

B.4. Promoting Physical Health Clinical Guidelines and Monitoring Provider Adherence

Physical health clinical practice guidelines define our expected standards of practice. We make up-to-date treatment and diagnostic information available to Providers specific to membership demographics and service needs. Our QM committee, with participation from network Providers reviews and updates physical health clinical practice guidelines at least annually, and more frequently as clinical evidence is updated. We monitor evidence-based consensus statements, guidelines from nationally recognized healthcare organizations, and published peer-reviewed medical journals regularly to ensure that our guidelines include the most current industry information. Our QM committee also reviews the guidelines recommended for approval by our national QM committee. All guidelines are distributed across the organization and adopted by all relevant departments. **Table 3** provides a list of our physical health clinical guidelines that we intend to promote.

Table 3. Physical Health Clinical Guidelines. Our QM committee, with participation from network physicians, reviews and updates physical health clinical practice guidelines at least annually, and more frequently as clinical evidence is updated.

Condition	Clinical Practice Guideline
Asthma	**Title:** Diagnosis and Management of Asthma (EPR-3) **Source/Date:** National Institutes of Health, National Heart, Lung, and Blood Institute, December 2020
Children with Special Healthcare Needs	**Title:** Promoting Health for Children and Youth with Special Health Care Needs **Source/Date:** Bright Futures, 2017
Chronic Kidney Disease	**Title:** Evaluation and Management of Chronic Kidney Disease Guideline Source/Date: National Kidney Foundation, Kidney Disease Outcome Quality Initiative, January 2021
COPD	**Title:** Global Strategy for Diagnosis, Management, and Prevention of COPD **Source/Date:** Global Initiative for Chronic Obstructive Lung Disease, January 2021
Diabetes	**Title:** Standards of Medical Care in Diabetes **Source/Date:** American Diabetes Association, January 2022
Heart Failure	**Title:** Management of Heart Failure **Source/Date:** American College of Cardiology, August 2017
Hypertension	**Title:** Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults **Source/Date:** American College of Cardiology, August 2018
Obesity	**Title:** Comprehensive Medical Care of Patients with Obesity **Source/Date:** American Association of Clinical Endocrinologists, July 2016
Perinatal Care	**Title:** Guidelines for Perinatal Care **Source/Date:** American College of Obstetricians and Gynecologists, September 2017
Pregnancy Management	**Title:** Routine Prenatal and Postnatal Care **Source/Date:** Michigan Quality Improvement Consortium, June 2020
Sickle Cell Anemia	**Title:** Management of Sickle Cell Disease Source/Date: National Heart, Lung, and Blood Institute , December 2014

Monitoring Adherence to Physical Health Clinical Guidelines

With the development and release of each clinical guideline, we also develop methods for monitoring adherence. To measure adherence, we evaluate:

- Claims and encounter data
- UM statistics
- Potential over- and underutilization information

- Polypharmacy data
- Appeal trending
- Quality-of-care information
- Clinical health outcomes measurement using metrics (e.g., HEDIS specifications)

We measure Provider performance every year based on at least two clinical guidelines, and we will provide the Division with a summary of the results and any corrective actions taken. When outliers are identified, our Medical Directors contact Providers to educate them and address barriers that prevent adherence.

Our practice guideline process, shown above in **Table 3**, is a cycle of ongoing monitoring as outcomes are remeasured and specific interventions and programs are enhanced with each cycle.

Once a program is approved for implementation, various departments, committees, and subcommittees continuously monitor activities and track the predefined performance measures. The QM committee reviews measurements at least annually. Any problems detected with the intervention or significant variations from performance standards are reported for further review and action.

Prior to implementation, a critical review of all proposed evaluation metrics is conducted. To ensure the validity and reliability of the data, these reviews use specific criteria. Our staff and committees review multiple sources to assess performance against available external national benchmarks, performance measures, and goals. **Table 4** highlights sample measures used by our affiliate health plans to assess performance and monitor implementation of clinical practice guidelines.

Table 4. Sample Measures. Our affiliate health plans use a variety of sources and measures to monitor, assess, and harmonize the selection and implementation of clinical practice guidelines, which serve as standards across our health plans.

Area of Treatment	Guideline Title & Source	Identified Measure	Organization HEDIS 2021 Rate	Goal: NCQA 75th Percentile	Goal Met or Not Met
ADHD	Diagnosis, Evaluation, and Treatment of Attention-Deficit Hyperactivity Disorder in Children and Adolescents—AAP	ADHD—Initiation Phase	56.28%	51.83%	Met
Immunizations	Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, United States, 2018—CDC and Prevention Advisory Committee of Immunization Practices	Childhood Immunization Status—Combo 10	44.77%	73.48%	Met
		Immunizations for Adolescents—Combo 2	42.33%	24.62%	Met
Diabetes Care	Diabetes Guidelines—American Diabetes Association	75% A1C Control <8	53.04%	55.96%	Not Met
Asthma	Guidelines for the Diagnosis and Management of Asthma—National Institutes of Health & National Heart, Lung, and Blood Institute	75% Asthma Medication Ratio	79.80%	68.13%	Met
Obesity	Recommendations for Preventive Pediatric Health Care—Bright Futures/AAP	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	85.50%	80.54%	Met

B.5. Policies, Procedures, and Processes to Conduct Provider Profiling

High-quality care provides individuals with better overall health and well-being and reduces costs. Regularly measuring the performance of our PCPs and assessing the quality of care being delivered ensure continuity and improve overall outcomes.

We gather data to use in Provider profiling from sources such as claims and encounters. This data is used to generate meaningful utilization trend reports by Provider and Provider type. We can then generate individual Provider profiles for review by our QM committee, the Provider representative team, and individual Providers.

Once gathered, we share the data with Providers. We distribute profile reports on a periodic basis to PCPs with more than 50 Members assigned to their panel. Some metrics related to specific clinical quality initiatives might be distributed more frequently to Providers who do not meet thresholds or for those with monitoring in place due to previous profiling results. Highlights of aggregate results are included in our Provider newsletter. We provide individual performance metrics, peer performance, and national benchmarks as well as missed services reports for HEDIS results to participating Providers on our secure Provider portal.

We use key utilization data and quality measures to identify low-performance trends and address high-risk health conditions related to population demographics. This includes assessing the network to meet the enrollment profile, annual review of membership and Provider demographics (preferred language, ethnicity, race, physical/cognitive disabilities, and others), local and applicable national geographic population demographics, and health status measures (i.e., HEDIS) as available.

We offer training on specific policies and procedures to Providers as needed to improve metrics once areas for improvement have been identified. Such continuing education is provided by internal staff who regularly interact with Providers (e.g., healthcare services, Provider representative, claims, Member grievances and appeals, QI, anti-fraud, UM, and pharmacy teams).

Using clinical initiatives, recredentialing profiles, and performance indicator monitoring (e.g., after-hours access), we profile Providers to assess the quality of care they deliver and create a consolidated profile aggregated from clinical, utilization, administrative, and satisfaction metrics. Combined, these procedures provide an integrated view of Provider performance. The data demonstrates how effective our extensive network is at securing access to care, utilization of benefits, and quality of care for Members.

We successfully monitor Provider performance using an innovative scorecard that measures performance on key clinical measures based on evidence-based clinical practice guidelines. The scorecard profiles Providers on their current versus previous year comparative statistics, including enrollment, utilization and payment, current performance on HEDIS measures, and bonus payments, including bonus payments made to date and bonus potential remaining. We have found that the Provider scorecard display of outstanding bonus potential is an effective motivator for Providers to intensify their performance improvement efforts.

Our Provider representative team provides training at Provider sites to help meet our performance goals and improve quality of care delivered to Members. Tools and resources are shared with Providers, including clinical practice guidelines, screening tools, and other best practices tailored to each clinical measure to help Providers improve performance. HEDIS performance and trends are also discussed at QM committee meetings.

B.6. Methods to Ensure Noncontracted Providers' Quality of Care

Through our experience coordinating care in other States, we have developed policies and procedures and a system of continuous performance to ensure that Members receive quality care from noncontracted Providers. We will establish and maintain a strong network, and we strive to achieve less than 5% of the total contracted spend with nonparticipating Providers. We will proactively collaborate and engage with noncontracted Providers to encourage them to be involved in our efforts to improve Member health outcomes in Mississippi and provide quality care.

We have a variety of resources at our disposal to monitor and ensure the quality of services from noncontracted Providers, including:

- Claims and authorizations from both contracted and noncontracted Providers
- Performance and compliance data for all Provider types via geomapping/analytics reporting, which monitors network accessibility, identifies gaps and deficiencies, and verifies compliance with the State's time and distance standards of 30 minutes or 30 miles for urban distances, or 60 minutes or 60 miles for rural distances
- Complaints, grievances, and satisfaction surveys
- Network service gaps through electronic visit verification of service request and delivery time frames
- Continuous improvement efforts including:

- Quarterly reviews of grievance and appeal summaries, updated geomapping and time/distance reports, Nurse Advice Line reports, Provider satisfaction surveys, and summaries of activity with noncontracted Providers
- Member complaints about accessibility, scheduling, wait times, and delays, and an annual access study that examines network appointment availability, after-hours access standards, and related performance
- Documentation of missed appointments and appropriate follow-ups

Our quality oversight and proven processes ensure quality of care for Members. Qualified out-of-network Providers who are willing to provide services enter into agreements to support continuity and quality of care. These Providers are contacted for potential transfer into our network. The agreements incorporate guidelines we have established for communication and coordination with the PCP and our Care Managers. Noncontracted Providers also receive education regarding appropriate claims submission requirements; coding updates; electronic claims transactions and electronic fund transfers; and our Provider manuals, website, and fee schedules. These requirements ensure that out-of-network Providers adhere to policies established through our QM program and that we receive appropriate data regarding the Member's care.

If a request for authorization is received for services with a noncontracted Provider, or if it is determined that services are required from an out-of-network Provider, or if a Member is receiving emergency services, we begin to communicate with that Provider. The following guidelines will help us ensure the quality of care delivered by noncontracted Providers:

- Non-emergency services are subject to PA to ensure clinical appropriateness.
- Inpatient services and recurring outpatient services are subject to ongoing concurrent review to ensure quality and appropriateness.
- Noncontracted services are subjected to retrospective review and additional analysis.
- We work to offer the noncontracted Provider a contract; upon electing to participate, they will be subject to the CVO's credentialing process.

As evidenced by Mississippi's rank in access to PCPs (49th) and preventable hospitalizations (48th), for Members in historically underserved urban and rural areas, access to quality healthcare services can sometimes pose a challenge. Identifying the need for multiple single-case agreements in specific regions or specialties serves as an opportunity for improvement, allowing us to identify when there is a need for expanding our Provider networks in those regions. In addition, we educate Members about the value of using contracted Providers to avoid the issues associated with using noncontracted Providers.

B.7. Proposed Policies and Procedures for Reducing Provider Preventable Conditions

Never Events, or deaths due to medical error, are the third leading cause of deaths in Mississippi behind heart disease and cancer. Most of these deaths are preventable through strict Provider adherence to evidence-based guidelines and practices. Reducing Provider preventable conditions, including Never Events, is important to ensuring quality Member care. Thus, we have a process to identify, investigate, review, and report any potential quality of care issues, Never Events, or service issues affecting Member care.

Policies to Reduce Provider Preventable Conditions

Never Events are reportable, adverse, inpatient events related to errors in medical care that are clearly identifiable and preventable. These events are extremely rare medical errors that "should never have happened" and can cause severe injury or death to a patient. Written policies are in place to ensure UM or care management staff report potential quality of care, Never Events, and service issues. UM staff must submit a potential quality of care referral form to our QM department for further follow-up, which then researches, resolves, tracks, and trends potential quality of care issues.

Procedures to Reduce Provider Preventable Conditions

If a potential Never Event is identified during the clinical review process, the facility or Provider must submit medical records with their claim. UM staff document the potential Never Event, including the instructions given to the facility in the clinical notes. They also notify the claims analyst to look at the nonclinical note field. Services related to the Never Event are documented in the nonclinical note. Never Events include but are not limited to surgery on the wrong body part, surgery on the wrong patient, or the wrong surgery on a patient.

When we identify or are notified of a potential Never Event, the following steps occur:

1. The case is sent to our medical claims review team to make an official determination.
2. Medical claims review staff review medical records and discuss them with the Medical Director to determine whether a Never Event occurred.
3. The Medical Director makes the ultimate determination of what should or should not be approved, and documents this in the nonclinical notes.
4. Services pertaining to the Never Event are placed in denied status.
5. UM/medical claims review staff complete a potential quality of care referral form for all Never Events; confirm the appropriate reason for the referral; write a summary of the issue or complaint, including dates of service and service reference numbers and hand-deliver or send the form via interoffice mail to the quality department.

B.8. How We Encourage Providers to Use EHR and e-Prescribing Functions

Provider satisfaction with EHR technology is achieved through high levels of Provider engagement. We foster open communication and collaboration with Providers and invite and encourage Providers to offer input and feedback on EHR guidelines and processes. We proactively engage them through inclusion in our QM committee and Provider advisory boards to discuss needs for new or streamlined guidelines. To maximize buy-in and encourage Providers to use EHR and e-prescribing functions, we make information available through direct communication and in-person meetings, by phone and email, and via health plan leadership and UM staff explaining the benefits of use.

A secure notification platform will be used to push actionable, clinically relevant information directly into the Providers' workflow within the EHR. This capability supports better patient care, improves coordination, reduces readmission, helps track and share information about high-risk patients, and allows clinical reminders such as those related to EPSDT, immunizations, preventive and chronic condition care needs, prescription fill needs, and overall wellness visits as a support in ensuring Members' best care and health outcomes.

This process allows for electronic transfer of information between the Providers' and CCOs' digital platforms, enabling both organizations to streamline the PA process and lay a foundation for its future automation. Benefits of using the 278 PA transaction process include:

- Reduced UM administrative burden and costs
- Improved PA turnaround times and reduced transcription errors
- Fulfillment of contractual requirements and avoidance of financial penalties
- Addressing of network Provider requests and improvements in Provider satisfaction
- Increased direct access to network Provider EHR platforms

Information supporting the safety and value of e-prescribing will be available. In addition, our innovative partnership will allow us to push medication reminders into the Provider's EHR to further promote the value of e-prescribing in the normal Provider workflow.

C. QUALITY MEASUREMENT

Data measurement is an essential part of QI. This process involves collecting, tracking, and analyzing data for specific measures, such as clinical quality measures and Member satisfaction or service performance, and incorporating ongoing remeasurement and monitoring. By effectively using data, our QM team can evaluate the success of initiatives, interventions, changes in processes, or utilization patterns.

C.1. Data Analytics and Data Informatics Capabilities

We maintain a comprehensive health information system that collects and integrates the data necessary to drive performance improvement and QM activities. Our system ensures the reliability and completeness of information received from claims, HIEs, common data platforms, the Provider representative team, Member services call center employees, grievances and appeals, care management, UM, credentialing, public health departments, and demographic databases, including SDOH. We use this data to identify potential opportunities for improvement, prioritize areas of focus and establish measures, and align with health and service priorities

identified through Provider and Member feedback. Based on thoughtful analysis of the data and process, we define the targeted population, identify and refine what we can measure frequently, and establish a baseline and goal.

To achieve the objectives of the QM program, we use our:

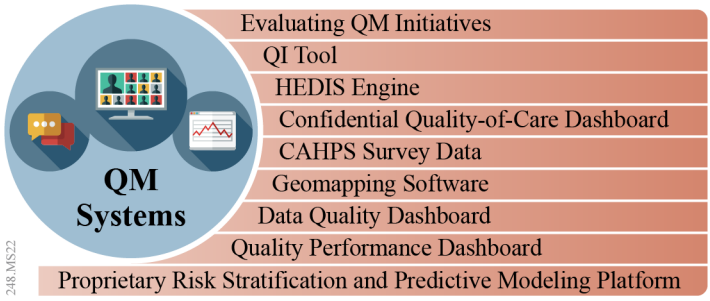
- Core health IT system
- Care management platform, a Member-centric health management software application
- Proprietary risk stratification and predictive modeling platform used to develop strategies and interventions

Our health IT systems track the activities and progress of Members throughout the course of care management. Through our secure, online Provider portal, Providers can access Member-specific enrollment data, quality performance reports, and claims status. By combining evidence-based guidelines and Member claims data, we support electronic outreach and notification, such as appointment reminder text alerts and medication alerts, which leads to dynamic Member engagement. Data, reports, and analyses are leveraged by management teams and care management staff and made available to the Division and Federal regulatory agencies.

Analytics and Informatics to Drive Performance Improvement and QM Activities

Our QM systems use our integrated IT platforms to fully support all standard and ad hoc quality, clinical, population health, and SDOH data collection, analysis, advanced analytics, and reporting. They also support call center performance, network access and availability, and Provider performance, including VBP metrics. Our integrated reporting environment is intentionally scalable to meet any new or revised requirements. Examples of the systems and tools we use in QM are noted in **Exhibit 9** and described in the subsections that follow.

Exhibit 9. QM Systems and Tools use our integrated IT platforms to fully support all types of reporting.



Evaluating QM Initiatives. To evaluate the efficacy of our QM initiatives, we will use HEDIS, other quality performance metrics, and SMART goals developed for each intervention. We will leverage both quantitative data and qualitative information—such as Member and Provider feedback gathered through contacts with our call center, face-to-face meetings with Members and Providers, and interactions with regulators—to inform our QM initiatives, strategies, and interventions. Using the data and information we collect, we will identify trends and commonalities among Members in each population health stream and deploy resources to areas where they are most needed.

QI Tool. A suite of quality dashboards accessible through the executive dashboard allows our QM and care management teams to review, track, and trend Member gaps in care and identify targeted interventions.

HEDIS Engine. Driven by our health quality application, the HEDIS engine enables us to track and monitor the performance of various medical record review vendors daily. This ensures that we are capturing the most accurate and timely Member data needed to drive real-time quality initiatives. Administrative data (such as claims/encounters, labs, and pharmacy information) and supplemental data are fed into our reporting system, and data is refreshed monthly.

Confidential Quality-of-Care Dashboard. This dashboard tracks quality-of-care concerns at the individual Member level from identification through investigation and resolution. The confidential quality-of-care dashboard is used by designated quality-of-care team management to review trends and systemic issues and refer them to the professional review committee. The professional review committee evaluates selected high-severity quality-of-care concerns forwarded from the Member services call center, Provider services call center, the QM department, or the peer review panel as they relate to individual PCPs/Providers and renders decisions concerning continued participation. The professional review committee also evaluates practice patterns, including quality-of-care issues related to individual PCPs/Providers.

CAHPS Survey Data. We leverage CAHPS survey data to evaluate and reduce healthcare disparities based on race, ethnicity, and other factors. We analyze this data to determine which areas of service have the greatest effect on Members' overall satisfaction. We analyze areas of opportunity for improvement to aid in increasing the quality of care provided to ensure that Members are receiving culturally and linguistically appropriate services and identify any gaps in clinical care. Language service utilization is another source of data used to identify potential disparities. We document and address identified areas of opportunity through barrier analysis and interventions.

Geomapping Software. Heat maps are created to identify clusters of Members with a specific healthcare target, such as a missed HEDIS service, access-to-care challenge, or other disparity. These reports help us identify areas of opportunity, prioritize intervention efforts, and provide more Member-centric benefits. Our Member services department uses these tools to help Members identify the nearest contracted facility or Provider for the needed service. Detailed information is available to assist Members with scheduling appointments and to ensure that they can access the care they need. These tools aid in filling any gaps in care to provide a seamless experience for the Member.

Data Quality Dashboard. Built for our executive leadership, the quality operations dashboard provides an up-to-date snapshot of current HEDIS projects. This dynamic reporting tool provides drill-down statistics across a multitude of population health categories for our affiliated health plans across the nation, including displaying the progress and comparisons of the medical record retrieval process. Year-over-year trending helps to ensure chart collection and abstraction goals are met, while also keeping a pulse on the accelerated HEDIS timelines. Importantly, this report informs our executive leadership on status, which drives QI strategies by care management, as well as continuous oversight and monitoring of QI intervention performance and outcomes.

Quality Performance Dashboard. Analytics tools, including our quality performance dashboard, allow us to drill down on measures to evaluate specific populations based on race/ethnicity, gender, age, geographic location, and other factors, such as SDOH. We monitor internal and external data inputs monthly and quarterly to evaluate population health outcomes and the effectiveness of our strategies and initiatives in meeting the goals and targets we set. We also study this data to identify emerging trends that point to new challenges our membership and communities are facing.

Proprietary Risk Stratification and Predictive Modeling Platform. This platform identifies gaps in care and opportunities for improvement. It retrieves data from our comprehensive data lake to deliver real-time insights at the population, population segment, Member, Provider, and assigned Care Manager levels, and benchmarks performance against nationally recognized standards, such as NCQA's Quality Compass percentiles and State performance goals. It applies a Member stratification model to score and target outreach prioritizations.

To improve health and quality of outcomes, QM staff use timely data and analytics that address physical health, BH, and social health measures, including measures of health disparities and reporting on disease-specific performance (e.g., hypertension and diabetes) as well as other key areas (e.g., maternity outcomes). We use this data to design interventions to improve Members' health outcomes. For example, the HEDIS monthly trending report, obtained from our HEDIS engine, is used to track month-over-month trending for each HEDIS measure. Data for multiple HEDIS years is also included to track year-over-year trending, so any significant change in the rate can be identified and examined by our QM program staff and QM committee to identify and explain the root cause. QM staff and analytical resources routinely review performance reporting data against identified benchmarks and goals. These analyses are used to identify actions or tactics needed to improve performance. Actions for improvement include:

- Assessing the effectiveness of current QM activities
- Developing and measuring activities and interventions aimed at addressing the issue or issues
- Researching established standards, performance goals, and benchmarks to identify updates that may be appropriate based on new clinical practice guidelines or industry standards
- Identifying additional measures to monitor progress
- Continuously analyzing performance-level monitors to sustain improvement
- Conducting barrier analysis on the measures to identify the issue(s) and define priorities

C.1.a. Type of Build Necessary to Create Reports

We are experienced in the use of data to generate necessary reports using established analytical tools and to create new reports and develop enhancements that leverage existing reports (See 4.2.2.4 Appendix 2: Quality Sample Reports). We derive additional data used for report creation from claims, encounters, pharmacy, and supplemental sources, as well as vendor claims and encounter information, such as labs.

Once data is collected, our QM team processes data through several methods such as electronic software and applications, manual collection processes, and available external resources. We work with IT on the processes and resources needed to integrate these sources to efficiently and adeptly create custom reports that allow us to assess gaps in care and QM activity results. We evaluate our QM program and strategies continuously throughout the year, analyzing relevant performance measures and preparing accurate and compliant reports.

Our systems meet the requirements to submit performance reports and adherence to QM policies and procedures. Our systems also incorporate processes to send appropriate data required for public review that informs stakeholders about our performance. Examples of data and reports include HEDIS performance measures, CAHPS survey results, and BH Member satisfaction results.

In addition, we collaboratively and proactively build reports to meet Providers' identified needs. For example, we leverage our advanced business intelligence and reporting capabilities to model and review pharmacy data from the PBA to identify potential overutilization and underutilization. We develop targeted reporting for identified Providers to proactively send alerts about drug interactions and recalls, ensuring a greater level of quality-of-service delivery and Member safety.

C.2. Innovative Approaches for Accuracy and Efficacy of QM Programs

Complete and accurate data received from our network Providers and facilities is a key component to ensuring we have an accurate and efficacious QM program. To address this potential gap, we will implement the following two innovative approaches to secure timely and accurate data from our Provider partners.

Innovative Approach 1. *Implementing timely and secure notification and capture of data.*

We leverage interoperability standards developed by HL7® International around clinical document architecture to send critical gap-in-care notifications directly into Provider EHRs for specific assigned patients. Clinical document architecture transfer enables the Provider to be informed of all the Member's health information and clinical care gaps and to provide the Member with the most effective form of treatment. Furthermore, we are developing expansive ADT notification capabilities to alert Providers when their assigned Members have received treatment at a facility. The combination of real-time data and Provider incentives to act upon it is a key lever for driving value into the Mississippi healthcare system and will create an accurate and efficacious quality measurement system.

Innovative Approach 2. *Rewarding Provider practices for pursuing data aggregation and secure data sharing.*

Through VBP arrangements and incentives, we will reward Providers for sharing data with our health plan through secure HIPAA-compliant feeds, including the completion of key tests and exams, immunizations, lab results, pharmacy data, and SDOH Z codes. Providers who complete data aggregation certification through NCQA will receive incentives. Feeds will also be counted toward HEDIS compliance, which reduces the administrative burden of medical record review on the health plan and Provider groups.

Our Provider quality and practice transformation program establishes the strategy, operational direction, and tools for Provider engagement and practice transformation. We will collaborate with the CEO, network, and operations staff to provide strategic direction for Provider quality and practice transformation to help Providers understand how to improve quality and risk-adjustment accuracy.

We have selected the most qualified Providers, who are critical to ensuring participation in the program, and we are committed to their success. We understand that not all Providers are at the level they need to be. To engage Providers and improve their understanding of the program, we will provide materials for transformation, encourage participation in the joint operating committee, and work with internal teams and other groups to

instill Provider loyalty and trust. We will create a path to enable accuracy and efficacy by providing practice information and forums through which Providers can seek real-time assistance.

[END OF RESPONSE]

4.2.2.4. APPENDIX 1: ANNUAL PROGRAM EVALUATION/PROGRAM DESCRIPTION/ WORK PLAN

2023 Quality Management Program Evaluation (Draft Template)

Introduction. We conduct an annual program evaluation to assess if we met performance goals and objectives. The QM program evaluation includes analysis against goals and identification of barriers and interventions. The program evaluation also includes trending from previous years.

Adequacy of QM Program Resources: Example language Included in Program Evaluation. We completed staffing analysis to evaluate resources. No staffing gaps were identified.

Leadership Involvement/Provider Participation: Example Language Included in Program Evaluation. The QM program benefited from leadership and Provider involvement. The Medical Director cochaired the QM committee. Members of senior leadership and external Providers participated within the QM committee structure. The program description, work plan, policies and procedures, guidelines, and reports were reviewed and approved during committee meetings.

Committee Structure: Example Language Included in Program Evaluation. The Board of Directors has ultimate responsibility for strategic direction of the program and oversight of the QM committee. The QM committee recommends policy decisions, analyzes and evaluates progress and results, and institutes follow-up.

The QM committee includes health plan and external Provider network participants. Health plan participants include the Chief Executive Officer (CEO), Medical Director, Quality Management Director, clinical leaders, dedicated BH Provider, and delegation oversight, network, and operations leadership. Network Providers on the QM committee include PCPs, specialists, and BH Providers.

Membership Growth: Example findings included in Program Evaluation. Mississippi had a total membership of XX at the end of 2023.

Facilitating Care for Health Plan Members: Example Language Included in Program Evaluation. Our health plan monitors programs to ensure that timely and appropriate services are provided and health outcomes are improved. Our health plan contracts with Providers, organizations, facilities, and institutions to deliver healthcare.

Addressing Cultural, Racial and Ethnic, and Linguistic Needs of our Members: Example Language Included in Program Evaluation. Our health plan assesses Member cultural and linguistic needs and preferences. Information gathered annually is used to identify and reduce cultural and/or linguistic barriers. Members are informed of interpreter services through Member handbook, website and newsletters. Clinical performance and Member experience measures are analyzed by race, ethnicity, language, gender, geography, and SDOH factors to determine if disparities exist.

Example Language Included in Program Evaluation: Evaluating Effectiveness of Program Related to Cultural and Linguistic Needs of Health Plan Members. The separate report, attached in the evaluation appendix, includes an analysis of cultural and linguistic needs and preferences, interventions, and services. It identifies and addresses key barriers and discusses prioritized quality interventions with dates and status to highlight effectiveness.

Example of Finding Included in Annual Analysis. We developed cultural competency training for Providers and distributed it to the Provider network. This training was identified as high priority to address barriers related to different communication styles/cultural preferences between Providers and Members.

Population Assessment: Example of Language Included in Program Evaluation. We performed a population assessment about structure and adequacy of resources and processes. We use assessment results to update activities and internal and community resources.

Example of Finding Included in Program Evaluation. The top conditions were identified as hypertension, diabetes, COPD, and asthma. A key social need identified was related to housing instability.

Example of Demographic Analysis Included in Program Evaluation. Our membership included XX% White, XX% Black, XX% Asian, XX% American Indian, and XX% Unknown Members. Our Members had a higher proportion of Black individuals (XX% versus XX% statewide). Most Members (XX%) spoke English as their preferred language. Spanish was the most requested language.

HEDIS Performance: Example of Language Included in Program Evaluation. We evaluate effectiveness of initiatives using key performance measures. HEDIS rates were reported in 2023 for Medicaid and CHIP. A separate report, attached in the evaluation appendix, reviewed HEDIS performance compared to national benchmarks, prior year results, and goals for future.

Example of HEDIS and Performance Measure Analysis Included in Program Evaluation. XX out of XX rates for measures increased from the prior year. Measure performance showed measure rates that scored above the 66.66th national Medicaid HMO percentile, indicating goals were met. The rates that scored at or below 10th percentile or at 90th percentile or more will be attached in the evaluation appendix.

Effectiveness of Network-wide Safety: Example of Language Included in Program Evaluation. Our health plan monitored and made efforts to improve network-wide safety and clinical care through various activities.

Example Analysis of Effectiveness of Network-wide Safety Included in Program Evaluation. Provider education included articles regarding patient safety. Investigation of potential quality-of-care issues was completed. More than XX potential issues were identified. Annual data collection and assessment of data were conducted about hospital participation with Leapfrog Group.

Member Experience: Example Language Included in Program Evaluation. Each year, we conduct a focused evaluation of Member satisfaction survey results and complaints and appeals data. The evaluation focuses on CAHPS results, telephone access, and BH experience results to identify opportunities for improvement and appropriate interventions.

Example of Member Experience Analysis Included in Program Evaluation: Member Satisfaction Survey Results. Overall performance was measured through reporting of child and adult Medicaid CAHPS surveys. XX out of XX measures performed above the 66.67th percentile; XX out of XX measures performed below the 66.67th percentile. We used key primary and secondary drivers to identify priority areas. We will reevaluate interventions to determine effectiveness and modifications.

Member Complaints and Appeals Evaluation: Example Language Included in Program Evaluation. We evaluate complaints and appeals as part of overall review of Member experience. We focus analysis on total numbers of complaints and appeals, trends, and comparison to goals set at ≤ 5 per 1,000 PMPM.

Example of Analysis of Complaints and Appeals Included in Program Evaluation. XX complaints were resolved for health plan Members. The volume increased from Q1 to Q2 and decreased in Q3 and Q4. Goals of 5 per 1,000 PMPM were met. XX appeals were resolved for health plan Members. The appeals increased from Q1 to Q2, Q2 to Q3, and Q3 to Q4. From the first to the second half of year, there was a reduction in appeals resolved. Goals of 5 per 1,000 PMPM were met.

Telephone Access Standards—Member Access: Example Language Included in Program Evaluation. We evaluate Member access to the health plan's Member services call center functions by service level, average speed of answer, and abandonment rates at least quarterly.

Example of Analysis of Telephone Access Results Included in Program Evaluation. We achieved the following metrics: Service Level: 95%; Average Speed of Answer: 23 seconds; Abandonment Rate: 1.77%. Goals were met.

BH Experience Results: Example Language Included in Program Evaluation. Our health plan analyzes BH experience results and/or related complaints and appeals analysis.

Example of BH Experience Analysis Included in Program Evaluation. XX% of respondents felt that it was usually/always easy to get treatment/counseling.

Continuity of Care: Example Language Included in Program Evaluation. Continuity and coordination of care is essential to improving outcomes. A detailed report details results, barriers, and interventions in place.

Provider Experience and Performance Outcomes: Example Language Included in Program Evaluation. Experience of Provider network is evaluated in customer service/Provider relations, network, utilization/care management, health management, claims, pharmacy, and overall satisfaction and loyalty.

Example of Provider Experience Analysis Included in Program Evaluation. Ratings increased for Finance Issues, Utilization and Quality Management, Provider Relations, and Pharmacy. Composite ratings that decreased were Overall Satisfaction, Network/Coordination of Care, and Health Plan Call Center Staff.

Delegation Oversight: Example Language in Program Evaluation. Delegation oversight activities and reports are reviewed at the delegation oversight committee, which reports to the QM committee. The delegation management committee requires corrective action of delegates when necessary.

Example of Delegation Oversight Review Included in Program Evaluation. We initiated XX new delegation agreements. We executed XX pre-delegation audits prior to delegation. All goals were met.

Improvement Projects: Example Language Included in Program Evaluation. Goals established for PIPs were met/not met.

Areas of Focus/Recommendations for Next Year: Example Language included in Program Evaluation.

Example of Areas of Focus and Recommendations Included in Program Evaluation. Based on the QM program evaluation, significant changes to the program are not needed. The areas of focus and recommendations included identifying interventions for prioritization that address clinical measures not meeting established goals; working on potential over- and underutilization to ensure that Members receive appropriate healthcare; monitoring committee structure to ensure discussion, action items, and next steps occur during meetings; and ensuring that QM reviews nonclinical complaints with individual Providers and potential quality-of-care cases are appropriately investigated.

Appendices: Key Example Reports that Are Included in the Appendix.

- Culturally and Linguistically Appropriate Services Program Analysis
- Population Assessment
- Quality Performance Measurement
- Member and Provider Experience Analysis
- Potential Quality-of-Care Issue Trends
- Continuity and Coordination of Care Evaluation
- Member Complaints and Appeals Review
- Improvement Project Summary

2023 Mississippi QM Description (Draft Template)

Introduction: QM Program—Achieving QI Goals

The 2023 Mississippi QM program complements the Triple Aim goals of the Institute for Healthcare Improvement (IHI) to improve the health of Members, enhance the experience for Members, and reduce healthcare costs. We drive continuous improvement through measurement, evaluation, and tracking and based on feedback received from Members/authorized caregivers, Providers, facilities, community-based organizations (CBOs), and other stakeholders. We use critical strategies to meet program goals emphasizing personalized care by Providers and programs that address culturally and linguistically diverse needs; and helping individuals navigate healthcare.

QM Program: Key Components—Infrastructure and Framework

Key QM program components include the following principles:

- Establish structures, processes, plans, and strategies to meet internal, program, and external requirements.
- Complete contracting with individual Providers, Provider organizations, and facilities.
- Define and establish specific roles that clearly delineate lines of accountability and responsibilities.
- Create, review, and update goals and objectives as needed on an ongoing basis.
- Identify, define, and manage the unique needs of Members by identifying and stratifying Members according to healthcare utilization and/or potential risk and coordinating services during transitions.
- Evaluate issues, problems, or concerns through causal analysis; develop action plans to correct identified problems; and use evaluation methodology.

QM Program Philosophy: Values, Assumptions, and Operating Principles

- Well-defined program structure supports achievement and defines excellence through continuous improvement.
- Priority is to improve healthcare and health outcomes for Members with chronic conditions, culturally and linguistically diverse backgrounds, complex and/or unresolved needs, and/or multiple care transitions.
- Teams and teamwork are vital to the improvement of healthcare and services.
- Data collection and analysis are critical to solving problems and improving processes.
- Each employee contributes to health plan quality processes and results.
- QI is maintained by meeting accreditation requirements and Federal and State regulations.
- Feedback is incorporated from health plan Members/caregivers, Providers, and CBOs.

QM Program Key Goals

- Review, analyze, and understand Member demographic and epidemiological data to address Member needs.
- Use a multidisciplinary committee structure for further achievement of QM program goals.
- Implement and evaluate activities that improve quality, health outcomes, Member safety, and service.
- Ensure that interventions address cultural, racial, ethnic, linguistic, and social risks and needs of Members.
- Apply sound approaches and methods to evaluate clearly defined indicators and performance measures.
- Measure and improve Member and Provider satisfaction with physical health and BH care and/or services.
- Support collaboration between Members and Providers to promote effective health promotion and wellness.
- Maintain compliance with Federal and State regulatory and accreditation requirements.

QM Program Objectives

Planned activities/interventions that address quality and safety of clinical care, service, and Member experience; QM program scope; QI methodology and assessment; persons assigned, responsibilities, and training; time frames for meeting each objective; monitoring of previously identified issues; and coordinated strategies to carry out the QM program.

Scope of Program Activities

Program scope addresses Members' entire healthcare experience through culturally and linguistically appropriate healthcare and services that are equitable and address Members' physical health, BH, and social needs and risks. Program scope includes healthcare and services in institutional, outpatient, and/or home care settings. Contracted Provider groups, PCPs, specialists, facilities, and ancillary Providers may render services.

Continuously Evaluating Important Aspects of Care and Service

Our health plan monitors key aspects or activities that include:

- Access/availability
- Continuity/coordination of care as evaluated through analysis of healthcare and services received
- Appropriateness of care for over- and underutilization, compliance with guidelines, and complaints
- BH care measured by compliance with guidelines
- Management of chronic conditions and acute care
- Member safety/medical error reduction/avoidance activities
- High-risk/high-volume/problem-prone care
- Preventive care and chronic condition management as measured by clinical practice guideline compliance
- Activities for Members with special healthcare needs who may need care management or care coordination
- Performance measurement and interventions to address performance gaps
- Member and Provider satisfaction with physical health and BH care
- Medical coverage documents
- Review of potential quality-of-care cases, serious reportable adverse events, and hospital-acquired conditions
- Medication management
- Timely and appropriate healthcare and services for Members with culturally and linguistically diverse needs
- Review and analysis of demographics, health status, and utilization of Members and communities
- Information systems performance and data capture
- Plan-determined internal and collaborative QI projects with other health plans
- Identification, analysis, and improvement of social needs/risks to ensure Members receive person-centered care

Employing Data Sources and Methodology to Drive QI

We collect and use many data sources to analyze and evaluate the QM program and planned actions. Staff assess data accuracy and completeness before the release of reports and analysis. The improvement methodology is applied on an ongoing basis and annually as part of the annual quality program evaluation.

These data sources include medical, BH, laboratory, and pharmacy claims and encounters; medical records; Provider and Member feedback; complaints and appeals; statistical, epidemiological, and demographic data; authorizations and denials; enrollment and disenrollment data; HEDIS, State-specific and other performance measure results; access and availability data; geographic, appointment, and after-hours access results; BH Member experience; and SDOH, including social risks and social needs.

QM Strategy

The QM program strategy incorporates key principles: 1) program effectiveness monitoring by comparing performance measures results to benchmarks, goals, and thresholds; 2) activities that reduce healthcare disparities, improve health outcomes, improve Member safety/reduce medical errors, and address SDOH; and 3) management of goals, timeline, barrier identification, and mitigation planning.

Identifying and Establishing Priorities for QI:

Staff, Medical Directors, external Providers, Members, CBOs, and other stakeholders submit priority areas for improvement. Focus areas are prioritized and identified through the QM committee, senior management, and/or

the State. Focus areas are identified based on importance to Members and Providers, social risks/social needs, and/or known or suspected under- or overutilization.

Using an Established Methodology to Implement QM Activities

The QI activity is **planned** by defining the objective, predicting potential outcomes, and developing a project plan. The health plan **does** the intervention, documents findings, and captures data. The health plan then **studies** the data, compares results to the initial objectives, and summarizes findings of the activity. The health plan **acts** to identify changes to the intervention and determines the next time frame or cycle for improvement.

Rapid-cycle process improvements are made based on Member and/or Provider intervention results. The methodology addresses gaps in performance. Changes made to address performance may include policy and procedure updates; staffing or training; network Providers or scope of services; or tools, materials, and systems.

Identification and Investigation of Potential Quality-of-Care Cases and Adverse and Sentinel Events

Potential quality-of-care referrals are evaluated through a documented process. The issue is investigated through outreach to Providers, investigation by clinical staff, case preparation for the dedicated committee and Medical Director, case resolution and completion, and reporting of systematic trends to the QM committee. Potential pharmacy over- and underutilization is also monitored by reviewing Provider prescribing patterns.

Evaluating Timely and Appropriate Continuity and Coordination of Healthcare and Services

Evaluation of continuity and coordination of care comprises:

- Review of transition of care processes and effectiveness for Members with complex needs
- Home-based, community, and social service program review to address Member needs
- Coordination of medical and BH care through information exchange, appropriate diagnosis, treatment and referrals, treatment access, appropriate use of medications, primary/secondary preventive BH programs, and addressing needs of Members with SMI
- Evaluation of processes and outcomes related to management of chronic conditions and comorbidities
- Tracking of quality-of-care issues, including adverse events linked to gaps in continuity and coordination
- Review of Member and Provider satisfaction survey results and grievances and appeals
- Oversight of delegated activities

BH QM Activities

Our health plan ensures that medical and BH activities are integrated within the plan so that:

- An adequate and available BH network addresses medical and social needs for Members
- Access is available so that Members receive timely BH services
- Effective coordination of care is provided between BH Providers and PCP
- High rates of Member satisfaction are in place related to access to and quality of BH services
- Adequate BH care is provided across the continuum of care to Members
- Appropriate linkages are made to ancillary support services (e.g., school systems)
- Service delivery is checked so that care is available in a timely manner and in appropriate settings and levels

Reviewing Data to Identify and Address Potential Over- and Underutilization

Potential over- and underutilization is reviewed using cross-functional teams; Provider collaboration through potential quality-of-care review; Member complaints and appeals analysis; Provider medical, pharmacy, and utilization data review; performance measurement rates; oversight of Member satisfaction; and utilization by delegates.

Evaluating Access and Availability of Care and Services

Access and availability of care and services are monitored through evaluation of geographic access to PCPs, high-volume and high-impact specialists, high-volume BH Providers, and hospitals; assessment of Member

cultural and linguistic needs and preferences; evaluation of telephone access; evaluation of public transportation; evaluation for access and availability; and oversight of delegated activities.

Implementation of the QM Program Through Stakeholder Collaboration

Physical health and BH Providers and CBOs collaborate in QI activities and review of preventive health and clinical practice guidelines. The health plan collaborates with the Division and external quality review organization on projects.

Collecting and Analyzing Member Satisfaction Data Sources for QI

Member satisfaction data collection and analysis entail reviewing sources that impact Member satisfaction, including CAHPS survey results, BH Member experience, disenrollment information, complaints and appeals data, barrier and improvement opportunities, and initiative design and evaluation, and presenting survey results, analysis, and interventions to the QM committee.

Evaluating the Effectiveness of the QM Program

The QM program is evaluated using multifunctional teams that analyze opportunities, actions, and results; clearly stated meeting minutes/action items; work plan review and update; and changes in strategies.

Organizational Structure Supporting QI: Lines of Accountability and Oversight

The Board of Directors has ultimate responsibility for the QM program. The Board delegates authority for the QM committee to the Medical Director and CEO. The QM committee/subcommittees recommend policy decisions, evaluate activity results, and institute needed action and follow-up. Committee participants include key health plan leaders and network Providers. The Member advisory committee also includes participation of Members. Individual Providers attend committee and subcommittees and give input into program planning, design, implementation, and evaluation.

Health Equity and Cultural Competency Plan/Culturally and Linguistically Appropriate Services Program

Our health plan's Health Equity and Cultural Competency Plan ensures that Members receive culturally and competent and linguistically appropriate services that are effective, equitable, understandable, and respectful. Our plan is based on national standards for culturally and linguistically appropriate services in healthcare.

The Health Equity and Cultural Competency Plan goals and objectives are to collect and analyze Member race, ethnicity, language, disability status, geography and SDOH factors; identify specific cultural, linguistic, and SDOH-related disparities; analyze HEDIS measure results for potential disparities; select critical barriers found through analysis; provide staff with information, training, and tools to address identified barriers; implement activities related to the ADA requirements, such as Provider, staff, and Member training; and evaluate program for completion of activities and overall effectiveness.

Areas of training for staff and clinicians include the changing demographics in the US, key components of cultural competency, diversity in different types of medical care, tips on communicating with individuals with different backgrounds, LGBTQ+ community, SDOH, implicit bias, systemic racism, health disparities and equity, geography, language access services, and caring for seniors and persons with disabilities.

A health information system is in place to collect, analyze, and evaluate Membership and Provider network based on race and ethnicity, gender, languages spoken, and geography. Data is also collected about SDOH. Many systems are utilized and analyzed to compare against previous years and thresholds. Data analysis is conducted at least once a year to understand Member demographics.

Data Analysis
Periodic needs or population health assessments are conducted to identify Member needs, care expectations, and key drivers of satisfaction related to access and healthcare. The analysis identifies actionable concepts that could be applied to policy and program development. This analysis also allows for ongoing tracking.

Language Services
Members can access language services, such as interpreting and written translation, and programs and services that are congruent with cultural norms. From the time a Member enrolls, Member services call center employees work with Members to identify key preferences and needs based on language, culture, and issues of personal importance.

Evidence-based Clinical Practice and Preventive Health Guidelines
Clinical practice and preventive health guidelines are adopted and sent to network Providers. Guidelines are based on scientific evidence, review of literature, or appropriate authority. Recommendations are based on guidelines. The recommendations are suggested for making clinical decisions. Clinical practice guidelines focus on medical and BH issues. Preventive health guidelines are based on national consensus that focus on children and adolescents and adults. Guideline effectiveness is measured against clinical practice guidelines for acute or chronic medical conditions, BH clinical practice guidelines that address children and adolescents and adults, and preventive health guidelines through HEDIS measures.

QM Program Evaluation
A formal evaluation of the QM program is conducted annually. Evaluation of QM activities also describe limitations and barriers to improvement. The evaluation includes:

- Activity and PIP implementation, identifying quantifiable improvements
- Trended indicators and analysis of changes in trends and barriers that impact rates and improvement actions
- Identification of opportunities to strengthen Member safety activities
- Evaluation of resources, training, scope, and content of the program and Provider participation
- Identification of limitations and barriers and recommendations for the upcoming year
- Evaluation of indicators for care management, care coordination, satisfaction, and additional programs
- Evaluation of the overall effectiveness of the QM program

Actions by the health plan are based on results of improvement activities. A systematic process is used to begin actions to improve performance. This process supports and improves procedures, systems, quality of service, cost, and healthcare. The process to identify actions includes qualitative barrier analysis to identify the issues and define priority areas; activities that address the issues; standards, performance goals, and benchmarks to assess effectiveness; and analysis to monitor performance levels and sustained improvement.

Table 1. 2023 QM Work Plan (Draft Template)

Objective	Previously Identified & Parties Responsible	Timeline	Action Plan/Benchmark Goal
1. **Program Structure: We maintain a QM program structure that clearly defines processes and individual responsibility.**			
Example: Review and approve QM program description and work plan.	QM	By 03/31/2023	Ensure timely review/approval is completed for QM program description and work plan.
2. Quality and Safety of Clinical Care			
Example: Implement potential quality-of-care process.	QM	By 01/2023	Make sure that potential quality-of-care issues are tracked and investigated.
3. Program Operations: We maintain a fully operational QM program with active committee and Provider participants.			
Example: Maintain meetings/structure.	QM	All year	Ensure that 100% of components of minutes are addressed using checklist.
4. Health Services Contracting: Network Providers cooperate with the QI program.			
Example: Ensure contracts specify cooperation with QM.	Network	By Q1 2023	As contracts are amended, replaced, or issued, the following requirements are maintained, and 100% of PCP and Provider contracts contain required language for quality.
5. Availability of Providers: PCP, BH, and Specialty Care			
Example: Maintain and monitor number of network PCPs.	QM/Network	By end of Q4 2023	Establish measurable standards for the number of PCPs. Maintain and review policy on primary care standards at least annually.
6. Accessibility of Services: Primary Care and Member Services Call Center			
Example: Maintain access to primary and specialty care.	QM	Q4 2023	Evaluate CAHPS results related to primary and specialty care appointment access.
7. Accessibility of Services: BH Care			
Example: Maintain access to BH care.	QM	Q4 2023	Conduct annual evaluation of Provider medical and BH appointment access standards.
8. Member and Provider Experience			
Example: Assess Member satisfaction.	QM	By end of Q4 2023	Analyze CAHPS and BH Member experience results.
9. Continuity and Coordination of Medical Care			
Example: Identify and act on opportunities to improve coordination of medical care.	QM	By end of Q4 2023	Annually collect data to conduct quantitative and causal analysis to identify opportunities for improvement. Determine and implement interventions.
10. Continuity and Coordination Between Physical Health and BH Care			
Example: Improve continuity/coordination.	QM	By end of Q4 2023	Collect data and conduct quantitative and causal analysis to identify collaborative activities at least annually related to medical and BH care.
11. Provider Directory			
Example: Evaluate Provider directory.	QM	By end of Q4 2023	Perform an annual analysis of the Provider directories. Identify and act on opportunities.

Objective	Previously Identified & Parties Responsible	Timeline	Action Plan/Benchmark Goal
12. Standards for Medical Record Documentation			
Example: Write and distribute medical record documentation policies.	QM	By Q4 2023	Maintain policy and procedure that addresses confidentiality, documentation, record keeping and availability.
13. Delegation Oversight of QI, UM, Credentialing, and Claims			
Example: Oversee delegation for key operational areas (as appropriate).	QM	By Q4 2023; quarterly reports completed	Complete annual assessments, including follow-up with corrective action. Monitor receipt and evaluate quarterly reports from delegates and follow-up.
14. Culturally and Linguistically Appropriate Services (CLAS) Program			
Example: Complete CLAS documentation.	QM	Q1 and Q4 2023	Complete CLAS program description and evaluate annual performance. CLAS program description will be completed by Q1 2023. CLAS evaluation will be done by end of Q4 2023.
15. Population Health Management			
Example: Evaluate population health management strategy success.	QM	By end of Q4 2023	Analyze the effectiveness of the population health management strategy and implement interventions.
18. Appeals			
Example: Maintain appeals program.	Grievances and Appeals	By 01/2023	Develop appeals policies and procedures and process for review, and investigate appeals.
19. Appeals			
Example: Maintain PIPs and other State requirements.	QM	Ongoing during 2023	Develop and maintain PIPs during 2023 for key priorities. Ensure all QM requirements are being met for the Division.

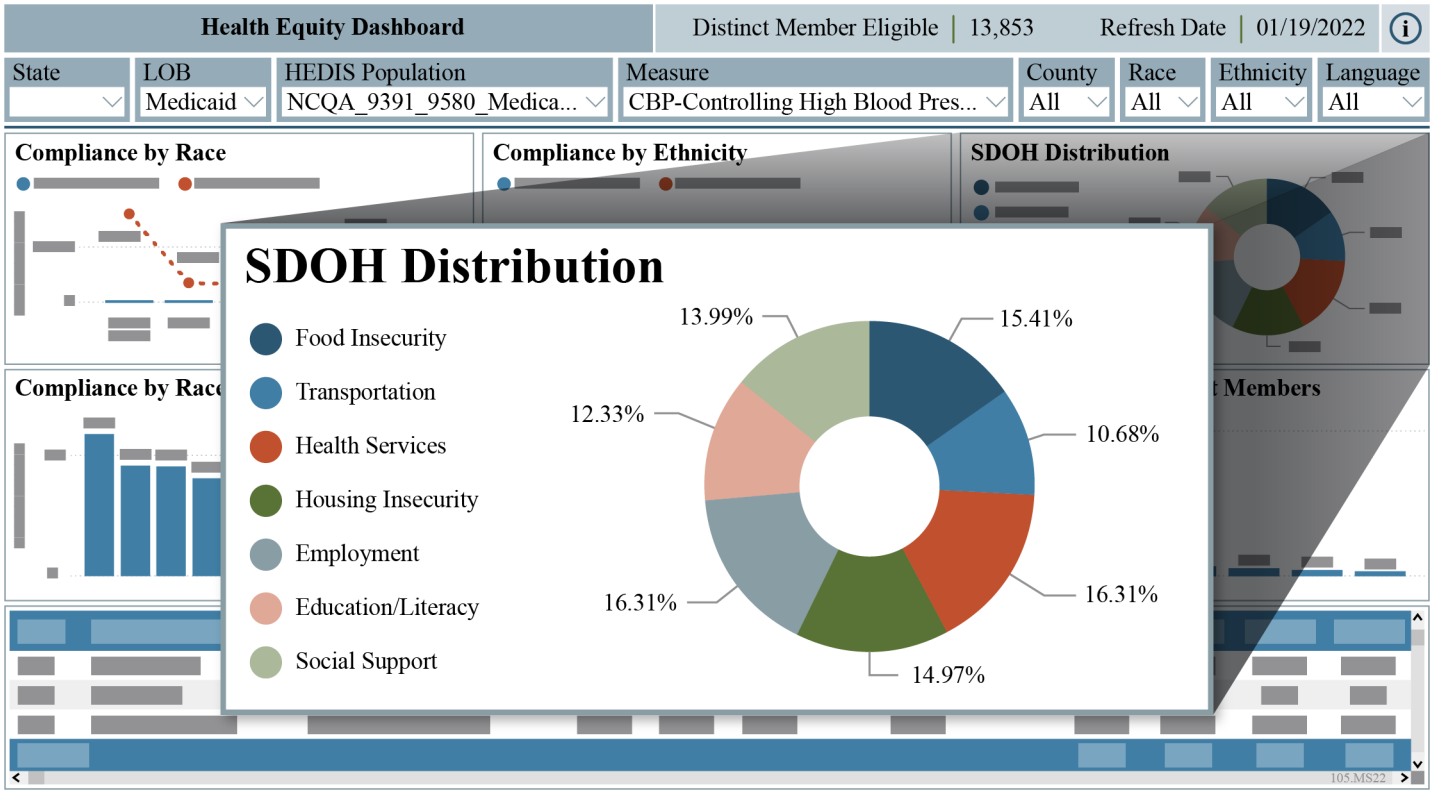
4.2.2.4. APPENDIX 2: QUALITY SAMPLE REPORTS

QM Program: Sample Quality Measurement and Performance Reports

We are highly experienced in generating quality measurement and performance reports from complex data sets to continuously evaluate and inform our programs and initiatives. Our existing technology systems are fully capable of meeting and exceeding all QM program requirements. In support of the CCO Program, we will leverage our advanced business intelligence analytics and data informatics capabilities to drive ongoing performance improvement and quality management activities.

The Exhibits presented in this Appendix provide samples of excerpts from reports that we propose to use for the CCO Program Contract.

Exhibit 1. Sample Health Equity Dashboard. We leverage our health equity dashboard to provide data-driven insight and measure the success of our QM program strategies, including SDOH distribution among populations and cohorts.



Culturally and Linguistically Appropriate Services (CLAS) Reports

We recognize the importance of diversity and will conduct ongoing assessments to determine whether Members' needs are being met. Our health plan will assess the cultural, ethnic, racial and linguistic needs and preferences of its Members on an ongoing basis. Information gathered during regular monitoring and annual network assessment will be used to identify and eliminate cultural and/or linguistic barriers to care through the implementation of programs and interventions. Race/ethnicity and language data will be used to assess the existence of disparities and to focus quality improvement efforts towards improving the provision of culturally and linguistically appropriate services (CLAS) and decreasing health care disparities. The plan works to ensure that limited-English-proficient Members have equal access to quality health care through culturally and linguistically appropriate Providers, staff and written materials.

Our evaluation will provide an overview of completed and ongoing activities for CLAS, assess the plan's performance on trending of measures, analyze efforts to reduce disparities and improve the provision of CLAS, including barriers, and evaluates the overall effectiveness of the CLAS program. We will annually evaluate our performance on CLAS activities, including all delegated functions. This evaluation includes a description of completed and ongoing CLAS activities for the previous year

Exhibits 2 through **5** provide samples of excerpts from reports.

Exhibit 2. Sample Linguistic Preference Assessment – Medicaid. We conduct in-depth analysis of Member linguistic preference to evaluate Provider network capabilities of meeting the needs of Members.

CLAS Analysis – Linguistic Preference Assessment – Medicaid

Mississippi

In-depth analysis was conducted on Spanish speaking physicians by county to assess the areas to concentrate to develop network

Goal: <1:2,500 Provider to Member Ratio.

County	Members who speak Spanish	Members who speak Spanish (0-19)	Number of Spanish speaking Family/General practice	Ratio of Spanish speaking Family/General practice Providers* to Spanish speaking Members	Number of Spanish speaking Internal Medicine Providers	Ratio of Spanish speaking Internal Medicine Providers* to Spanish speaking Members	Number of Spanish speaking Pediatric Providers	Ratio of Spanish speaking Pediatric Providers* to Spanish speaking Members (0-19)
Hinds	0	0	0	NA	3	NA	0	NA
Harrison	0	0	2	NA	1	NA	2	NA
DeSoto	0	0	4	NA	7	NA	8	NA
Jackson	8	5	2	1:4	1	1:8	2	1:3
Rankin	0	0	0	NA	1	NA	0	NA

* Ratios are rounded to nearest whole number

99% of Medicaid Members identify English as a preferred language and 1% of Medicaid Members preferred language is unknown. There are zero Medicaid Members with Spanish as a preferred language in Hinds, Harrison, DeSoto and Rankin counties. Additionally, about 2% of Medicaid Providers report speaking Spanish. Provider Contracting will continue to evaluate these counties to determine the availability of Spanish speaking Providers and will target any identified Providers for contracting outreach.

Exhibit 3. Health Care Disparities Assessment – Medicaid. We analyze and evaluate HEDIS® results for potential cultural and linguistic disparities that may prevent Members from obtaining the recommended key services.

CLAS Analysis – Health Care Disparities Assessment – Medicaid

Mississippi

Clinical Performance – Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care by Race/Ethnicity

Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	HEDIS® 2021			HEDIS® 2020	HEDIS® 2019	HEDIS® 2021	Goal
Race	***Num***	***Denom***	***HEDIS® Rate***	**Reported Rate**	**Reported Rate**	**Reported Rate**	***67th Percentile***
American Indian or Alaskan Native	NA	NA	NA	99.03%	NA	95.38%	88.30%
Asian	NA	NA	NA	99.03%	NA	95.38%	88.30%
Black or African American	227	238	95.38%	99.03%	NA	95.38%	88.30%
Native Hawaiian or Other Pacific Islander	NA	NA	NA	99.03%	NA	95.38%	88.30%
White	163	170	95.88%	99.03%	NA	95.38%	88.30%
Other	NA	NA	NA	99.03%	NA	95.38%	88.30%
Declined/Unknown	2	3	66.67%	99.03%	NA	95.38%	88.30%
Ethnicity							
Hispanic or Latino	NA	NA	NA	99.03%	NA	95.38%	88.30%
Not Hispanic or Latino	390	408	95.59%	99.03%	NA	95.38%	88.30%
Declined/Unknown	2	3	66.67%	99.03%	NA	95.38%	88.30%
Total	**392**	**411**	**95.38%**	**99.03%**	**NA**	**95.38%**	**88.30%**

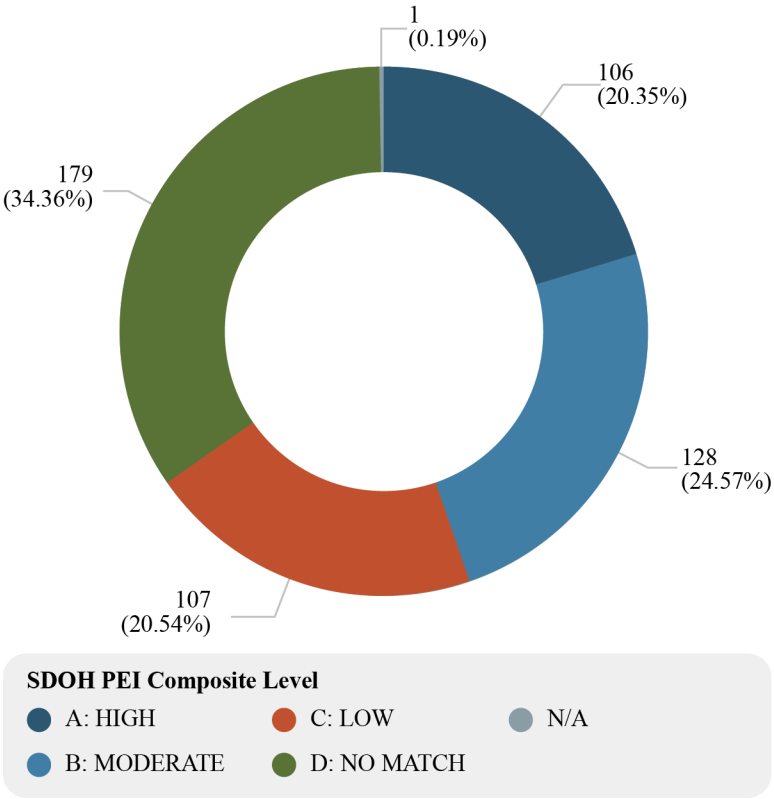
- **Overall Analysis:** The HEDIS® 2021 reported rate was above the 67th percentile goal by 7.08 percentage points. The goal was met by the Black or African American and White race groups and the Not Hispanic or Latino ethnicity group.
- **Race Groups:** The White race group had the highest HEDIS® 2021 rate and the Declined/Unknown group had the lowest.
- **Ethnicity Groups:** The Not Hispanic or Latino ethnicity group had the highest HEDIS® 2021 rate and the Declined/Unknown group had the lowest.

Exhibit 4: Sample Health Care Disparities Assessment – Medicaid. We analyze the impact of health disparities on populations by measuring and evaluating Member compliance with recommended course of clinical care by identified SDOH Level.

CLAS Analysis – Health Care Disparities Assessment – Medicaid

Mississippi

Clinical Performance – Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care: Non-Compliant Medicaid Members by Social Determinants of Health Level



The Healthcare Quality Performance Tool defines social determinants of health as "the economic and social conditions that influence individual and group differences in health status."

Among Medicaid Members non-compliant for Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care, a large proportion (24.57%) are considered to be at the moderate social determinants of health (SDOH) level, followed by low SDOH level (20.54%) and high SDOH level (20.35%). The compliance rate is highest among Medicaid Members with a moderate SDOH level (83.88%), followed by low SDOH level (83.81%) and high SDOH level (88.31%).

Exhibit 5. Sample Health Care Disparities Assessment – Medicaid. To analyze the Member experience, we evaluate CAHPS® rates by race/ethnicity and gender to help identify and eliminate barriers to care through the development of targeted data-driven, programs and interventions.

CLAS Analysis – Health Care Disparities Assessment – Medicaid

Mississippi

Member Experience – Rating of Health Plan by Race/Ethnicity and Gender

Rating of Health Plan	CAHPS® 2021 – Child Survey			CAHPS® 2020 Rate	CAHPS® 2019 Rate	CAHPS® 2021 Reported Rate	Goal
Race	Num	Denom	CAHPS® Rate				67th Percentile
American Indian or Alaskan Native	8	11	75.0%	NA	NA	70.0%	75.3%
Asian	13	13	100.0%	NA	NA	70.0%	75.3%
Black or African American	151	177	85.3%	74.5%	NA	70.0%	75.3%
Native Hawaiian or Other Pacific Islander	4	4	100.0%	NA	NA	70.0%	75.3%
White	129	166	77.8%	70.1%	NA	70.0%	75.3%
Other	18	22	83.3%	33.3%	NA	70.0%	75.3%
Declined/Unknown	NA	NA	NA	NA	NA	70.0%	75.3%
Ethnicity							
Hispanic or Latino	12	20	60.0%	77.8%	NA	70.0%	75.3%
Not Hispanic or Latino	275	329	83.6%	74.2%	NA	70.0%	75.3%
Declined/Unknown	NA	NA	NA	NA	NA	70.0%	75.3%
Gender							
Female	140	174	80.6%	NA	NA	70.0%	75.3%
Male	157	189	83.3%	NA	NA	70.0%	75.3%

- **Overall Analysis:** The CAHPS® 2021 reported rate was below the 67th percentile goal by 5.3 percentage points. The goal was met by the Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White and Other race groups, the Not Hispanic or Latino ethnicity group, and the Female and Male gender groups.
- **Race Groups:** The Asian and Native Hawaiian or Other Pacific Islander race group had the highest CAHPS® 2021 rate and the American Indian or Alaskan Native group had the lowest. The Black or African American, White and Other groups increased in rate for CAHPS® 2021.
- **Ethnicity Groups:** The Not Hispanic or Latino ethnicity group had the highest CAHPS® 2021 rate and the Hispanic or Latino group had the lowest. The Not Hispanic or Latino group increased in rate for CAHPS® 2021, whereas the Hispanic or Latino group decreased.
- **Gender Groups:** The Male group had a higher rate of satisfaction with the health plan compared to the Female group.

Population Health Assessment Reports

We strive for full integration of physical health, BH, and social support services to eliminate fragmentation of care and provide a single effective plan of care for Members. To determine the necessary structure and resources for our programs, we will perform a population assessment to determine the appropriateness of resources and processes used to address Member needs. The population assessment is completed using data that is integrated from multiple systems. The review of this data assists us in identifying Members for various population health management programs and initiatives. The assessment includes an evaluation of population mix, Member service and community needs, as well as demographic factors such as race, ethnicity, and preferred language. The assessment o includes an evaluation of the prevalence of conditions specific to the populations served.

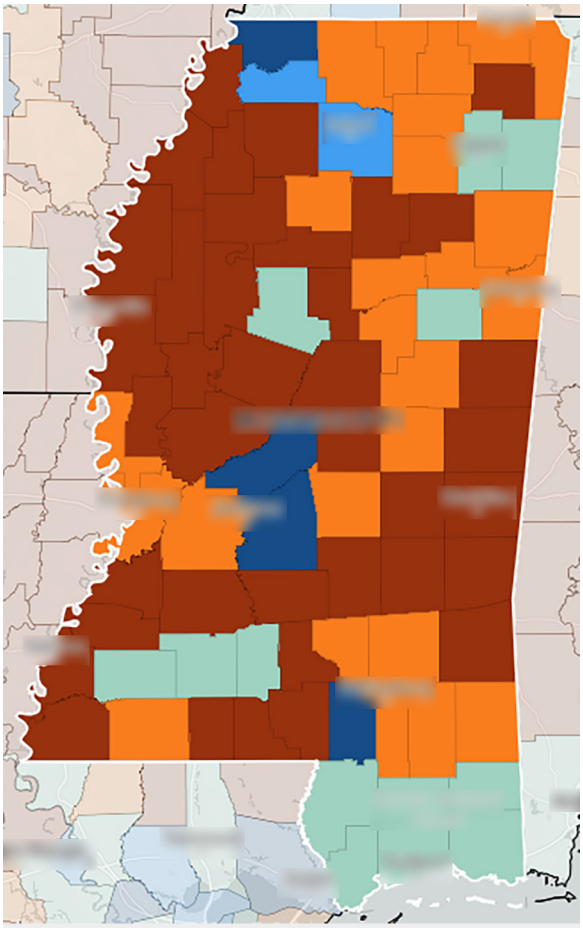
We identify at-risk Members who may benefit from care management through an analysis of integrated data. The population assessment informs updates to our population health management activities and resources (including community-based resources) to address Member needs. We conduct this analysis on an ongoing basis to determine the appropriateness of our programs.

Exhibits 6 through 9 provide samples of excerpts from our assessment reports.

Exhibit 6. Social Determinants of Health: Distressed Communities Index. By leveraging our advanced reporting capabilities, we can generate population assessment reports from data aggregated from a variety of sources to continuously inform our population health program and strategy.

Mississippi

Social Determinants of Health: Distressed Communities Index



Distress scores are calculated based on seven well-being variables:

1. No high school diploma
2. Housing vacancy rate
3. Adults not working
4. Poverty rate
5. Median income ratio
6. Change in employment
7. Change in business establishment

A community with a score of 80 or higher is considered to be in distress, indicated by shades of deep orange. Communities with a score of 20 or lower are considered to be prosperous and are shown in shades of dark blue.

Economic Indicators for Mississippi

% of Population Living in Distressed Communities	45.4%
% of Population Living in Prosperous Communities	5.9%

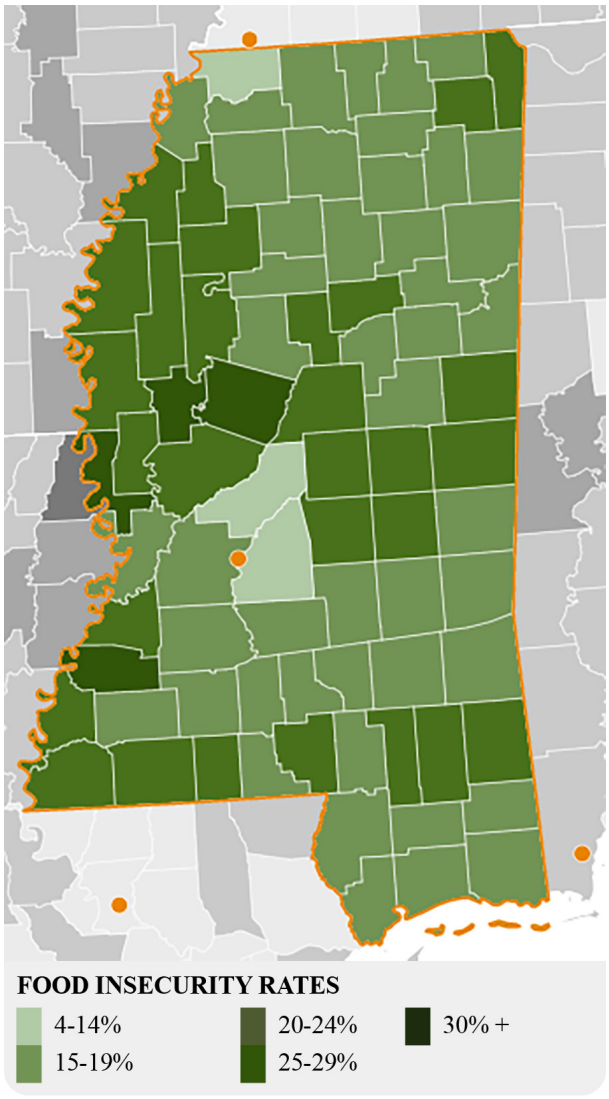
Source(s): Economic Innovation Group (2020)

Exhibit 7. Social Determinants of Health: Food Insecurity. We use our population health assessment reports to analyze SDOH data to inform, measure, and evaluate our population health strategy with the goal of removing barriers and improving the quality of life for Members.

Mississippi

Social Determinants of Health: Food Insecurity

According to the United States Department of Agriculture (USDA), food insecurity is a "household-level economic and social condition of limited or uncertain access to adequate food for a healthy diet."



Number of Food Insecure People	550,370
Rate of Food Insecurity	18.5%
Number of Feeding America Foodbanks	1

Top 5 Most Food Insecure Counties		
County	**Rate**	**Number of People**
Issaquena	29%	400
Holmes	26%	4,640
Humphreys	25%	2,070
Jefferson	25%	1,790
Wilkinson	24%	2,130

Source(s): Feeding America (2018)

Exhibit 8. Social Determinants of Health: Educational Attainment. Our health assessment reports consistently demonstrate that educational attainment is one of many critical SDOH factors that have significant correlation to an individual's health and wellbeing.

Mississippi

Social Determinants of Health: Educational Attainment

Graduation Rates in the Most Populated Counties		
County	**H.S. Graduation Rate**	**% Health Plan Membership in Co. (All LOBs)**
Hinds	88%	9%
Harrison	89%	9%
DeSoto	90%	4%
Rankin	89%	3%
Jackson	90%	7%
Mississippi	85%	
U.S.	88%	

Source(s): U.S. Census Bureau (2019); CDC BRFSS (2021)

Populations without completion rates indicate the sample size was too small to calculate a reliable percentage.

Exhibit 9. Social Determinants of Health: Severe Housing Problems. Aggregate data from our health assessment reports demonstrates a strong correlation between individuals with housing insecurity and enrollment in government-sponsored healthcare programs, indicating housing will be a significant SDOH among our likely membership.

Mississippi

Social Determinants of Health: Severe Housing Problems

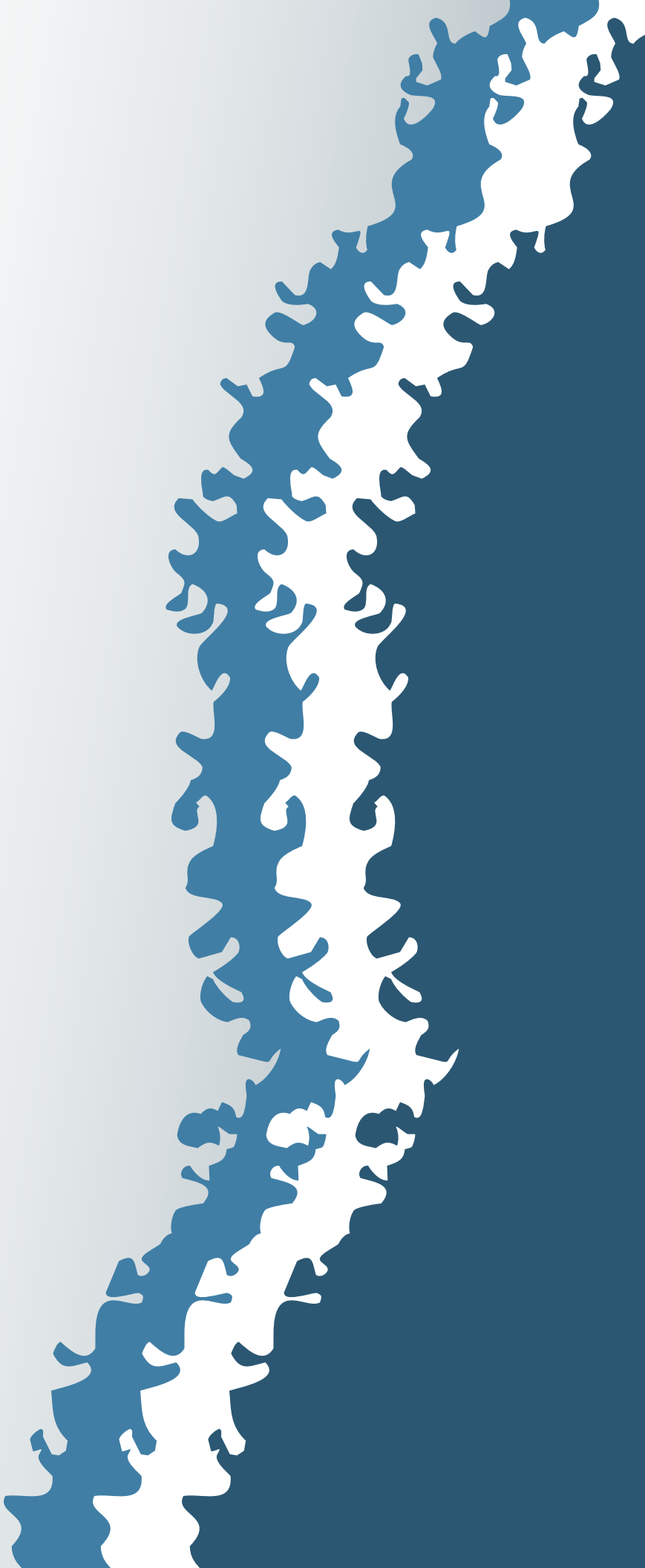
Rates in the Most Populated Counties			
County	**Prevalence of Severe Housing Problems**	**Number of Households with Severe Problems**	**% Health Plan Membership in County (All LOBs)**
Hinds	20%	17,694	9%
Harrison	19%	14,179	9%
DeSoto	13%	8,479	4%
Rankin	9%	5,131	3%
Jackson	13%	7,322	7%
Mississippi	15%	165,034	
U.S.	16%	20,572,800	

Source(s): Robert Wood Johnson Foundation

(Note: The 2021 County Health Rankings used data from 2013-2017 for this measure)

4.2.2.5

Utilization Management



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4.2.2.5: UTILIZATION MANAGEMENT

A. UTILIZATION MANAGEMENT APPROACH

Our approach to UM ensures each Member receives medically necessary and appropriate care at the right place and the right time. Using evidence-based practices and clinical decision support tools, our UM approach aligns with and supports key Division goals for the CCO Program, including easing Provider and Member administrative burdens while promoting timely access to services. We will accomplish this through:

Our UM approach ensures clinically appropriate care that is accessible, timely, well-coordinated, and equitable, which improves outcomes and reduces costs over time.

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- **Consistency of UM performance**. We will provide a system of utilization review consistent with the requirements of 42 CFR Part 456, 42 CFR 438.210, and in accordance with Mississippi Code Ann. § 41-83-1 et seq. and other applicable sections (1972, as amended). As described within our response to Question J below, our staff training, support, and monitoring processes result in high levels of consistency with selection and application of nationally recognized clinical criteria.
- **Compliance with all applicable Federal, State, accreditation, and contractual requirements**. Our UM program will meet all Draft Contract § 8.16 requirements. We will submit our written UM program descriptions for each line of business covered by this Contract for annual review and approval by the Division by January 1 of each calendar year. Our UM program description will outline program structure and accountability for all requirements. We will use our annual UM work plan to monitor and continuously improve the compliance, quality, and effectiveness of our UM program. Our enhanced workflow management system will support timely reviews, ensuring compliance with standards and processes and the overall quality of our UM program through an integrated 360-degree Member/patient view, UM and correspondence management, automatic turnaround time management and notifications, and analytics and reports.
- **Streamlining UM processes to ensure Provider satisfaction and timely response.** We will support, listen, and work hard to resolve service request concerns from all Providers (in network, out of network, and even out of State) because our shared mission is to serve CCO Members. Our proactive approach to UM is designed to eliminate confusion and create transparencies, delivering on-demand support tools to ensure Provider satisfaction and timely Member access to needed care. ***We only require PA for those services for which review is necessary to ensure quality of care, prevent FWA, and identify and support Members with a high-risk/high-cost course of treatment.*** We continuously review our PA list to identify routinely authorized services that we can remove from the list without impacting quality. For those services that require PA, we make the process easy through simple self-service tools on our Provider portal, including near real-time authorization status. We look forward to collaborating with the Division, PBA, and other Mississippi CCOs in developing uniform medical, BH, and pharmacy PA forms, including "smart" electronic authorization forms to reduce technical denials due to incorrect or missing information.

Our Holistic, Collaborative Approach to UM

We are committed to improving health and lives in Mississippi, supporting Member access to timely care, removing barriers, and reducing administrative burden. Our **holistic, collaborative** approach to UM, addressing physical health and BH as well as SDOH, ensures Members receive the most appropriate and highest quality of care. Through integrated care rounds, our physician leadership coordinates Member care with UM care management staff, reviewing Member care issues; facilitating peer discussion regarding application of evidence-based criteria and care management interventions; identifying characteristics of the local delivery system that may impact clinical decision-making; and evaluating the consistent application of criteria and policies and procedures. Our fully integrated UM team is trained to interpret and apply medical necessity criteria and clinical and evidence-based guidelines to determine medical necessity, conduct denial and appeal reviews, and provide navigation assistance in support of Providers.

Our approach will be **collaborative,** working with Providers, our managed care partners, and State agencies to support transparency and reduce abrasion. For example, we have collaborated with Providers in a successful EHR initiative to increase interoperability of our care management system with Provider EHRs. This interoperability will provide our UM staff direct access to information to proactively respond to medical necessity authorization requests and to facilitate the concurrent review process. Throughout

all UM processes, Providers will have access to our Medical Directors for peer-to-peer consults and service request reviews. We will also proactively convene joint operating committees with key Providers, vendors, and stakeholders, and will meet frequently to discuss effective communication and opportunities for transparency and improvements in administrative processes.

UM and quality staff will collaborate with communities across the State and use data analysis to understand and incorporate into our approach the local health and social factors that impact utilization and outcomes. Our UM staff will also collaborate with our Care Managers, Medical Directors, and State agencies to identify opportunities to improve the lives of the Members they serve. For example, for a hospitalized foster care Member who no longer meets inpatient criteria but has no appropriate post-discharge placement, our UM staff will work with our Care Managers and Medical Directors to coordinate with MDCPS to authorize a continued stay while the agency secures an appropriate placement.

A.1.a. A Description of the UM Program

Our UM program will deliver timely, high-quality, evidence-based, and cost-effective services across the continuum of care in compliance with all Contract requirements. Our Medical Director is responsible for oversight of the UM program with support from the CEO, clinical leadership, and healthcare services committee, a subcommittee of our QM committee.

Structure. Our UM program provides a structure to monitor the efficiency and quality of UM services and is designed to ensure the delivery of services is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. It promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care while integrating a range of services appropriate to meet individual Member needs.

Member Care. It is also designed to maintain flexibility, adapting to changes in a Member's condition, and will influence Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care is provided
- Evaluating the medical necessity and efficiency of healthcare services across the continuum of care
- Defining the review criteria, information sources, and processes used to review and approve the provision of items and services, including prescription drugs
- Coordinating, directing, and monitoring the quality and cost effectiveness of healthcare resource utilization
- Implementing comprehensive processes to monitor and control the utilization of healthcare resources
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness
- Reviewing processes to ensure care is safe and accessible
- Ensuring that qualified healthcare professionals perform all components of the UM and care management processes
- Ensuring that UM decision-making tools are appropriately applied in making medical necessity decisions

Processes. The UM Program includes end-to-end processes, including:

- Preservice and admission review
- Concurrent review
- Transitional care
- Discharge planning
- Continuity and coordination of Member care post hospital discharge
- After hours availability (on-call program)
- Retrospective review
- Medical case management for specific conditions and specialized clinical programs
- Clinical policy and criteria development
- Provider appeal processing
- Utilization data analysis, including monitoring for over- and underutilization
- Evaluating Member and Provider satisfaction
- Staff education and quality oversight

Evaluation. To keep the UM program current and appropriate, we will annually evaluate the program's structure, scope, criteria, policies and procedures, and the annual work plan to determine effectiveness and need for change. We will submit a copy of our evaluation to the Division annually. Our Medical Director provides oversight for the UM program and processes as well as the annual evaluation.

A.1.b. Accountability for Developing, Implementing, and Monitoring Compliance with Utilization Policies and Procedures

Our Mississippi-based Medical Director will be responsible for the UM program and will assist the UM Coordinator in the development, implementation, and compliance of UM policies and procedures. Our CCO clinical leadership plays a vital role in this process, ensuring compliance with State, Federal, and NCQA requirements. Our process for ensuring accountability for developing, implementing, and monitoring compliance with contractually required UM policies and procedures is summarized in **Table 1**. Following the table, we summarize the processes these accountable parties follow to develop, implement, and monitor policies and procedures.

Table 1. Accountability for Developing, Implementing, and Monitoring Required UM Policies and Procedures

Required Policy/Procedure	Accountability		
	Developing	Implementing	Monitoring
Criteria and procedures for the evaluation of medical necessity of medical services	Medical Director, healthcare services committee	UM Coordinator	UM Coordinator, Medical Director, healthcare services committee, CEO
Criteria and procedures for preauthorization and referral	Medical Director, healthcare services committee	UM Coordinator	UM Coordinator, Medical Director, healthcare services committee, QM committee, CEO
Criteria and procedures for review, reconsideration, appeal, and grievance mechanisms for Providers	Grievance and Appeals Coordinator, grievance and appeals committee	Grievance and Appeals Coordinator, Chief Operating Officer (COO), Operations	Grievance and appeals committee, COO, healthcare services committee, QM committee, Medical Director, CEO
Mechanisms to detect and document underutilization as well as overutilization of medical and BH services	QM committee, QM Director, UM Coordinator, healthcare services committee, Medical Director	QM Director, UM Coordinator	QM committee, QM Director, UM Coordinator, healthcare services committee, Medical Director, CEO
Mechanisms to assess the quality and appropriateness of care, treatment, and/or any service plan furnished to a Member with special healthcare needs at least every 12 months, or more often when the Member's circumstances or needs change significantly, or at the request of the Member	QM committee, QM Director, UM Coordinator, healthcare services committee, Medical Director	QM Director, UM Coordinator, Network/Contracting Manager	QM committee, QM Director, UM Coordinator, healthcare services committee, Medical Director, Network/Contracting Manager, CEO
Availability of utilization review criteria to Providers	Medical Director, healthcare services committee, Network/Contracting Manager	UM Coordinator, Network/Contracting Manager, Director Web Services, Medical Director	UM Coordinator; Network/Contracting Manager; Director, Web Services; Medical Director; CEO
Involvement of actively practicing board-certified physicians who are licensed in Mississippi in the program to supervise all review decisions and to review denials for medical appropriateness	Peer Review Committee, Medical Director, healthcare services committee (includes BH and Perinatal Medical Directors)	Medical Director, COO, Human Resources, CEO	Medical Directors, peer review committee, healthcare services committee, CEO
Availability of physician reviewer to discuss determinations by telephone with physicians who request such	Medical Directors, UM Coordinator	Medical Directors, UM Coordinator	Medical Director, UM Coordinator, CEO
Evaluation of new medical technologies and new application of existing technologies and criteria for use by network Providers	Medical Directors, healthcare services committee, QM committee	UM Coordinator, Medical Directors	Medical Directors, healthcare services committee, UM Coordinator, QM Director, CEO

Required Policy/Procedure	Accountability		
	Developing	Implementing	Monitoring
Annual evaluation of the UM program to determine effectiveness and need for change	QM Director, healthcare services committee, Medical Director	QM Director, UM Coordinator, Medical Director	QM Director, UM Coordinator, healthcare services committee, Medical Director, CEO

Accountability for Developing UM Policies and Procedures

Our healthcare services committee will be responsible for the overall development, approval, and oversight of UM policies and procedures. Our Medical Director will chair the healthcare services committee, whose membership will include the Mississippi-based clinical leadership and physicians from our local Provider network representing a range of specialties. The healthcare services committee will be responsible for review and approval of the UM program description and annual work plan, and for evaluating and making recommendations to the QM committee based on the annual UM program evaluation for the CCO Program. The healthcare services committee will also be responsible for reviewing and approving all clinical criteria and policies, including preauthorization and referral policies related to review, reconsideration, and grievance and appeal mechanisms for Providers. The healthcare services committee will assess effectiveness of UM interventions by reviewing data, trends, and outcomes and monitoring consistency of medical necessity decision-making. We will communicate UM policies and procedures to our Providers via the Provider manual, the Provider portal on our website, and during direct contact with our Provider services staff.

Accountability for Implementing UM Policies and Procedures

Under the direction of our Medical Director and UM Coordinator, our clinical team of RNs, licensed BH professionals, physician reviewers, and pharmacists will be accountable for implementing our UM policies and procedures. Working as an integrated team, our staff will use evidence-based clinical guidelines, their knowledge and understanding of the Mississippi healthcare delivery system, and their years of professional experience in conducting medical necessity determinations to improve the life and ongoing health of CCO Program Members. These clinicians will work as an ***integrated team, using a single clinical platform*** to provide a seamless experience and comprehensive support for Members and Providers in delivering timely, high-quality care.

Our in-depth **training program** for our UM staff will include modules on how to effectively apply clinical criteria consistently, UM policies and procedures to ensure their understanding and ability to implement the UM program, and key topics, such as health disparities and the impact of SDOH on quality of life and health outcomes. We will structure our training program to deliver ad hoc trainings, such as whenever there is a change in clinical review criteria or UM policy and procedure. Our trainers will be responsible for developing and implementing initial and ongoing curriculum for UM and care management staff as well as providing a standardized training program for all healthcare services staff.

Accountability for Monitoring Compliance with UM Policies and Procedures

Monitoring Authorization Timeliness

Our reporting and tracking mechanisms ensure authorization completion within required time frames to ensure timely access. Our UM dashboard includes all metrics related to authorizations, including real-time monitoring of each request with at-a-glance color-coded information about time frame to expiration.

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Each year, our healthcare services committee will select the compliance and performance metrics to include in the annual UM work plan, which then drives the focus areas for monthly monitoring and oversight activities. Our Medical Director, Behavioral Health Director, Perinatal Health Director, Medical Directors, UM Coordinator, and QM Director will share responsibility for monitoring compliance with UM policies and procedures monthly, annually, and as needed. In conjunction with the healthcare services committee, they will monitor clinical and service indicators to evaluate compliance with Contract requirements as well as performance against work plan goals and national and regional data and thresholds, such as region-specific inpatient and outpatient utilization, pharmaceutical utilization, Member and Provider satisfaction survey responses, grievance and appeal data, access standards, and surgical procedure utilization statistics.

Suite of Monitoring and Audit Tools to Support Compliance

Our Medical Director and UM Coordinator will use standard and ad hoc monitoring and auditing processes to evaluate compliance for each level of UM staff, Medical Directors, and BH reviewers. For example, our daily UM reporting dashboard will identify PAs that may contain errors or potential delays, along with our current turnaround time for PAs, allowing the UM Coordinator to reach out to staff to correct or educate in near to real time. **Table 2** describes some of the methods we use to monitor compliance with UM policies and procedures. Our UM Coordinator will oversee our integrated UM team responsible for PAs, inpatient and outpatient medical necessity/utilization review, reconsiderations, medical necessity decision-based grievances and appeals, and other UM activities aimed at ensuring Members receive timely, clinically appropriate, and cost-effective care. Our UM Coordinator will continuously monitor and evaluate the performance of the UM staff and promote interdepartmental integration and collaboration in support of our whole-person approach to care management and UM. Our Medical Directors will hold weekly meetings with the UM staff to review current Member care issues, providing an opportunity for real-time assessment of consistency of application of benefits and review criteria.

Our healthcare services committee will monitor aggregated results by area (UM staff, Medical Directors, BH reviewers, pharmacy), identify trends, and seek external physician input as needed to identify opportunities for improvement and corrective actions, such as additional training, more frequent monitoring, or editing a policy or procedure to improve clarity and consistency of application. For example, in 2021, our inter-rater reliability audits identified two areas for improvement, and we conducted MCG refresher training to help reviewers consistently identify and select the correct criterial points based on available clinical information.

Examples of Monitoring Methods. **Table 2** highlights examples of methods we use to monitor compliance with UM policies and procedures.

Table 2. Sample Methods for Monitoring Compliance with UM Policies and Procedures

Method	Identified Performance Measure	Frequency
Inter-rater Reliability Audits	Consistency of medical necessity decision-making	Quarterly and as needed
Internal Quality Audits	Compliance with UM policies and procedures	Monthly and as needed
Analysis of Clinical and Nonclinical Performance	UM key performance indicators	Monthly
Adherence to UM Time Frames	CCO Program contractual requirements	Hourly (real-time), daily, monthly, quarterly, and annually
Survey and Analysis of Member and Provider Satisfaction	• Member satisfaction survey • Provider satisfaction survey • Complaints, grievances, and appeals • Disenrollment trends	• Annually • Annually • Monthly • Annually
Analysis of Provider Performance Against Clinical Guidelines	Evaluate network Providers against at least four of the clinical guidelines using HEDIS measures	Annually

A.1.c. Data Sources and Processes to Determine Which Services Require PA and How Often These Requirements Will Be Reevaluated

Data Sources to Determine PA Requirements

Data sources we will use to determine which procedure codes should require PA will include:

- The Mississippi Medicaid Technical Amendment Bill and the State's standardized list of PA requirements
- The national procedure code set and modifications
- Procedure code volume, cost, approval rate
- Procedure codes with changes in number of requests
- Grievances and appeals, including overturn rates
- Quality-of-care concerns
- FWA monitoring
- Utilization trends that present opportunities for improvement, such as health disparities, specific diagnostic clusters driving utilization, and high utilization of high-cost/high-risk services

- Member and Provider complaints and satisfaction
- Local under- and overutilization trends that differ from norms established by CMS, evidence-based clinical guidelines, information from peer-reviewed professional journals, and State utilization reports and provide insight into characteristics of the local delivery system and local standards of care
- Patterns of pharmacy utilization that do not conform to known safety standards
- Provider satisfaction with PA requirements

Processes to Determine Which Services Require PA and Frequency of Reevaluation

Our healthcare services committee will meet formally once a quarter or as needed. We might convene an ad hoc meeting of the healthcare services committee to evaluate a new code, procedure, or guideline and recommend a change to our clinical policies when time is of the essence. For example, when a State required us to have a PA process for DME codes with CMS-determined quantity limits, we convened an ad hoc meeting of our healthcare services committee to review the new State guidelines and developed specific PA policies and procedures.

The committee will begin by reviewing the State's Medicaid PA requirements to ***ensure we do not develop any policies or PA requirements that are more restrictive*** than those established for the FFS program. They will then conduct a formal review of national procedure code set modifications from the prior year. They will review procedures that have been eliminated from the national code set and removed from the PA list, and evaluate new codes for effectiveness, potential for abuse, and expected utilization.

The committee will also examine ***aggregate paid and unpaid claims at the procedure code level and conduct longitudinal review to compare and select procedures for PA*** based on our goal of ensuring timely, high-quality, equitable, and cost-effective care while striving to reduce Provider burden. The committee will analyze utilization, along with overall number of PA requests and the rates of approval and denial based on medical necessity criteria, to identify services, procedures, surgeries, devices, supplies, or drugs that have the potential for overutilization or are high-cost/high-risk treatments. ***They will look for trends indicating an opportunity for improvement, such as a PA requirement that may be creating an unnecessary barrier to patient care or is not effective or valuable in managing utilization***. We will also monitor and evaluate PA requirements to ensure compliance with 42 CFR Part 438, Subpart K, Mental Health Parity.

The committee's review will be informed by their understanding of health disparities and local characteristics and patterns of care, and we will gather feedback from Mississippi regulators, Providers, and Members to further inform this review. We will do this through Member and Provider satisfaction surveys and regular Provider Representative contacts with network Providers, by soliciting feedback from network Providers participating in our QM committee, and during PA clinical discussions with requesting Providers. We will also participate in any Division-required meetings and work groups related to quality, utilization, and care management and incorporate recommendations and best practices into our review. The committee will make recommendations for PA requirements to the QM committee for approval.

Time Frames for Reevaluation

The annual PA and coding review process begins in the first quarter of each year. Quarterly, the healthcare services committee will monitor the ongoing effectiveness of our PA requirements. For example, when we remove a PA requirement, the committee will monitor utilization to determine if there is an increase in the service that is outside of expected rates.

Examples of How We Have Used Data to Inform PA Requirements

In late 2019 we identified more than 400 services that we regularly authorized with few denials based on medical necessity. We developed an internal process to allow for administrative approval of these services to reduce Provider burden and improve turnaround time for decision-making, and we used retrospective monitoring to identify any emerging trends in overutilization.

A.1.d. Process and Resources Used to Develop Utilization Review Criteria

We will use nationally recognized and standardized utilization review criteria for medical necessity determinations. Our clinical leadership, supported by the healthcare services committee and the QM committee,

will be responsible for developing, approving, and monitoring effectiveness of utilization review criteria. Utilization review criteria as well as clinical practice guidelines undergo an annual review by clinical editors after a review of published evidence in the most widely read and referenced journals and various databases. Our healthcare services committee will evaluate benchmarking data annually and update as needed, based on a thorough review of all available data, including claims data from other sources, such as the PBA. Our healthcare services committee will review all utilization review criteria, clinical practice guidelines, and medical policies at least annually, but as often as necessary based on evolving evidence and whenever necessary for evaluation of new medical technologies or new application of existing technology and criteria. As needed, the committee will make recommendations for changes to the QM committee for approval.

Clinical Practice Guidelines

We will adopt and disseminate clinical practice guidelines to reduce inter-Provider variation in diagnosis and treatment, and we will measure clinical practice guidelines adherence annually. All guidelines will be based on scientific evidence, review of medical literature, or appropriate clinical authority, such the American College of Obstetrics and Gynecology, the CDC, National Institutes of Health, ASAM, or SAMHSA. Our preventive health guidelines rely upon sources such as Healthy People 2030, HEDIS, the AAP, and the US Preventive Services Task Force. We will include the AAP's Fostering Health: Standards of Care for Children in Foster Care guidelines for foster care Members. The healthcare services committee will review clinical practice guidelines annually and recommend updates to the QM committee as new recommendations are published. Our current clinical practice guidelines align with health disparity priority areas in Mississippi:

- Asthma
- COPD
- Coronary artery and other vascular disease
- Diabetes
- Gestational diabetes
- Heart failure
- Hypertension
- Obesity
- Opioid management
- Substance abuse treatment
- Depression
- ADHD

Medical Policies

When a nationally recognized, evidence-based guideline is not available, the available guideline is not consistent with the local standards of care, or there is a new or emerging treatment/technology or use of an existing treatment/technology, we will conduct a comprehensive review of existing algorithms and guidelines from recognized professional societies, articles, and textbooks. We will engage our network Providers in developing medical policies specific to their area of clinical expertise and experience in the local delivery system. We will present the results of our review, along with recommendations from our network Providers, to the healthcare services committee for review, modification, and approval, and we will review the policies at least annually thereafter.

How We Communicate UM Requirements

We will disseminate our approved list of PA requirements, clinical practice guidelines, and utilization review criteria, as well as any updates, to our Providers at the time of onboarding, via our Provider manual, during Provider Representative office contacts, on our website, and upon request. Our Provider portal will offer a PA lookup tool for Providers to easily identify those services requiring PA and a criteria transparency tool to allow our Providers to review the criteria used to determine medical necessity. We will encourage our Providers to refer to the Provider portal for the most current information.

We will offer Provider orientation that includes clinical criteria, UM policies and procedures, how to access criteria and request a PA, and how to contact our UM staff for assistance. We will reinforce this information during Provider services and UM contacts. We will include a definition of "medically necessary" consistent with the CCO Program Contract, along with Provider performance expectations, utilization review criteria and processes, and PA requirements during orientation, in the Provider manual, and on the Provider website. We will disclose the evidence-based criteria used to determine medical necessity and will make the clinical basis for a medical necessity determination available upon request to any attending physician who has been unsuccessful in their attempt to reverse an adverse determination.

A.1.e. Expected PA Clinical Criteria by Program Area

We have experience in PA of physical health, BH, and pharmacy services for adults, children, and individuals with special needs. We will propose the use of nationally recognized guidelines from MCG, which are based on published medical evidence, clinical expertise, and objective, standardized analysis of various databases. These will be supplemented with BH-specific criteria from ASAM, Level of Care Utilization System (LOCUS), Child and Adolescent LOCUS, and the American Association of Community Psychiatrists. **Exhibit 1** describes the evidence-based decision support tools we expect to use for PA clinical criteria.

Exhibit 1. Expected PA Criteria

1	Applicable federal mandates and CMS guidelines including national coverage determinations and local coverage determinations
2	State regulations and Mississippi-specific criteria guideline sets
3	Delegated third-party clinical criteria guidelines reviewed and approved for UM use in compliance with our policies
4	Corporate guidance documents and policies including our clinical policy and our clinical review
5	Licensed external decision-making criteria, MCG, American Society of Addiction Medicine, Level of Care Utilization Systems and Child and Adolescent Level of Care Utilization Systems, American Association of Community Psychiatrists
6	National Comprehensive Cancer Network • Level of evidence 2A or above may be considered for approval
7	Hayes Technology Assessment • Hayes Rating of B or better for the treatment/device may be considered for approval • Hayes Rating of C or below does not have proven benefit or sufficient evidence and would not be approved
8	UpToDate is a industry recognized evidence-based Clinical Decision Support tool for specialty care services
9	Technology assessments established by nationally accepted governmental agencies, physician specialty societies, associations, or academies and published in peer-reviewed medical literature
10	Well-controlled studies published and referenced in medical or scientific literature with relevant clinical evidence supporting the assertion that the requested modality would provide benefit to the Member and a clinical advantage over its competitors (two independent studies are preferred)
11	Specialty consultations by a third-party reviewer or an independent review organization

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A.1.f. Process for Regularly Reviewing PA Requirements for Their Effectiveness and Potential Need for Updates

Our process for reviewing PA requirements includes monthly, annual, and ad hoc reviews as well as ongoing monitoring through steps detailed above. Our CCO Medical Director, clinical leadership, and healthcare services committee will use monthly, annual, and ad hoc reports from major areas of healthcare services to evaluate utilization data to detect over- and underutilization that indicates potential need for PA updates. This data will include inpatient admissions and readmissions, ER visits, outpatient visits, surgical procedures, diagnostic testing, and pharmacy utilization. This review will include UM KPI reports monthly to compare inpatient and outpatient services authorized and requested from the current period to the corresponding prior period, both on a monthly and year-to-date basis to identify potential need for updates. In addition to identifying trends in utilization that present opportunities for improvement in PA effectiveness and a need for updates, ***we will use this data monthly and annually to identify variances from national and local norms, to create heat maps for health disparities, and to forecast future claims activity***. Specific data and reports used in this review include:

- UM reports that sort data by admission type and specialty services, such as NICU admissions and BH ER visits and admissions
- Diagnosis-level reports that use clinical classification algorithms to identify trends at the condition level and highlight specific diagnostic clusters driving utilization
- Data on authorization volumes and denial rates
- Member and Provider satisfaction information

Our clinical leadership will review the approval rates, cost of the procedure, clinical need, and utilization trends to identify the PA requirements that are most effective in driving both quality of care and cost effectiveness. In no instance will we impose limitations or exclusions with respect to covered services, including PA and utilization review standards, that are more stringent than those permitted in the applicable laws, policies, and procedures.

Healthcare Services Committee

Our healthcare services committee will review all clinical review criteria, clinical practice guidelines, and internally developed medical policies at least annually, but as often as necessary. The need to review criteria more frequently will be based on evolving evidence or to evaluate new and emerging treatments, medical technologies, and pharmaceuticals; new application of existing technology and criteria; and high-cost or high-risk treatments that would benefit from PA to ensure Members are receiving the right care, from the most appropriate Provider, and at the right level for their condition. Our healthcare services committee will include participation by network Providers, who may offer suggestions for changes in policies and procedures. As needed, the committee will make recommendations for changes to the QM committee for approval.

A.1.g. PA Processes for Members Requiring Services from Nonparticipating Providers or Expedited PA

PA of Services from Nonparticipating Providers

We believe our Members will be best served by qualified network Providers who understand our policies, procedures, clinical guidelines, and communication workflows and are more likely to engage in collaborative care with our clinical staff. However, there may be times when the most appropriate Provider to meet a Member's needs is not in network, such as if there is no Provider currently available in the region or State who can support the Member's needs, or the requested service or level of care is medically necessary and exclusively provided by a nonparticipating Provider or facility. When our UM staff verify the service meets medical necessity criteria but is not available in network, they will authorize the service, collaborate with Provider network/contracting in obtaining a single-case agreement with the out-of-network or out-of-area Provider, and coordinate sharing of medical records, as needed. Our network/contracting staff will also offer the out-of-network Provider an opportunity to join our network.

Continuity of Care for New Members Receiving Services from Nonparticipating Providers

We will comply with Division requirements for continuity of care for new Members and honor all existing authorizations for 90 days or until we are able to contact the Member/Provider. If we are not able to contact the Member/Provider, we will honor the PA until it expires. We will authorize additional visits/services beyond those initially approved when the request is in the Member's best interest based on the reason for the continued out-of-network access, the medical necessity, and the Member's progress or response to the current plan of care. Our UM staff will coordinate transitions to a network Provider to ensure continuity of care, including facilitating transfer of medical records and communication between the transferring and receiving Providers.

How We Process Expedited Requests for PA

We will not require PA of either in- or out-of-network emergent physical health or BH services. We will provide 24/7/365 access to a UM reviewer for Members with conditions that are not emergent but where a delay in treatment could threaten the Member's life, health, or optimum recovery. Our UM team will accept requests for expedited PA via phone or fax during normal business hours. After hours and on weekends and holidays, our nurse advice and BH/SUD lines can accept expedited requests. When a Member or Provider calls after hours or on weekends or holidays to request an expedited medical necessity review, we will route the request through our voice response system to a voicemail system that converts the message from voice to text and sends it to the email box of the on-call UM reviewer. If the caller contacts our 24/7/365 nurse advice or BH/SUD lines, the person answering the call will accept the request and forward it to the on-call UM email box so the caller does not have to hang up and call a different number. Our on-call UM reviewers will regularly monitor the email box to ensure timely review and response.

We will make an expedited medical necessity determination as promptly as the Member's health requires but within no more than 24 hours of receiving the request. We may extend the 24-hour time frame upon request of

the Member or Provider, or we may validate and document the need for additional information and how the extension will best serve the Member's healthcare needs.

A.1.h. The Offeror's Approach to Reducing the Number of PAs Required

Approach Based on the Triple Aim and Improving the Lives of Our Members and Providers

We have adopted the Triple Aim of enhancing Member experience, improving clinical outcomes, and lowering costs. Eliminating unnecessary PA requirements and reducing the complexity of our PA process are key ways we seek to achieve these goals. Requiring PA only for those services for which clinical review is necessary to ensure quality and effectiveness helps us to improve Member access to necessary care and reduce Provider administrative burden.

Reducing the Number of PAs Required

We will begin by reviewing UM data to identify PAs with a high rate of approval or where the requested procedure is within a standard of care or best practice. ***Our clinical leadership will recommend removing a PA requirement with a high rate of approval when it is not high cost/high risk.*** If the procedure is a component of a best practice standard of care, we will take one of two actions: 1) recommend removing the PA requirement and monitor utilization going forward; or 2) move the procedure to our clinical auto-authorization process, where we are able to track potential overutilization in real time while eliminating the need for clinical review and an unnecessary delay in treatment. For example, in markets where we have access to ADT data or regularly generated State inpatient reports, we automated our OB/newborn PA process to remove the need for Providers to notify us if the length of stay is within parameters established by clinical criteria.

Reducing the Complexity of the PA Process

We seek not only to reduce the number of PAs required but to make the process of obtaining needed authorizations as easy as possible for Providers. ***Our clinical criteria transparency tool will inform Providers of the applicable review criteria when we do not authorize the requested service.*** Additionally, we will accept PA requests and supporting documentation via fax, secure email, phone, and mail but will provide ongoing Provider education and training to improve rates of online submission and use of the self-service options available on our website, which are available 24/7/365.

Our secure web-based electronic review request system for PA and prepayment review will be accessible to Providers and Division staff, allowing Providers to submit PA requests and requests for prepayment review, upload supporting documentation, track and check status of PA requests, view determinations for all services, and receive authorizations in a HIPAA-compliant environment (HIPAA ASC X12 278 transaction), reducing the time and cost inherent in fax and telephone interactions. We will assign a unique tracking number to each review record, and our system will auto-generate an authorization number and required notices. Our website will include role-based access rules and the ability for users to view and securely download all data, analytics, or reports that are specific to the user defined by the user's profile and security access. Our website will include a PA lookup tool to help Providers determine what services require PA. Our system will route requests that don't meet criteria, along with any supporting documentation, to a UM reviewer.

We are currently enhancing our automated PA process to include a broader range of procedures, thereby reducing the number of PAs requiring clinical staff review and decision-making. **This will bring "near real-time PA approvals" to Providers when medical necessity criteria has been met and all supporting information has been provided.**

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Providers will be able to access the Provider web portal quick reference guide on our public website to get instructions on how to register for the secure portal and how to submit requests and documentation. Our PA review guide; PA request forms for medical, behavioral, and pharmacy services; and a list of services requiring PA in narrative form, along with a more detailed list by CPT and HCPCS codes, will be available on our website. We will include contact information for our UM staff and instructions on the information the Provider needs to include in a PA request in the Provider manual and on the website. Finally, we will make preservice and claims appeal forms available online, along with instructions on how to submit an appeal. We will encourage Providers to access the Provider portal so they are using the most current UM and PA information.

A.1.i. How the Offeror Will Ensure That PAs Do Not Delay Treatment in an Emergency

We do not require PA of in- or out-of-network emergency physical health or BH treatment and will cover and pay for post-stabilization care in accordance with 42 CFR 422.113 (c). We will educate all Providers on our PA requirements, including those related to emergency and post-stabilization services, and how to use our PA lookup tool to determine what services require PA. We will include this information in the Provider manual and on our website. If a Provider contacts our UM team, Nurse Advice Line, or BH/SUD line for PA of emergency care, we instruct them to provide the care but encourage them to notify us if the Member is admitted or there is a need for post-stabilization services that would benefit from care management or transitions of care support. In this way, we can ensure there are no gaps in care, and we can assist in minimizing the risk of admission or readmission.

A.1.j. Processes to Ensure Consistent Application of Criteria by Individual Clinical Reviewers

Our authorization, PA, and prepayment review procedures rely upon evidence-based clinical criteria and include two levels of review. A qualified health professional licensed in the State of Mississippi with clinical knowledge and experience in UM will conduct our first level of review. If a request does not meet criteria during the first level review, we will escalate it for second-level review by an appropriate healthcare professional. An individual who has appropriate expertise in addressing the Member's medical, BH, or LTSS needs will conduct our second-level review, which will comply with 42 CFR § 438.210 (b)(3) for any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Our nurses, physicians, and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty, will be currently licensed or certified by the Mississippi State licensing agency or hold a multistate license with Mississippi privilege.

We have designed our UM policies, procedures, and processes to ensure consistent application of medical necessity criteria by individual clinical reviewers. We will perform real-time supervision and performance monitoring, discuss Members with complex needs at weekly case rounds, and employ formal auditing protocols and review schedules to identify and respond to opportunities for improvement in training, performance, or processes.

Validate Staff Qualifications

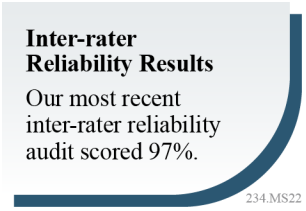
We will hold our clinical and nonclinical professionals to a rigorous review of qualifications and experience and require them to meet the license and/or certification requirements of their profession. All licensed professionals must have a current unrestricted license as designated by their specific position. We verify licenses with the licensing board/agency upon employment and upon renewal date thereafter. The human resources department and hiring management will be responsible for ensuring ongoing monitoring in accordance with State and Federal requirements.

Deliver Intensive Orientation and Ongoing Education and Training

We will begin with our individual clinical reviewer's onboarding process, which includes an education and training curriculum developed by clinical leadership and is updated annually or more often as necessary. We will orient the new employee on our whole-person, integrated holistic approach to UM and care management and their role and responsibilities within the integrated multidisciplinary team. We will train them on our UM program and policies and procedures, our clinical system, approved evidence-based clinical guidelines, medical policies, local delivery system, and regulatory and contractual requirements, along with confidentiality, conflict of interest, and FWA. We will partner new clinical reviewers with an experienced staff member during their orientation period to ensure they understand regulatory standards and consistently follow policies, procedures, and clinical criteria. We will continue to partner them with an experienced staff member who will reinforce training on consistent application of clinical criteria and ensure compliance with UM policies and procedures when they transition from the classroom to their new role. Each employee will have a role-based annual training requirement, including company-wide training (cultural competence, compliance, code of conduct, confidentiality, etc.) and position-/discipline-specific competency training, as well as an annual performance evaluation. We are currently supporting a group of Care Managers in achieving Diabetic Educator Certification

so they can assist Members with improving self-management skills and serve as clinical resources for our UM and care management staff.

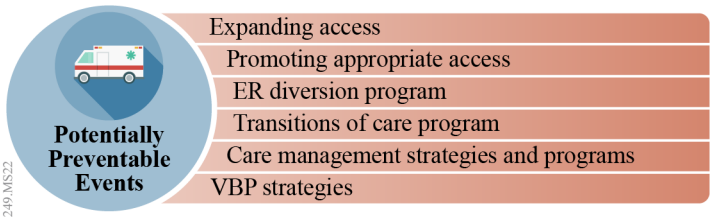
Conduct Regular Monitoring and Auditing to Ensure Performance and Identify Improvement Opportunities



Our clinical leadership team will be responsible for monitoring compliance with all required training, identifying and reporting on individual employee or functional area performance trends, and addressing any deficiencies. ***We will conduct quarterly inter-rater reliability audits and monthly UM audits for each clinical reviewer, including UM staff, Medical Directors, BH Directors, and Clinical Pharmacists.*** Clinical audits will include current and new or updated clinical criteria. Our internal auditor will provide feedback to the manager/director of the department and conduct group training, as needed. We will also track and trend complaints, grievances and appeals, and UM KPI reports to identify potential issues with consistent application of criteria. When we introduce new or updated criteria, we will provide training and monitor understanding and consistency of application until we are confident our UM staff is correctly applying the new or updated criteria. Our UM Team Leaders and internal UM Auditors will work together to monitor performance in real time. While our team leaders mentor and evaluate staff, our auditor will conduct daily review of all adverse UM determinations, identifying and responding to opportunities for improvement through individual and group training.

B. METHODS

B.1. How We Will Manage Unnecessary ER Utilization, Avoidable Hospitalization, and Readmissions



Potentially preventable events include unnecessary ER utilization, avoidable admissions, and readmissions as well as inappropriate lengths of hospital stays. Potentially preventable events are generally driven by barriers in access to primary, urgent, and specialty care (including Provider availability, health equity and social barriers) and a need for comprehensive care management interventions and follow-up to coordinate care, supporting appropriate access to needed services during transitions of care and across settings, and improving health literacy and self-management skills. We will address potentially preventable events drivers by:

- **Expanding access** to timely primary, urgent, and specialty care, including developing a statewide urgent care network; work with the CVO to credential FQHC advance practice nurses and physician assistants and urgent care center physicians as PCPs; allowing pharmacists to work at the top of their license based upon Mississippi scope of practice standards; using telehealth to expand Member access to primary and preventive care, including BH services; and bringing preventive and primary care services to areas with high incidence levels of potentially preventable events and/or Provider shortages through ***our innovative mobile health program, including mobile units and semi-permanent trailers.***
- **Promoting appropriate access** through Member support and health education, including ***promoting the PCMH through our PCP assignment process*** and improving utilization of PCP visits.
- Our successful **ER diversion** program to identify and address inappropriate ER utilization.
- Our laser-focused **transitions of care** program to reduce readmissions and ER utilization, and support follow-up care.
- **Care management strategies and programs**, such as remote patient monitoring and specialized support for Members with chronic or rare conditions who are at risk for potentially preventable events. Our UM staff are often the first to identify high-risk and rising risk Members who would benefit from care management as they conduct prospective and concurrent medical necessity reviews. Our UM staff will refer these Members for care management assessment, so the Care Manager can work with the Member to help them receive the right care, at the right time, at the right level of care, from the right Provider.
- **VBP strategies** to improve access to preventive and primary care and incentivize participating primary and specialty care Providers to reduce potentially preventable events and address disparities.

Expanding Access to Primary, Urgent, and Specialty Care

Many Mississippi communities have an insufficient number of PCPs and specialty Providers. According to the Health Resources Services Administration, there are 91 medically underserved populations/areas in Mississippi. We will address access issues by increasing Provider availability, using our telehealth policy, and offering our innovative mobile options to supplement Member access in areas of the State with few Providers or with social gaps that impact access and health outcomes.

Increasing Provider Availability

We will attempt to recruit all qualified Mississippi licensed PCPs and work with the CVO to credential FQHC advanced practice nurses and physician assistants as PCPs. We will also develop a statewide urgent care network to expand appropriate alternatives to ER use for non-emergent conditions and offer urgent care Providers an opportunity to be credentialed as PCPs. Additionally, we will collaborate with the State PBA to allow pharmacists to perform at the top of their license, based on Mississippi laws and regulations for pharmacist scope of practice. We will support Providers through our practice transformation strategy, which may include workforce development or technology enablement.

Using Our Telehealth Policy to Manage Potentially Preventable Events

To address access issues that can lead to potentially preventable events, our telehealth program will leverage a broad range of various remote technologies and methodologies to improve Member access to healthcare services across a wide spectrum of health disciplines. ***Our telehealth offering will include access to physical health, BH and select specialty services and will accommodate different aspects of telehealth, such as urgent care visits, follow-up Provider visits, post-hospitalization visits, mental health counseling, and prenatal and postpartum care.*** We will also allow other Provider types to deliver telehealth as defined by the revised rules, including BH Providers, supervised practitioners, audiologists, speech-language pathologists, occupational therapists, physical therapists, speech-language pathology aides, audiology aides, occupational therapy assistants, physical therapist assistants, dentists, and dietitians. To ensure we have a robust telehealth network, we will develop local relationships with academic medical centers and specialty practices and we have contracted with a national telehealth provider. We will take these steps to improve provider access to specialists.

We will develop collaborative relationships with our telehealth Providers to educate Members and Providers on the availability of telehealth and remote monitoring services. For example, we may work with a PCP in engaging a Member with diabetes or congestive heart failure to actively participate in remote monitoring to build stronger self-management skills. We are also adding telehealth and remote monitoring educational and outcomes statistics to our Provider newsletter to encourage Providers to effectively use these programs to support their Members. ***Our telehealth solutions are available to Members on both our website and mobile platform.*** Based upon feedback and internal quality monitoring, we continuously look for opportunities to enhance our Member portal to improve visibility of detailed telehealth information and instructions. In 2021, we launched a successful Member outreach campaign to improve the effectiveness of telehealth visits, which includes ***a telehealth toolkit for Members that offers a tip sheet on how to prepare for the appointment, a pen, notepad, and a phone stand*** for easier video participation. For Members who lack Internet access, we will be able to provide one phone per head of household, with unlimited calling to Member services and unlimited texts between the Member, care management, and Member services. Members will be able to download telehealth apps onto their smartphone, and ***we will provide limited data for telehealth.*** Our staff will help Members apply for the FCC's Affordable Connectivity Program, which provides discounts on Internet access and Internet-enabled devices, including tablets, laptops, and desktop computers.

We will also ***bring telehealth access to Members through our mobile health program's mobile units and semi-permanent trailers*** (described below), which will provide Members with limited or no Internet service the ability to schedule and participate in telehealth visits in their own community.

Supplementing Access with Mobile Options

To supplement access in areas with limited Providers and rural areas requiring longer travel times for care, particularly the Delta region, and thereby reduce potentially preventable events, ***we will offer mobile options that bring care and support directly to Members***. Our mobile health program will offer mobile units and semi-permanent trailers equipped to offer primary and urgent care visits, and private

telehealth space and equipment for access to specialty Providers. We will use UM data analytics to identify locations with the highest rate of potentially preventable events and preventive care gaps and deploy a help center to address those disparities. ***We will also be able to relocate as needed in response to emergencies or natural disasters.***

Promoting Appropriate Access to Primary and Preventive Services

We will promote appropriate access to prevent potentially preventable events through our PCP assignment process that reflects our strong emphasis on the Member relationship with a PCMH; support and education on appropriate access; and one-on-one support for appropriate access for Members.

Using PCP Assignment, Promoting PCP Visits, and Supporting the Medical Home

We will promote appropriate access to prevent unnecessary acute utilization by linking each Member with a PCP of their choice that truly works for them and has the necessary support to serve as a robust medical home. A consistent, positive relationship between a Member and their PCP, in which the Member feels respected and has an active voice in their care, supports improved health outcomes and health equity and reduces the likelihood of potentially preventable events. For new Members who do not select a PCP, our PCP assignment methodology will promote Member choice and convenience by assigning based on a previous relationship when available. When there is no record of a previous relationship, we will look for any PCPs to which the Member's family is already assigned, as well as Provider ability to meet the Member's language and cultural needs, if known, and proximity to the Member's home. Our Care Managers will solicit feedback from Members who are auto-assigned to a PCP to determine satisfaction with the assignment or whether the Member would like to choose a different PCP. Our Member services call center employees ***will work with Members to help them identify and select Providers that meet their preferences*** related to gender, race/ethnicity, language, and location. We will also help Members identify PCPs that meet specific needs, such as having adjustable exam tables for Members in a wheelchair.

Our Member services call center employees and care management staff work with Members to ensure access to needed preventive and primary care visits by helping with scheduling and arranging transportation, including accessible transportation options for Members with disabilities. We will also assist in identifying childcare when needed.

We will support PCPs to promote appropriate access through education and clinical and administrative tools available on our Provider portal and through value-based contracting programs that incentivize improving access, resolving care gaps, and reducing health disparities. In addition, our care management staff will provide care coordination and care management support to both Members and Providers. ***We will further support PCPs to ensure appropriate access and reduce potentially preventable events by offering clinical support tools, such as a nationally recognized specialist telehealth consultation platform***. This HIPAA-compliant e-consult platform will provide access to more than 120 specialties and subspecialties with a guaranteed 12-business-hour response time and a mean response time of 4 business hours. Additionally, we will engage our PCPs in improving our approaches to promoting appropriate access by giving them a seat at the table and including them in our QM committee and healthcare services committee activities.

Educating Members and Supporting Their Appropriate Access to Care

Another way we will promote appropriate access and reduce potentially preventable events is to offer a range of Member supports and education. Our Member information packet, website, and other targeted educational materials will provide information on the importance and role of the PCP as the medical home and how to contact us for assistance with scheduling and transportation. While we will not require PA for emergency services, we will educate Members on the appropriate use of emergency services, along with how to access our 24/7/365 Nurse Advice Line and Behavioral Health/Substance Use Disorder (BH/SUD) line and our urgent care network, during new Member orientation, in the Member handbook, on the Member website, and during direct Member outreach and engagement, such as our Emergency Room Diversion program. Further, our Nurse Advice Line and BH/SUD line will offer access to a healthcare professional 24/7/365 for any clinical questions and concerns.

Bringing Education and Support to Members in Their Communities

In addition to our mobile health solution, we will also promote appropriate access through ***high-touch, field-based care management team, including CHWs who will provide intensive, face-to-face education and support.*** CHWs will be available to Members and care management staff to support Member education, access to care and addressing SDOH needs.

Addressing SDOH which leads to Potentially Preventable Events

We know that health equity challenges and social barriers lead to increased ER visits, inpatient utilization, and readmissions. We will offer education and support to Members through our SDOH service locator and referral platform. We make this platform available to Members and Providers, and it is integrated into care management systems and workflows. Our platform uses a widely used search engine to interpret information in 132 languages and is zip code driven, so we can route Member requests for community-based services convenient to their location. Once a Member submits a referral request via the platform, a local CBO will "claim" it, indicating they have accepted the referral and will be responsive to the Member's need. Care management staff follows up to ensure the Member has accessed the services and that services are meeting their needs. Additionally, we will provide education and support on the usage of the platform through our mobile health program, to offer offering face-to-face assistance and referrals to community-based services needed to reduce disparities and address SDOH, such as food insecurity and transportation. For example, our mobile unit staff can show the Member how to access our SDOH service locator and referral platform either through the Member portal or the Member mobile app.

ER Diversion Program

We will implement our successful ER diversion program in which our staff collaborate with the PCP, the Member, and a pharmacist, when appropriate, to identify and address root causes for inappropriate utilization.

Reducing Potentially Avoidable ER Visits

Between 2019 and 2021, our ER diversion program in one State decreased ER visits from 98.4/1000 to 68.4/1000, with a 30.5% reduction in potentially preventable ER visits.

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We will use claims data, internal referrals from UM, care management, or the PCP, and pharmacy data to identify Members who appear to be overusing or misusing ER services. We will evaluate the clinical appropriateness of their ER utilization and educate them regarding the importance of primary and preventive services, the availability of our Nurse Advice Line and BH/SUD line and urgent care network, and the appropriate use of ER services. We will notify the PCP of the potential overuse and may offer additional care management services based on Member needs. Through this program, our CHWs will reach out to Members with more than two ER visits for non-ER conditions within six months to help identify and resolve barriers to care or SDOH that may be the underlying cause of their ER utilization. For example, if overuse is related to pain management concerns, we will assess for referral to a pain clinic or pain management specialist and, as appropriate, coordinate with the PBA on a referral to the PBA's pharmacy lock-in program. Our ER diversion program monitors Members for up to 90 days based on their acuity and risk levels.

Transitions of Care Program

We will offer a two-tier transitions of care program based upon the Member's risk score. We will assess Members with lower risk scores to confirm their discharge plans are adequate and their post-discharge needs are being met. When our assessment identifies those Members who might benefit from the more intensive transitions of care program in place for Members with higher risk, such as those with a history of low primary/preventive care utilization or inadequate informal supports, we will offer our transitions of care program through care management outreach.

The transitions of care team, or assigned Care Manager when appropriate, will conduct a transitions of care assessment of the Member's health status, health behaviors, social support system, and Member-specific goals when they are at higher risk for readmissions. We will then use this information to develop and update a person-centered care plan. To optimize health outcomes, we will align the care plan with evidence-based guidelines, developing it in collaboration with the Member, family, and/or caregiver, and we will share it with the PCP via the Provider portal. Our process will ensure the Member has an active voice in their care plan and understands

how to continue the care plan activities throughout transition of care settings. We will achieve this by providing education, coaching, and self-management support in the following seven domains:

- Knowledge of Triggers/Red Flags
- Timely PCP/Specialty Care Follow-up
- Medication Self-management
- SDOH
- Dietary and Nutrition Needs
- Home Health
- DME Needs
- Personal Health Record

We will authorize and coordinate medically necessary services while promoting Member self-management and encouraging empowerment during our post-discharge contacts. Our Care Managers will attempt to contact the Member within 72 hours of discharge to assist with follow-up care, including assessing if the Member has complied with discharge instructions and assisting with referrals, appointments, transportation (for MississippiCAN), prescriptions, and coordinating care with the PCP. If the transitions of care staff make a referral for a Member, they will contact the Member within 48 hours after making the referral to confirm follow-up.

We also offer specialized transition of care programs for Members with complex care needs, such as through our NICU program. Members admitted to a NICU will receive high-touch inpatient and post-discharge care management, including assistance with follow-up appointments, lactation support, education on red flags and signs and symptoms, and the availability of our Nurse Advice Line and BH/SUD line.

Care Management Programs and Strategies

Our Care Managers will provide proven interventions that reduce potentially preventable events for individual Members through our care management program, including person-centered assessments and the development of integrated care plans that incorporate preventive and primary care, as well as BH and specialty care, services appropriate to the Member's condition, age, and healthcare needs. For those with serious BH needs, the care plan will include a crisis plan. Care planning will also assess and integrate SDOH needs that can impact clinical status and cause potentially preventable events if not addressed. Throughout the person-centered care management process, Care Managers will provide health literacy and condition and self-management education to help Members reduce the likelihood of exacerbations that can result in potentially preventable events. They will also help Members access needed care (e.g., scheduling appointments and transportation) as well as social services. In addition, our Care Managers are trained to identify unique health risks or disparities facing individual Members, and will incorporate person-centered, Member-informed interventions designed to mitigate the likelihood of preventable events.

Our population health, care management, and quality programs will develop evidence-based interventions and program level strategies to address our entire membership as well as targeted programs for subpopulations experiencing unique health risks or disparities, such as those described below. We will report data to the Division regarding these efforts as required.

Chronic Condition Management Remote Monitoring

In our affiliate partners programs with similar geography and demographics, we use a combination of in-State Providers and programs and national telemonitoring vendors to provide comprehensive remote monitoring options for Members with chronic conditions. Our comprehensive solution will help Members manage their chronic conditions by sharing vital signs, weight, and oxygen saturation level using a wireless-communication-standard-enabled scale, blood pressure monitoring cuff, thermometer, or pulse oximeter. ***We will seek to work collaboratively with local Providers offering telemonitoring services, such as the University of Mississippi Medical Center, and augment areas not served*** by those Providers with a national vendor offering telemonitoring services. Our goal is for clinical members of the Member's interdisciplinary care team to have access to real-time, Member-provided data needed to effectively monitor for changes in condition and efficacy of Member self-management so they can proactively address increasing symptoms by connecting them to primary care, urgent care, or telehealth services. ***We will include data-sharing and communication protocols in our telemonitoring contracts to ensure we apprise our Care Managers and the Members' PCPs of the Member's status and any interventions or recommendations.*** If we identify a Member without Internet access who would benefit from telemonitoring, we will attempt to resolve their access issues, including providing them with a cellphone and assisting Members to apply for the FCC's Affordable Connectivity Program, which

provides discounts on Internet access and Internet-enabled devices, including tablets, laptops, and desktop computers.

Specialized Care Management for Rare Conditions

We will provide specialized care management for Members with 19 rare conditions, such as sickle cell anemia, cystic fibrosis, hemophilia, HIV, and Crohn's disease. Specialized care management staff will provide in-depth education to increase a Member's knowledge about their condition and improve self-management skills. We will assign Members to a Care Manager who regularly assesses their self-management skills; develops a person-centered care plan that addresses appropriate use of medication and medication adherence; and coordinates care through telephonic exchanges, mailings, or online interactions. Members will be able to contact a care management team member with questions through a 24/7/365 telephone access line or a web-based Member portal. The rare conditions care management team, including social workers, case managers, and an expert medical advisory board that can provide advice and help solve urgent care coordination problems, supports the Care Manager in reducing the risk of potentially preventable events. The Care Manager will collaborate with the Member's Care Team (e.g., PCP/specialist, other Care Managers, Pharmacist, pharmacy, etc.) to ensure all the Member's goals, interventions, and progress are captured, aligned and integrated with the Member's care and treatment plans within the Member's personal health record. See additional information on how we use data from this program to reduce costs in our response to RFQ § 4.2.2.5.B(4) below.

VBP Program Strategies to Reduce Potentially Preventable Events

VBP programs are an additional input into our overall strategy to reduce potentially preventable events. We will use VBP incentive strategies to improve access, prevent and close care gaps, and reduce potentially preventable events. We will analyze utilization data to identify opportunities for improvement in under- and overutilization that can also inform our VBP models and help to establish baseline and goals for Provider performance. This will include analysis of UM data based on Member conditions, level of care, and demographics to identify health disparities, gaps in care, and root causes of potentially avoidable ER visits, admissions, and readmissions. We will then select incentive measures that reflect key preventive and condition-specific goals for health equity and improved health outcomes and integrate them into our VBP model. ***Our VBP program strategy recognizes the critical role SDOH and access play in the well-being of CCO Program Members and aligns UM and care management initiatives with population health and VBP targets to create a unified strategy in which our plan will support VBP Providers to reduce potentially preventable events.*** For example, as part of our population health program and analysis, we identify a trend in underutilization in a rural community, we will alert network Providers of their Member's care gaps. Our health equity and SDOH manager may also schedule a mobile help center for that community to engage Members in primary care and telehealth visits (sharing information with the Member's PCP to ensure continuity of care), connecting them to our CHW who can assist them with SDOH, refer Members to care management as needed, and provide health education.

We will offer innovative VBP models that map to specific population health goals, based on our successful experience in multiple States. In another example of our experience, an affiliate partnered with peer recovery centers through a shared savings VBP model and developed a peer reach-in program to direct care to appropriate outpatient settings and reduce ER visits, admissions, and readmissions. ***The program improved access to care by 79%, with improved rates of PCP visits and follow-up after an ER visit,*** exemplifying "right care, right place, right time."

Our Medicaid affiliate in another State partnered with two large integrated health systems to develop a sickle cell anemia pay-for-performance VBP arrangement in alignment with their population health goal of reducing inequities and disparities in the Black population. **In the first year following implementation, inpatient utilization decreased by 17%**.

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B.2. How We Will Cooperate with Hospital Providers Regarding Post-discharge Efforts for QIPP PPHR

We will partner and coordinate with hospital Providers participating in QIPP PPHR with integrated data analytics, referral workflows, joint operating committees, and wraparound care management programs, including our transitions of care program described above. We will develop best practice processes for timely identification, tracking, and referring those Members to our transition of care program, where we will coordinate services with hospital Providers to prevent future readmissions.

We will actively collaborate with our hospital Providers on a targeted data-driven quality initiative aimed at reducing unnecessary admissions and readmissions. We will begin by incorporating the Division's PPHR data with our plan data and analyzing trends across the State. We will then drill down into the utilization patterns at high-volume ERs and hospitals to identify potential readmission diagnoses and root causes of readmissions. We will engage and collaborate with the hospital Provider to review this information and identify Members for program outreach. We will develop workflows for Provider hospitals to refer high-utilizing Members, developing communication and process flows to facilitate timely referrals to our transitions of care team, and to assist in identifying and resolving specific access or SDOH barriers that may prevent or interfere with post-discharge follow-up.

We will also provide technical support to hospitals with high utilization that are under a QIPP Potentially Preventable Complications program CAP, including collecting and analyzing data; setting goals for high-utilizing Members; developing Provider- and Member-specific interventions, such as Member and Provider education and community outreach; and measuring and evaluating the effectiveness of those interventions. Finally, we will formally evaluate the quality initiative's success with our partner hospital Provider and the State, share lessons learned and best practices identified and incorporate them into our UM, care management, population health, and disease management programs and strategies.

We will comply with the Division's reporting requirements, including the overall comparison of PPHR rates using the actual-to-expected ratio, which measures the actual number of hospital readmissions compared to the case-mix adjusted level of readmissions for Members discharged from that hospital.

B.3. How We Will Identify and Address Trends in Over- and Underutilization

We will identify trends in over and underutilization through cross-functional work teams that include representation from UM, care management, QM, our Medical Directors, and Provider Representative . Our integrated data and analytics reporting will support work team activities, including:

- Tracking potential quality of care issues, including adverse events, critical incidents, and sentinel events
- Reviewing Member grievances and appeals
- Evaluating UM and care management reports
- Reviewing medical, pharmacy, and utilization data
- Monitoring performance measures and other quality metrics relative to targets, including preventive health measures and adherence to clinical practice guidelines (e.g., flagging measures that fall below the 10th percentile as a potential indicator of underutilization)
- Reviewing Member satisfaction and utilization trends

Work teams will also perform comprehensive analyses of clinical utilization trends by area of healthcare service, including inpatient, outpatient, ER, professional, pharmacy, therapies, and DME, with a focus on priority populations, such as maternal/child, Members with chronic conditions, and those with known health disparities, to identify and address over- and underutilization of services. Our staff will use our customizable utilization and UM key performance indicator reports to identify and monitor utilization trends relevant to the priority needs of our Mississippi membership and will ***use this data to address over and underutilization trends with support activities*** such as:

- Evaluation of clinical guidelines and utilization review criteria, policies, and procedures to identify needed updates or development to remove barriers to access
- Development or modification of care management programs and strategies
- Development or modification of individualized Member or Provider education
- Identification of Members for pharmacy lock-in or prescribers for outreach and support, if required
- Identification and development of strategies to address health disparities
- Identification of trends that indicate potential SDOH gaps in a geographic area
- Development of value-based arrangements that target identified over-, under-, or misutilization, such as underutilization of recommended preventive services or inappropriate use of the ER for non-emergent care.

In one of our affiliate plans, our NICU program resulted in a 23% reduction in Avg. NICU length of stay in the first 6 months of the program.

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One example of how we will identify and address over- and underutilization is our comprehensive approach to improving perinatal and neonatal utilization and outcomes. We will combine analytics, outreach, care management, and digital solutions to support early identification of women with high-risk pregnancy to improve access to prenatal care, engage Members in early and adequate prenatal care and post-partum follow-up, reduce rates of premature delivery, low birth weight infants, NICU days, and readmissions, and educate Members on well-child care, including EPSDT. These solutions will include:

- **Maternity analytics platform**. Our artificial intelligence-enabled high-risk pregnancy identification tool will analyze claims and other data for maternal alcohol/drug use, history of premature delivery, asthma, diabetes, maternal age, tobacco use, and chronic conditions to ***proactively identify candidates for our high-risk OB program***. This will generate a daily risk stratification report of pregnant Members that our Care Managers will use to quickly contact at-risk Members and engage them in the appropriate level of prenatal care while addressing SDOH and health disparities.
- **NICU UM solution**. We will offer an integrated UM and care management program for NICU newborns and their parents. Dedicated Maternity UM nurses will conduct concurrent review, collaborate with parents and Providers in discharge planning, monitor transition of care through 60 days post-discharge, and provide care management and health education. This program will involve the development of ***collaborative relationships with key Providers in Mississippi, especially the University of Mississippi Medical Center, Jackson; North Mississippi Medical Center (Tupelo); and Le Bonheur Children's Clinics.***
- **Addressing racial, ethnic, and geographic disparities in prenatal care**. In another State with a large rural population, our affiliate offered a targeted care management program that included ***at-home postpartum visits by a nurse practitioner to improve postpartum utilization and reduce disparities***. ***This initiative improved postpartum visit rates for Black Members by 37% in the first year and for the overall population by 15% in the first two years.*** We will offer this program in Mississippi and enhance it with a maternity support program for Black women, a culturally competent digital health platform that will connect Black expectant mothers with critical resources needed to improve pregnancy outcomes. This program will address low engagement rates, unmanaged chronic conditions, and the impact of racism, all factors contributing to underutilization of recommended prenatal and postpartum care and poor maternal-child outcomes, which drive potentially preventable events.

- **Mobile health program resources to improve access in rural areas.** ***We will bring our mobile unit and semi-permanent trailers to underserved areas***, such as the Delta and the coast, to improve access to prenatal care, including telehealth access to perinatal specialists, perinatal care coordination, health education, and referral to CBOs that address SDOH.

- **Community engagement.** To address potential underutilization in our perinatal population, we will establish a specialized program to reach and engage newly enrolled pregnant women. We will pair each new pregnant Member under the age of 20, a cohort with historically low timely prenatal care HEDIS rates, with a CHW. CHWs will cultivate warm and trusting relationships with Members through in-person visits, helping them connect with an OB/GYN and attend prenatal visits, identifying any potential SDOH that might impede success (transportation, housing, nutrition), educating them about self-care and the importance of attending office visits, and helping select a pediatrician for the new baby. ***Our staff will visit Members every month during pregnancy and visit them in the hospital when they deliver. They will also visit Members at home monthly for three months*** to verify each mom's recovery and a healthy start for the baby and will support postpartum and baby's well-child visits.

B.4. How We Will Analyze Pharmacy Utilization Patterns to Improve Care and Reduce Costs

Reducing Costs Using Pharmacy Analytics

Drug utilization reports were recently used to identify inappropriate dose optimization of a specialty cancer drug which increased the cost by 108%. Through this identification and education of the pharmacy and provider, we were able to reduce the monthly cost of the drug by almost $20,000.

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We will analyze and use all available pharmacy utilization data in our medical and BH PA processes, population health strategies, and care management program to improve care and reduce costs. Our systems will ingest industry-standard and proprietary files (including pharmacy claims and authorizations from an external PBA) to perform advanced analytics to identify favorable and unfavorable trends and improve care and reduce cost. ***We have implemented and integrated the needed applications and systems to accept and provide data to the PBA and Division and will make them available from Day 1***. This will provide integration capabilities to exchange data with the PBA and the Division. ***We will establish secure connections to systems critical to the coordination of care.*** This will allow us to coordinate care for Members by viewing targeted Member pharmacy data in real time, including claims adjudication and PA data, daily pharmacy claims data, and daily prior authorization data. We will assist in developing and implementing service level agreements with the PBA related to these processes and availability of communication channels to efficiently resolve any data discrepancies or timeliness issues that may occur.

We will integrate all available pharmacy data into our clinical system, including data provided by the PBA, data collected during health risk assessment and transitions of care, and data related to physician-administered drugs and implantable drug systems that we will manage. Our UM, care management, and pharmacists will use this data to analyze pharmacy utilization patterns to improve care and reduce costs.

Collaboration with System Partners on Innovation and Reduced Administrative Burden

We will continuously study and implement new ways to improve UM processes and time frames. For example, we have developed evidence-based criteria for physician-administered drugs and collaborated with States, other MCOs, and vendors in aligning criteria across plans in other markets. We look forward to collaborating with the Division, the State PBA, and other Mississippi CCOs in developing uniform PA forms (medical, behavioral, and pharmacy), including smart electronic authorization forms, that would reduce the chances of technical denials due to incorrect or missing information. We view Providers as key partners in improving quality and access. In addition to our quality initiatives, practice transformation program, and value-based contracting program, we will collaborate with Providers to implement our successful EHR initiative to increase interoperability of our clinical system with Provider EHRs. This will give our UM staff access to information required to make a medical necessity determination without needing to request additional information.

Enhance Risk Stratification and Population Health Analysis

Our risk stratification and predictive modeling engines will analyze pharmacy data and patterns to enhance identification of, and provide deeper insight into, individual Member risk level and population trends that indicate potential barriers to care or opportunities for improvement. For example, adding pharmacy utilization patterns to our stratification and predictive models helps us identify Members with rare and complex conditions so we can prioritize them for care management outreach, thereby improving health outcomes and reducing overall medical and pharmacy costs.

Our population health analytics separate utilization patterns according to race, gender, age, and geographic location, allowing us to ***identify trends and disparities in under- and overutilization of medications that we can address with care management interventions or population health strategies.*** For example, a low rate of medication adherence in a particular community might be the result of Provider access issues or SDOH barriers that we could help resolve by bringing one of our mobile health program solutions to that community.

Improve Identification of Members for Care Management

Pharmacy data also helps us identify Members who may need care management but for whom we don't have other data that indicates clinical risk. We do this by identifying Members who are prescribed medications typically used to treat conditions that meet the automatic enrollment criteria for care management, as required in

Draft Contract § 7.4.3.3.1. We will identify Members for specialized care management of rare conditions by integrating the review of available pharmacy and medical data in the UM process, such as when the clinical criteria used to determine medical necessity includes pharmacy elements (such as home health services for drug administration) as well as when we are determining the medical necessity of physician-administered drugs and implantable drug systems. ***In other States where we work with a single State PBA, pharmacy data is available sooner than medical claims data and allows us to identify Members and intervene more quickly.*** For example, in one case, our affiliate identified a Member with pharmacy PA for Zolgensma®, which prompted outreach to the parents of a child with spinal muscular atrophy to assist them in accessing covered and non-covered community-based services.

As described above, we also leverage the expertise of our NCQA-accredited rare condition care management program to provide holistic care, including comorbidity management, to Members with complex and rare conditions. These Members have specialized, often unique needs, including comorbidities and needs for specialty medications. These Members are also often frequent ER utilizers and experience readmissions. Using real-time pharmacy and medical claims data, EHRs, and health plan and specialty pharmacy referrals, the rare condition care managers identify these Members earlier and proactively provide support to better manage their holistic care needs through evidence-based interventions. This program's whole-person approach focuses not only on medication but on the wide range of barriers Members with complex conditions face in accessing needed care, avoiding preventable utilization, and improving their quality of life. Care managers will work to address all Members' needs, wherever they are in their condition journey, to help improve access to care, improve outcomes, and help them live their best life.

Identify and Address Prescription Over- and Misutilization

We analyze pharmacy utilization patterns as part of our predictive modeling and population health analytics to identify Members with over- or misutilization and refer them to care management for assessment and possible intervention. For example, we might refer a child on antipsychotics to a BH Care Manager, who will collaborate with our clinical pharmacist, the PCP/prescriber, and family in developing and managing drug regimen recommendations.

We will coordinate with the PBA in identifying and managing Members who qualify for the pharmacy lock-in program in accordance with 42 CFR § 431.54. Our UM staff might identify a Member based on ER or inpatient utilization and refer the Member to care management for education, support with behavioral changes, and collaboration with the prescribing Provider to address potential overuse of specific medications. We will collaborate with the PBA in determining if the Member should be enrolled in the lock-in program, including notifying the Member of their lock-in enrollment and their appeal rights and providing them with a list of locked-in Providers/pharmacies or settings of care. ***We will coordinate with the PBA in administering the program by sharing reassessment data and outcomes, including behavior changes and updates to the Member's care plan.***

During a recent state of emergency, one of our health plans collaborated with their internal pharmacy department, care management, IT staff, the State Medicaid agency, and the State PBA to ensure lock-in Members could access pharmacy care after a pharmacy and Provider's offices were destroyed. Our affiliate worked with their State and PBA partners to successfully modify the lock-in restrictions for three weeks, allowing Members to maintain access to their medications during a difficult time in their life.

Identify and Disseminate Best Practices for Promoting Adherence

We analyze pharmacy patterns to identify Providers with Members who have higher medication adherence rates and, in collaboration with care management and Provider services staff, engage with these Providers to identify best practices, tools, and education that we can incorporate into our clinical program and Provider education strategy to help to improve medication adherence for Members and practices with lower adherence rates.

Support Self-management of Chronic Conditions and Improved Outcomes

We will analyze pharmacy data for utilization patterns to ensure we have a comprehensive picture of all the chronic care supports a Member has received. ***Pharmacy data will be instrumental in supporting care and improvement in maternal and infant health, chronic disease management, and BH outcomes***. A few examples of how we will use pharmacy data are to monitor adherence by high-risk OB Members using

hydroxyprogesterone, pregnant Members using prenatal vitamins, and Members using Hepatitis C medication. Identifying Members who are non-adherent allows us to assist in addressing barriers to care or care management gaps, and provide additional tools to ensure the Member achieves adherence and improved clinical outcomes.

We will also incorporate pharmacy data into our HEDIS measure monitoring. For example, we will use pharmacy data to identify children and adolescents younger than 18 years old who have been prescribed typical and atypical antipsychotics but whose medical record does not contain documentation of metabolic monitoring in the past 12 months. By integrating the pharmacy data from the PBA with our medical data, we can provide additional resources and outreach to ensure proper clinical care and support for the identified Members.

How We Will Ensure Medication Continuity of Care Upon Enrollment and Ongoing

Ensuring Medication Continuity of Care Upon Enrollment and Ongoing

We have developed processes to ensure medication continuity upon enrollment and ongoing, and we continue to refine them based on our experience working with Medicaid Members, Providers, State agencies, and single PBAs in multiple States. We use an automatic monthly file transfer process wherein claims and PA data for Members transferring from another CCO or FFS Medicaid are integrated into our clinical system to quickly identify medication continuity needs, honor existing prescriptions and other pharmacy authorizations as required, coordinate with prescribers both in and out of network to communicate about authorizations, and educate Members and Providers to continue with currently authorized medications with no changes during the transition.

Integrate Pharmacy Data to Quickly Identify Medication Continuity Needs

We integrate data from the prior CCO and the PBA into our clinical and risk stratification systems to quickly identify new Members with existing PAs and referrals, and those with active prescriptions requiring PA. We will work collaboratively with the Division and PBA to develop systems and processes needed for timely identification of new enrollees with existing prescriptions, particularly when the medication requires PA. Our care management staff will use PBA data to identify new Members with gaps in care who require outreach and education, and will help Members overcome access issues that negatively impact their ability to obtain or appropriately use prescribed medication.

We will work closely with the PBA to receive, transmit, integrate, and exchange data as directed. We will seek to execute a data-sharing agreement with the PBA and develop policies and procedures for exchanging data subject to access controls and requirements necessary to comply with State and Federal privacy requirements. We will collaborate with the Division and the PBA to develop processes for sharing medical data, including claims and diagnostic codes, medical outpatient drug, and prior authorization data with the PBA or the Division as required. We will exchange data following State and Federal laws and regulations, including 45 CFR parts 160 and 164.

Honor and Coordinate Existing Authorizations

We will honor all pharmacy authorizations for the required continuity period and until the prescriber determines the need for any changes to the prescription. We will comply with the Division's requirements for continuity of care related to physician-administered drugs, including honoring existing PAs regardless of prescriber network status. ***Our UM and care management staff will make every effort to coordinate care with the prescriber, so the Member does not experience an interruption in care or services.*** If we identify a non-network prescriber, our Provider contracting team contacts the Provider to either join our network or execute a single-case agreement when continued care is medically necessary and in the best interest of the Member.

Member and Provider Education and Support

Our central message to Members and Providers during a transition is to continue with currently authorized care with no changes during the continuity period or until the Provider determines a change is required. We will collaborate with the Division and State PBA in providing detailed information to Members on obtaining pharmacy services, including when and how to contact the PBA and how to transfer a prescription or obtain PA. We will work with the Division, the PBA, and other CCOs to develop standardized language to ensure continuity upon new Member enrollment. We will provide the new Member with contact information for our

Member services call center and 24/7/365 Nurse Advice Line and BH/SUD line, and provide instructions on how to obtain services, including those related to pharmacy, off hours, on weekends, and holidays. We will also make this information available in our Member and Provider handbooks and on our Member and Provider websites.

Our Member services call center employees in other States with single PBAs have detailed policies and procedures for appropriate handling of calls received by our call center that are the responsibility of the PBA, including warm transfers, responding to calls received after business hours, and handling pharmacy-related grievances and appeals in accordance with regulatory and contractual requirements. Our Provider services call center employees will provide information to Providers on the transition to a single PBA and where to call for help with pharmacy services issues. We will build on these policies and procedures to ensure a smooth transition for our Mississippi Members and Providers.

In one State with a single State PBA, we worked with the PBA to identify Members who needed additional assistance obtaining necessary medication to:

- Contact Members in the pharmacy lock-in program who might need to get to a lock-in pharmacy or Provider and provide override
- Contact Members via text who had a prescription filled in the past 30 days with information on how to get replacement medications
- Telephone Members in care management who were on chronic medications or DME/oxygen
- Use the PBA pharmacy claims system to monitor Member fills of needed medication and reach out directly to pharmacies to reduce the risk of point-of-sale denials
- Add automatic voice response messaging to our Member line to direct them to the correct place for assistance
- Train our 24/7/365 Nurse Advice Line and BH/SUD line staff on the transition to a single PBA so they can educate/direct/assist Members, as needed, after hours, on weekends, and on holidays.

During another transition to a single statewide PBA, a Member contacted us because they needed a specialty injectable drug for a rare condition that was only available from one specific pharmacy. The network transition caused the pharmacy to receive a point of service rejection. Our team contacted the pharmacy, resolved the issue, and followed up with both the pharmacy and the Member to confirm they had received the drug and did not experience a gap in treatment.

We also provide intensive education and support to Providers to ensure they understand changes to billing procedures. During a recent single PBA implementation in another State, some home infusion drugs, which had been paid under both the pharmacy and medical benefit, were transitioned to only being covered under the medical benefit. Our affiliate identified and contacted each home infusion pharmacy, resolved contracting issues, and educated them on how to bill for the drugs under the medical benefit, ensuring Members did not experience a gap in care.

Integrate Systems, Data, and Workflows

We will leverage our experience in other States transitioning to a single pharmacy benefit management model to design and deploy seamless, integrated solutions and capabilities in partnership with the Division and the PBA. ***To improve Member health outcomes and wellness, we can integrate the PBA's real-time claims application with our customer relationship management and care management platforms.*** We will incorporate all available claims, PA, call center, and other data files into our existing systems and tools to execute our care management programs and health and safety program, and to conduct Provider outreach and education. We will collaborate with the PBA in developing a clear understanding of our respective roles and responsibilities, and creating call center, data exchange, and grievances and appeals workflows. If appropriate, we will also partner with the Division to design and implement new capabilities to further the Division's goals, such as delivering and using daily call-tracking files with the PBA to address the needs of Members and Providers efficiently and effectively.

Proposed Collaboration Strategies to Ensure Medication Continuity

We have developed a range of models in response to State requirements and priorities in States in which we work with a single PBA. We will support the Division by sharing lessons learned, common challenges, and effective solutions in other States to ensure medication continuity during the transition and to ensure Member

and Provider satisfaction. Below we propose collaborative strategies, based on our experience, that will support a smooth transition to the PBA and continuity of care for Members.

Work Group to Plan for Transition to the PBA

To ensure smooth and seamless implementation of a single PBA and uninterrupted access to care for CCO Members, we recommend establishing a pharmacy benefit work group. The work group can share best practices, identify areas for improvement, and discuss solutions. We would be honored to take the lead in establishing this work group and partnering with the Division, the PBA, and other CCOs to help achieve the Division's goals and expectations for pharmacy benefits. The work group could also review and discuss common operational and clinical issues and concerns, and compliance with any new requirements that impact Members and Providers. Once we have achieved the Division's goals for transition to a single PBA, we can refocus these meetings to address ongoing communication and Member- and Provider-level support.

For example, during a similar transition in another State, our affiliate worked collaboratively with all MCOs to develop standard communications for Providers, including letter templates and messaging related to pharmacy benefits. The health plan created a single Provider contact list to eliminate duplicate messages by having the MCOs take turns sending standard communications. They also took the lead in developing instructions and conducting workshops to educate Providers about the differences between PBA- versus CCO-processed PAs (physician-administered drugs), and fielded questions about the transition and how it would affect current processes. This collaboration continues, and all parties see it as beneficial.

Leading up to the go-live of another State PBA implementation, an affiliate led the way in providing information needed to ensure project readiness. The health plan coordinated file delivery and benefit setup changes between their PBA and the new State PBA, ensuring the Preferred Drug List (PDL) coding for the new PBA was correct. For example, when performing a PDL coding comparison between what the health plan had coded versus what the new PBA would have coded, it was determined that there were several types of contraception left off the PDL, which would have caused more than 2,500 Members to receive a rejection at pharmacy point of sale starting on Day 1. Our affiliate was successful in bringing this to the attention of the department of Medicaid and the PBA, and were able to resolve the issue, preventing any negative impact to medication continuity.

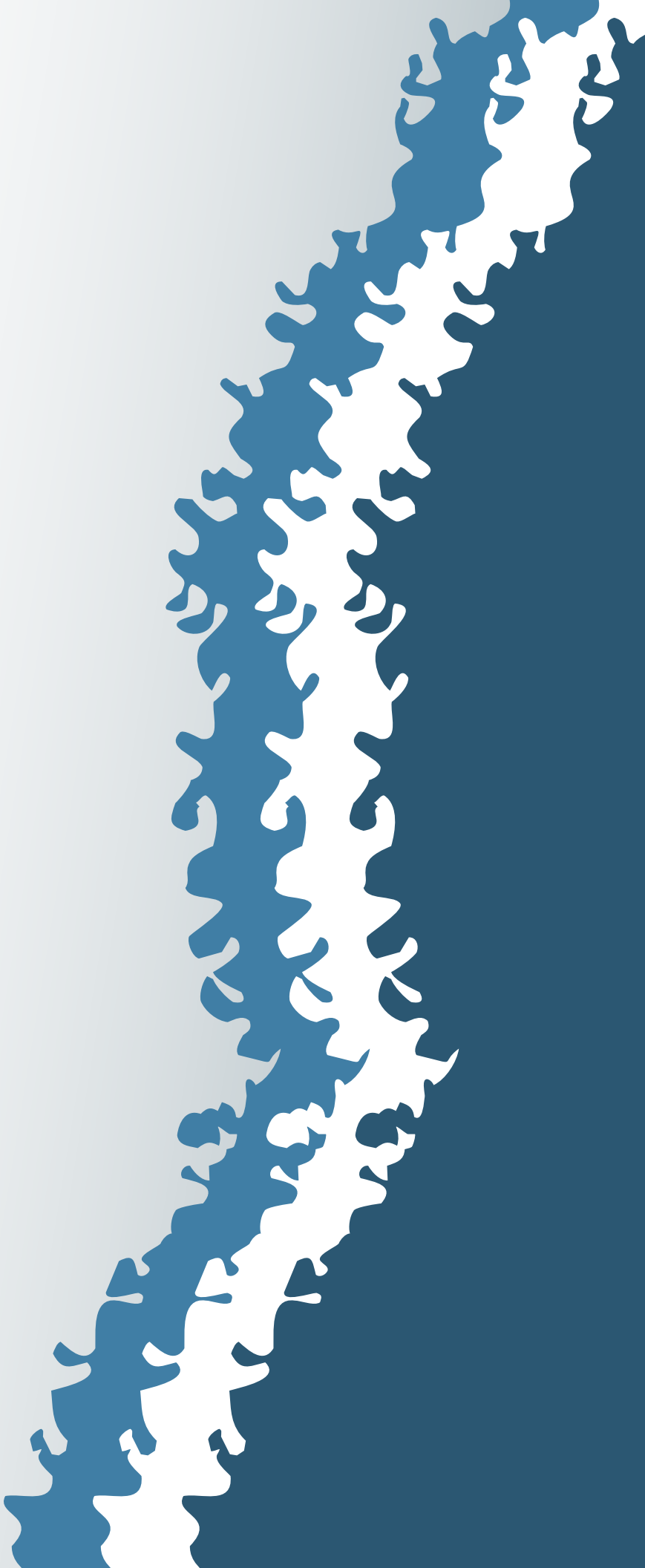
Ongoing Collaboration to Resolve Issues and Ensure Continuity

We also recommend ongoing collaboration among the Division, the PBA, and the CCOs after initial implementation to identify and address barriers to medication continuity. For example, during a recent single PBA implementation in another State, our affiliate collaborated with both the department of Medicaid and the State PBA to resolve point-of-sale issues Members were having with COB claims. They collaborated with the State and PBA to identify the root cause, which led to the development of a new process for creating and delivering clean TPL files that would not cause erroneous rejections at the pharmacy. ***This enhanced process alleviated $1 million per month in additional costs to the Medicaid program for our affiliate alone.*** The health plan was instrumental in creating the new data exchange process, which allowed them to provide pharmacy TPL files directly to the PBA, increasing the speed to apply correct data and reduce COB rejections at the pharmacy. Our affiliate also collaborated with the PBA to develop a process for health plans to provide point-of-sale overrides when necessary to prevent a gap in treatment.

[END OF RESPONSE]

4.2.2.6

Information Technology



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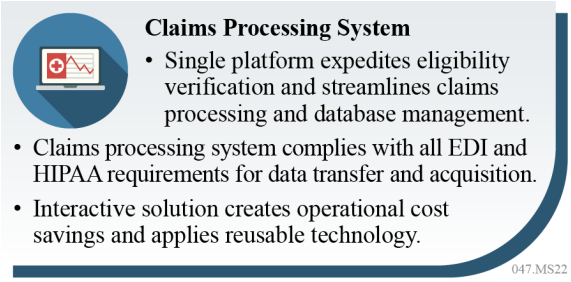
4.2.2.6: INFORMATION TECHNOLOGY

A. CLAIMS PROCESSING

Perhaps the most important work we undertake to secure a high level of Provider satisfaction is timely, accurate claims processing and payment. ***In 2021, our affiliated health plans processed approximately 60 million claims, with an average adjudication rate of 99.53% within 30 days, including claims with secondary quality review.*** This far exceeds the Draft Contract requirements of 90% of clean claims paid within 30 days. ***In 2021, our average claims turnaround time was 6 days with an auto-adjudication rate of 82%.*** We expect to exceed these standards and execute similar results for Mississippi.

Our claims processing and integrated subsystems are tested and proven, currently implemented and operational, and fully capable of supporting all CCO Program functional areas in their current state, without the need for system updates or modification. Configuration for Division-specific requirements will be complete by readiness review. In support of claims operations, ***we will implement an expedited quality and accuracy process in Mississippi to ensure we meet or exceed key performance indicators (KPIs) in the claims management process.***



Further, an important element of our claims processing success is our innovative ***prelaunch testing service for hospitals and large Provider groups***. We will also include end-to-end contract configuration and claims adjudication testing with key Providers around the State before go-live, including those who may have nonstandard claims or lack of infrastructure.

The following describes our claims processing system used to ensure compliance with Contract requirements and interfacing operational systems that will support major functional areas of the CCO Program.

A.1 Our Claims Processing System

Our modernized, cloud-based, and scalable core administrative (admin) system functions as our centralized enterprise claims processing and information retrieval system and features the capability and capacity to effectively manage the Contract requirements of the CCO Program. It will enable us to perform all operational and administrative functions in compliance with all Contract requirements specified in the Draft Contract § 16.5, Health Information System, and § 9.1 Claims Management, including § 9.1.2 Claims Processing and Retrieval System. Our core admin system is fully integrated with all subsystems and throughout our entire health information ecosystem to include utilization, grievances and appeals, encounter management, and disenrollment for loss of other than Medicaid eligibility.

Our system collects, analyzes, integrates, and reports data through secure internal and external API interfaces while facilitating HIPAA-compliant information sharing among stakeholders, simplifying interactions with the Division, Providers, and other oversight agencies. ***Our core admin system serves as the central navigation hub and all-encompassing integration point for data exchange and transmission among all integrated core systems and applications.*** It provides flexibility and rules-based features and functions tailored specifically to Division requirements.

We share the State's and the Division's emphasis on data transparency to allow for the best treatment decisions for quality and cost, using evidence-based guidelines that support better health outcomes and meaningful use of health IT. Our core admin system ensures that all data is managed appropriately and facilitates compliant information sharing among stakeholders while maintaining compliance with EDI and HIPAA requirements. It interfaces with required operational systems and supports any future IT architecture or program changes. For example, we can interface with other operational systems, such as the MES/MMIS operated by the Division, as required by the Division, to access, inquire, and bidirectionally share information. All clinical, encounter, and care management data is sent to the Division in adherence to required State and Federal formats, including HL7® FHIR®, API, and USCDI, on a regular basis as defined by the Division.

Our experience and IT solutions provide us with a strategic advantage in managing MississippiCAN and CHIP populations and enable us to seamlessly integrate information and data components across health plan operations. We have recently successfully implemented our IT systems to support multiple Statewide Medicaid programs on time with 100% accuracy by all readiness reviews. Our continuous investments in innovative technology as part of our ongoing transformational IT digital journey have delivered superior health plan operations by elevating and advancing our IT architecture and infrastructure. Further, ***we host all core health IT systems and operations in our highly secure and fully redundant IT cloud, which enables us to quickly and reliably implement our systems and services.*** We distribute technology systems and services across our IT cloud by regions composed of multiple geographic locations, meaning ***our employees can use services without disruption, whether in the field, in a remote home office, or within one of our office locations.***

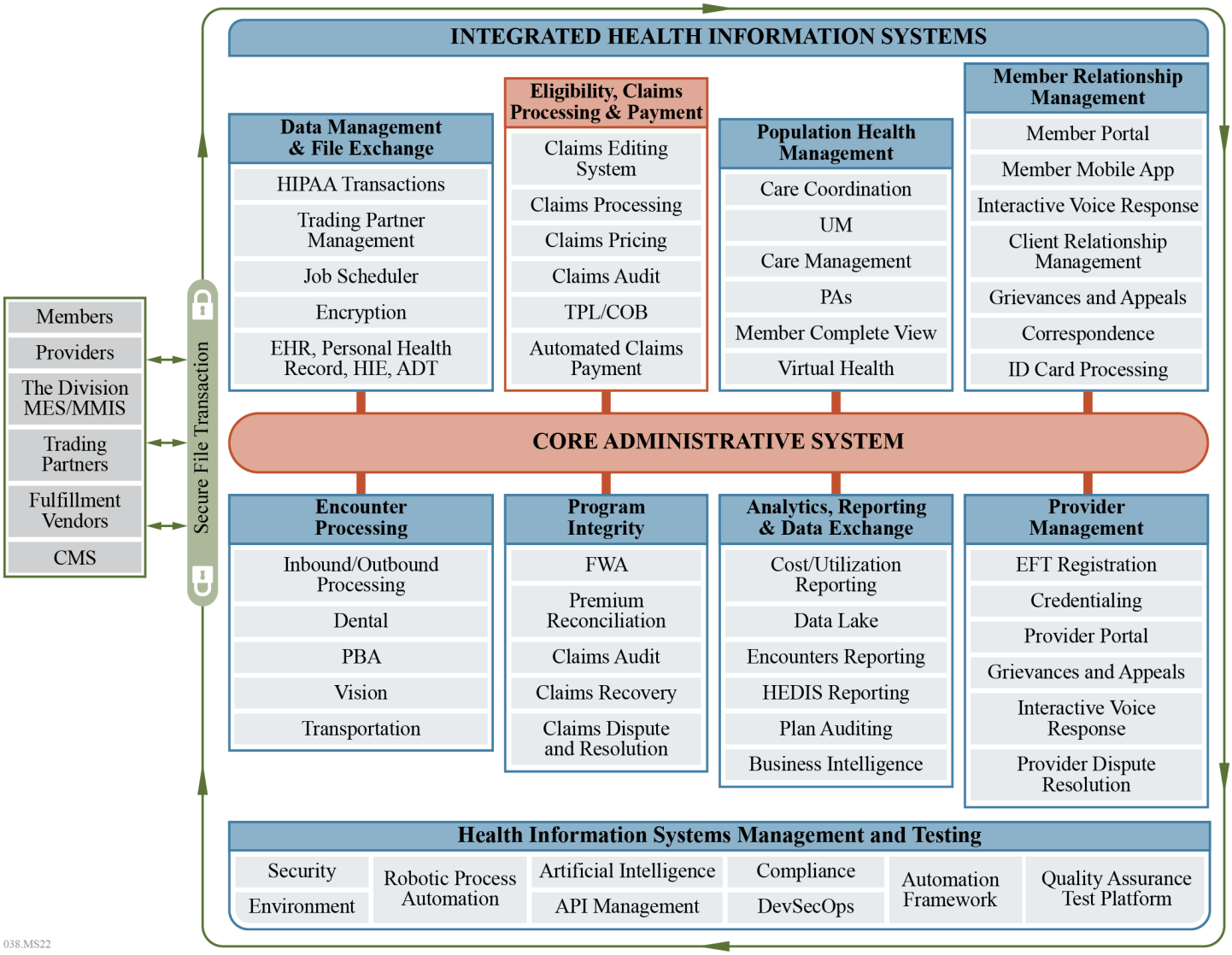
A.1.a. Diagram Describing Components of the Claims Processing System and Supporting Systems

All health plan management functions, including all RFQ-defined program functional areas, will be supported by our core admin system and fully integrated subsystems. Our fully integrated suite uses products and components designed specifically to support the delivery of healthcare services, creates operational cost savings, and applies reusable technology. It also includes custom solutions, such as a feature-rich web portal for Providers and Members, which improves interactions that result in considerable operational efficiencies, such as automated Provider claim submission and easy access to health plan information.

Our cloud-based health information system combines custom and SaaS applications built specifically to support Medicaid programs. Our API gateway—a single, unified platform for data aggregation—uses industry-leading technology to govern real-time integrations with built-in security controls at the application layer in our "Zero Trust" security fabric, which maintains strict access controls, thereby promoting greater security throughout the network. We have deployed the API gateway in the IT cloud, ensuring that both data and business services are highly reliable, secure, integrated, and monitored, 24/7/365. All systems and services are linked to identity management and OAuth 2.0 security for both individual and system-to-system authorization and are reviewed biannually as part of our entitlement compliance review process.

Exhibit 1 provides details for each component of our core admin system and integrated supporting systems, including integrated claims processing functions, used to ensure compliance with Contract requirements.

Exhibit 1. Systems Diagram. Our API gateway enables streamlined data flow for all service-to-service integration between systems internally and externally.



Our highly configurable core admin system interfaces with Division systems and other systems as required and provides services in accordance with MississippiCAN and CHIP standards and requirements.

A.1.b. How Each Component Will Support Major CCO Program Functional Areas

All RFQ-defined program functional areas and requirements are supported by our core admin system and fully integrated subsystems. **Table 1** describes the specific systems and solutions we are deploying to support the CCO Program, including all program functional areas as well as other core systems and subsystems that are currently operational and integrated and will be fully configured for Division-specific requirements by readiness review.

Table 1. Key Systems and Functionality. All RFQ-defined CCO Program functional areas and requirements are supported by our core admin system and fully integrated subsystems.

Key Systems and Applications	Description of Core Functionality	Functional Areas Served
Core Admin System	Our core admin system is configured specifically to address government healthcare functions. As our core claims processing solution and integration point for data exchange and transmission among all integrated information systems and applications, our core admin system provides flexibility of rules-based features and functions tailored specifically to Division requirements.	Member enrollment and eligibility management Provider Network management Claims processing Encounter submission COB for claims with TPL Reporting

Key Systems and Applications	Description of Core Functionality	Functional Areas Served
Client Relationship Management Platform	We use our client relationship management platform to provide seamless contact and opportunity management across all systems and channels of care to provide a complete Member picture, enabling insight and engagement opportunities for a deeper understanding of Members.	Member contact management Care management Member eligibility, enrollment, and disenrollment management
Care Management Platform	A fully integrated and comprehensive care management platform that coordinates Member care, services, and outcomes at the individual and system levels. The system unites care management functions for increased productivity, efficiency, and accurate and timely reporting. It maintains Member care and population health data, care plans, and stratification and interventions, consistent with Medicaid/Medicare requirements.	Core care management platform and portal
UM Platform	Supports PA and concurrent review for care and behavioral health treatment. The system integrates with MCG (clinical guidelines) and our core admin system (for eligibility information) and has configurable escalation rules, a user access management function, and comprehensive search functions.	Pre-certification and PA request management for inpatient/outpatient service
Grievances and Appeals Platform	Our G&A platform is a modern, advanced, and fully unified application platform that provides clinical guidelines to inform medical and clinical care teams and supports grievances and appeals, including associated care-related documents, improving outcomes through more effective UM.	Grievances and appeals Referrals and prescriptions Automatic service-level agreement management and notification Reporting
Provider Portal	Our Provider portal offers a consolidated payer platform for Providers across the country. It provides a single source for eligibility and claims processing with a common user interface.	Member eligibility Provider services Claim status PA submissions and tools
Member Portal	Our Member portal provides personal health information and access to services, including benefit coverage, telehealth, transportation, Nurse Advice Line, healthcare management, women's health services, Member ID cards, and a doctor finder.	Member services and engagement Member health and care management Access to care
Member Mobile App	Our Member mobile app provides Members with the same features as our Member portal through their mobile device. It also offers mobile chat features to empower Members to take charge of their healthcare. By integrating within our client relationship management platform environment, our app provides a seamless Member experience through all channels of care.	Member eligibility, enrollment, and disenrollment management Member services and engagement
Claims and Encounters Management System	A custom-developed web-based application, our claims & encounters system offers a 360-degree view of claims and encounters, collects encounter data from all systems at a common gateway entry (for example, raw 837 files), and processes data through submission.	Claims processing edits, corrections, and adjustments Encounter submission
Payment Integrity	Supports both pre-pay and post-pay utilization reviews by using best-in-class integrated vendor solutions. This provides us true cost avoidance measures as well as comprehensive machine-learning algorithms to analyze post-payment data from multiple claims so that we can identify suspicious billing patterns within our claims systems.	Surveillance utilization review Fraud investigation Payment integrity
Health Quality Application	Our healthcare quality application calculates performance on each HEDIS measure. Administrative data, such as claims/encounters and labs, and supplemental data is fed into our reporting system, and data is refreshed monthly	Quality improvement Reporting
Mobile Assessment Application	Our mobile assessment application fully integrates with our care management platform. It fully supports assessments and care planning during face-to-face and community-based site visits.	Care management solution and portal
Claims Gateway	All received claims go through our claims gateway, which will apply State-specific criteria. The tool screens claims and sends them to our core admin system for adjudication. This system is compliant with all regulatory standards with proven scalability.	Claims processing edits, corrections, and adjustments Encounter submission
Eligibility & Enrollment Gateway	Our eligibility & enrollment gateway automates the end-to-end eligibility inbound processes, decreasing processing time and improving overall performance.	Member eligibility, enrollment, and disenrollment management
Compliance Management Tool	Our compliance management tool provides automated comprehensive compliance oversight and proactive identification of risk.	Program integrity

Key Systems and Applications	Description of Core Functionality	Functional Areas Served
HIE Integration Platform	Our internal HIE integration platform is an aggregated intelligence application that provides real-time Member health data from different source systems and HIEs. The Member data in this can be amalgamated from different sources to support proactive Member care.	Interoperability Care coordination HIE
Financial Management System	Our financial management system and fully integrated modules facilitate the flow of financial information. All data is integrated with our core admin system, and extracts from the finance subsystems can be published.	Financial, Provider, testing

Our fully integrated claims processing system and subsystems are built to support all MississippiCAN and CHIP programmatic functional areas, ease administrative burdens, drive our population health program through advanced big data and analytics, and promote real-time transparent measurement and reporting.

A.2 Modifications or Updates to Our Claims Processing System

Our core admin system is fully designed for large government payer healthcare programs and to support the CCO Program in its current configuration. It has no architectural limitations; as a result, we can expand system capacity as necessary. Our flexible and scalable core admin system surpasses the business and technical standards of the CCO Program without significant modification, updates, or customization and can be further modified and customized to meet the Division's needs.

As with all new Contract requirements, configurations are required to address benefits and rate codes based on CCO Program requirements. Our rigorous vetting process and detailed business analysis ensures all requirements are included, configured, and tested prior to implementation to ensure compliance within each provision of the Contract. Our core admin system affords us the ability to quickly modify or update Contract details and program requirements in an agile methodology based on timelines outlined and required by the Division.

A.3. Our Claims Processing Operations

We strive to be the health plan of choice and deliver a seamless and reliable experience for Providers. Our proposed claims processing operations will incorporate a comprehensive claims processing program and proven payment strategy that will increase Provider satisfaction while also decreasing Provider abrasion and administrative burden, allowing them more time to focus on supporting MississippiCAN and CHIP Members.

Our organized and collaborative claims processing operations provide a solution that harnesses superior automation and data management. From offering multiple methods of claims submission to aggregating required support information and documentation for reporting and analytics, our operational approach will be developed specifically to meet the needs of the CCO Program. We will comply with all applicable Mississippi and Federal regulations outlined in the RFQ, including full compliance with HIPAA guidelines and regulations. We will process and pay Provider claims in compliance with CCO Program requirements.

By using the enhanced automation and streamlined workflow of our core admin system, our fully integrated claims processing system enables superior operational efficiency, enabling us to consistently deliver impressive average turnaround times with low denial rates across our affiliated health plans. We are proud of our enterprise-wide history of consistently exceeding claims processing service levels.

The following subsections detail our claims system and proposed processes for meeting specific CCO Program Contract requirements.

A.3.a. Claims Processing Systems That Will Support This Program

We adjudicate claims in a timely and accurate manner through our core admin system, which serves as our core claims processing and information retrieval system. Our core admin system (claims processing and information retrieval system) complies with all components of 42 CFR 433.116 and enables us to meet or exceed all CCO Program claims processing requirements and standards specified in the Draft Contract.

Using advanced technology for auto-adjudication contributes to consistently fast claims turnaround times. Our core admin system has demonstrated the capacity and capability to process and pay claims accurately, on time,

and to the Division's specifications. The system and its complementing business rules are highly configurable, meaning faster implementation, flexibility to accommodate change, and consistent accuracy. We configure validation rules, pre-payment controls, and adjudication edits to Mississippi specification, which serve as checkpoints, ensuring claims completeness and appropriateness.

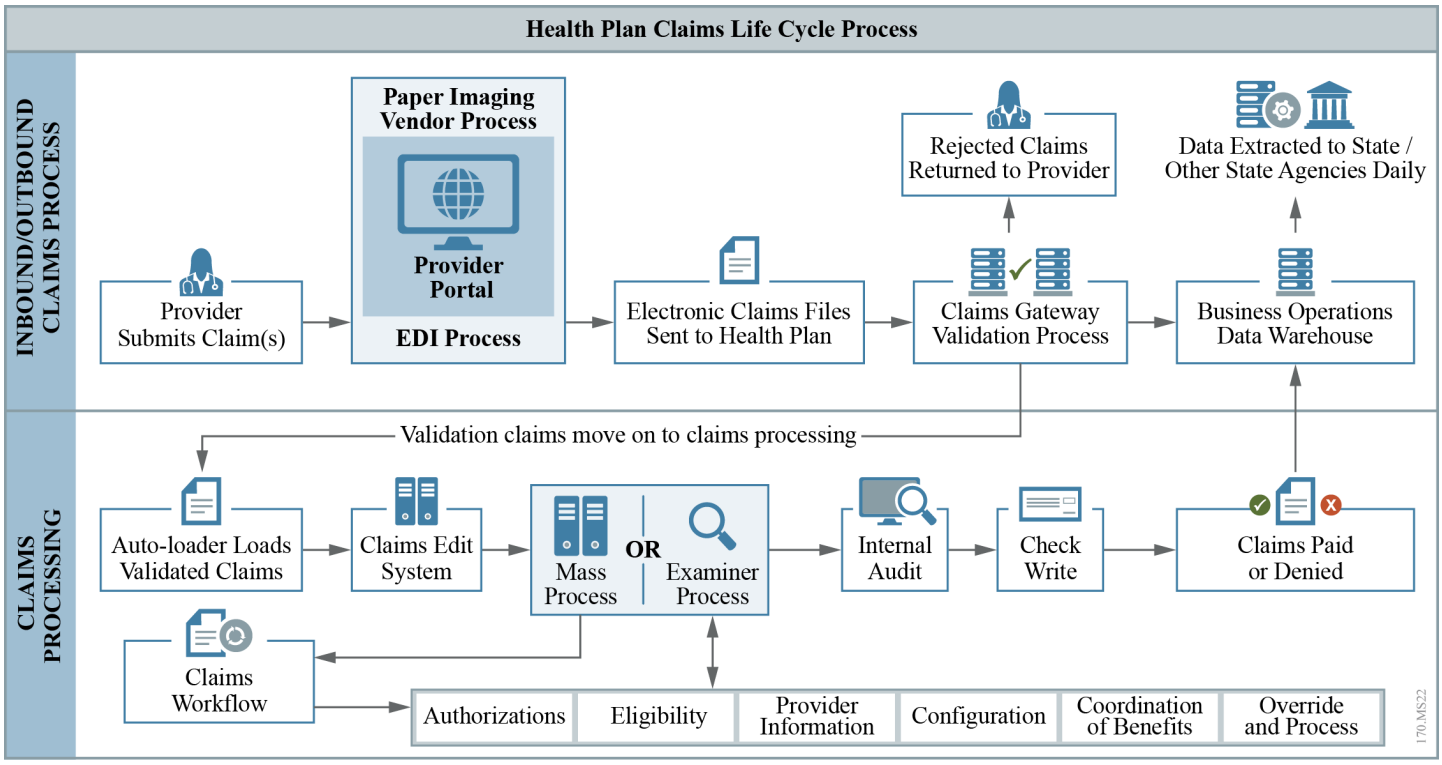
Additionally, our core admin system is fully integrated across our health information system, streamlining claims management processing and secure data management, retrieval, and exchange. Our system is HIPAA compliant and will be modified on an ongoing basis in accordance with the Division's defined rules and requirements.

Claims Life Cycle Process

Efficient claims processing begins with Providers' ability to submit their claim with ease. Providers can choose their method of submission by using our user-friendly Provider portal, through an EDI clearinghouse, or via mailed paper form. While we anticipate that most claims will be submitted electronically, to meet the needs of our smaller Providers, especially those in rural areas where electronic submission may not be possible, we allow Providers to submit paper claims, and our systems will convert them into an electronic format. We work closely with the Provider community to encourage and support electronic submittal, and most claims are submitted electronically via the Provider portal or clearinghouse, which facilitates accuracy and timeliness and benefits the Provider revenue cycle.

Our claims adjudication process ensures claims that pass the validation processes of our EDI system are loaded into our core admin system for timely and accurate claims processing and payment. All claims are processed in receipt date order. Our processes ensure a prompt and accurate turnaround that meets all regulatory and program compliance standards. Our system's efficiency has resulted in a high percentage of auto-adjudicated claims, saving time and ensuring accuracy. We provide our end-to-end claims life cycle process in **Exhibit 2.**

Exhibit 2. Claims Life Cycle Process. Our claims adjudication process ensures that claims that pass the validation processes are loaded into our core admin system for prompt and accurate turnaround that meets or exceeds all regulatory and program compliance standards.



Providers benefit from our technology for auto-adjudication, our consistently fast and accurate claims turnaround times, and the transparency around the process. Throughout the life cycle of a claim, Providers can view and manage their submissions via our online Provider portal. This tool will be available to all Providers, allowing real-time access to their data and account. The increased visibility provided by the tool will reduce delays in notification regarding claim status, strengthening communication and expediting issue resolution.

A.3.b Standards for Speed and Accuracy

Timely and accurate payment of claims is a high priority. In light of this, we will maintain a suite of Division-specific claims payment policies and procedures. Our support team strives to meet performance standards by ensuring all documents contain updated, accurate information. As required under 42 CFR 447.46, we will pay or deny 90% of all clean claims (as defined by Miss. Code Ann. § 83-9-5 and 42 CFR 447.45[b]) for covered services within 30 calendar days of receipt and 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. We process and report on all claims in accordance with program requirements.

As previously noted, in support of the CCO Program, we will also implement a proven expedited quality and accuracy process to ensure that our claims KPI standards not only meet but exceed requirements. With this process in place from receipt of an auto-adjudicated claim to Provider payment, our claims processing system and operations enables us to ***pay more than 99% of clean claims within 30 calendar days, and more than 99.9% of clean claims are paid within 90 calendar days.***

Capturing claims data correctly at the start helps ensure accuracy, timeliness, and a complete information set. ***Our secure Provider portal offers user-friendly submission of electronic claims directly to us, providing a high level of self-service.*** Our electronic claims submission analysis identifies opportunities for Provider assistance to improve claims quality, timeliness, and accuracy and ensure a high-quality Provider experience. Our processes include training, technical assistance, and other activities to ensure Providers and Subcontractors submit the right information in the right format.

Claims adjustment data and claims audit results help identify errors, analyze root causes, correct issues, promote transparency, and improve policies. Our quality management approach focuses on the root causes of issues to identify the accountable functional area and implement corrective action plans.

Before go-live, core systems supporting CCO Program operational and functional areas will undergo thorough user acceptance testing, which includes claims, Provider configuration, eligibility, and encounters. End users will perform a comprehensive series of test cases to ensure we meet requirements before we place the system into production, remediating any issues identified during this testing phase to align with the Division.

We also use various reports, applications, and tools to manage claims speed and accuracy. Our claims management team monitors claims inventory through reports, which are run daily to monitor claims activity and processing to ensure accurate, timely adjudication. Our team also uses proven processes and procedures to ensure all claims are adjudicated in an accurate and timely manner. We enable both standard compliance and ad hoc reporting to meet timeliness standards and conduct mock compliance and quality audits to ensure payment accuracy. Various reports and applications are used to monitor and manage the claims inventory effectively.

We work closely with our Providers and Subcontractors to ensure they submit timely, accurate, complete claims and required encounter data elements and comply with format and data submission requirements. We provide education to all Providers and Subcontractors through training, technical assistance, and other activities to ensure proper claims submission and HIPAA compliance. We educate them on electronic submission methods and web portal resources. As a result, we have been able to dramatically increase our rates of EDI adoption.

A.3.c. Process for Dealing with Discovered Compliance Issues Through an Expedited Process

Our claims process provides a solution that harnesses superior workflow, automation, and data management. As such, ***our quality scores consistently average 99% accuracy or greater in affiliate health plans, and we anticipate similar results in Mississippi.*** From offering multiple methods of claims submission to aggregating required support information and documentation for reporting and analytics, our successful Provider payment approach and process will be developed specifically to comply with CCO Program requirements. We also maintain a library of more than 1,000 claims-related policies that will be tailored to the program.

We have implemented market-specific strategies for addressing potential program compliance, Provider payment, and system-level issues expeditiously. We use various reporting tools, including our claims KPI dashboard and additional in-house applications, to manage claims inventory, speed, and accuracy. By using our internal advanced business intelligence and data visualization solution, our claims management team monitors

daily claims inventory and activity to ensure accurate, timely adjudication. We also conduct regular audits to ensure data accuracy and identify any system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is performed to locate the source of the errors and remediate the issue.

Regular internal audits ensure we meet performance requirements and accuracy standards. Audits include verification of payment accuracy against Provider contract terms and adherence to regulatory and internal guidelines and policies to ensure all reimbursement contract requirements are implemented.

A.3.d. Process for and Time Frame to Correct Programming Errors

Our system's efficiency results in a high percentage of auto-adjudicated claims, which shortens turnaround times and ensures accuracy. In short, ***we use a higher level of system automation and enhanced quality workflow to significantly reduce the potential for misprocessed claims.*** As such, programming errors are rare within our claims life cycle process. Should a programming or systemic error occur within our process, we have expedited adjustment workflow and recovery workflow processes in place.

Process for Addressing Provider Payment Issues

We will implement the following Mississippi-specific strategies to address Provider payment issues: Provider education program, accurate claims payment system, demographic and payment identifier loads, a proactive testing approach with Providers before go-live, and claims adjudication reports that identify denial levels versus expected levels. This will minimize payment issues during implementation and transition. If variances occur beyond 5% from expected, we will troubleshoot and apply proactive root cause analysis and solution planning with Providers and EDI contractors.

Underpayments. While our goal is accurate and timely payments the first time, we will also maintain stringent systems designed to remediate any payment errors. Underpaid claims will be adjudicated daily outside of the core claims processing system by a ***dedicated Mississippi adjustments unit.*** The adjustments team will review the submission for accuracy, test the claims to ensure updated configuration provides the expected outcome, and adjudicate the claim for immediate payment. To further improve accuracy, adjustment projects will be logged in an online system that captures claim details and root causes for analysis and remediation.

Overpayments. Like underpayments, overpayments can be a result of a variety of factors. Our cost recovery unit will use a proven "three-way" approach to claims recovery: proactive recovery by looking for overpayments in the claims payment system, reactive recovery following notification received from the Provider or Member, and use of vendors for post-payment review. The cost recovery unit will verify the validity of the overpayment, review and address Mississippi requirements, and create the recovery record system. Once we receive the refund, recovery staff will process it and complete recovery retention activities.

Timeline for Correcting Misprocessed Claims

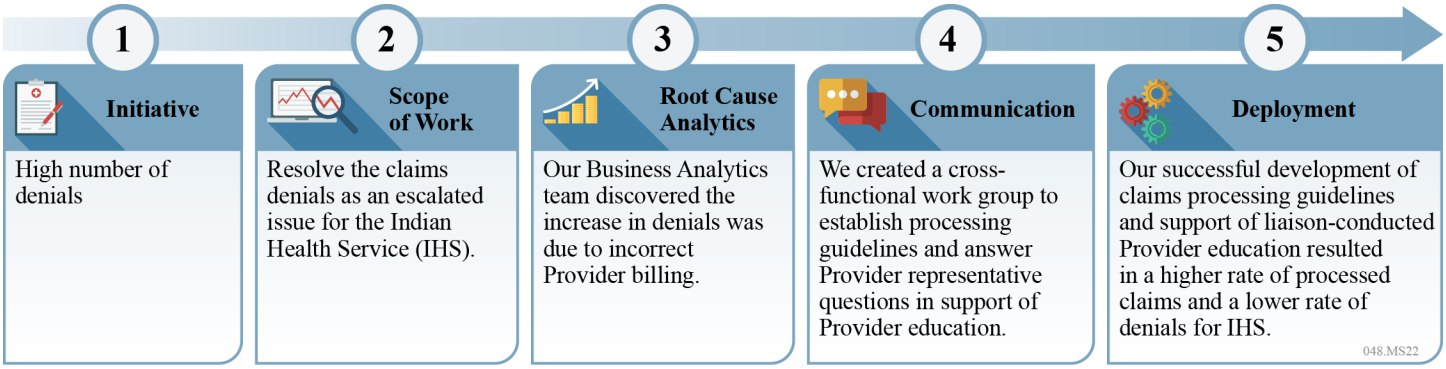
Our target recovery workflow timeline for correcting misprocessed claims is 30 calendar days from the identification of the misprocessed claim. This timeline includes claim overturn, payment, and system configuration, when applicable. We can also pull a claims and adjustment report to expedite the turnaround time based on cause and estimated liability. This is not a frequent occurrence within our process.

A.3.e. Process of Identifying and Addressing Deficiencies or Contract Variances

To ensure payment and program integrity, we leverage our robust reporting and analytics data lake. We generate highly accurate reporting to identify deficiencies or variances with individual claims across the claims processing and payment life cycle. Our claims management task force, a part of our greater claims management team, cross references advanced reporting to assess deficiencies. Based on our findings, we develop a corrective action plan to research, resolve, and report back to team leadership on the resolution of identified deficiencies. A cross-functional Provider payment initiative team has also been formed to identify root causes and mitigate under/overpayments. This team includes individuals with end-to-end work experience who focus on identifying and implementing more efficient claims processes. They work closely with other functional teams, such as the centralized Provider telephonic and web portal teams, to understand common payment inquiries and concerns.

Example of Addressing Deficiency. Exhibit 3 provides an example of how we worked cross-functionally to assess and resolve deficiencies in an affiliate health plan.

Exhibit 3. Resolving a Deficiency for the Indian Health Service (IHS). Our end-to-end claims workflow includes a cross-functional, team-based approach for identifying and addressing deficiencies and variances at each step to ensure a more efficient and refined claims process.



B. TECHNOLOGICAL SYSTEMS

Our health information system supports all CCO Program functional areas, including all implemented and integrated technology systems, subsystems, applications, and components across our operations. The system ensures all data collection and exchange capabilities comply with the requirements in 42 CFR § 438.242 and seamlessly connect in real time and in near real time for Member- or Provider-facing data. Our system architecture and infrastructure will provide the Division and other program stakeholders with superior operational functionality and ensure secure, HIPAA-compliant exchange of health information. The claims processing system and integrated components aggregate critical information from disparate data sources, including the Division, Providers, and Subcontractor systems while maintaining compliance with EDI and HIPAA requirements. We will configure our system to achieve the objectives and meet all standards of our quality assurance program.

For advanced key performance indicator (KPI) monitoring, data insights, and action planning for all business operations and functions, we will leverage advanced BI, a comprehensive data mining and dashboarding solution that provides interactive data analytics, visualization, and business intelligence capabilities, including machine learning and predictive modeling. Advanced BI extracts data from our data lake platform, which resides in the IT cloud environment, and serves as our single source of truth for data aggreged from all fully integrated systems, enabling us to comb through massive amounts of data; discover trends, relationships, and anomalies in disparate data sets; and turn them into valuable business insights.

As shown in ***Table 2, our custom internal executive dashboard leverages advanced BI to give our health plan leadership complete oversight of program-specific data through a single user interface.*** The dashboard unifies data for business performance management, empowering us with the unique ability to consistently measure and analyze the success and efficiency of our business operations, systems, and strategies while also ensuring ongoing quality improvement (QI). Further, as part of our commitment to leveraging technology to give the Division a superior level of program insight and transparency, ***we will design a customized Mississippi partner portal to provide the Division with key insights into operational areas and help analyze trends and the efficacy of initiatives and programs.*** The Mississippi partner portal will leverage the same technology as our internal executive dashboard and will provide authorized Division staff with a snapshot of key program data through a user-friendly interface accessible through a secured HIPAA-compliant CCO Program dashboard.

Table 2. Executive Dashboard and Integrated Data Analytics Suites. We use the power of our executive dashboard to analyze and evaluate business operations and functions and ensure the success and efficacy of our systems and strategies.

Complete Operational and Systemic Oversight of CCO Program Through a Single User Interface	
Technological System:	Executive Dashboard
Programmatic Purpose:	Unifies data for business performance management, providing us with detailed analytics and insight into key functional areas
Core Functionality:	• Enables comprehensive CCO Program oversight and monitoring • Monitors KPIs across operations, programs, systems, and strategies • Generates data visualization and reports with intelligible insights • Delivers data-informed analytics and predictive modeling for action planning and process improvement

Fully Integrated Business Intelligence Suites		
Dashboard Integration	**Performance Function**	**Key Data Elements**
Care Management Suite	Ensures we produce a consistently effective Care Management System/Strategy	• Enables care management program monitoring and adherence • Displays task statuses for monitoring • Monitors staff caseloads for evaluation • Provides outcomes for oversight and monitoring
Quality Solutions Suite	Measures the success of our quality management (QM) strategies	• Displays snapshot of current HEDIS® projects • Provides drill-down statistics across population health categories • Generates quality performance benchmarking • Identifies year-over-year trends
Dashboard Integration	**Performance Function**	**Key Data Elements**
Utilization Management (UM) Suite	Effectively analyzes utilization, and helps us create strategies to ensure utilization is appropriate	• Provides authorization analysis • Enables inpatient and recently discharged monitoring • Provides transitions of care identification and work • Enables high ER utilization reporting • Details UM staff and Medical Director productivity analysis • Provides insight into UM workflow operations • Details authorization turnaround time compliance
Population Health Analytics Suite	Measures the efficacy of our population health initiatives and helps us adjust our population health strategies	• Provides population insights based on demographics, SDOH, and other factors • Evaluates population health outcomes • Measures the effectiveness of our strategies and initiatives on meeting goals and targets • Identifies emerging trends • Prioritizes outreach and initiatives

While our powerful executive dashboard will enable us to continually and effectively evaluate and refine CCO Program operations, systems, and strategies through advanced analytics, data visualization, and predictive modeling, we leverage a variety of systems and tools to support health plan functions and aggregate data. These systems and tools are detailed in the following sections.

B.1 How We Will Leverage Our Technology to Ensure a Consistently Effective Care Management System

Our care management platform supporting the CCO Program will be developed, implemented, and maintained in accordance with the standards and requirements set forth in the Draft Contract. As the core information technology solution for our care management program, our care management platform is fully integrated with our health information system, including our core administrative system (claims processing and information retrieval system).

By centralizing care management activity, information, and documentation into a powerful technology solution, our care management platform ensures that we are producing a consistently effective Care Management System and streamlined workflow for managing all population health program data. The care management platform generates a complete and individualized view of Member information and needs, while also ensuring compliance with NCQA standards, HIPAA, and other State and Federal requirements. The platform resides in our IT cloud and enables workflow across risk, care, and QM activities for government-sponsored healthcare programs, enabling our care team and other clinicians to effectively manage services for Members, regardless of medical complexity or social needs.

Our care management platform gives care team participants direct access to real-time data for program monitoring by combining and organizing data from core administrative and care coordination systems into an integrated view, including all elements of care and population health management as well as UM. The platform also maximizes opportunities for communication and relevant information sharing between key stakeholders in a Member’s health. We accomplish this collaboration by extending access to our care management platform to contracted Providers, including nonclinical community service Providers, to leverage its capabilities for Members under their care. We also educate Providers on how to use the platform for optimal effectiveness. Providers can use the platform not only to collaborate with one another on the care of Members within a region, but to closely coordinate care if Members move between regions. Further, as part of providing care management

in Mississippi, we will develop relationships with both State and local agencies, as well as CBOs, for both input on our Care Management Strategy and Member referrals for services.

By leveraging our care management platform, we will maximize our ability to create and deliver upon Member care plans, as well as identify and address care gaps, specialty services and support needs, and transitions in care, as appropriate. The platform also shares data with Member and Provider portals, enabling real-time access to personal health information, care assessments, and other services. Further, the platform integrates with our print and fulfillment vendor, which allows Member letters to be visible to all core platforms that support Member engagement, either through our call center or through our operational business and clinical departments.

Table 3 details the technologies we will leverage to ensure we produce a consistently effective Care Management System.

Table 3. Care Management System and Functions. Our information technology ensures consistency in care management and coordination by uniting care management functions and data within our powerful, centralized care management platform.

Technological Systems	Description and Core Functionality
Care Management Platform	A fully integrated and comprehensive care management solution that coordinates Member care, services, and outcomes at the individual and system levels. The solution unites care management functions for increased productivity, efficiency, and accurate and timely reporting. It maintains Member care and population health data, care plans, and stratification and interventions, consistent with Medicaid/Medicare requirements. **Major Functional Areas Served:** Central Care Management System and portal
Risk Stratification and Predictive Modeling Platform	Our stratification platform enables early identification of Members' risks and changing needs, so we can align our care management efforts, interventions, and ongoing monitoring to ensure every Member gets the right level of care. Our platform identifies risk level while also providing a complete picture of challenges the Member is facing, including disparities and SDOH barriers, to facilitate targeting Members for early and frequent preemptive outreach. We enhanced our stratification platform to capture potentially preventable events, such as admissions, readmissions, complications, and ER visits. **Major Functional Areas Served:** Member stratification and predictive risk management; identification of Members who may need care coordination and/or care management supports
Client Relationship Management Platform	We leverage our client relationship management platform to provide seamless contact and opportunity management across all systems and channels of care to provide a complete Member picture, enabling insight and engagement opportunities for a deeper understanding of Members. **Major Functional Areas Served:** Member contact management; care management; Member eligibility, enrollment, and disenrollment management
Consent and Preference Management System	Our consent and preference management system captures, manages, and centralizes Member communication consents and preferences. It includes salient metadata, such as the who/when/where of changes, for auditing purposes. It integrates consents and preferences across all Member touchpoints for real-time enterprise view and dissemination to ensure subsequent interactions follow suit. **Major Functional Areas Served:** 42 CFR Part 2 compliance; downstream data usage; interoperability compliance (Member consent for electronic health information exchange)
Telehealth	We use telehealth as a tool for facilitating access to needed services virtually in a clinically appropriate manner that are not available within our network. Our telehealth offering will include access to physical health, behavioral health, and select specialty services. Across our organization, we have effectively used telehealth to facilitate access to needed services, reducing costs by providing an alternative option to expensive urgent care and ER visits. We will expand access to telehealth services by adding direct linkage on our Member portal to our national telehealth Provider, UMMC, and other Mississippi network Provider telehealth sites. **Major Functional Areas Served:** Integrated telehealth solution for real-time care coordination
Mobile Assessment Application	Our mobile assessment application completely integrates with our care management platform. It fully supports assessments and care planning during face-to-face and community-based site visits. Care team participants can enter information and access data, including claims, lab results, past assessments, visit logs, and current care or care plan information. **Major Functional Areas Served:** Care coordination system and portal

B.2 How We Will Leverage Our Technology to Measure the Success of QM Strategies

Our QM processes and systems encompass all aspects of health plan operations, and our quality infrastructure and approach support and inform every element of the Medicaid programs we administer. We leverage a variety of methods, systems, and tools to measure the success of our QM strategies and identify improvement opportunities we will use to drive Member, Provider, and system-wide interventions for continuous QI. Those

primary methods include data and analytics; Member, Provider, and community feedback; and interdepartmental reporting. We will configure our system to achieve the objectives and standards of the quality assurance program.

We maintain a comprehensive platform solution that collects and integrates the data necessary to implement our QM objectives. The platform ensures the information received from all internal and external systems and interfaces is reliable and complete. This data will be used to prioritize areas of emphasis, implement evidence-based guidelines, design interventions, and evaluate the effectiveness of our QM activities. With our Medicaid program experience, we have created an agile framework with capacity for new report development and enhancements that leverage existing reports.

The QM program will leverage our integrated IT platforms to fully support all standard and ad hoc clinical, quality, population health, and SDOH data collection, analysis, advanced analytics, and reporting. The deployment of our QM strategy also supports monitoring call center performance, network access and availability, and Provider performance, including value-based contracting metrics. Our integrated reporting environment is intentionally scalable to meet any new or revised requirements. **Table 4** details the technologies we will leverage to measure the success of QM strategies for the CCO Program.

Table 4. QM Systems and Functions. We leverage a variety of advanced technologies and tools to ensure continuous QI and measure the success of our QM program strategies.

Technological Systems	Description and Core Functionality
QI Tool and Health Equity Dashboard	Our QI tool allows our QM team to review, track, and trend Member gaps in care to identify targeted interventions. Our clinical QI tool pulls data from our comprehensive data lake platform to deliver insights at the Member, Provider, and assigned Care Manager/Care Coordinator level and benchmarks performance against nationally recognized standards, such as NCQA's HEDIS quality measures, State performance goals included in the Division's Comprehensive Quality Strategy, and other statewide initiatives. Our QM team also uses our internal health equity dashboard to assess, measure, and report on the quality and success of population health programs, initiatives, and strategies. **Major Functional Areas Served:** Improve Member outcomes and quality of care; identify over- and underutilization; report quality and population health indicators at the population level and by race and ethnicity, geography, language, and disability status, and by SDOH
HEDIS Engine	Driven by our health quality application, the HEDIS engine supports our HEDIS reporter and analytics platform, enabling us to track and monitor the performance of various medical record review vendors daily to ensure we are capturing the most accurate and timely Member data needed to drive real-time quality initiatives. Administrative data, such as claims/encounters and labs, and supplemental data is fed into our reporting system, and data is refreshed monthly. **Major Functional Areas Served:** QI; reporting
Quality-of-Care Dashboard	Our custom-built, internal management-level quality-of-care dashboard tracks quality of care concerns at the individual case level from identification through investigation and resolution by our peer-review protected professional review committee. We also use our quality-of-care dashboard to review trends and systemic issues and refer them to the professional review committee. **Major Functional Areas Served:** Tracks quality of care concerns; identifies trends and systemic issues for review and resolution
Data Lake Platform	The data lake, which resides in our IT cloud platform, enables us to comb through massive amounts of data; discover trends, relationships, and anomalies in disparate data sets; and turn them into valuable business insights. It is generally used for pre-built predictive analytics. This system will be used for a wide range of key CCO Program needs, such as Member location, health disparity, risk stratification, and SDOH analytics to improve outcomes. The platform serves as our central data repository for claims, reference data, and supplemental claims information, in addition to capitated physical health, BH, dental, vision, and prescription encounters and HIPAA-noncompliant encounter data. Further, it provides data to various downstream applications, including vendor extracts, and provides regulatory and statutory reporting. In addition, the data lake serves as a quality data repository, which we use to manage and prepare data from all internal and external sources, and makes it consumable for our NCQA-certified HEDIS engine. We then produce standardized quality indicators and identify care gaps. We will work with Providers and Members to close these care gaps, helping improve health outcomes. **Major Functional Areas Served:** Reporting; quality insight

B.3 How We Will Leverage Our Technology to Analyze and Ensure Appropriate Utilization

We use nationally recognized, evidence-based criteria to guide clinical decision-making, ensuring program Members receive the right level of care in the right setting at the right time. To effectively analyze utilization and create strategies to ensure utilization is appropriate, our UM systems and processes include end-to-end reporting, auditing, and monitoring of the quality and cost-effectiveness of healthcare resource utilization.

We perform comprehensive analyses of medical utilization trends by area of healthcare service, including inpatient, outpatient, professional, therapies, and durable medical equipment (DME) to identify and address over- and underutilization of services. Our standard UM and KPI reports will monitor utilization trends in the MississippiCAN and CHIP populations. We will use our customizable reports to identify and address utilization trends that may be driven by access issues and/or health disparities and will use this data to support clinical guidelines development; follow evolving trends in healthcare delivery, such as the impact of COVID-19; and monitor changes in authorization request volumes.

***As part of our ongoing IT digital journey*,** we have invested heavily in business automation services by developing and deploying automated tools and processes to enhance UM workflow, such as:

- **Enhanced data integration.** Collaborating with large health systems and Providers to ingest the 278 transaction into EHR technology.
- **Automated prior authorization (PA) process.** Allowing specific procedure and diagnosis codes to be authorized through an auto-expedited workflow.
- **PA lookup tool.** Empowering Providers to quickly and conveniently search for PA codes to determine if a specific code requires approval.

These efforts have proven successful by reducing UM administrative costs, reducing PA decision turnaround times while minimizing transcription errors, addressing Providers' requests while improving satisfaction, increasing access to Provider EHR platforms, and using data to determine over- and underutilization of services.

Table 5 details the technologies we will leverage to effectively analyze utilization and create strategies to ensure utilization is appropriate.

Table 5. UM Systems and Functions. We leverage sophisticated technologies, tools, and processes to effectively analyze utilization and create strategies that improve Members' ability to receive the right care in the most appropriate setting at the right time.

Technological Systems	Description and Core Functionality
Core Admin System	PA requests are reviewed and decisioned in our core admin system. **Major Functional Areas Served:** PA reviews and decision-making
UM Platform	Our UM platform functions as a workflow management system that supports PA, concurrent review, care management, and BH activities. It integrates with clinical guidelines and our core admin system (for eligibility information) and has configurable escalation rules, a user access management function, and comprehensive search functions. The platform supports guiding Providers if a PA is required for a code, utilization review and Medical Director escalation, authorization automation, integrated Member/patient 360 view, correspondence management automation, automatic service-level agreement management and notifications, and analytics and reports. **Major Functional Areas Served:** Pre-certification and PA request management for inpatient/outpatient service requests, referrals, and prescriptions; integration with an automated PA rules engine for auto approvals via our Provider portal; PA-not-required functionality; 278/HIE/HL7® integration; UM; reporting
Provider Portal	Providers submit authorization request to our health plan via the Provider portal. Additional submission options include fax, phone, and mail. **Major Functional Areas Served:** Receipt of authorization request

B.4 How We Will Leverage Our Technology to Measure the Efficacy of Population Health Initiatives and Adjust Population Health Strategies

The overarching goal of our population health approach is to improve health outcomes by building resilient communities. In accordance with Draft Contract § 16.5.2 Population Health Data, our health information system possesses the collection and analytic capacity to execute a population health management program.

To measure and evaluate the efficacy of our population health initiatives and adjust population health strategies, we will use HEDIS; other quality performance metrics; and Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goals developed for each intervention and engagement strategy. For the CCO Program, we will use this information to continuously measure and adjust existing population health initiatives, interventions, and strategies, and develop new approaches as populations' needs evolve over time.

We will leverage both quantitative data and qualitative information—such as Member and Provider feedback gathered through calls to our call center, CBO council meetings, face-to-face meetings with Members and Providers, and regulators—to inform our population health initiatives, strategies, and interventions, and we will

deploy resources by identifying trends and commonalities among Members in each population health stream. While our centralized care management platform remains the system of truth for the larger population health program, we will leverage a variety of systems and tools to measure the efficacy of population health initiatives and adjust population health strategies, as shown in **Table 6**.

Table 6. Population Health Systems and Functions. We will use a variety of systems and tools to aggregate data to measure the efficacy of population health initiatives and adjust population health strategies.

Technological Systems	Description and Core Functionality
Care Management Platform	Our care management platform is part of our larger population health program, which coordinates healthcare through socially and demographically grouped cohorts and physical health and BH needs and includes disease management, QI objectives, and targeted interventions to impact positive health outcomes. **Major Functional Areas Served:** Care management; population health management
Stratification Platform	We conduct data analytics and predictive modeling using our stratification platform to quickly identify Members who need care management and outreach. Analytics allow identification of opportunities to create and implement evidence-based, best practice initiatives delivering excellent and innovative care in the most cost-effective ways. The platform captures a broad array of sources and types of data to create a comprehensive picture of the factors that combine to influence the overall health of the population, including socioeconomic and SDOH factors; cultural, ethnic, and racial factors; and community, health literacy, healthcare access, and cultural impacts. It maps individuals to population health streams and stratifies Members into program-specific risk levels based on factors we consider in determining risk. **Major Functional Areas Served:** Analytics and predictive modeling; stratification informatics; population health insight and risk level assignment
HIE and Admission, Discharge, and Transfer (ADT) Feeds	Our population health team monitors HIE data and real-time ADT feeds across practices and Provider sites, including PCPs and high-volume specialists, for utilization trends in primary care and ER use. Using real-time data provides us visibility into ER admissions, so we can quickly triage Members to a Care Coordinator. **Major Functional Areas Served:** Determine over- and underutilization; care management triage
SDOH Closed-loop Referral System	Our SDOH closed-loop referral system is a social care platform that offers access to all social programs that address SDOH issues in our communities, such as access to food, housing, and transportation. **Major Functional Areas Served:** SDOH referral system to connect Members to services
Chronic Illness and Disability Payment System	By leveraging predictive modeling software, our chronic illness and disability payment system begins our stratification process upon notification of enrollment for all Members. Our chronic illness and disability payment system, along with other tools and software, uses historical and State data to initially identify Members who could be considered high risk. **Major Functional Areas Served:** Member stratification; predictive modeling; identifying Members who may be high risk

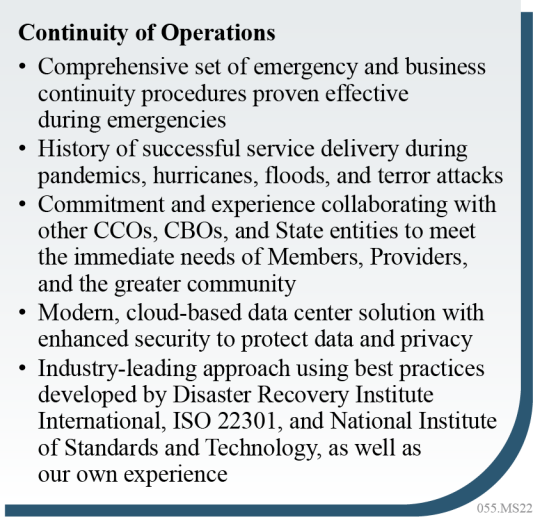
Our QM program's infrastructure spans our entire organization, with critical responsibility for quality in every department. Our QM program identifies the core responsibilities of each department, and they leverage the advanced technologies described throughout the response to this section to deliver consistently effective programs, strategies, and initiatives for their respective functional or operational service areas. Health plan leadership is empowered with a heightened level of quality oversight through our comprehensive executive dashboard, which leverages powerful technology to unify data for business performance management across all health plan functions and operations. In support of CCO Program operations, we will leverage advanced technologies to consistently measure and analyze the success and efficiency of all business operations, systems, and strategies while also ensuring ongoing QI.

[redacted].

4.2.2.6 Appendix 1: D. Continuity of Operations

D.1. Our Proposed Emergency Response Continuity of Operations Plan

Our approach to disaster recovery and business continuity, within our continuity services function, is comprehensive and aligns to industry best practices. This function is staffed with highly experienced, skilled, and trained professionals and consists of the following disciplines: emergency management, incident management, crisis management, business continuity, disaster recovery, and third-party resilience. The leadership at the helm of our program has over 80 years of experience and expertise, our Business Continuity Management (BCM) leadership team oversees and administers the business continuity and disaster recovery (BCDR) plan and maintains up-to-date business processes and information. We are supported by a continuity services executive and a Crisis Management Director with more than 20 years' experience each. Our Business Continuity Director has more than a decade of experience, and our Disaster Recovery Director offers 30 years of information services and technology experience.



Our emergency response capabilities have been tested successfully through various disasters over the last few years during a range of disasters and crises, including hurricanes, fires, and the ongoing COVID-19 pandemic. Additionally, we have successfully faced multiple large-scale disasters elsewhere, including hurricanes Laura, Sandy, and Maria; west coast wildfires, and the southern deep freeze of 2021. Our comprehensive approach to emergency response and continuity of operations planning captures mission-critical services, functions, technology systems, and associated infrastructure. We are prepared to leverage our knowledge, capabilities, and extensive experience to ensure continued services to support Division staff and CCO Program operations, Members, and Providers.

Case Study: Devastating Tornadoes

In December 2021, when devastating tornadoes struck, one of our affiliate health plans took immediate actions to support our staff, Members, Providers, and their communities. Within the first 24 hours our organization:

- Engaged our affiliate's ***local incident management team and our enterprise crisis management team*** to assist with quickly dispatching resources and support
- Used our ***emergency notification system and threat intelligence platform*** to pinpoint potentially impacted staff and facilities and reached out to them to ensure they were safe
- ***Contacted all Members in the hardest hit communities*** and continued outreach to all Members in the surrounding counties in the days that followed
- Ensured every ***Member in active case management or in the middle of an inpatient stay*** was contacted to confirm they were safe and to help with healthcare needs
- Ensured every Member in the impacted counties who filled a prescription in the last 30 days received a text to notify them that our affiliate health plan was ***approving emergency medicine refills*** for anyone who lost their meds during the storm and where to go to get them
- Arranged for a truckload of ***water and other emergency supplies*** for the hardest hit community
- Worked with ***local community organizations*** to provide additional resources and mobilized staff to help with local community recovery
- Donated $200,000 to a ***tornado relief fund***

Bringing Best Practices for Collaboration Across Mississippi

At our organization, facilitating exceptional care for Members covered by government contracts like the CCO Program is our only business, not just a line of business. As such, our emergency response and business continuity plans will be tailored specifically to meet the needs of Mississippi and requirements of the new Contract. We are committed to partnering with the Division, fellow CCOs, CBOs, and Providers to share our best practices and to ensure continuity of care for Members, no matter the incident.

As a best practice, we collaborate with fellow CCOs in preparation for and during an incident. For example, during hurricanes, members of our incident management team worked directly with fellow CCOs to provide, store, and distribute supplies in affected areas, storing the supplies when they arrived and distributing them to Members and employees. In preparation for a disaster, we will facilitate webinars and an in-person symposium with fellow CCOs, Division staff, and industry subject matter experts (SMEs) to educate, train, coordinate, and plan as a cohesive front for any disaster that could affect Mississippi and its MississippiCAN and CHIP populations. This proposed format also supports cybersecurity and privacy.

Using our proven incident approach and experience, along with our highly skilled and trained teams, we will ensure our plan is tailored to mitigate incidents that may impact Mississippi. We look forward to bringing our best practice of collaboration and communication with fellow CCOs to Mississippi.

We summarize our plan addressing aspects of pandemic preparedness and natural disaster recovery within the remainder of this section.

Emergency Response Continuity of Operations Plan

Our proposed BCDR plan details the policies and procedures we have in place to deal with states of emergency and public health emergencies, in accordance with the Draft Contract, § 4, Covered Services and Benefits. It also includes processes for continuous testing of system functions to ensure ongoing continuity of covered services and benefits for MississippiCAN and CHIP Members that continuously exceed the minimum service requirement through the programs, initiatives, and other service items enumerated throughout the Draft Contract.

The BCDR plan conforms to strict State and Federal requirements and guidelines and ensures that critical processes and data are maintained for Provider and customer support services. It also defines protocols to notify Providers and appropriate government agencies if an incident negatively impacts our business. We will further tailor our plan upon contract award to meet specific Mississippi Medicaid Coordinated Care program requirements and collaborate to ensure we are all collectively meeting the needs of impacted membership. We will submit our BCDR plan to the Division for review and approval during readiness review and on an annual basis over the course of the contract.

We continuously optimize the distribution of services across the hybrid cloud to ensure the best Member and Provider experience. We ensure that mission-critical systems meet or exceed operation requirements. All critical services are deployed into a primary and disaster recovery site and feature local high availability with remote disaster recovery. This means that enrollees and Providers will not typically experience outages outside of scheduled maintenance periods and declared disaster recovery incidents. We distribute technology systems and services across a hybrid cloud composed of four operating locations:

- **Primary:** South Central US
- **Secondary/disaster recovery:** North Central US
- **Systems:** Our owned-and-operated data center
- **Disaster recovery:** Our owned-and-operated data center

Our IT environment is architected to rapidly recover critical business functions, applications, and individual systems to either the same or an alternate data center regardless of the event causing the outage.

Additionally, data center and network operations center staff monitor systems, including applications, databases, network, and routers/switches. We have a suite of proactive enterprise monitoring tools that monitor systems, applications, and infrastructure performance to provide early detection of episodes that impact operations. We have also established an incident management process via an IT service management program, which allows for timely resolution of business-critical incidents. We notify impacted stakeholders of incidents that affect business users and provide regular updates until issue resolution, including a dashboard where real-time information, including network activity from our data center to our office locations, can be viewed.

D.1.a Employee Training

We provide training annually to employees responsible for BCDR plan development and recovery procedures as noted in **Exhibit 4**. Topics typically include individual responsibilities, Division-specific processes, and plan preparation, coordination, and communication procedures. Member and Provider services call center employees are trained to respond to calls and can contact our organization's medical professionals as needed. We use a multifaceted training approach that follows FEMA recommendations. We will also provide education and training to Providers to enhance awareness and help develop an understanding of emergency protocols and expectations.

Exhibit 4. Employee Emergency Preparedness Training. All employees participate in annual training to create awareness and promote preparedness.

Bolstering our overall employee preparedness, ***we have over 400 people to serve on our crisis and extended incident management teams***. In addition, critical employee leaders and employees in Member- or Provider-facing roles receive specialized training at least annually. For example, our Mississippi health plan ***Care Managers will receive emergency management training at the start of employment and annually thereafter.***

Our crisis and incident management teams conduct training tailored to specific emergencies likely to occur in locations where we provide services. These teams will develop training for our MississippiCAN and CHIP team, ensuring they have the tools, processes, and resources they need to provide the right response when it is most critical. It is important to note that, if a natural disaster renders call center operation inoperable in the State, our automatic call distribution will route callers to overflow call center operations throughout the US to ensure seamless continuity of service for both Members and Providers. As such, we cross-train our teams across locations, so we will be ready to support the CCO Program at a moment's notice. In fact, as part of our business continuity load balancing and risk reduction strategy, our call center staff in other States will take CCO Program Member calls on a daily basis to ensure ongoing education and training.

D.1.b Essential Business Functions and Responsible Key Employees

Within our BCDR plan, we identify essential business functions and employees needed to address critical operations and support functions to enable continued operations with minimal disruption. Care Managers will prepare Members and their caregivers ahead of time by providing emergency contact information and sharing expectations related to services and procedures. Partnering with Members, Care Managers will also develop and document backup plans that address emergency disruptions.

Our BCDR processes address accessibility and continuity of care management, UM, and pharmacy services for Members and Providers during business interruptions. Our plan will ensure all critical business functions remain operational in the event of an unanticipated interruption to normal business operations, which may include a network or power outage, weather events, fire, terrorist events, or security emergencies.

Commitment to Serving Where We Live

Our organization is committed to serving Members and the communities where we live. To support and encourage our employees to volunteer in community-based initiatives, ***we offer three days paid volunteer time to our employees to assist in these efforts.***

To support and encourage our employees to volunteer in community-based initiatives, we offer **three days paid volunteer time** to our employees to assist in these efforts.

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Through our protection services operations center, we continuously proactively monitor for potential threats that could impact our operations or Members. When we identify a threat to Member-supporting operations or that impacts Members directly, we distribute notifications to key leadership to ensure prompt actions are taken to respond to the situation and continue critical services. This response is part of our standard and expected BCDR operations. However, in the aftermath of a disaster or emergency, such as a recent Category 4 Atlantic hurricane

that ravaged the southeastern US, employees across our health plans volunteer to serve in their communities to assist as part of stabilization and cleanup efforts. Further, ***as part of our mobile health program, we can quickly activate our mobile units and semi-permanent trailers from other States to assist in relief efforts*** in the community in the immediate aftermath of a severe event.

D.1.c Contingency Plans for Covering Essential Business Functions

Our comprehensive BCDR plan supports the resumption of critical business functions and information systems in the event of a disaster. We have identified and trained incident management teams to execute necessary steps. Our recovery strategies consider loss of staff and loss of location scenarios. We have trained response teams who execute necessary steps and recovery strategies. We also have the capabilities to operate fully remotely when necessary, which mitigates situations when the workplace becomes unavailable. Due to the COVID-19 pandemic, most staff are currently working remotely, and we can quickly and safely enable staff to resume operations in the workplace. ***Employees in critical operational functions are cross-trained at other locations to allow the transfer of workload if one location is impacted by an incident.***

Technology controls include high availability to maintain operations during minor disasters, such as a single floor or a single building that is impacted by a virus attack or power outage, and a disaster recovery data center to support failover of critical systems.

Once life safety is ensured, greater focus will be placed on the resumption or continuity of business operations. The business continuity team will facilitate the various planning elements involved. Development and ongoing refinement of our program will be based on continually updated risk assessments and business impact analyses. Risk assessments identify internal and external risks that can potentially impact business operations. By assigning a probability and impact to each risk, criticality can be established, which helps to rank the risks and prioritize mitigation efforts.

The business impact analysis identifies essential business functions and the potential impact an incident could have, which aids recovery prioritization. In addition, it captures IT applications and resources required to support business functions. The tool also maps out business and technological dependencies that allow for streamlined preplanning and incident mitigation. As part of the business impact analysis, we analyze the impact of interruptions to key service requirements to set recovery time objectives and determine an optimal approach to risk mitigation and disaster preparedness. We will update the risk assessment and business impact analysis at least annually. The strategic objectives of the business impact analysis study identify the existence and relative criticality of the following key elements and determine the impact upon those elements of an unplanned disruption to normal business activities:

- Key business processes
- Key personnel
- Human resources policies
- Computer systems and recovery procedures
- Communication systems
- Interdependencies between key business processes, personnel, and systems
- Vital records
- Dependencies upon critical vendors
- Worksite vulnerabilities
- Availability of alternate work facilities

As shown in **Table 10**, our business recovery procedures are developed to prescribe steps to restore departmental operations.

Table 10. Essential Business Operations and Contingency Plans. To ensure continuity of services to Members and Providers during an emergency or disaster, essential operational functions and systems are designed with high availability, with contingency plans in place to restore business operations expeditiously.

Essential Operational Function	High-level Overview of Contingency Plan
IT	High availability, data replication, backups
Call Center	Cross-training of staff for active call sharing strategy across different sites

Essential Operational Function	High-level Overview of Contingency Plan
Care Management	Many staff work in the field and have remote capabilities; staff can work on-site if field work is impeded; office-based work is handled by those able to work remotely
Claims Processing	Shared services are geographically dispersed; cross-training among sites; redundancy is built into electronic processing of claims
Member and Provider Grievances and Appeals	Transfer workload to a site that is not impacted
Pharmacy	Cross-training of staff; transfer workload across multiple locations
Provider Services	Staff have ability to work remotely or on-site; cross-training of staff
QI	Staff have ability to work remotely or on-site; cross-training of staff
UM	Cross-training of staff; transfer workload across multiple locations
Member and Provider Portals	Network redundancy, high availability, backups

D.1.d Communication with Staff and Suppliers when Normal Systems are Unavailable

If normal systems are unavailable due to a business interruption, our BCDR plan indicates the order in which essential parties are notified as well as time frames for notification. We leverage appropriate communication channels to notify Members, Providers, and the Division, including updating our automated call distribution message, our Member and Provider web portals, and our corporate website with appropriate information and instructions.

We use an emergency notification system to broadcast critical information to key personnel identified with the plan and impacted employees and stakeholders. ***The incident notification system sends emails, texts, and phone calls (personal and work) to our staff and is tested biannually.*** The incident notification tool will have a conference bridge feature, allowing for support teams and business leadership to collaborate upon notification. We also maintain a status line that employees can call for information regarding the status of an incident that affects their office or location.

In the case of a business interruption, specific operational departments contact suppliers to relay information regarding service interruptions. Furthermore, during certain incidents when a Provider or supplier calls into our call center, they will immediately hear a tailored message with pertinent incident information. We also have outbound fax blast and email capabilities for sending messages to Providers or suppliers during an emergency.

We will notify the Division regarding relevant and major incidents, such as those impacting critical operations like delivering services to Members and stakeholders, by contacting relevant individuals per contract guidelines.

D.1.e Plans to Ensure Continuity of Services to Providers and Members

Our BCDR policy and process address accessibility and continuity of care management, UM, and pharmacy services for Members and Providers during business interruptions. This will ensure all critical business functions remain operational in the event of an unanticipated interruption to normal business operations, which may include a network outage, weather events, and medical, fire, and security emergencies. This plan will provide for the continuation of critical services if such a business interruption occurs.

The Mississippi incident management team will collaborate with core teams, such as the Member services call center; healthcare services, including care management and UM; and medical affairs to review impact to membership and develop the necessary work-around procedures to meet the needs of our most vulnerable Members. We have identified recovery strategies to continue operating depending on the length of the incident. Departments have identified and documented operational business recovery procedures to restore each of the critical business functions. Disaster recovery plans are categorized by department, business function, and recovery time objective.

Additionally, Providers are contractually required to provide and coordinate all covered services to Members. In doing so, our goal is to maintain operational quality management standards and continuity of services, if possible and appropriate, even during a disaster. Further, we do not require PA for medical services during disasters. Hospitals and Providers are expected to provide necessary services and advise us thereafter.

Ensuring Continuity of Care for Members

Care Managers and UM staff will be available during and after a disaster to help Members and Providers obtain necessary care and services. Care management staff will work proactively with vulnerable Members in areas prone to significant weather events, such as flooding and tornadoes, to develop an action plan in the event of an emergency.

Additional information regarding emergency preparedness will be located on the Member portal, the public website, and through our mobile app. Furthermore, during certain incidents, when Members call our call center, they will immediately hear a tailored message with pertinent incident information. We have outbound SMS text message capabilities and can send messages to Members during an emergency. Helping Members and the Division by preplanning before a disaster is also part of our emergency response and disaster recovery plan.

The plan is given a prioritized leveling to ensure safety and that the resources to meet Member care needs are accessible, including access to housing, food, medication, power sources for DME, and identification of local emergency contacts and personnel to assist if needed. UM staff, the clinical pharmacy team, and Medical Directors will work with government contracts and compliance teams to ensure regulatory approvals and prioritization take place during natural disaster events.

Care Managers inform Members and their caregivers of services and procedures during and immediately following an emergency, including targeted outreach to Members on the county emergency management office's special needs registry. To assist in emergency care planning, we document whether the Member intends to evacuate or remain in their residence in their file and whether, during the emergency, their caregiver can take responsibility for services normally provided by our vendors or if we need to continue services. We document the plan of care during and following an emergency.

If operations cease due to a disaster, we inform affected Members and notify respective facilities where they receive services to make arrangements for continued essential services. The care management team's responsibilities following an emergency or disaster event include:

- Recontact all Members to ensure no changes in status or residence
- Identify any immediate interventions needed and develop the Member's plan
- Provide additional service coordination for Members displaced by disaster to meet current needs
- Expedite service coordination for Members who contact our call center or care management staff as determined by urgency of need
- Provide Members who have relocated temporarily with instructions on how to apply for services in area of current residence (Members may receive authorizations for service with noncontracted Providers during a limited time while they establish new residence and apply for new services.)

Members continue to have access to our Nurse Advice Line, our BH/SUD line, and through our national telehealth Provider to ensure continuity of care.

We commit to coordinating and collaborating with the Division and their selected PBA on emergency protocol when a declaration of emergency is issued to help ensure Members have access to medications.

When any of our service areas are affected by a disaster and a declaration of emergency is issued, our pharmacy team will collaborate with the Division and the PBA to initiate standard operating protocols, which include:

- Enabling the pharmacies to bypass early refill, PA, and non-formulary edits without calling us or the PBA (72-hour emergency override)
- Allowing the PBA pharmacy and Member call centers to authorize medications that edit beyond the scenarios mentioned above, on behalf of our health plan
- Specialty and mail order programs will ship to alternative addresses to ensure continuity of care

The PBA will notify the pharmacy network of the above protocols via email/fax blast and by posting them on their website. The protocols are also listed in the Provider manual. Under the guidance and instruction of the Division, we will leverage our experience and resources to help provide consistency and ease of administration during an emergency.

Ensuring Continuity of Services to Providers

Providers will be contractually required to provide and coordinate all covered services to Members. It is also important to note the following:

- We will not require PA for medical services during disasters.
- Hospitals and Providers will be expected to provide necessary services and advise us thereafter.
- Information regarding disaster recovery protocols will be available in the Provider manual. The manual also outlines Provider expectations for ongoing Member support if a Provider experiences a disaster.
- We will alert the network of the incident and provide information regarding protocols via email/fax blast, the Provider portal, Provider call center, and public website.
- During certain incidents, when a Provider calls into our call center, the Provider will immediately hear a tailored message with pertinent incident information.

Additionally, we have outbound SMS text message and fax capabilities, and we can send messages to Providers during an emergency.

Recovery Time Objective for Major Components

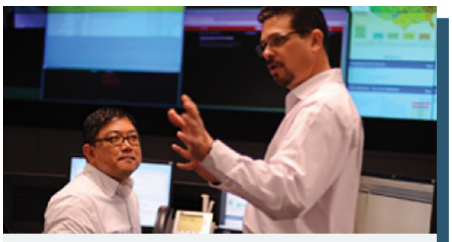
Our 12-month average availability for major systems is 99.99%, with a recovery time objective of 0 to 24 hours. In the event of an emergency or disaster, Members and Providers can expect communications systems to continue working. ***Once the disaster recovery plan has been invoked, restoration of essential operational functions and transactional systems can be expected within 24 hours.*** Reporting and analytics will be recovered after transactional systems. Through collaboration with the Division, we will configure our plan, including time frames of expected restoration of services to meet State needs and contract requirements. **Table 11** summarizes our recovery time objectives for major components.

Table 11. Recovery Time Objectives for Major Component. We analyze the impact of interruptions to key service requirements to set recovery time objectives to minimize downtime of essential operational functions and transactional systems.

Systems	Experience/Recovery Time Objectives
Communications: Telephone, Fax, Email	Available during recovery
Member and Provider Portals	Restored within 24 hours
Transactional Systems: Claims, Utilization, and Care	Restored within 24 hours
Reporting and Analytics	Restored within 48 hours

D.1.f Security and Privacy Requirements

HIPAA, the HIPAA Privacy Final Rule, and the American Recovery and Reinvestment Act of 2009 requires that covered entities protect the privacy and security of individually identifiable health information. In compliance with program requirements, we will execute the Division's BAA and DUA before contract execution. We confirm that all activities under this contract will be performed in accordance with all applicable Federal and/or State laws, rules, and/or regulations and the provisions of the Draft Contract, §15.29, Privacy/Security Compliance.



More Than an Ounce of Prevention

Simply preparing to recover systems and data isn't enough. We proactively monitor them, too. For example, we invested in a state-of-the-art enterprise cyber defense system that, among other functions, includes a computer incident response team to address cybersecurity threats as they materialize.

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Cybersecurity. Our cyber defense system monitors systems for unusual activity around the clock. Systems, processes, and procedures are in place to prevent malicious acts and to remediate them when detected. The information security incident response plan will document the steps to take for remediation. The security operations center portion of our cyber defense system will maintain constant vigilance for malware attacks. For suspected malware infections, the computer incident response team of the cyber defense system will investigate conduct a thorough investigation and take appropriate measures to remediate.

Physical Security. We have a physical security team staffed with knowledgeable and experienced security professionals who oversee and administer the security program, policy, and physical access controls at our

facilities. Our physical security team monitors our security perimeter 24/7/365 for threats and maintains up-to-date information on our access control systems. Our facilities are protected using industry best practices, including physical perimeter access controls, sentinel surveillance, intrusion monitoring technology, and an ongoing employee training program.

Data Backup. Data backups will be performed on a server-by-server basis, so there will be some variations based on what is requested by the system owner. Typically, a full backup will be performed every weekend (termed “weekly”), and a differential backup will be performed nightly (termed “daily”). The first weekly backup of the month will be identified as the monthly backup. Each backup will be retained at the primary data center for 35 days and duplicated to the disaster recovery site, where it also will be retained for 35 days. Monthly backups will be archived at the recovery site and retained as required by our data retention policy. Per policy, files will not be stored on workstations, and backups will not be performed on workstations.

D.1.g Testing Plan

We will conduct tests annually and on an ad hoc basis through simulated disasters and lower-level failures. Our BCDR plan includes comprehensive annual testing of critical systems and business functions to ensure we meet recovery time objectives and recovery point objectives. A summary report of BCDR plan testing, including results, will be provided to the Division on an annual basis within 30 days of the request. The report will include the test results, failure points, and any necessary CAPs.

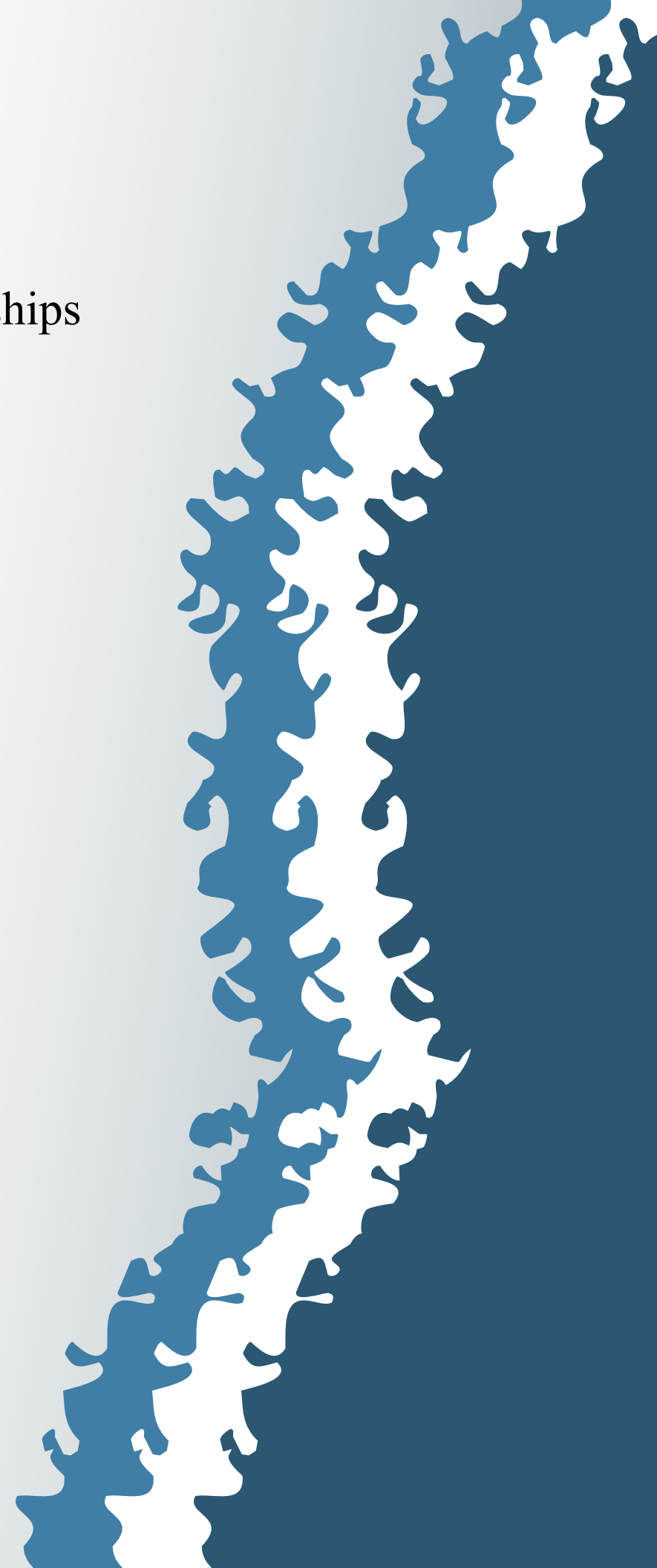
To help provide continuous care and services, our BCDR strategies include annual system testing to demonstrate system restoration as required. IT services include core, care, and web portal systems; infrastructure, including servers, databases, telecommunications, network, and data centers; daily help desk and desktop support; and support for regulatory submissions to State and Federal entities. Business users will be engaged at their respective office location or may test from home, as the testing scope warrants. This will ensure our ability to provide access to critical information related to Member and Provider services.

Additionally, an annual business continuity exercise will incorporate incident management team training, including topics such as incident management team roles and responsibilities, incident assessment, and incident action plan development, culminating in working through an exercise scenario. The exercise will address preplanning and assess our ability to transfer some or all operations to other locations, sustain operations over an extended period, and/or sustain operations with a reduced number of staff.

[END Of RESPONSE]

4.2.2.7

Subcontractual Relationships and Delegation



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4.2.2.7: SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION

A. SERVICES TO BE SUBCONTRACTED

The Subcontractors we have selected for the CCO Program will support us in delivering the full scope of covered and value-added services. We recognize that we are ultimately accountable for and must oversee all functions and responsibilities are provided through Subcontractors. We are committed to diligent and robust performance, oversight/monitoring, QM, and financial stewardship of the CCO Program on behalf of the Division.

Our four proposed Subcontractors have established relationships with us and solid track records of successfully serving Medicaid and CHIP populations.

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While we subcontract certain services as permitted under applicable regulatory requirements, we do not delegate management of any potential risk related to the provision of those services. We take full responsibility for Subcontractor performance; therefore, we select Subcontractors only after diligent vetting and confirmation of their proven records of high-quality service for the benefit of CCO Program Members. We hold ourselves and our Subcontractors accountable for Member outcomes, overall performance, and every dollar spent. All our Subcontractors are located in the US.

Our Subcontractor oversight program will be customized for the CCO Program to ensure ongoing oversight of Subcontractor services, receipt and reconciliation of all required data, appropriate utilization of healthcare services, delivery of administrative and healthcare services that meet RFQ-required standards, adherence to required grievance policies and procedures, and a timely and effective process for addressing Subcontractor deficiencies or contractual variances.

A.1 Services We Plan to Subcontract if Chosen as a Contractor

The services we plan to subcontract are described below.

Administrative and Healthcare-related Services. Our parent company is an experienced managed care company that provides healthcare services for Medicaid, Medicare, CHIP, and other government healthcare programs. They will provide the following services:

- Human resources and training
- Facilities
- IT
- Legal
- Marketing and public relations support
- Corporate finance
- Claims
- Clinical programs
- Member/Provider call center overflow
- Administrative clinical program support
- Clinical telephony
- Network management support
- Healthcare services support

Vision Services. This Subcontractor will provide routine vision benefits, including eye exams and eyewear. They will also be responsible for maintaining and managing the following services:

- Provider network of optometrists, retail providers, and opticians
- Provider education
- Provider network development
- First-level Provider appeals
- Resolution of Provider issues
- Customer service functions for Members and Providers
- Claims processing for post-service payments
- Benefit and eligibility administration
- Value added benefits

Dental Benefits. This Subcontractor will provide dental benefits administration that includes:

- Member and Provider call center services
- UM
- End-to-end claim processing
- Instant online claim estimator
- Instant online explanations of benefits
- Provider profiling reports and analytics
- Integrated benefit portals for Providers and Members

NET services. This Subcontractor will provide 24/7/365 non-emergent medical transportation, NET, and non-emergency ambulance and stretcher services using, as appropriate, sedan and taxi service (excluding rental cars), wheelchair van transport, stretcher transport, volunteer drivers, and gasoline reimbursement programs.

All vehicles used to provide transportation services to eligible Members will comply with applicable State and Federal safety standards. If the Subcontractor's network transportation providers are incapable or unwilling to provide adequate transportation services to Members, they will coordinate and compensate other networks to provide the required services.

A.2 Our Relationship to Potential Subcontractors for Each Subcontracted Service

We have identified four Subcontractors to provide services for the CCO Program. For each Subcontractor, our business relationship is that of Contractor–Subcontractor. We have no ownership and/or control of any proposed Subcontractor.

We have active contracts and ongoing successful, collaborative working relationships with all four Subcontractors. The lengths of experience with the Subcontractors are:

- Three years with the administrative and healthcare-related services Subcontractor
- Three years with the vision Subcontractor
- Five months with the dental Subcontractor
- One-and-a-half years with the NET Subcontractor

As discussed in our response to RFQ § 4.2.2.7.B, all Subcontractors understand our policies and procedures and actively participate in our rigorous Subcontractor oversight program as a condition of our agreements and partnership with them.

For the CCO Program, we make the following commitments:

- All Subcontractors will comply with applicable Contract and Division requirements.
- Our relationship with Subcontractors will comply with applicable RFQ requirements, including Draft Contract § 1.9, Ownership and Financial Information and § 13, Subcontractual Relationships and Delegation.
- We will not subcontract any portion of services to be performed under this Contract without the prior written approval of the Division.
- Any subcontract must be submitted to the Division for advance written approval.
- The Division may inspect, evaluate, and audit any of our Subcontractors at any time.
- The Divisions shall be indemnified by us for all claims that arise against any Subcontractor.

B. SUBCONTRACTOR OVERSIGHT

B.1 Subcontractor Oversight Program

Our Subcontractor oversight program will be customized for the CCO Program to ensure:

- ongoing oversight of Subcontractor services,
- receipt and reconciliation of all required data,
- appropriate utilization of healthcare services,
- delivery of administrative and healthcare services that meet RFQ-required standards,
- adherence to required grievance policies and procedures, and
- a timely and effective process for addressing Subcontractor deficiencies or contractual variances.

In this response, we first describe the most critical step in ensuring a successful relationship with a Subcontractor: the pre-delegation audit. We then describe our Subcontractor oversight program, with specific information that responds to the requirements in RFQ § 4.2.2.7.B.1.a–h.

Pre-delegation Audits

When we identify a need for Subcontractor services, we place a high priority on identifying potential Subcontractors with prior Medicaid and CHIP experience. We then prequalify each Subcontractor using a comprehensive pre-delegation audit process to evaluate their ability to meet or exceed contractual agreements; program requirements; applicable CMS, Federal, and State requirements; applicable NCQA standards; and our company's compliance program standards.

Our due diligence process is exhaustive, including:

- Interviews with Subcontractor staff

- Review of the Subcontractor's website, policies, procedures, documented workflows, committee minutes, and other files as applicable
- Assessment of financial qualifications and strength
- An information security assessment to ensure that their infrastructure can effectively protect Members' protected health information

We spend as much time as needed to ensure we have the right Subcontractor for the job. A highly complex audit might take more than 500 hours to complete.

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Every step of the pre-delegation audit is evaluated through the "eyes and experience" of the Member. When we interview Subcontractor staff, for example, we assess their level of courtesy and helpfulness from the perspective of a Member who calls the Subcontractor for information or to schedule an appointment. We navigate the Subcontractor's website to see if it will be user-friendly for the Member. We may even call the Subcontractor's call center line to listen to the voice prompts and find out how many transfers are required to speak with a representative.

The scope and duration of each audit is driven by the complexity and number of functions to be subcontracted. A highly complex audit—for example, of a Subcontractor who will provide Member-facing services such as vision or dental benefits management—might easily take more than 500 hours.

After the pre-delegation audit is complete and we have decided to engage the Subcontractor, we carefully draft, negotiate, and execute all applicable BAA, nondisclosure, independent contractor, and other necessary agreements to document the Subcontractor's services and/or delegated functions for each contract. The written agreement that governs our monitoring and oversight, which we refer to as a delegation agreement, will meet all requirements in Draft Contract § 13, including:

- Delegated activities or obligations and related reporting responsibilities
- File exchange and encounter data submission requirements
- Operational service-level and key performance standards
- Member rights regarding grievances and appeals, State fair hearings, continuation of benefits during pending appeals, and (for CHIP Members) independent external review rights
- Provisions protecting Members against balance billing
- Provision regarding gratuities
- Revocation and termination/sanctions language if a Subcontractor's performance is not satisfactory
- CAP process and expectations
- Language that confirms the right of the Division and Federal regulators with jurisdiction to inspect, audit, and evaluate Subcontractor books, records, contracts, computers, or other electronic systems for up to 10 years after the end of the Contract period or the date of completion of any audit

In addition, each delegation agreement will include any language the Division has identified within the Contract that governs Subcontractor oversight.

B.1.a Ongoing Oversight of Subcontractors

Our program to conduct ongoing, disciplined, and robust Subcontractor oversight ensures high-quality services and effective delivery of subcontracted services to Members and Providers. We take our responsibility to reduce potential risk to our organization and the Division seriously and derive the most value from our third-party partners.

Summary of Oversight Activities

Subcontractor oversight requires established policies and processes, accountability, and an unwavering commitment to review performance, audit subcontracted functions, and stay in close communication with Subcontractors, the Division, and other stakeholders. In addition, we must work diligently to help Subcontractors meet our high standards of performance excellence and, if needed, correct poor or nonperformance with CAPs and other contract enforcement options.

Our Subcontractor oversight activities are summarized below.

Reports. We review daily, monthly, and quarterly reports outlining performance of delegated responsibilities, such as file exchanges and call center statistics. We access every available source of information to help assess performance. For example, when we do our monthly review of complaint/grievance reports we assess the data against indicators of Member and Provider satisfaction. The outcome may be not only a CAP to improve Subcontractor performance, but also modifications to policies and procedures to help improve overall delivery of services.

We access every available source of information—from call center statistics and satisfaction surveys to complaints and grievances—to help assess Subcontractor performance and support optimal delivery of subcontracted services.

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All reviews are conducted to ensure delivery, accuracy, and completeness of Subcontractor services. We use report data to confirm compliance with the State's metrics and key performance indicators. We also analyze data to identify any emerging risks that, once identified, can be swiftly addressed, remediated, and/or mitigated.

Audits. We conduct audits for each function delegated to each Subcontractor every year, more frequently when requested by the Division or as required by State or Federal agencies. Annual audits follow a format similar to pre-delegation audits. We also conduct ad hoc audits if we identify noncompliance or a trend in Member complaints received by call center staff. Our State delegation oversight committee reviews annual and ad hoc audit results and decides on the appropriate course of action, which may range from a CAP to termination, if necessary.

Meetings. Regularly scheduled internal meetings are opportunities to assess Subcontractor performance against key performance indicators. We also conduct monthly and quarterly meetings, in many cases jointly with Subcontractor staff and appropriate program stakeholders, to discuss Subcontractor performance and opportunities for improvement.

CAPs and Other Contract Enforcement Options. Our policies and procedures include guidelines for enforcement of nonperformance and corrective actions used to improve performance, typically in the form of a CAP. Our subcontracts provide for financial penalties for Subcontractor noncompliance. Subcontractors may be sanctioned, required to pay penalties, or have their delegated functions revoked if performance is inadequate. In the event of a Subcontractor's significant underperformance, the subcontract may be terminated.

Organizational Infrastructure that Supports Subcontractor Oversight

Our Mississippi based Compliance Officer, in conjunction with our Chief Executive Officer (CEO), directs our CCO Subcontractor oversight program and receives support from our delegation oversight experts across our organization, as well as the delegation oversight committee, compliance committee, QM committee, and joint operating committee(s), as applicable. The functions and structure of these entities are detailed below.

Delegation Oversight Staff The delegation oversight staff lead and oversee day-to-day Subcontractor oversight, auditing, and performance monitoring, including performance requirements for all delegated functions, required reporting and interfaces, and review of contract compliance requirements, logged complaints, and functional performance measurements. They monitor Subcontractor performance and contract compliance in their assigned areas of expertise using internal and external performance metrics that flag noncompliant Subcontractors for follow-up and intervention. With their local presence, knowledge, and expertise of Members, State requirements, and communities supporting the Members, these staff are well-positioned to conduct this critical oversight function.

Ongoing oversight and management of Subcontractors also includes health plan staff who engage with Subcontractors in functional areas such as care management and call center services. The health plan has internal operational meetings where teams—such as delegation oversight, pharmacy, and procurement—review Subcontractor performance against key performance indicators.

Delegation Oversight Committee. The delegation oversight committee is the governing committee responsible for evaluating Subcontractor performance. Committee leadership includes our Medical Director and managers and directors across key functional areas, such as QM, compliance, Member services, and Provider services. This committee is ultimately responsible for analyzing Subcontractor information reported through regular dashboard reports, ad hoc reports, audits, performance checks, and in-person on-site monitoring. It conducts a

monthly review of Subcontractor oversight activities, makes delegation decisions, and recommends actions to take against noncompliant or underperforming Subcontractors.

Compliance Committee. Chaired by our Compliance Officer, this committee's primary responsibility is to ensure compliance at every level of the organization. The committee members are accountable for operationalizing compliance and remediating risk and deficiency without delay. The committee meets no less than quarterly to review and approve compliance and program integrity plans, as well as policies and procedures.

QM Committee. The QM committee reviews regular monthly reporting on Subcontractor performance, including any implemented CAPs. It oversees auditing and monitoring activities and, as needed, provides QI recommendations to the delegation oversight committee.

Joint Operating Committee. This committee reviews Subcontractor performance with the Subcontractor and the CCO. Topics discussed include adherence to key performance indicators, CAPs (proposed, in-progress, and completed), and any Contract-related changes requested by the Division.

Compliance Officer. As a voting member of the delegation oversight committee, the Compliance Officer works closely with Subcontractors to ensure they implement, maintain, and monitor their own compliance programs based on contract requirements. Subcontractors also must report program integrity issues to the Compliance Officer.

Types of Reports Required from Each Subcontractor

Subcontractor reporting requirements vary by the type of services being subcontracted. Each Subcontractor's delegation agreement, which is reviewed and approved by the Division, clearly documents the content and submission frequency of required reports. **Table 1** presents some examples of the types of reports required by Subcontractors. As appropriate and in compliance with Contract requirements, the report information we receive from Subcontractors is assimilated into the required reports we submit to the Division.

Table 1. Examples of Subcontractor Reports. Each Subcontractor's delegation agreement includes our expectations for the content and frequency of required reports.

Subcontractor Service	Report Name	Report Content
NET	NET Subcontractor Oversight Report	Summary of on-site visits and findings, resolution of complaints by NET subcontractor, CAPs, and NET providers who have been suspended or terminated
UM	Monthly Authorization Summary Report	Summary of the number of services approved or denied, partial approvals, and appeal requests, including a breakdown of services provided based on the benefit delegated
Call Center Data Analytics	Monthly Member Call Center Performance	Number of total calls received, number of calls answered within 30 seconds, percentage of calls abandoned, and average talk time
Call Center Data Analytics	Monthly Provider Call Center Performance, UM	Number of total calls received, number of calls answered within 30 seconds, percentage of calls answered within 30 seconds, number of calls abandoned, percentage of calls abandoned, and average talk time
Claims Processing	Monthly Claims Processing Report	Number of total claims paid, total claims denied, claims paid within 30 calendar days, claims paid within 90 calendar days, percentage of claims paid within 30 calendar days, percentage of claims paid within 90 calendar days, and average turnaround time for paid claims

B.1.b Receipt and Reconciliation of Required Data, Including Encounter Data

Our proactive process evaluates and ensures Provider/Subcontractor compliance with data submission requirements, including encounter data. Our CCO staff, in collaboration with the delegation oversight team, will closely monitor encounters from our Subcontractors and work to remediate issues or errors. ***We will meet with Subcontractors on a biweekly basis to review and discuss issues with encounter performance and compliance.***

Contracts with Subcontractors contain data and reporting requirements specifying timeliness, accuracy, and data quality metrics. ***We perform quality and completeness checks throughout the claims/encounter submission process.*** Monthly reports identify, track, and benchmark metrics (e.g., encounter submission rates), which

enable us to identify underperforming or noncompliant Subcontractors. We continually validate encounter data to ensure appropriate volumes of received and submitted encounters.

As part of our quality and completeness checks, we accept and verify submissions through our secure web portal. Providers, Provider groups, and Subcontractors submit claims/encounters through a secure socket layer, and submissions are automatically logged and tracked. Submissions, including errors, can be viewed to enable resubmissions as needed. Further, claims/encounters are received daily from clearinghouses that format electronic data into standard 837 formats. Each claim is routed through a preprocessor and then through our claims gateway. An image of the claim is generated and can be retrieved through a claim viewer. We work with Providers and an EDI clearinghouse to identify barriers in moving to electronic functionality, and we regularly evaluate systems to determine areas for improvement.

As part of our oversight process, we perform audits on Subcontractors to ensure submission of all encounters. We select specific days and require the Subcontractor to submit their complete claims data set for the dates of service selected. The data are then compared to the encounters we have for that Subcontractor. We use a customized web-based application that performs most of the functions/requirements automatically. That tool helps monitor the Subcontractor's submission, identifies the resubmissions of the previously denied encounters, checks encounter completeness, and monitors file failure. Our process generates complete, accurate encounter data and facilitates the timely submission of encounters consistent with required formats.

B.1.c Ensuring Appropriate Utilization of Healthcare Services

We have adopted a NCQA-compliant delegation oversight approach. Our Subcontractor delegation agreements document compliance requirements and ensure appropriate service utilization each month. Our delegation oversight team monitors utilization levels and, when variances occur or fall outside the expected range, we then assign a CAP through the delegation oversight committee and monitor to full resolution.

We use a rigorous quality assurance process to verify that every Subcontractor's deliverables, activities, and/or services adhere to a defined set of quality criteria and that Subcontractors respond promptly to requests for information and follow-up action. For the new Contract, we will customize our performance management and audit criteria to meet the Division's and the CCO Program's quality metrics. Our QM committee provides oversight and requires NCQA-compliant annual delegation audits of Subcontractors. Quality monitoring helps ensure that the deliverables, activities, and services provided by Subcontractors adhere to a defined set of quality criteria.

B.1.d Ensuring Delivery of Administrative and Healthcare Services Meets All Required Standards

As noted earlier in this response, we conduct pre-delegation audits to ensure Subcontractors have the resources and processes in place to meet contract requirements and standards. By scheduling pre-delegation audits, we can determine if a Subcontractor is fit to provide such services; in the unlikely event that the Subcontractor is deemed unfit, we implement an alternative plan (e.g., selection of a different Subcontractor) to meet our contractual obligations. If we decide to enter into an agreement with a Subcontractor to provide or purchase services, our Compliance Officer or designee will first notify and seek prior approval in writing from the Division. Upon Division approval, we will comply with terms of the agreement and notify the Division of any significant changes in the agreement.

B.1.e Ensuring Adherence to Required Grievance Policies and Procedures

While we require our Subcontractors to fully participate in the complaint and grievance investigation process, ***we take full responsibility for processing any Member complaints and grievances related to Subcontractor services; this is not a function we delegate to our Subcontractors***. Any complaints or grievances received from Members are handled with urgency and are a critical component of our evaluation/validation of Subcontractor compliance and performance.

Our internal processes and workflow measures instruct Subcontractors to place warm transfer calls to our Member services call center employees regarding a complaint or grievance. If Member services call center employees identify significant and/or serious issues, they immediately notify the delegation oversight team,

which addresses the issue with the Subcontractor. We require a daily summary report of all calls, which is reviewed by our delegation oversight staff to confirm timely adherence to policies, procedures, and Contract requirements. To ensure the performance of all delegated functions and responsibilities and compliance with Subcontractor agreements, we also review monthly and quarterly reports, including claims payment timeliness and grievances and appeals. Those reports give us insight into the Subcontractor's performance and allow us to track and trend any Subcontractor issues. Subcontractor performance and compliance with complaint/grievance policies and procedures are reported to the health plan and to the delegation oversight committee.

Our goal is always to develop and maintain relationships with Subcontractors that support high-quality services delivery and minimize occurrences of complaints and grievances. We reinforce those working relationships at every opportunity, whether during a meeting with health plan staff or a joint operating committee meeting or during a Subcontractor's interaction with a Care Manager. When an issue arises, we work closely with the Subcontractor to strategize options for resolution designed to prevent future complaints and grievances.

B.1.f Addressing Subcontractor Deficiencies or Contractual Variances

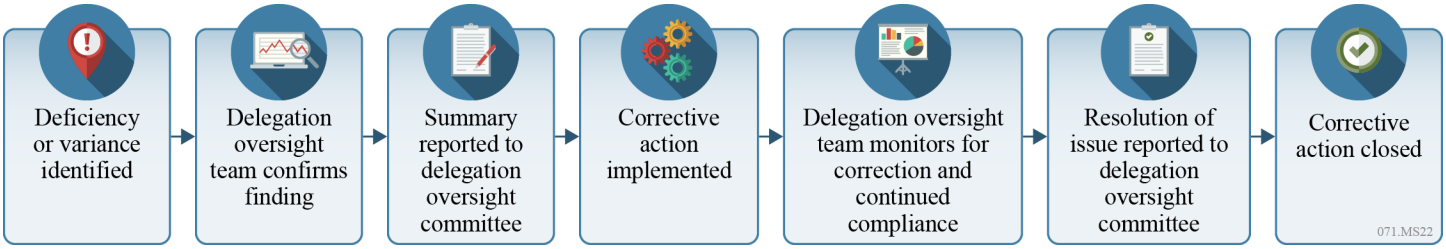
Our Subcontractor delegation agreements and internal policies and procedures include guidelines for enforcement of underperformance, nonperformance, and corrective actions designed to improve Subcontractor performances. We conduct ongoing oversight of delegated functions as stated in each delegation agreement to ensure each Subcontractor meets their responsibilities. As stated earlier in this response, the agreement specifies activities and reporting responsibilities delegated to the Subcontractor, along with remedies for under-/nonperformance.

Follow-up to under-/nonperformance may include CAPs, sanctions, penalties, revocation of delegated functions, and/or contract termination. We work collaboratively with our Subcontractors to support their delivery of all services as required. In that way, we treat them as partners. However, we also build performance guarantees into the contract so nonperformance/poor performance will be taken seriously, with the understanding that it can result in significant financial penalties. We conduct oversight internally for virtually all operations, as well as through outside audit firms if/as independent and specialized expertise may be warranted.

When a deficiency or contractual variance is identified and a CAP is required, our delegation oversight team works with the Subcontractor to resolve any issues. CAP items are not closed until the Subcontractor can demonstrate that the issues have been resolved—for example, through updated/approved policies or workflows or a passing score on a file reaudit. Updated and completed CAPs summarizing remediation efforts are taken to the delegation oversight committee for formal closure.

Exhibit 1 depicts the steps involved in addressing a Subcontractor deficiency or contractual variance.

Exhibit 1. Addressing a Subcontractor Deficiency or Contractual Variance. Our delegation oversight team is integral to the implementation and monitoring of a Subcontractor's CAP.



Example of How We Addressed a Subcontractor Deficiency

An annual audit of a dental subcontractor for one of our affiliate health plans identified use of the incorrect date of receipt for adjustment claims. The date of receipt issue was the result of the subcontractor receiving claims files from the clearinghouse twice daily (at 7 a.m. and 5 p.m.) but assigning the 7 a.m. files as being received the previous day. The consequence was that the adjustment claims were not meeting State/Federal timeliness and/or accuracy standards.

Our affiliate identified the need for a remediation plan to ensure use of the clearinghouse date of receipt and not the subcontractor's date of receipt. They placed the subcontractor on a CAP and reported that full remediation would require system enhancements. In the interim, the subcontractor's claims processors entered diary notes to

document dates, and a compliance audit conducted by our affiliate confirmed acceptable use of diary notes. Our affiliate conducted two reaudits, both of which the subcontractor failed (in part due to a transition of work between internal resources). The next reaudit occurred as part of an annual audit that confirmed correct documentation of receipt dates. The CAP was closed, and our affiliate has identified no further deficiencies in this area.

B.1.g Acknowledgment of the Requirement to Perform Annual Quality Review of Subcontractors

In compliance with Draft Contract § 13.5, we acknowledge our responsibility to monitor each Subcontractor's performance on an ongoing basis, conduct a formal Subcontractor review at least once a year, and include the results of the review in our annual QM program evaluation. We will ensure that our annual QM program work plan includes all requirements in Draft Contract § 8.4.1.

B.1.h Ensuring Proper Classification of all Subcontractor Expenses

Subcontractors are required to comply with the same policies we follow regarding classification of administrative and medical expenses. We understand our obligation to submit MLR data to the Division on the proportion of premium revenues spent on clinical services and QI and, in addition, that our adjusted MLR must meet or exceed the CMS requirement of 85% for the State's fiscal year. For this Contract, we will ensure that MLR reporting is conducted by staff who are knowledgeable about CMS and Division policies related to MLR requirements—including the differences between medical and administrative expenses.

In addition to a clear understanding of what constitutes an administrative expense, we are well aware of what should *not* be claimed as a medical expense—for example, subcontractor fees related to performing claim recovery and subrogation services, liquidated damages, and bad debt expense. ***As fiscal stewards of government healthcare funds, we commit to the Division that we will scrutinize every MLR prior to submission to ensure proper classification of subcontractor expenses.***

For each of our Subcontractors, we develop a tailored process to properly classify Subcontractor expenses. The approach for each Subcontractor depends on the nature and specific language of our agreement with that Subcontractor. For example, for invoices where administrative itemization is available, we deduct 100% of any such costs. In instances where administrative itemization is not available, we create an assumption of an administrative overhead percentage based on analysis of our agreement with the Subcontractor, our experience in similar markets, and our historical experience across our other health plans with similar agreements.

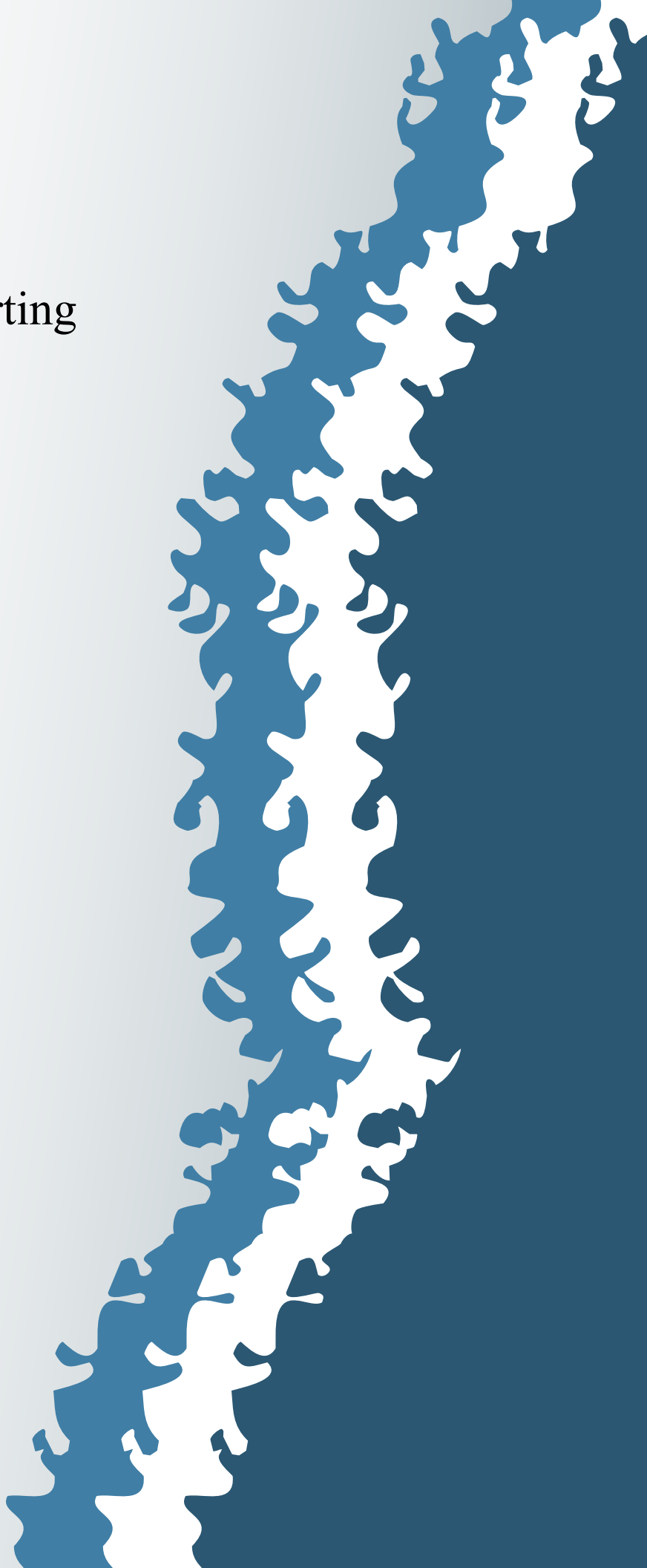
We provide the following three examples of how we calculate administrative costs:

- For a transportation subcontractor where our contract includes a specific flat administrative fee in addition to separately billed claims, we deduct 100% of administrative costs, including that flat monthly administrative fee or any itemized administrative expenses on all other invoices (for actual claims).
- For a dental contractor where we pay a capitated rate per Member for the provision of a broad range of quality, technology, FWA, and purely administrative services (in addition to claims billed separately), we deduct 80% of capitated costs as excluded administrative costs. This is based on a review of the contract and an estimate that 20% of the costs relate to services qualifying for inclusion in the numerator of the MLR calculation.
- For a vision contractor with whom our contract specifies we pay a fully capitated rate for all claims, quality, technology, FWA, and purely administrative services, we deduct 10% of capitated costs as administrative expenses. This is based on a historical review of similar fully capitated agreements in our experience and those of our sister companies.

[END OF RESPONSE]

4.2.2.8

Financial and Data Reporting



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4.2.2.8: FINANCIAL AND DATA REPORTING

A. FINANCIAL REPORTING

We will comply with the Division's financial reporting requirements outlined in the RFQ, including those detailed in Draft Contract § 11, Financial Requirements, Exhibit C: Medical Loss Ratio (MLR) Requirements, and applicable State and Federal laws and regulations.

A.1. Approach for Supplying Data as Determined by the State to Develop Actuarily Sound Capitation Rates

We have validated processes in place to supply data to the Division to certify the actuarial soundness of capitation rates as specified in 42 CFR § 438.5(c).

Supporting Actuarially Sound Capitation Rates
We use GAAP to calculate and report MLR, including allowable medical expenses and administrative costs.
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We will use the Division's financial template to support the capitation rates for the State's fiscal years. Below are the categories of financial data and the related sources of data that we believe provide the most complete and accurate data possible:

- **Earned premium data.** Source: premium reconciliation application, 820 transactions
- **Enrollment data.** Source: actuarial data, data warehouse data
- **Claims data.** Source: actuarial data, data warehouse data
- **Administration and reinsurance data.** Source: finance data, general ledger

Below, we describe steps we will take to pull data from these sources to maximize accuracy and completeness.

Earned Premium Data

We will ensure accurate reporting of capitation revenue and earned premiums using the following process:

1. The Division will provide us with monthly 820 files for MississippiCAN and CHIP. The files contain Member-level transactions that we will load into a database. When aggregated, the 820 transaction details tie to the expected cash deposit.
2. When we receive the deposit, we will reconcile the cash to the 820 totals and remittance advice provided by the Division. We will document reconciling items and send follow-up requests to the Division, as needed, to resolve variances.
3. We will compare 820 transactions to a rate table containing Contract rates and supporting actuarial rate sheets. The rates reflect risk and region adjustments per rate cell for the incurred periods.
4. If the 820 file information and State payments match the Contract rate, we will use this schedule to calculate revenue, net of pass-throughs.
5. If there is a variance between Contract rates and paid rates, we will record the difference as a receivable or payable and reconcile it with the Division through subsequent 820 adjustments or during the Division's fiscal year reconciliation process.
6. Our accounting team will calculate at-risk revenue and premium taxes based on recorded/accrued revenue.

Enrollment and Claims Data

We will use an established data warehouse with related tools developed by Milliman specifically for the healthcare industry. As a health plan, we will employ Milliman as an application service provider. Our actuarial department maintains new user account setup and training, and Milliman provides support.

The data warehouse contains Provider and Subcontractor data from various sources (e.g., claims, incurred but not reported claims, and enrollment), and data is refreshed monthly. This reporting tool allows us to aggregate data in different ways for various purposes, such as analyzing cost and utilization data by Member demographic and rate cell.

Administration and Reinsurance Data

Our accounting system is operated and maintained in accordance with Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board. The system is the single, centralized repository for all accounting entries, including all adjustments, and allows us to report on entries in our general ledger, rather than using another derivative application.

Our Mississippi health plan CFO and our Regional CFO, in conjunction with our Regional Controller, is responsible for establishing and maintaining adequate internal control over financial reporting. Internal controls are in place to provide reasonable assurance on the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Our accounting system produces standard monthly, quarterly, and annual financial reports and ad hoc financial reports related to financial transactions and ongoing business activities. Through standard and ad hoc reporting, we will provide all reports in accordance with MississippiCAN and CHIP reporting requirements established by the Division. Further, our information will be reported in compliance with all Mississippi and Federal laws governing reporting and disclosure requirements. We produce financial reports, such as balance sheets, income statements, and budget-related reports, with budget variance, year-to-date, and period-to-date report capabilities that can be used for all general ledger, accounts payable, and financial statement presentations in accordance with GAAP.

To ensure accuracy and completeness, our Regional CFO and our Mississippi health plan CFO will review the information pulled from the various financial systems and draft reports for submission to the Division to identify any issues or inaccuracies and correct them before submission. If the Division or one of the Division's auditors identifies any issues, whether they relate to a data issue or a misunderstanding as to the intended data requested, our Mississippi CFO will address the issue and provide revised versions of the reports to the Division and/or Milliman.

We will provide the Division with copies of all quarterly and annual filings submitted to the Mississippi Insurance Department and audited financial statements annually.

Encounter Data

We understand the critical importance of the acceptance and accuracy of encounter data to the management of the CCO Program. We will successfully collect and submit complete, accurate, and timely Member encounter data to the Division in accordance with 42 CFR 438.242 and 438.818 and Division requirements, including those specified in Draft Contract § 16.7, Member Encounter Data.

Our systems and mechanisms are in place to obtain all necessary data from Providers and Subcontractors to ensure our ability to comply with Member encounter data reporting requirements.

All Provider and Subcontractor encounters will be thoroughly validated based on the Division's required data formats. Any encounter data that fails validation criteria will automatically pend for review by our encounter staff. The staff will research and respond to rejections, denials, and partially accepted encounters by working across teams to ensure accurate and timely submission of Provider and Subcontractor encounters.

Our processes ensure encounter data submissions correctly reflect all claims data, including paid claims, denied claims, voided claims, zero dollar paid, claim adjustments, and encounters in which we had a capitation and/or VBP arrangement with a Provider.

We will submit complete and accurate Member encounter data no later than the 30th calendar day after the date of adjudication in Division-required HIPAA-compliant standards for information exchange.

A.2. Approach for Timely Completion and Reporting of MLR Reporting Requirements

Detailed processes will guide our submission of accurate and timely MLR reporting, including development of the MLR Report, in accordance with the format and manner prescribed by the Division. We have reviewed the requirements contained in Exhibit C of the Draft Contract and will comply with them.

Approach for Timely Completion and Reporting of the MLR Report

Our Mississippi health plan, locally-based CFO will be responsible for managing completion of the MLR Report. The key to meeting this requirement will be how the transactions are recorded in our proprietary financial system. The data required to accurately calculate the numerator and denominator for the MLR Report will be recorded in the financials in a manner that it is easily identified and extracted for the calculation. Our accounting department will calculate the MLR monthly, and we will record any potential liability in compliance with GAAP. Easy access to data (e.g., incurred claims, expenditures for activities that improve healthcare

quality, and expenditures for fraud reduction and adjusted premium revenue), coupled with the monthly process to calculate the MLR, will allow us to accurately fulfill the Division's MLR reporting requirements on time.

We will submit the MLR Report to the Division by April 1 of each year in the prescribed format and manner, and we will meet the Division's requirements for each reporting quarter. We will also submit the required additional reports listed in Exhibit C with submission of the annual MLR Report.

Our CFO will attest to the accuracy of the MLR calculation in accordance with 42 CFR 438.8(n). Our Mississippi-based Compliance Officer will be responsible for ensuring the accuracy and timeliness of MLR reporting and perform quality checks on reports and forms before submission, including confirmation of the appropriate attestation.

As with our other required reports, MLR Reports will be included in our list of all Division standard and ad hoc reports with priorities and due dates. For recurring Division-required reports, such as the MLR Report, we will automate tasks and processes to ensure timely submission. This systematically generates advance notice of upcoming reports by creating a "Future Delivery" ticket that is reviewed, assigned, and tracked to completion.

Computation of Medical Claims and Non-claims (Administrative) Costs

We will follow State and Federal guidelines and GAAP when computing medical claims costs and non-claims (administrative) costs and will apply this approach in Mississippi. Medical claims costs are tracked and analyzed via the data warehouse, and non-claims costs are captured and tracked in our general ledger.

Our approach includes medical and administrative costs from Subcontractors. ***Our Subcontractor agreements contain specific data and reporting requirements and performance targets, specifying timeliness, accuracy, and data quality metrics, allowing us to conduct computations to meet State requirements.*** In addition to a clear understanding of what constitutes an administrative expense, we are well aware of what should *not* be claimed as medical expense—for example, Subcontractor fees related to performing claim recovery and subrogation services, liquidated damages, and bad debt expense. As fiscal stewards of government healthcare funds, we commit to the Division that we will scrutinize every MLR prior to submission to ensure proper classification of Subcontractor expenses.

For each of our Subcontractors, we develop a tailored process to properly classify Subcontractor expenses. The approach for each individual Subcontractor depends on the nature and specific language of our agreement with the Subcontractor. For example, for invoices where administrative itemization is available, we deduct 100% of any such costs. In instances when administrative itemization is not available, we create an assumption of an administrative overhead percentage, based on analysis of our agreement with the Subcontractor, our experience in similar markets, and our historical experience across our other health plans with similar agreements.

Here are three examples of how we calculate administrative costs:

- For a transportation contractor with which our contract includes a specific flat administrative fee in addition to separately billed claims, we deduct 100% of administrative costs, including the flat monthly administrative fee or any itemized administrative expenses on all other invoices (for actual claims).
- For a dental contractor with which we pay a capitated rate per Member for the provision of a broad range of quality, technology, FWA, and purely administrative services, in addition to claims billed separately, we deduct 80% of capitated costs as excluded administrative costs. This is based on a review of the Contract and an estimate that 20% of the costs relate to services qualifying for inclusion in the numerator of the MLR calculation.
- For a vision contractor with which our contract specifies we pay a fully capitated rate for all claims, quality, technology, FWA, and purely administrative services, we deduct 10% of capitated costs as administrative expenses. This is based on a historical review of similar fully capitated agreements in our experience and those across our health plans.

We will also recalculate the MLR for all impacted State reporting years if a retroactive change is made to the capitation payments.

B. DATA REPORTING

We maintain an established and validated health information system that collects, analyzes, integrates, and reports data in accordance with State and Federal Medicaid and CHIP requirements. Our reporting systems are specifically designed for Medicaid and CHIP programs and can be easily configured to meet Division encounter data and other program reporting requirements.

B.1. Encounter Data

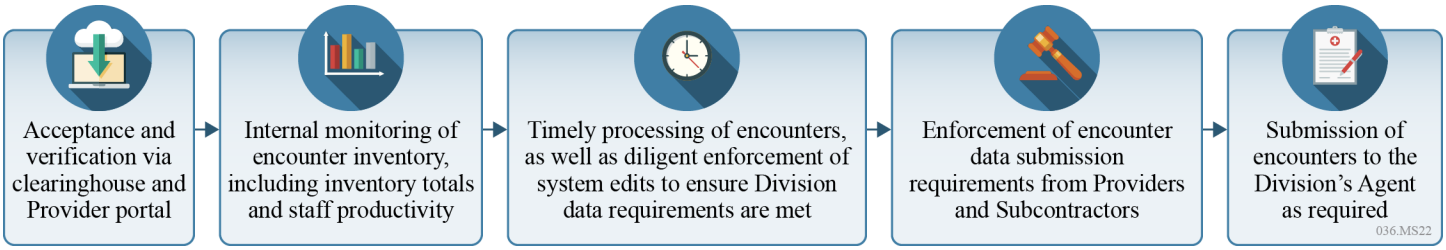
We have carefully reviewed the encounter data requirements and will leverage our successful experience across the nation to collect and submit complete, accurate, and timely Member encounter data to the Division in accordance with 42 CFR 438.242 and 438.818 and Division requirements, including those specified in Draft Contract § 16.7, Member Encounter Data.

We have systems and mechanisms in place to obtain all necessary data from Providers and Subcontractors to ensure our ability to comply with the Division's Member encounter data reporting requirements. Our process to meet the Division's requirements will include:

- Implementing processing rules based on the Division's requirements and Encounter Companion Guides for timely collection, validation, and submission of encounter data
- Validating accuracy of both inbound and outbound encounter data
- Performing acceptance/verification of encounter data received via paper (e.g., scanning and imaging), including all paper CMS-1500 and UB-04 claims
- Avoiding duplicate encounter data by configuring our claims processing system with standard and Mississippi-custom edits to prevent duplicate claims payment and performing pre-submission edits on files before we submit them to the Division
- Working closely with Providers and Subcontractors in work groups and ad hoc meetings to share best practices and address concerns

Our process to meet Division requirements is illustrated in **Exhibit 1.**

Exhibit 1. Encounter Process. Our tightly managed process will ensure complete, accurate, and timely submission of encounter data to the Division.



To ensure complete, accurate, and timely reporting of encounter data, we will hold weekly meetings to discuss any issues with submission and to share best practices. With representation from our encounters team, Provider data management team, and Subcontractors, these operationally focused meetings will provide a platform to collaboratively drive solutions and meet Division encounter data requirements.

Our Mississippi-based operations team will prepare an annual Data Completeness Plan for submission to the Division in accordance with Division specifications.

Collecting Encounter Data

Providers and Subcontractors are contractually required to submit timely and accurate encounter data for all services delivered to Members, including value-adds. This also applies to Providers and Subcontractors that we pay through a capitated or VBP arrangement.

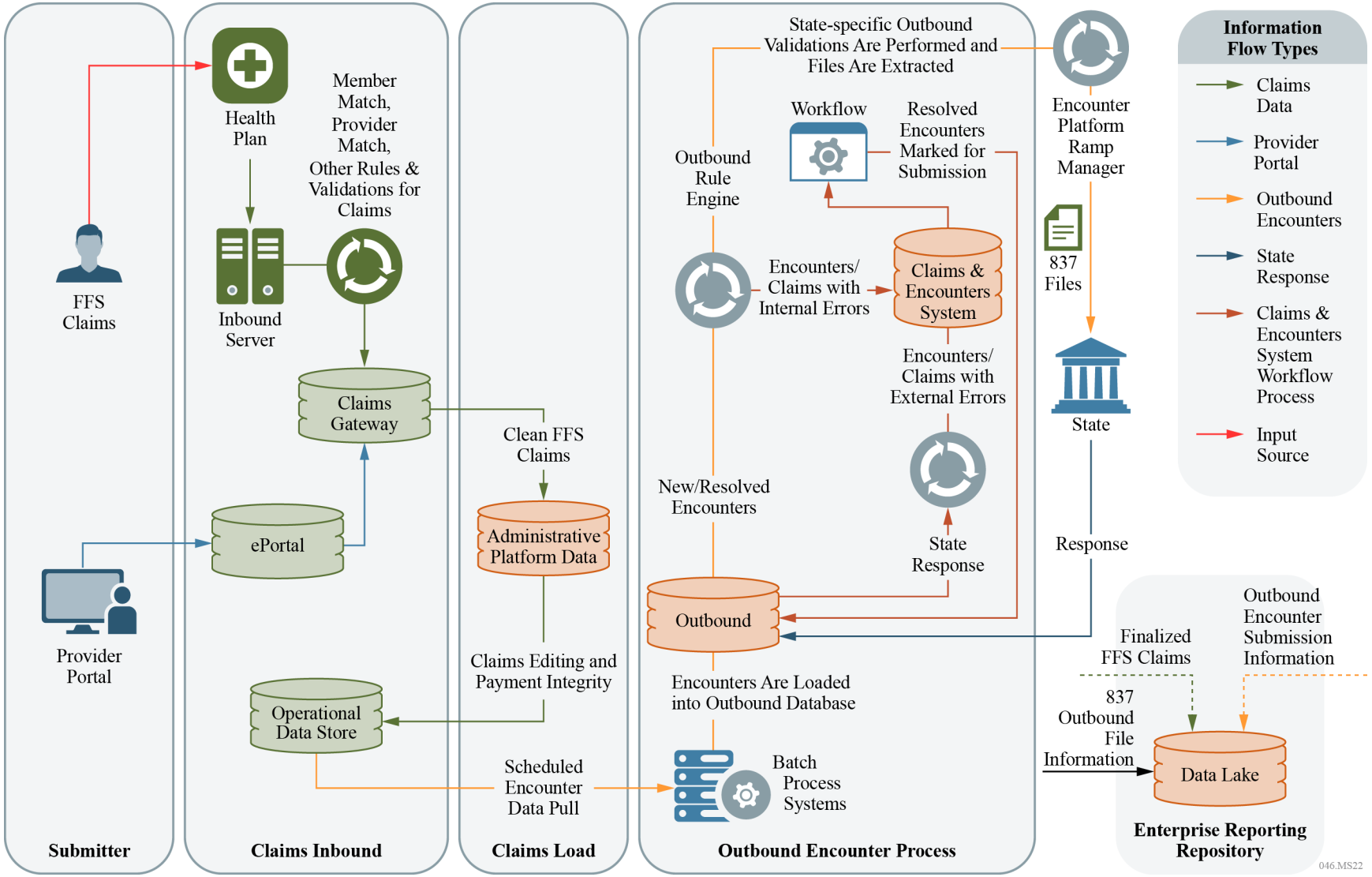
We collect encounter data through electronic submissions via EDI clearinghouse, Provider portal transactions, and paper claim submissions. Our claims and encounters management system manages the flow, generation, and submission of encounter data. Our internal workflow monitors and reports on encounters throughout their life cycle—from claims payment through encounter submission.

Our process will minimize additional administrative work for the Division and reduce Provider abrasion by identifying and resolving any encounter issues early in the process. ***We will configure both our inbound and***

outbound rules to edit against HIPAA and Mississippi requirements to ensure complete, accurate, and timely encounter submission to the Division. The process creates internal and external rejection errors for encounter submissions, identifying who is responsible for resolution in the encounter error workflow process.

Exhibit 2 illustrates our proposed encounter workflow, from claims submission through reporting to the Division.

Exhibit 2. Claims and Encounter Workflow. Defined processes and workflows will support our ability to meet Division requirements.



Validating Encounter Data

We load Provider and Subcontractor encounter data into a production database within 24 hours of file receipt. ***All Provider and Subcontractor encounters will be thoroughly validated based on the Division-required data formats to ensure completeness, accuracy, and adherence to requirements.*** This automated process ensures completeness of encounter submissions and confirms that key fields (e.g., Member Medicaid ID, Provider NPI, claim type, place of service, revenue code, diagnosis and procedure codes, amount paid, and claim payment date) are populated accurately for every encounter submission.

When an encounter is processed, it is assigned a status of one of the following:

- Submitted
- Accepted
- Partially Accepted
- Internally Rejected
- Externally Rejected
- Void/Replace
- Frozen
- Awaiting Response

Any encounter data that fails validation criteria automatically pends for review by our encounters staff. The staff researches and responds to rejections, denials, and partial acceptances by working across teams to ensure complete, accurate, and timely submission of encounters.

Our processes ensure encounter data submissions correctly reflect all claims data, including paid claims, denied claims, voided claims, zero dollar amount claims, claim adjustments, and encounters in which we had a capitation and/or VBP arrangement with a Provider.

Resolving and Resubmitting Denied Encounters

We validate encounter files to ensure HIPAA compliance and return invalid files to Providers and Subcontractors for correction. Our process will minimize additional administrative work for the Division and reduce Provider grievances. Once the file passes HIPAA validation, we review the data to ensure its content meets HIPAA requirements and our internal standards. Encounters that fail any inbound edits are returned for correction.

For Division-adjudicated encounters reported in response files, we will reconcile them against originally submitted encounters, log them during the reconciliation process, and resubmit them with the correction, if necessary. The process also includes claims and encounters system retrospective data analysis, which we share with all internal stakeholders to improve the process. ***A business encounter work group will meet regularly to review any flagged errors and resolve the encounters for resubmission.*** The group, which will consist of our Mississippi health plan Chief Financial Officer (CFO) and analytics and key support staff from various departments and teams (e.g., claims, encounters, IT, system configuration, and eligibility), will evaluate retrospective data and coordinate departments to address submission errors/rejections and resubmissions. The work group will also coordinate any remediation efforts needed for the resubmission process.

Subcontractor Data

When we receive an inbound encounter file from a Subcontractor, we send a 277CA file to them, indicating encounters that were accepted and denied. Encounters in accepted status will be moved forward for submission to the Division. As with Provider encounter data, Subcontractor encounter data goes through a series of validation edits to ensure only complete and accurate data will be submitted to the Division. Encounters that fail validation will be reported to the Subcontractor. The encounters team will meet with Subcontractors regularly to address any issues or concerns.

Submitting Encounter Data to the Division

We will submit complete and accurate Member encounter data no later than the 30th calendar day after the date of adjudication in accordance with Division-required HIPAA-compliant standards for information exchange.

Our encounter process will be supported by a Mississippi-based encounters team and dedicated subject matter experts from our parent company's encounters and IT teams. ***Our Mississippi encounters team will use an internally developed dashboard to monitor the status (accepted or rejected) of encounters submitted to the Division.***

Monitoring Timeliness of Encounter Submission

We use multiple reports to help manage the submission of encounters and ensure we are meeting timeliness thresholds. This includes outbound key performance indicators that indicate the external acceptance rate based on submission date or date of service. Using key performance indicator reports, we can quickly identify any month that is at risk and refocus efforts to maximize timeliness.

Monitoring Data Completeness, Accuracy, and Provider and Subcontractor Compliance

Defined processes guide our evaluation of Provider and Subcontractor compliance with State encounter submission requirements. **We perform quality and completeness checks throughout the claims/encounter submission process.** Monthly reports identify, track, and benchmark metrics (e.g., encounter submission rates) that enable us to identify underperforming or non-compliant entities. In addition, we perform encounter/claims audits for Subcontractor submissions for completeness and accuracy. We audit Subcontractors by reconciling the submitted encounter records against paid claims and audit sub-capitated Subcontractors by gathering paid claims data for our health plan against submitted encounters. For large group/sub-capitated Providers, we conduct medical records reviews and claim level audits. We consistently validate encounter data to ensure appropriate volumes of received and submitted encounters. Our quality and completeness checks adhere to the following standards:

- **Acceptance and verification of claims/encounters via the Provider portal.** Providers, Provider groups, independent practice associations, and Subcontractors submit claims/encounters through Transport Layer Security (TLS). Submissions are automatically logged and tracked. Submissions, including errors, can be viewed to enable resubmissions as needed.
- **Acceptance and verification of claims/encounters via clearinghouses.** Claims/encounters are received daily from clearinghouses that format electronic data into standard 837 formats. Each claim is routed through a pre-processor and then through the claims gateway. An image of the claim is generated and can be retrieved through a claim viewer. Daily files are loaded into our core administrative system. We also work with Providers and EDI clearinghouses to identify barriers in moving to electronic functionality and regularly evaluate systems to determine areas for improvement.
- **Internal monitoring of claims/encounter inventory, including inventory totals, claims aging, and staff productivity**. Our claims and encounters system offers various reports and metrics on trends across claims and encounter data processed within different stages and environments. Encounter submissions and responses are loaded into an operational data store that feeds into our claims and encounters system. Additional reports are also leveraged through our advanced business intelligence and data visualization solution and SQL server.

We will submit an annual Data Completeness Plan to the Division for review and approval and comply with all data completeness monitoring requirements.

Managing Non-submission of Encounter Data by a Provider or Subcontractor

Encounters contain important information regarding Members' healthcare services. Non-submission of encounter data by a Provider or Subcontractor can result in an incomplete health history and potentially a critical gap in care and services, and may also limit correct reporting and evaluation.

Monthly reports identify, track, and benchmark metrics (e.g., encounter submission rates) that enable us to identify Providers or Subcontractors that are not submitting accurate or timely encounter data. We also validate encounter data to ensure appropriate volumes of encounters are received by Providers and Subcontractors.

We work with Providers and Subcontractors to ensure encounter data is complete and meets our quality standards, valid code sets, HIPAA compliance, and more. If we discover an inconsistency in encounter submission rates or identify a missing data element, we engage the Provider or Subcontractor directly to address and resolve the issue. In our experience, non-submissions are often the result of technical issues that can be

remediated in a timely manner. If appropriate, our Provider representative or delegation oversight team will provide additional training and education to the Provider or Subcontractor, respectively.

B.2. Health Information System Data

Maintaining a Health Information System

We maintain an integrated reporting system that will enable us to produce intelligent, reliable, and compliant reports to meet Division requirements. Under the leadership of our Mississippi-based Chief Operating Officer and with independent oversight by our Mississippi-based Compliance Officer, we will use resources from our national analytics center of excellence to develop accurate and complete reports, including each of those outlined in Draft Contract § 16, Reporting Requirements, and MississippiCAN and CHIP Reporting Manuals, as well as new and ad hoc reports that emerge through the course of operations.

We own and operate our own health information system, which includes an integrated and highly configurable reporting component. Our health information system will allow us to collect, analyze, integrate, and report data in accordance with Division requirements. The systems and capabilities we will use to produce reports for the Division are already built, tested, and scalable so we can meet all MississippiCAN and CHIP reporting requirements.

Compiling and Integrating Data

Our management information system facilitates an integrated compilation of data from multiple internal and external sources and systems for compliant, streamlined data flow and reporting purposes.

Data Lake

We compile and store data from disparate sources in structured and unstructured formats in our data lake. **The data lake is key to our ability to deliver timely, accurate, and complete reports at any requested frequency**. Because data is stored logically according to the concept being reported on, and because data is predefined, indexed, and stored centrally, we can deliver highly responsive, custom ad hoc reporting, reducing time spent redefining and reconciling disparate data sources.

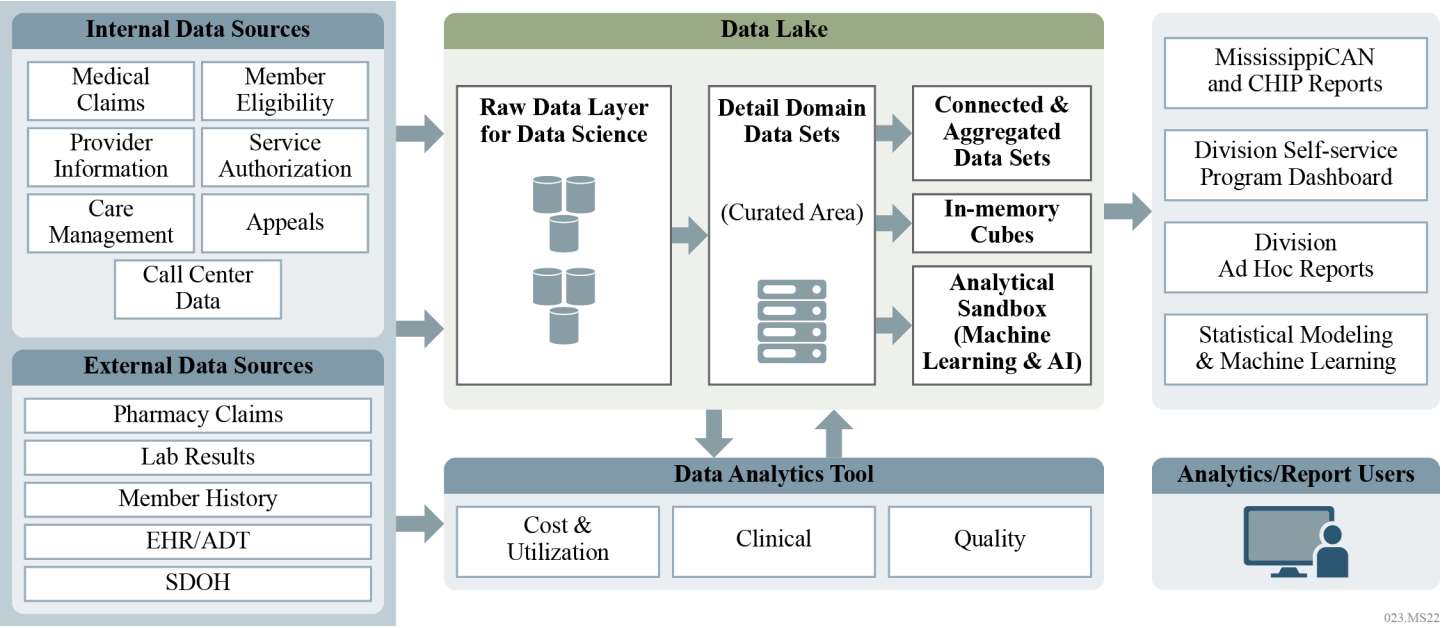
Collecting, Integrating, and Validating Data
Our data lake integrates internal and external reporting data and is highly scalable to meet the Division's reporting requirements.
133.MS22

The data lake integrates internal reporting data environments and relevant external data, including Subcontractor data. Storage and processing capacity within the data lake is highly scalable and comprises multiple servers and nodes linked by big data technology employing an industry-standard distributed processing framework. Overall, we manage several hundred petabytes of data and house more than 10 years of healthcare data, which supports various reporting and analytical needs.

The data lake uses industry-validated data governance, security, and quality tools coupled with a highly mature process to ensure available data is integrated into our systems and dashboards. In addition, the data lake significantly reduces development time and the opportunity for error by aggregating enterprise data and democratizing it for local reuse and report standardization while improving data accuracy and reducing time to generate and submit high-quality reports.

As detailed in **Exhibit 3**, the data lake stores various data, including claims and encounters, Member information and social/demographic data, service authorizations, PCP information, and population health data, all gathered, curated, and validated from internal and external sources. In addition to facilitating the swift generation of reports for the Division, our data lake will make all Mississippi KPI data immediately available for operational reports that our business units will use to chart and track progress toward Division performance standards and fuel predictive models that inform our strategies.

Exhibit 3. Data Lake. Data is compiled, aggregated, and stored in our data lake and will be used for MississippiCAN and CHIP reporting.



HIE

Our advanced platform and architectural capabilities will enable us to regularly transmit clinical, encounter, and care management data to the Division in formats adhering to the standards required by the State and Federal government, including HL7 FHIR, API and USCDI, through either direct transmission to the Division's interoperability platform or through the HIE. We will also integrate with any future Division government-to-constituent (G2C) customer identity and access management (CIAM) with Federation.

We can interface with other operational systems, such as the MES/MMIS operated by the Division, as required by the Division, to access, inquire, and bidirectionally share information such as Member eligibility and enrollment, claims and encounters data, and Provider profiles and demographic data. We also have capabilities to partner with the Division to establish an Enhanced HIE model that will eliminate the need for multiple CCO registry applications, improve the ability to refer and track SDOH, reduce unnecessary ER utilization, and improve health outcomes for Members.

Capability to Configure and Expand Systems

Our MIS infrastructure and reporting systems operate on a hyper-cloud environment, which allows us to efficiently scale, configure for agility, and deliver to meet Division reporting requirements. Our systems and software generate thousands of standard and ad hoc reports in various formats daily, weekly, monthly, quarterly, and annually from the central data lake. Within the data lake, definitions for concepts like "inpatient claim" or "unique Member" are defined and will be applied consistently for all Division reports. ***This standardization of definitions and business logic strengthens our ability to deliver on our Mississippi-specific reporting commitments on time, consistently, and compliantly, with minimal incremental development.*** Core to our configuration process is to have business owners, compliance leads, and data engineers review the comprehensive State requirements and templates for reports in advance. Once requirements are affirmed, data is aligned to the appropriate elements within the data lake. Any additional configuration needed beyond standard capabilities is identified and addressed expeditiously. All reports will be produced in test environments during implementation and validated with the Division to ensure alignment and accuracy.

Capability to Produce Reports in Predetermined Formats

Our report generation capabilities will fully support all financial and nonfinancial MississippiCAN and CHIP program reports based on Division requirements. To ensure accurate, complete, and timely submission, all reports and forms will be developed to Division specifications and submitted in compliance with submission dates and time frames enumerated in the Draft Contract, the MississippiCAN and CHIP Reporting Manuals, the Value-Based Purchasing Work Plan, and the Performance Measures Manual.

Demonstrating our experience and capabilities, in 2021 our specialized data analysis and reporting team successfully executed approximately 21,000 requests for new, ad hoc, and revised standard reports. To maximize efficiency and responsiveness to reporting needs and requests, we use a local approach supported by national resources. ***In Mississippi, we will have one manager and two lead analysts who will be dedicated solely to fulfilling reporting needs in Mississippi.*** Should reporting demands temporarily exceed the team's capacity, they can leverage the corporate data analysis and reporting team, who will be deployed to ensure on-time and compliant reporting.

In **Table 1**, we provide a crosswalk of the reporting areas and a high-level summary of how we will meet the Division's requirements to collect, analyze, integrate, validate, and report information.

Table 1. Crosswalk of Mississippi Reporting Requirements. Our health information system and reporting expertise will enable us to meet all MississippiCAN and CHIP reporting requirements.

Reporting Area	Our Capabilities and Systems to Meet Division Requirements
i. Utilization	Our health information system and data lake capabilities will enable us to collect, analyze, integrate, validate, and report on utilization and utilization management (UM) data. This will include, for example, the ability to detect and document under- and overutilization of services, authorizations by type of service (e.g., hospice services) and time frame, and status of requests for prior authorization. We use this information on KPIs to identify trends and opportunities to improve quality of care, health outcomes, and administrative and fiscal efficiency. We will submit monthly MississippiCAN and CHIP prior authorization reports to the Division, including all required information.
ii. Claims, Grievances, and Appeals (Section 16.2.9)	**Claims.** Our core administrative system collects and tracks claims paid by type of service (e.g., inpatient, professional); unique Member, including primary diagnosis; and Provider. **Grievances and Appeals.** We use a powerful tracking and reporting cloud-based software tool to collect and track the receipt and resolution of verbal, in-person, and written grievances and appeals. Tracking and reporting elements include the type (standard or expedited), basis of action (e.g., reduction of service, prior authorization denial, out-of-network Provider dispute), resolution time frame, and outcome (e.g., affirmed, denied, pending). It will also include referrals for independent external reviews (for CHIP Members) and State Fair Hearings (for MississippiCAN Members). This makes reporting seamless because the tool allows for advanced sorting and report generation that can be easily formatted to meet Mississippi reporting requirements, including requirement of the Mississippi Insurance Department. We will submit to the Division logs of grievances and appeals in accordance with the requirements of the Reporting Manuals, including a summary of any trends or commonalities.
iii. Disenrollment (for other than loss of Medicaid eligibility)	We use our next-generation, cloud-based platform built on AI technologies, which serves as our streamlined eligibility, enrollment, and disenrollment management and data exchange platform. Our eligibility & enrollment gateway serves as a master system of record, fully supporting and automating all elements of the enrollment, eligibility, and disenrollment process. The termination of a Member's enrollment in our health plan is performed based on the information received in the eligibility file transmitted via the termination transaction (T3) and/or recoupment (X5), inbound process. The Member disenrollment reason and transfer-out-of-plan information, provided on the enrollment roster, is loaded into the Member's record. For Member disenrollment for a reason other than loss of Medicaid eligibility (e.g., when a Member becomes a nursing home resident or enrolls in a waiver program), we will notify the Division within three calendar days of receipt of the Member Listing report of our request and provide written documentation of the reason. We will direct Member requests for disenrollment to the Division either orally or in writing.
iv. Member Characteristics	Our systems are configured to collect data on Member characteristics. For example, information on a Members' trimester of enrollment, appointments kept and not kept, and place of service is stored and tracked in our core administrative system. We use our risk stratification and predictive modeling platform to identify Members with similar characteristics, stratify them into actionable groups, and identify gaps in care for intervention.
v. Provider Characteristics	Provider characteristics, such as Provider type, demographic data (e.g., phone number and address), and reimbursement, are stored and tracked in our core administrative system. Providers can also use the Provider portal to verify Member eligibility, update demographic information, view Member gaps in care, submit claims, and submit requests for authorization and query the status of the request.
vi. Care Management Utilization	Members in care management are tracked and reported through our care management platform. The system maintains accurate Member care management data, including Health Risk Screening information and results, Comprehensive Health Assessment information and results, treatment plans, and stratification and interventions, consistent with Medicaid and CMS requirements, and fully integrates with our core claims engine. This will allow us to complete timely and accurate care management reports and other care management reporting as required by the Division.
vii. Clinical Data	Our system is configured to capture and report accurate and complete clinical data, including all indicators noted in Draft Contract §16.5.1 as well as utilization trends, care management plans, population health program outcomes, SDOH, and encounter data.

Reporting Area	Our Capabilities and Systems to Meet Division Requirements
	We will work closely with the Division's Systems Work Group on a mutual statement of work and schedule to implement software and hardware routing solutions required for successful delivery of all available data from our systems to the Division in accordance with State and Federal standards.
viii. Population Health	We use a variety of systems to collect, analyze, integrate, validate, and report population health data. For example, we use our risk stratification and predictive modeling platform to identify Members for care management and outreach. The platform captures a broad array of sources and types of data to create a comprehensive picture of the factors that combine to influence the overall health of the population, including socioeconomic and SDOH factors; cultural, ethnic, and racial factors; and community, health literacy, healthcare access, and cultural impacts. Our care management platform serves as our central integrated information technology system for managing population health data, including Health Risk Screening information and results, Comprehensive Health Assessment information and results, and care plans. The care management platform integrates and organizes data from core administrative and care coordination systems into an integrated platform, including all elements of care and population health management, UM, and care access and monitoring. Clinicians and authorized representatives can view each Member's current and historical records of services at a glance in one view, including services performed by ancillary vendors such as vision and dental Providers, which provides greater visibility into care treatment planning and management. We will report to the Division and network PCPs/PCMHs, at intervals designated by the Division, on the efficacy of our population health management programs for MississippiCAN and CHIP. We understand each program's report will be designed collaboratively between us and the Division.
Other Reporting Areas Referenced in the Draft Contract	
Provider Services (Section 16.2.1)	We will provide the Division with reports on general Provider services operations, including Provider enrollment, Provider services call center, staff training, and grievances and appeals. Our Provider enrollment information and reports will address new and terminated Providers to our network and Provider credentialing and recredentialing information received from the Division's Credentialing Committee. We will report information to the Division on our Provider network, including through the Provider Network Changes report, in the manner and time frame required. Collected in our core administrative system, we analyze Provider services call center data to identify trends and institute corrective actions to address Provider questions and concerns, particularly reoccurring issues. We will provide the Division monthly Provider call center reports including all required information (e.g., number of calls received, calls answered by a live operator or interactive voice response system, and calls abandoned) and quarterly reports on call center issues. We will also provide a monthly Call Trend report including the most frequent categories of calls. We will submit quarterly reports detailing our Provider services call center staff training, including training conducted, topics covered, and the number and position of staff who completed trainings, and monthly Provider Complaint and Appeal logs including all required information (e.g., internal case tracking number, source, and data resolved). Our geographic mapping software will allow us to create quarterly geomapping reports for the Division on our network by Provider and region using the Division's geographic accessibility standards.
EPSDT (Section 16.2.2)	With our affiliates, we are experienced in successfully complying with EPSDT CMS-416 reporting requirements. EPSDT utilization data from various sources, including claims, encounters, and immunization registries, is compiled in our data lake. We incorporate EPSDT data into our gaps-in-care monitoring strategies to create dashboards of Members who will benefit from outreach for education, coordination, and receiving preventive care services. The dashboards are generated using our quality improvement tool, our one-stop quality performance tool for our quality and clinical teams. They use the tool to review, track, and trend Member gaps in EPSDT services and Provider-level quality performance to identify targeted interventions. We also will report immunization data, relating to EPSDT and other preventive services, to the Mississippi immunization registry.
Financial (Section 16.2.3)	Our accounting system is operated and maintained in accordance with GAAP as established by the Financial Accounting Standards Board. The system is the single, centralized repository for all accounting entries, including pure period adjustments, and allows us to report on entries in the company's general ledger, rather than using another derivative application. Our accounting system produces standard monthly, quarterly, and annual financial reports and ad hoc financial reports related to financial transactions and ongoing business activities. Through standard and ad hoc reporting, we will provide all reports in accordance with MississippiCAN and CHIP reporting requirements established by the Division. Further, our information is reported in compliance with all State and Federal laws governing reporting and disclosure requirements. We produce financial reports such as balance sheets, income statements, and budget-related reports, with budget variance, year-to-date and period-to-date report capabilities, which can be used for all general ledger, accounts payable, and financial statement presentations in accordance with GAAP. Annually, we will submit to the Division copies of all quarterly and annual filings submitted to the Mississippi Insurance Department and audited financial statements. We will also file with the Division other financial reporting as required for the capitation payment development process.
Claims Denial (Section 16.2.4)	We will submit to the Division a listing of denials processed in a timely manner as specified in the Division's Reporting Manual. We will provide reports by denial category, including those listed in Draft Contract § 16.2.4. In addition to the Division-required reports, our claims, Provider representative, and operations departments will

Reporting Area	Our Capabilities and Systems to Meet Division Requirements
	monitor denials weekly using internally generated reports of the top 10 Providers with claims denials and top 10 claims denial reasons to quickly identify issues and institute remediation.
Provider Statistical Summary (Section 16.2.5)	We will follow all guidelines related to production of the Provider Statistical and Summary report, as requested on an ad hoc basis by Providers and/or the Division. Upon request of the report from a facility, we will confirm their name on the Division's list of eligible facilities. Upon confirmation, we will generate the report, validate its accuracy, and distribute it as appropriate.
Hospice (Section 16.2.6)	We will provide monthly Hospice Management, Hospice Prior Authorization, and Hospice Provider Detail reports for both MississippiCAN and CHIP in a time and manner required in the Reporting Manual and prepared in accordance with the Division's format. Our systems are configured to capture and report on the minimum items listed in Draft Contract §16.2.6.
Third Party Liability (TPL) (Section 16.2.7)	Our TPL application captures all information on third party resources that will allow us to accurately report to the Division newly identified health insurance leads; number of claims denied due to the existence of TPL on file; amount of all monies recovered from other insurance companies after we have initially paid the claim as primary; and amount of monies recovered from Providers due to audits, reviews, and/or disallowances.
Internal Audit (Section 16.2.8)	We will submit a report to the Division that details the annual review, completed activities, and corrective actions that are recommended or in progress, and the results of all clinical, administrative, and Member satisfaction surveys conducted during the immediately preceding year. The report will set forth any proposed modifications to our quality management system or policies and procedures.
Mississippi Insurance Department (Section 16.2.10)	We will submit to the Division copies of all reports submitted to the Mississippi Insurance Department.

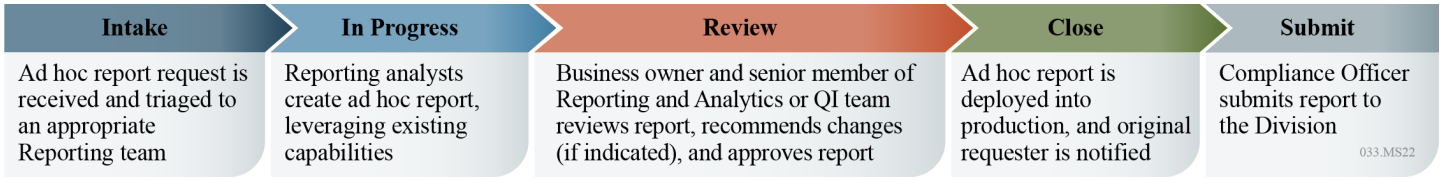
As indicated, we will include appropriate documentation, such as clinical records, attestations, and consents, with report submissions.

Ad Hoc Reporting

Regardless of the requested turnaround time, we will complete requests for ad hoc reports per the Division's needs and expectations. Upon receipt of a request from the Division, the operations team will log the request into an established report tracking system, which will automatically route the request to our reporting and analytics team. Upon receipt, the reporting and analytics team will review the request, meet with the operations team within one business day, and ensure alignment of the practical purpose for the Division's request, production requirements, and specifications.

The report will be assigned to an appropriate business owner based on the nature of the request (for example, population health, Member enrollment). The business owner will collaborate with the reporting and analytics team to pull and format any required data/information. A final response will be submitted to our Mississippi Operations department by the business owner after their review and approval from the previously assigned approver. The Mississippi Compliance Officer will perform a final review of the response and either request a revision or submit an on-time, accurate, and complete report to the Division. An overview of the ad hoc report development process we will employ for the CCO Contract is illustrated in **Exhibit 4.**

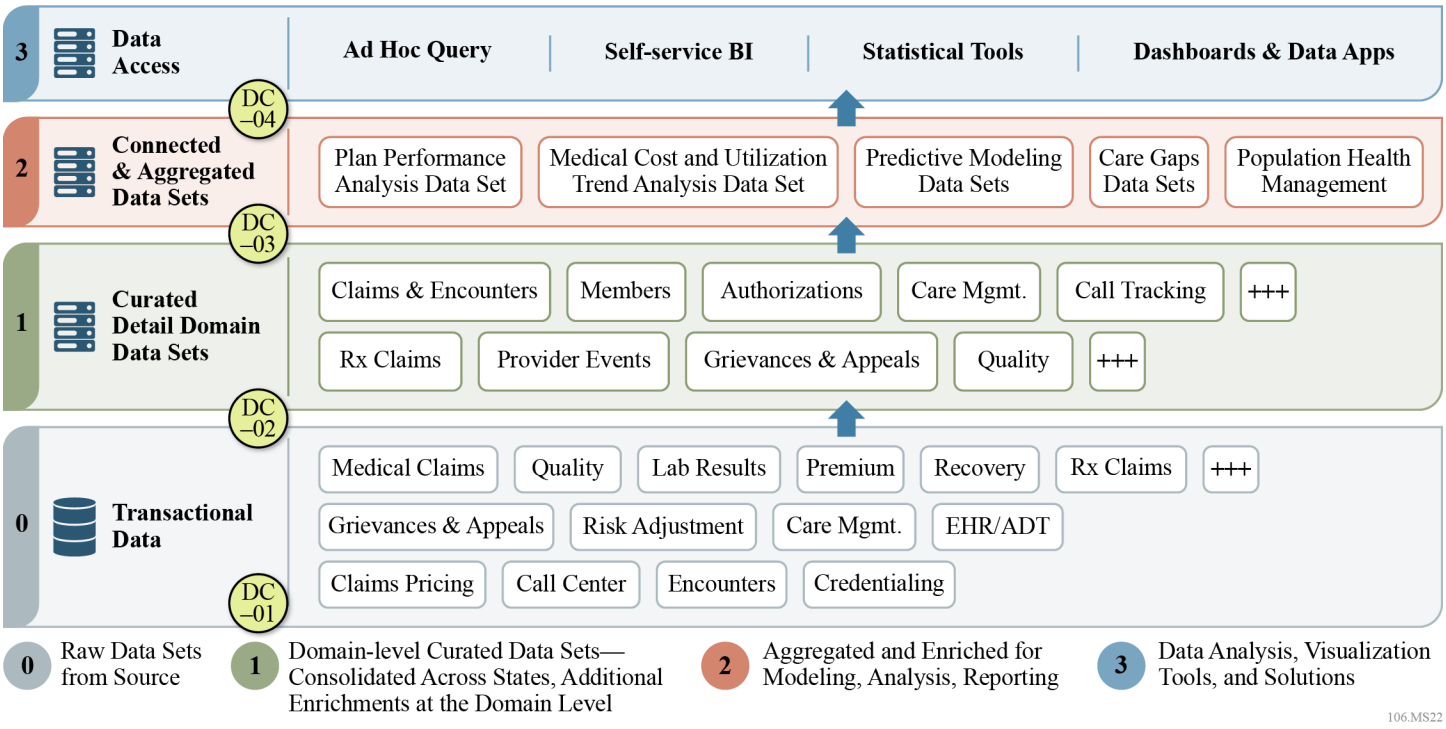
Exhibit 4. Ad Hoc Report Development Process. Our tightly managed process will ensure prompt and accurate response to the Division's requests for ad hoc reports.



Validating Data

We have established robust processes to ensure the highest quality data is available to end users. Data quality checks and validation scripts are implemented at various stages of the data transformation pipeline. **Exhibit 5** provides a high-level view of the different layers of data transformations and enrichments that take place within our data lake and the various points at which data validation and monitoring are executed (light green circles). The references to various systems and applications are illustrative and do not represent an exhaustive list.

Exhibit 5. Data Transformations and Enrichments Within the Data Lake. We ensure data quality through ongoing monitoring, tracking, and validation.



Data Validation Points

We use automated data governance and data quality tools to measure data quality, track data lineage, and establish data stewardship. As illustrated in **Exhibit 6**, we perform several validation, monitoring, and data certification processes to ensure the data used for reporting and analytics is of the highest quality, meeting all State requirements and expectations. The light green circles in the exhibit represent the points at which data validation and certification scripts are executed.

- **DC-01** illustrates the process of drawing the raw data sets from the direct source (Level 0). Our certification processes use automated tools to capture a snapshot of the data from the source platform and compare the quality against the data loaded in our data lake. ***Any variance above a business-defined threshold is red-flagged, and alerts are shared with our data operations team for corrective action.***
- **DC-02** certifies that the business definitions and rules applied to data at Level 1 are correctly applied and that the resulting data set reconciles back to the source data in terms of consistency, completion, and accuracy.
- **DC-03** certifies that data is aggregated or moved correctly from the Level 1 to Level 2 semantic layers, a region of our data lake that can be used to isolate and secure Mississippi-only data curations.
- **DC-04** is the final validation to confirm that the data in the underlying platform is displaying accurately on the consumption layer.

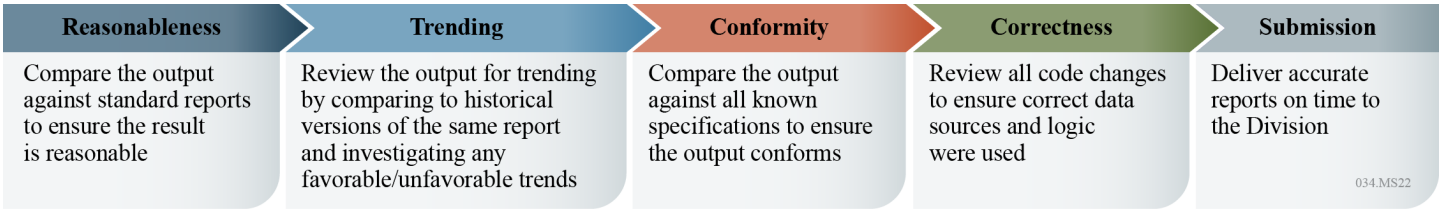
We also employ a data quality dashboard, shown in **Exhibit 6**, which is the primary data monitoring tool used by our reporting and analytics team to ***monitor the completeness, timeliness, and accuracy of data in the data lake.*** The reporting and analytics team uses this tool daily to proactively monitor data quality for internal and external reporting. Our reporting and analytics team also uses the dashboard to analyze root causes and for continuous data QI. For example, in the fourth quarter of 2020, the reporting and analytics team noted an unexpected drop in data timeliness scores due to a significant increase in data volume. In response, the data management team optimized data refresh jobs, thereby improving the availability of claims data by two hours and authorization data by three hours each morning. This improved efficiency enhances monitoring of Member care through real-time data by, for example, providing for greater insight into Providers' and our own managed care performance.

Exhibit 6. Data Quality Dashboard. We use our data quality dashboard to monitor data completeness, timeliness, and accuracy.

Ensuring Accuracy of Reports

Our Mississippi-based Compliance Officer will be responsible for ensuring the accuracy and timeliness of reported information and will perform quality checks on reports and forms before submission, ensuring business owner attestations for report content. Report accuracy and completeness will be reviewed collaboratively by our compliance and reporting and analytics teams, as well as the relevant operational area. Each department brings with it a different focus and area of expertise to ensure reasonableness, trending, conformity, and correctness. As illustrated in **Exhibit 7**, these quality assurance litmus tests work together to ensure all reporting is accurate, complete, and on time.

Exhibit 7. Quality Assurance Approach. A tightly managed process will ensure reports meet the Division's accuracy and timeliness requirements.



Reasonableness. The SME from the relevant operational area evaluates the report for reasonableness against their working knowledge of the subject matter. For example, if the Provider termination report does not include any terminations for the monthly report and our VP, Network Management knows of the termination of a Provider from our network, the report will be rejected and investigated. This process ensures reporting reflects the practical realities experienced and applied by our operational teams.

Trending. We evaluate the report based on trending comparisons between previous versions of the same report as well as other related reports. For example, if the very low birth weight report shows an upward trend, but the Member high-cost report indicates fewer Members with more than $100,000 in incurred costs, the data will be reviewed and investigated to either confirm the information in the report or revise the report and address any issues that caused the inaccuracy. This ensures reporting is consistent across multiple versions of the same report as well as across different sets of reports.

Conformity. We compare the final report against State specifications to confirm all the required information is present and in the correct format. If the specification indicates that dates should be represented as MM/DD/YYYY but the dates are being output as YYYYMMDD, the report will be rejected, so the reporting and analytics team can correct the format in the reporting logic. This ensures the report provides the exact and complete information required in a usable format.

Correctness. All new code and coding changes are reviewed for correctness by the reporting and analytics team, often in collaboration with the SME from the relevant operational area. For example, if a report illustrating PCP spend is modified to show spend segmented by Member region, all required code changes will be reviewed. If the segmentation has instead been conducted by Provider region, the report will be rejected, and the reporting and analytics team will make the correction. This ensures the report is capturing the intended information.

When a report is rejected, it goes back to both the reporting and analytics team and the appropriate SME. They review the issue and determine the next course of action, such as providing an explanation that the report is in fact correct or modifying the underlying code. Our internal process includes attestation by the responsible party to further validate accuracy and compliance.

Submission. Upon confirmation of report correctness, our Mississippi Compliance Officer will submit the on-time report to the Division.

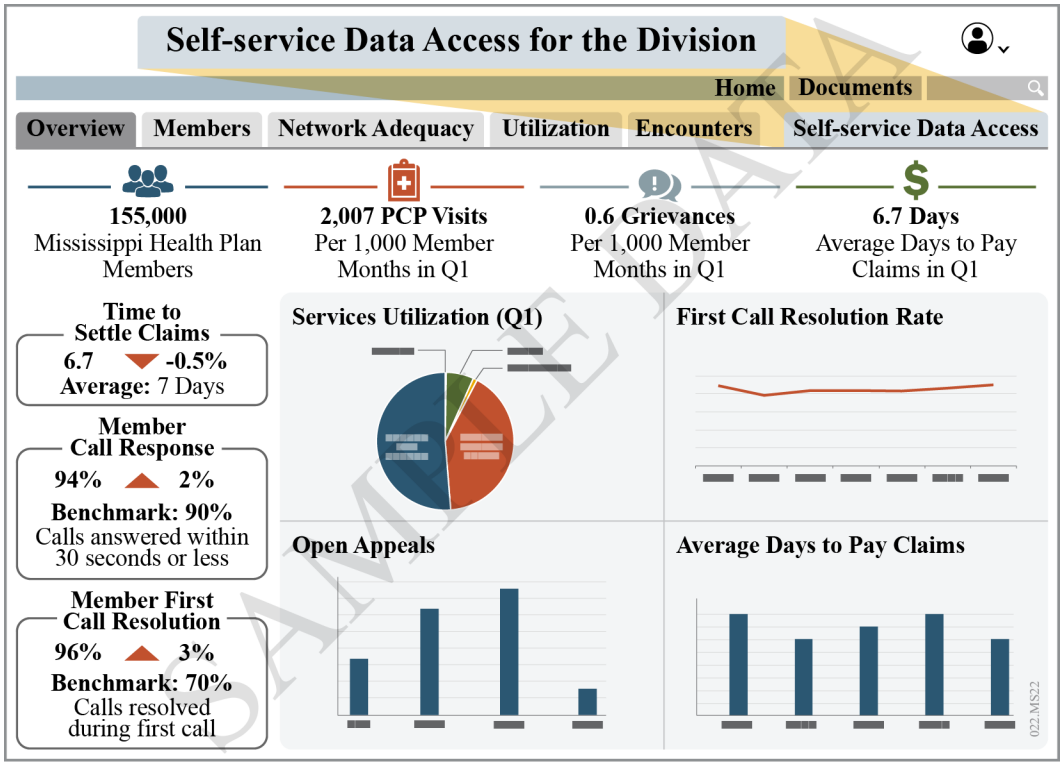
Monitoring and Evaluation Ensures Accurate Reports and Timely Submission

We will maintain a list of all Division standard and ad hoc reports with priorities and due dates. For recurring reports, we automate tasks and processes through our workflow management system to ensure timely submission. This systematically generates advance notice of upcoming reports by creating a "Future Delivery" ticket that is reviewed, assigned to an analyst, and tracked to completion. Reporting Managers ensure timely report development, testing, and delivery via automated alerts, ticketing, and assignments**.**

Reporting Dashboard: Mississippi Partner Portal

To proactively and transparently provide insight into key service metrics, we will establish an online, user-friendly Division program dashboard (see **Exhibit 8** for a sample) in addition to providing the Division's required reports. The reporting portal is a secure and compliant web-based interface that we will customize for the Division. ***Division staff will be able to access a self-service option that will provide access to all data relevant to care provided to Members, including encounters, care management, utilization, and quality data.***

Exhibit 8. Mississippi Partner Portal for the Division. We will deploy a customizable partner portal that will enable the Division to access relevant program data through a web-based interface.

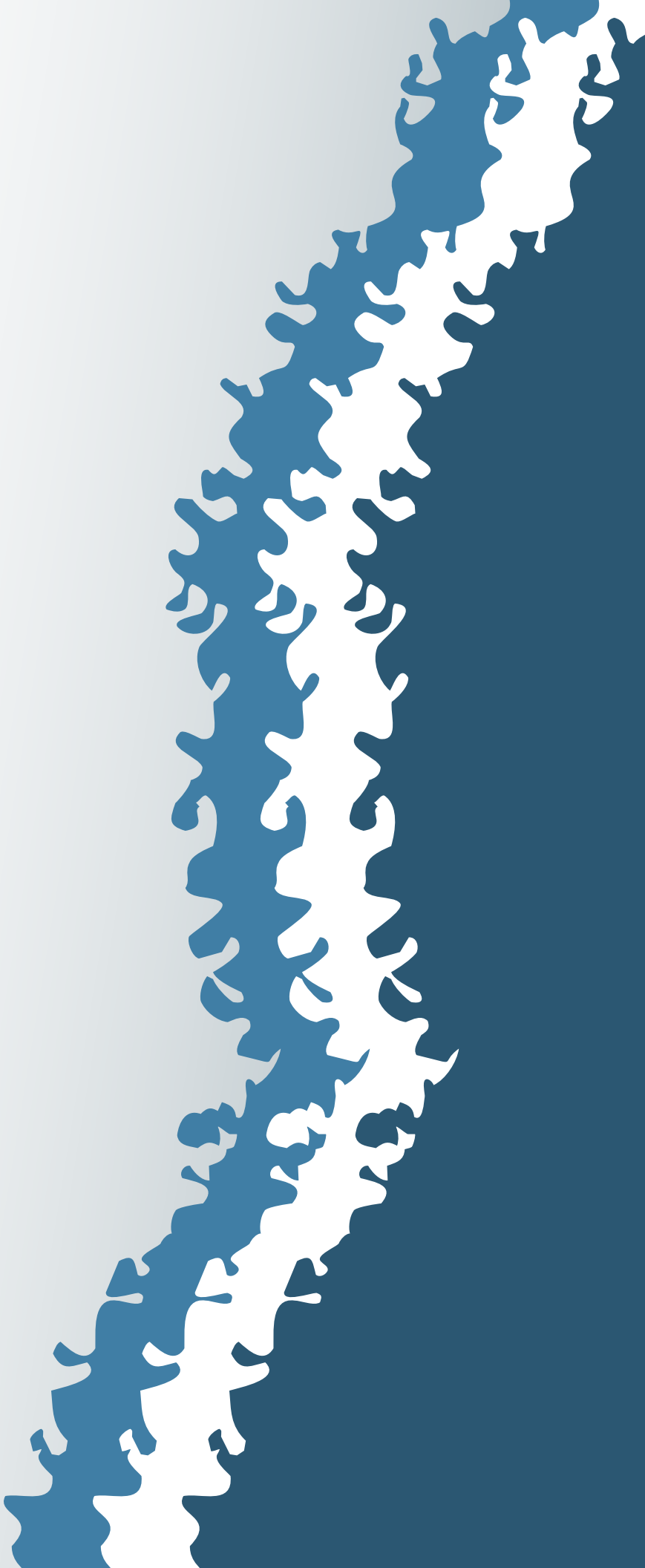


To support the Division in maximizing the value and capabilities of this tool, we will provide training to appropriate Division staff.

[END OF RESPONSE]

4.2.2.9

Program Integrity



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4.2.2.9: PROGRAM INTEGRITY

A. FRAUD, WASTE, AND ABUSE

A.1. The Fraud, Waste, and Abuse Program We Will Implement

We are committed to being good stewards of taxpayer dollars through our continued investment in FWA prevention, detection, and correction resources. Across the nation, our program integrity plan and processes addressing cost avoidance and overpayment recoveries ***saved Medicaid managed care programs $1.1 billion ($375.72 per Member per year) in 2020 and $1.4 billion ($375.58 per Member per year) from January through November 2021.***

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Our Mississippi-based Compliance Officer, who will report directly to the Chief Executive Officer (CEO) and the Board of Directors, will serve as the primary point of contact for all FWA efforts with the State and will be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the Contract. Chaired by our Compliance Officer, our Mississippi regulatory compliance committee will be responsible for oversight of our compliance program, Contract requirements, and monitoring the performance of our FWA activities. Our Compliance Officer, in collaboration with the Fraud and Abuse Manager, will have day-to-day responsibility for ensuring adherence to the FWA compliance plan and all applicable State and Federal FWA mandates.

To maximize program integrity and our commitment to investigating suspected FWA in Mississippi, we will employ a local, Mississippi-based FWA investigative staff supported by a centralized national Special Investigations Unit (SIU). At the local level, ***we will have at least two dedicated Mississippi-based Investigators to ensure effective program integrity, exceeding the requirements noted in Draft Contract § 10.1.3, Compliance Staff.*** The national SIU includes 87 FTEs who use nationwide tested and proven best practices in FWA prevention, detection, and correction and will ensure the local team has adequate resources and systems to carry out program integrity requirements for the MississippiCAN and CHIP programs. SIU resources are detailed in **Table 1.**

Table 1. SIU Resources. Our Mississippi-based FWA activities will be supplemented by specialized national support.

SIU Intake Team	Handles initial triage of our FWA compliance hotline
SIU Manager	Manages referral intake and investigative functions
SIU RN Investigators	Conducts FWA investigations related to clinical medical records
SIU Investigators	Conducts FWA investigations based on leads generated from data analysis, law enforcement, and regulatory referrals and assists with on-site audits and other FWA detection activities under the direction of the SIU Manager
SIU Supervisor	Oversees SIU certified coding analysts and conducts audits involving Provider FWA related to coding and billing issues
SIU Clinician Manager	Oversees the SIU RN Investigators
SIU Data/Certified Coding Analysts	Manages special data analytics and certified coding projects assessing potential FWA

Our proposed Mississippi-based Investigators and centralized SIU team have effective Medicaid claims investigations experience, including an understanding of coding and medical records review protocols. Team members also hold professional accreditations and certifications to include Certified Fraud Examiners, Accredited Health Care Fraud Investigators, Certified Professional Coders, and nursing, underscoring our commitment to combatting FWA. Complementing the experience of our team, SIU leadership brings extensive fraud detection strategy and planning expertise. This includes leadership experience in law enforcement and participation in the healthcare fraud task force within the FBI, as well as regulatory leadership in a State insurance Medicaid fraud division.

We have reviewed Draft Contract § 10.0, Fraud, Waste, and Abuse, and will comply with requirements.

A.1.a. Proactive and Reactive FWA Detection Methods

Proactive prevention is the most efficient and effective way to combat FWA. We educate all employees, Members and their LAR/caregivers, and Providers on how to prevent, recognize or detect, and report suspected FWA. We encourage anonymous, good faith reporting of suspected fraud and abuse by telephone through our dedicated, toll-free FWA compliance hotline or online through our secure website, both available 24/7/365. Our hotline and online reporting tools are widely communicated and used by both external parties, such as Members and Providers, as well as employees of our health plan.

A Detailed Work Plan Drives Our Methods and Focus Areas

In addition to leads into areas of focus from across the enterprise through referrals from utilization management, grievances and appeals, claims, finance, and targeted analytics, our SIU will develop a focused annual audit work plan as a complement to its overall FWA Plan, which reflects both local and national emerging trends and schemes. The work plan will describe key audit types and internal controls to execute as well as proactive work to be performed in the calendar year to assist in prevention, detection, and correction of FWA. These two plans will operate in conjunction with our Mississippi Compliance Plan to create a comprehensive program integrity road map for optimal compliance and oversight.

The SIU annual audit work plan comprises multiple factors, including trending FWA devices and alerts provided by organizations such as the National Health Care Anti-Fraud Association (NHCAA), Health Plan Management System fraud alerts, Investigations Medicare Drug Integrity Contractor, other anti-fraud organizations, audit vendor experiences, State agency collaborations, and HHS OIG work plans.

The Healthcare Fraud Prevention Partnership and the NHCAA, both of which we are members, are important resources. As a member of NHCAA, the SIU has access to the Special Investigation Resource and Intelligence System (SIRIS), the NHCAA information-sharing website that includes regular postings on potential Provider FWA activities by more than 100 US insurance companies. As a member of the Healthcare Fraud Prevention Partnership, the SIU has access to focus studies, white papers, and projects at the partnership that drive FWA outlier identification activities.

To expand our ability to identify schemes, and schemes that migrate from one community to another, our SIU monitors prevalent fraud situations within the states our affiliate health plans operate through various agencies, such as State regulatory agencies and the Federal Medicare Drug Integrity Contractors. In Mississippi, we will partner and collaborate with the Division's Office of Program Integrity and participate in industry roundtable discussions to further examine concerns and emerging trends at the local level.

We perform comprehensive data analytics on paid claims to develop an audit work plan identifying the scope of work and objectives and determine if a mitigation plan is necessary. In addition, the SIU uses a premier software application and data analytics tool to identify statistical outliers within peer (specialty) groups and services/coding categories.

We receive FWA leads provided by the SIU's internal fraud analytics solutions and vendor supported analytics vetted for outliers indicative of suspect behavior. As part of the analytics, algorithms can be categorized into areas of focus, such as BH or community mental health and rehabilitative services suspicious activity, that allow ranking and profiling into hierarchical percentiles of outlier behavior. Individual risks are measured and tallied to rank Providers at total risk exposure within the identified categories. SIU leadership reviews the highest risk areas on an ongoing basis through dashboards within the analytics tools to look for trends and new categories that are spiking.

We also review previous case investigation activity to determine if trends exist that require expanded review; an important component of machine learning is its proactive data analytics protocols. All of these concepts will be included in our annual FWA Mississippi compliance plan.

Sophisticated Technology and Analytics Support Our Efforts

In addition to the staff needed to execute our FWA compliance plan and SIU audit work plan, we will rely on technology and analytics to augment our work. All investigative activity is tracked in our FWA investigative care management system, a software application used by the SIU to track every aspect and activity of a case from the initial tip through case closure. Data elements captured and tracked include:

- Details of a case lead, including how, when, where, and whom from a lead came to the SIU and any specific regulatory due date or lead prioritization
- Details of the participants in the case and if and how suspects are linked to other cases
- All case status, assigned Investigators, initial suspect, and final amounts
- Activities such as details on data analytics, case development, closure, communication, data, documents, external requests, financials, linked cases, Investigator notes, interviews conducted, medical records, research, referrals, watch lists, appeals, CAPs, quality assurance reviews, correspondence, and pre-payment reviews
- Details of the audit sampling techniques, timing, timelines, outcomes, extrapolation, and status at any given point in the investigation pre- and post-appeal
- Details of referral activity, including reference identifications, methods, risk exposure, timing, and status
- An integrated document reference and storage facility to like documents to activities tracked
- Financial activity tracking of overpayments identified and recovered, at-risk amounts, cost avoidance, legal settlements, and restitution
- Key regulatory reporting fields necessary to support standard and custom reporting

There is a document storage facility within the application and an integrated query tool for reporting. It links to our FWA analytics tool as well for a comprehensive package of activities.

We use an advanced business intelligence and data visualization solution which allows us to run queries against claims data to identify statistical outliers and trends in Provider and Member information. The advanced business intelligence solution allows our SIU staff to drill down to specific targets/parameters to easily vet leads. Claims data sets are fed from our national claims and encounters management system, which contains all claims billed/paid, allowing for the capability to conduct peer-to-peer analysis. Visualization charts help our staff monitor billing trends and spike analysis. The tables are interactive and allow the user to drill down into details and model trends over time and across Providers, service codes, diagnoses, and more.

Payment Oversight Program

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect FWA, correct it, and prevent it from reoccurring.

Our payment oversight programs include:

- SIU investigations
- Pre-pay coding reviews
- Pre-pay medical/accuracy reviews
- COB/TPL/subrogation/mass tort
- Hospital DRG and bill audits
- Facility credit balance collections
- Lock-in protocols
- Post-payment claim reviews (e.g., coding, duplicates, retro terms, fee schedule, and contract rate adjustments)
- Utilization reviews
- Outlier and predictive analytics
- Pharmacy/medical synergies in data
- First tier, downstream, and related entities reviews
- Verification of service activities

To modernize and maximize efficiency of our approach, we integrated our claims payment, pre-payment, and post-payment claims activities, claims recovery, and SIU teams into one business unit. This business unit manages the claims experience from acceptance of a claim to adjudication to recovery and FWA monitoring. Embedding the SIU in this business unit fosters close collaboration between team members to share insights and trends, quickly identify and address outliers, and continually improve business processes to proactively enhance payment accuracy and prevention of FWA.

We apply an extensive array of pre-payment review measures, including claim edits, system setup validation, pre-payment reviews, and claims process improvement based on monthly trend analysis of leading and lagging quality indicators.

Proactive Methods and Approach

Pre-payment Review. Our pre-payment review process uses advanced detection engines and other mechanisms, described below, to identify and flag suspicious claims based on questionable patterns and trends. Suspect claims are reviewed and scrutinized by experienced clinical and investigative personnel in a pre-payment environment and may include medical record reviews and clinical assessments to determine appropriateness of payment.

Our success in avoiding FWA before payment of claim has led to increased claims processing accuracy and better trending of questionable billing practices. We apply refined processes to screen Providers, Subcontractors, and employees against State and Federal exclusions lists at the onset of initial contracting and monthly thereafter to prevent erroneous payment to excluded Providers, including those who have been debarred or suspended from participating in government programs.

We ensure accurate reimbursement based on medical policy, coding accuracy, and Contract adherence. We apply an initial set of edits in our core administrative system for pre-adjudication analysis followed by a secondary electronic comparison against local and national edits before releasing claims for payment. Our reviews include suspected medical expense leakage to identify waste trends. Pre-payment prevention reviews address improper coding and billing errors.

NCCI Code Edit Rules. We comply with NCCI guidelines to ensure proper claims coding and payment. Our claims adjudication process includes a dual pass application of NCCI rules to ensure claims are coded per State and Federal coding guidelines to address improper coding and billing errors and avoid inappropriate payment.

Pause and Pay. Our pause and pay pre-payment review program uses advanced detection engines to identify and flag suspicious claims based on questionable patterns and trends. Suspect claims are initially flagged for denial during the adjudication process and payment is temporarily paused pending receipt of medical records. Experienced clinical staff review supporting medical records that are provided. If we don't receive the requested documentation within the allotted time or if the documentation does not support the claim as billed, the claim remains denied in adjudication. If the documentation supports the claim as billed, we reverse the denial and release the claim into the appropriate payment cycle.

Emergency Department Coding (EDC) Analyzer. The EDC Analyzer uses built-in logic to review ER CPT and HCPCS codes to determine the appropriate ER level and returns the correct ER-visit level. Based on the recommended visit level provided by the EDC Analyzer, claims are priced appropriately for payment through the standard adjudication process.

Coding Validation Pre-pay Edits. This FWA solution addresses correct use of modifiers that are too complex to auto adjudicate, and accordingly, has a human review component. The edits involve ***a clinician's personal review of the clinical and coding information on the claim and in the Member's claims history to determine if the modifier has been used correctly where modifiers may have been used to override unbundling edits,*** such as 24, 25, 59, and 79.

Itemized Bill Review. We review high dollar and complex claims with an outlier or stop loss amount for unbundling and to ensure such claims are billed and paid appropriately. Defined protocols guide pre-payment reviews of high dollar and complex claims to confirm select claims are reimbursed correctly based on medical policy, coding accuracy, and Provider agreement terms. Medical records may be obtained and reviewed to confirm billing accuracy before payment is released.

SIU-initiated Pre-payment Review. This is initiated through the course of an investigation when an allegation of FWA is substantiated and/or when financial risk is significant. We will place a Provider on pre-payment review after our written request to the Division's Office of Program Integrity (OPI) for a pre-payment review has been approved. All pre-payment reviews will be completed within 12 months of case initiation, upon which time we will reevaluate the case to determine if the Provider's billing practices have changed and a continuation of the pre-payment review is necessary to prevent future improper payments or refer the case as a credible allegation of fraud.

Reactive Methods and Approach

Post-payment Retrospective Detection. We are actively engaged in detecting and preventing FWA on a proactive basis. However, since not all instances of FWA can be prevented, it is critical to employ processes that retrospectively detect and address FWA that may have already occurred. Examples of categories for post-payment reviews include investigations; COB/TPL/subrogation/mass tort law; hospital DRG and bill audits; and post-payment claim audits (e.g., coding, duplicates, retroactive terminations, fee schedule, and Provider agreement rate adjustments). We employ data mining and investigations to identify and report suspected FWA committed by network and out-of-network Providers, Members and their families/caregivers, employees, and other third parties. When we complete post-payment data mining and identify issues, we will update system configurations to mitigate reoccurrence and work with the Division's OPI for approval to further investigate and recover payments as applicable.

Our FWA detection software application pulls information from multiple public data sources and historical databases that track known fraud perpetrators. Similar in scope to the multiple steps that occur during tip triage, this research process for post-payment recoveries includes, but is not limited to:

- Integration of American Medical Association coding logic into the analytics to drive leads more informatively
- Alerts generation based on external data sources like the NPI Database, the HHS OIG List of Excluded Individuals/Entities, and State exclusion lists
- Use of a proprietary database that consists of a variety of data from external sources (e.g., board sanctions, actions against licensed network Providers, and more)
- Links to social media
- Use of approximately 1,000 algorithms, some with thousands of iterations, to identify FWA anomalies across 150 different categories and approximately 150 specialties
- Use of 149 algorithms for COVID-19-related issues
- Monitoring geomapping tracking to review the distance between Providers, Members, and services

We complement this with data outlier identification collaborations, such as the CMS Healthcare Fraud Prevention Partnership and NHCAA SIRIS, with industry referrals and State and Federal agency work groups.

Claims Audit Unit. The claims audit unit monitors and audits claims to ensure the quality and accuracy of payments and denials. They conduct post-payment audits on a random sample of auto-adjudicated claims. The unit refers post-payment trends and patterns identified in our audit processes or by a vendor as questionable to the SIU for review and investigation.

Verification of Services. Recognizing the important role Members play in identifying Provider FWA, we will employ two separate methods to meet the requirement in Draft Contract § 10.1.1, item 12, to verify whether services that were represented to have been delivered by network Providers were in fact received by the Member. Our methods for MississippiCAN and CHIP will include:

- **Member explanation of benefits (EOBs).** Every EOB we send Members will include additional instruction for them to call our Member services call center if they did not receive any of the services detailed in the EOB.
- **Monthly service verification letters.** Every month, we will mail letters to a sample of Members for whom we received a Provider claim or encounter to verify they received the service(s). In the letters, we will suppress information that, if revealed to other Members of the household, would be a violation of confidentiality requirements for records including women's healthcare, family planning, sexually transmitted diseases, and BH services. Similar to the explanation of benefits, the letter will instruct the Member to call our Member services call center if any of the services in the letter were not received.

Exceeding Contract Requirements to Identify Provider FWA

In addition to conducting audits on a sample of claims to verify services were received by Members, we will include instructions in every Member EOB to call us if they did not receive the services listed in the EOB.

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All Member services call center employees are trained to respond to Member calls regarding potential FWA and report the allegation through our FWA compliance hotline. Every Member tip of potential FWA is triaged by our SIU for investigation. Investigations include activities such as audits of Provider claims, source document evaluation, and/or Member interviews.

Conducting Post-Payment Investigations

If trends and patterns of concern giving rise to an allegation of potential FWA are confirmed as credible, we will immediately report it to the Division. Upon securing prior written approval from the Division, our SIU will conduct a post-payment investigation. The SIU conducts peer-to-peer comparisons for cost, service type, and diagnosis to identify outliers that warrant further investigation, matching medical and pharmaceutical transactions for reasonableness. Using our industry-leading FWA detection software, which employs multiple algorithms to identify billing outliers; over and underutilization; peer-to-peer comparative behavior patterns and trends; and geomapping distance analytics within the SIU, the SIU develops investigation leads and appropriate responses to allegations.

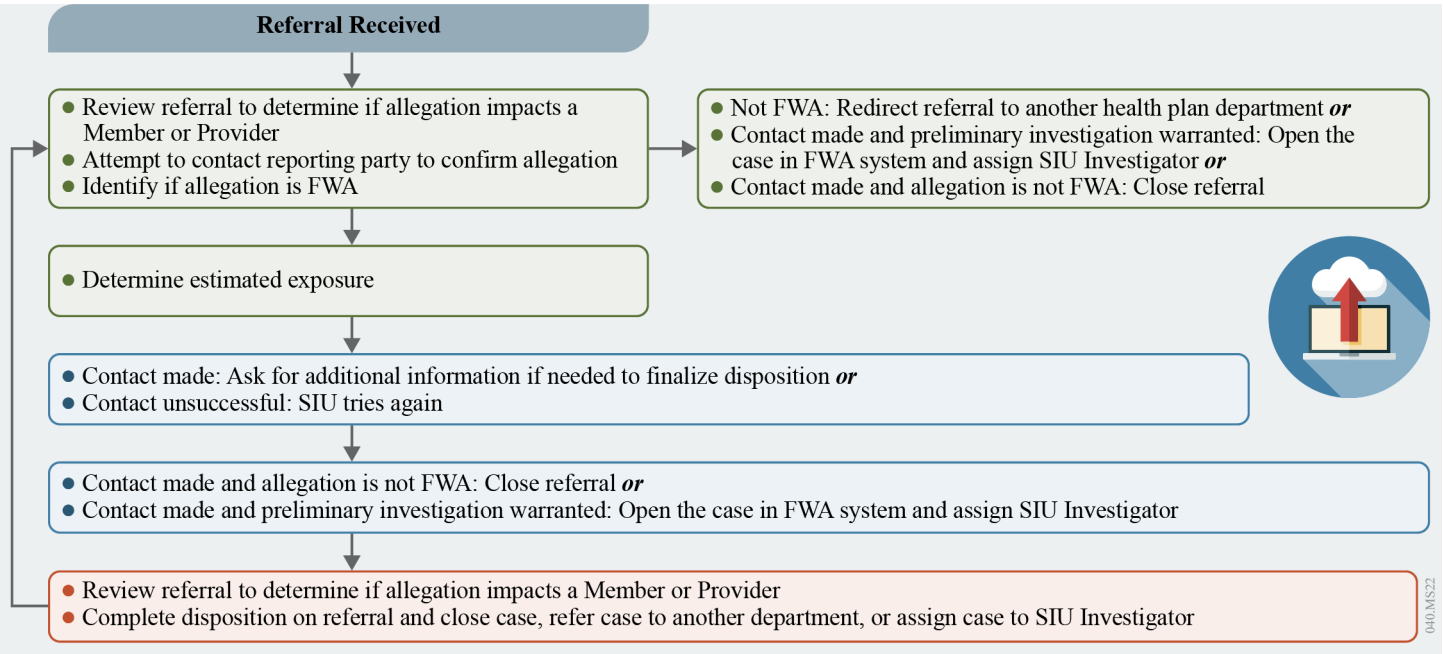
A.1.b. Process for Acting Upon Suspected Cases of FWA

When tips associated with allegations of potential FWA are received through one of the methods described above, including our compliance hotline, our compliance team forwards the tip to the SIU. Upon receipt of a tip, SIU staff begins the investigative process. More than 1,500 tips were received by the SIU in 2021 across our affiliate plans. A Triage Team Analyst from the intake team initially assesses tips to determine if there is enough information present to develop a lead for an investigation.

Process for Timely Tip Investigation

To assure timely investigation of tips, we follow a step-by-step process as illustrated in **Exhibit 1.**

Exhibit 1. Tip Investigation. We follow a defined process to thoroughly investigate reports of potential FWA.



Our tip triage process is efficient and will result in the timely initial handling of Mississippi tips within two to three business days.

Triaging Tips and Complaints

The compliance alert line system is used to track FWA and ethics/compliance complaints. It routes and tracks the complaint, provides key updates, and maintains a resolution status. Our compliance team, which vigilantly monitors complaints and related follow-up activities, passes possible FWA tips to the SIU, which begins its review for a credible allegation of fraud as illustrated in the Exhibit above.

The assigned Triage Team Analyst performs a preliminary assessment of the allegation to determine if sufficient information is available to pursue an investigation. The Triage Team Analyst factors in elements such as source, nature and scope of allegation, dollar amount, and past history and then ranks the factors to derive a risk score. Note, the SIU does not apply a dollar amount to determine if a case is to be investigated, only to prioritize cases with higher potential impact.

If there is sufficient information, the Triage Team Analyst builds an initial pre-case lead in our FWA investigative case management system, reviews scores in our fraud analytics system, and prepares a risk assessment within one business day of receipt. Each case is then assigned to an Investigator. In the event there is not sufficient information provided with the tip and there is no other way to gather further evidence, the tip is closed.

Initial Case Work and Risk Assessment Activities

Initial case work focuses on key areas such as background checks, resource research, and risk assessments. The SIU Investigator checks Provider licensure (certification) in public databases and reviews appropriate regulatory guidance related to services rendered and licensure/certification requirements. They may also initiate a claims history search under the specific Provider to identify patterns and outliers. Other investigative activity includes reviewing:

Using Risk Assessments to Prioritize Cases

SIU Investigators calculate and assign each case a risk assessment score to ensure resources are appropriately allocated to those cases with the greatest potential risk.

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- Provider contracts for service terms or restrictions
- Prior investigative cases and any audit education history associated with the subject of the investigation
- History of exclusion from HHS OIG List of Excluded Individuals/Entities and Mississippi State suspension and exclusion lists
- Claims adjudication system for memorandums and alerts in the Provider account for any adverse actions placed on the Provider (e.g., no pay no authorization)

Finally, the Investigator calculates a risk assessment score to determine priority. This innovative measure takes key factors into consideration such as: Does the allegation harm the Member? Does it involve identify theft? Is this a false claim being made? The Investigator also factors in the past history of the Provider and their geographic location.

The risk assessment score is assigned internally on a scale of 1 to 1,000. A score of 850–1000 is high priority, 400–849 is medium priority, and 0–399 is considered a low priority risk.

Conducting a Full Investigation

If an investigation seems to be warranted, and upon approval from OPI to proceed with such an investigation, the SIU Investigator will change the status of the case from “Pre-case” to “Case” in our investigative case management system.

The Investigator will determine whether an on-site audit (with OPI approval) or desktop audit is appropriate. The Investigator will obtain OPI’s approval to obtain medical records for review if such review is deemed necessary. The review may lead to Provider or Member interviews related to allegations.

After assessing the research, the Investigator will determine the overpayment amount for all improperly paid claims. They will upload all supporting documents and records relative to the case to the case management system.

The SIU will send, via the SIU tracking site, a draft audit findings letter, an audit summary report, and the completed OPI case approval form in advance of issuing findings to obtain approval from OPI to release.

The SIU will send a formal findings letter to the Provider, notifying them of their right to dispute any findings identified during the investigation and will issue a final revised finding after any additional documentation has been assessed.

Ensuring Timely Investigations. The SIU Manager will continuously review and monitor the aging of investigative cases and progress toward completion during recurring weekly one-on-one meetings with the Investigators to confirm subject matter experts are fully engaged in case progression and a timely closure is attained. The SIU engages in workload balancing to ensure cases are monitored and tracked for timely closure, using floater auditors to assist in case development and closure as needed.

Referring Credible Allegations of Fraud

The SIU will report Subcontractor, Provider, or Member fraud and/or abuse that we have reasonable cause to suspect or should have had reasonable cause to suspect a credible allegation of fraud, immediately to the

Division. After submitting the referral, we will take no further action on the specific allegation until the Division responds with further directions or approval to proceed with investigation.

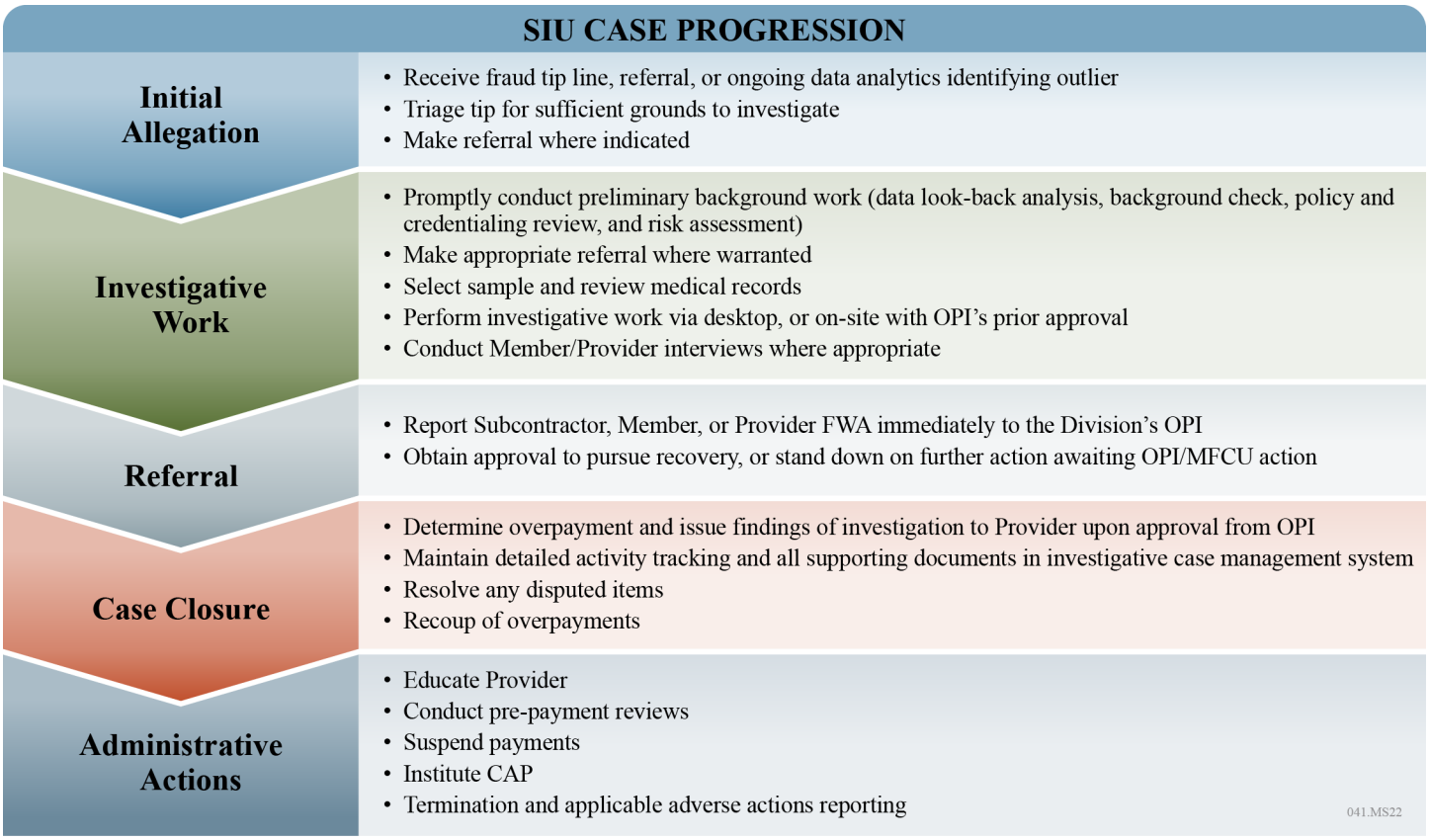
Ensuring Resolution is Documented

When an Investigator is ready to close a case, they prepare a case closure request document for quality assurance. The SIU Manager reviews the request and if approved, the status of the case is changed from "Open" to "Closed" in the case management system. Continuous status updates of every investigative activity are made in the system during the entire process of the investigation to ensure a thorough review is conducted.

Upon completion of a full investigation or verification that a full investigation is not warranted, the status of the case is additionally updated and marked as "Closed" in the alert line system, closing the circle from the original tip. Notifications, reports, and attestations to certain information will be sent to the Division on a monthly basis, including active reviews and their status.

Exhibit 2 illustrates our proposed processes for acting upon suspected cases of FWA.

Exhibit 2. Case Progression. Our SIU follows a defined process to ensure comprehensive investigation.



Corrective Actions for Investigations

If corrective actions are warranted based upon the findings of a Provider investigation, we initiate the following steps:

1. The Investigator contacts Provider services to consider potential termination of the Provider if a fraud allegation is supported.
2. If Provider termination is desired, we will submit a Provider Termination Work Plan and supporting documentation to the Division, which will assess the impact to Members and outline reassignment of Members to another PCP for continuity of care. The Provider Termination Work Plan will contain all the information required under the Model contract section 6.4.1.
3. If the Provider is not terminated, the SIU and Provider services and Provider network department leadership decide whether to place the Provider on a pre-payment review.
4. We notify the Provider under audit of formal findings and request reimbursement of overpayment.

5. If the overpayment identified is above set thresholds for a material case, the SIU requires the Provider to submit a CAP to inform us how they intend to remediate the deficiencies noted in the audit. The SIU and Provider services and Provider network department leadership approve the returned CAP, where applicable.

The Provider may be asked to rebill all impacted paid claims accurately, refund the appropriate amount, or agree to an extrapolated settlement. Front-end claim system edits may also be developed in conjunction with our configuration team to mitigate recurrences of the risk.

We also refer potential Member FWA to the Division, as appropriate, for investigation.

Mitigation Strategies. We conduct follow-up analytics to monitor compliance with any CAP, and the Provider will remain on the SIU watch list in the event the inappropriate billing behavior resumes. If the Provider has not harmed the Member and is fully cooperating, the SIU may provide education on appropriate billing practices and place the Provider on pre-payment review until an extended period of time has elapsed with accurate claims submissions to demonstrate a corrective action has indeed been achieved and maintained.

The effectiveness of the above process is monitored through key performance indicators and dashboards that track the highest risk alerts within the audit application to note changes in behaviors and risk rankings. Additionally, further data mining efforts take place across all health plans to determine if the risk has been remediated or is persistent and pervasive. Should the latter be determined, the annual audit work plan is evaluated and adjusted to maintain focus on the risk area with additional investigatory work. Edits in claims will be added and implemented enterprise-wide.

Evaluating the Effectiveness of the Risk Mitigation Plan on a Contract Year Basis to Show Continuous Process Improvement

Once the annual audit work plan is set and approved by the governing body, the SIU will begin its extensive system of audits that will occur throughout the year. We will conduct an analysis of the appropriate data for a specific risk. The SIU tracks key performance indicators on a regular basis and monthly reports are sent to the Compliance Officers in the State.

We determine the effectiveness of the annual audit work plan through:

- A review of the work plan
- An evaluation and tracking of goals
- Tracking the number of fraud and abuse referrals made to regulatory authorities
- Recoveries of overpayments identified
- Lessons learned
- A review of Provider billing behavior, which should lead to improved cost avoidance

A.1.c. Process for Complying with Federal Regulations Related to Disclosures and Exclusion of Debarred or Suspended Providers

Our Providers and Subcontractors will be screened in compliance with 42 C.F.R. § 455.436 at initial enrollment, reenrollment, and monthly thereafter to ensure any Provider or Subcontractor is not excluded or debarred from participation by Medicare, Medicaid, or OIG, including any other states' Medicaid program, or CHIP program, except for Emergency Services.. Providers will be validated against the State-certified Provider file to ensure they are registered with the Division. Approved Providers are then loaded in our Provider data system. All Provider system loads follow a structured process, including user acceptance testing and quality validations.

As described above, our Providers (and Subcontractors) are screened monthly against regulatory databases for potential sanctions as required. If sanctions are confirmed, the claims adjudication and other payment systems are configured to deny Provider claims, thus ensuring payments are only made to appropriate Providers. Every Provider in our claims processing system is screened monthly against the OIG, General Services Administration System for Award Management, Medicare Opt Out, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), all available State and Medicaid exclusions databases, and the Social Security Death Master File.

At the Division's request, we will provide a report that compares our Provider files against the databases described above, and a report of the exclusion check of our owners, agents, and managing employees, as well as subcontractors.

A.1.d. Process for Interacting with the Division, Including OPI

Collaborating with Other CCOs

We propose forming a work group with other CCOs to provide a vehicle for sharing best practices, lessons learned, and emerging trends and schemes to collectively strengthen our ability to combat FWA and preserve State funds.

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We will submit our Fraud and Abuse Compliance Plan to OPI for written approval within 90 calendar days of execution of a Contract. Furthermore, we will continue to review our Fraud and Abuse Compliance Plan at least annually and submit an updated plan to the Division for approval. Our Compliance Officer will participate regular in compliance discussions with the Division prior to implementing initiatives and processes, including best practices and mandates for FWA program compliance. We will also meet quarterly with the Division and OPI and exchange information related to potential FWA cases and/or current investigations. We will assist the Division in any investigation or prosecution of fraud, including assisting with law enforcement. This includes providing direct computer access to computerized data we store as requested by the Division. We provide access to any information possessed or maintained by the Provider to which both we and the Division are authorized to access. As an organization, we participate and engage in a number of regulatory program integrity meetings and initiatives in other states, which exposes us to relevant, emerging trends that we apply to our program, which will allow us to share best practices and emerging schemes with the Division.

We will work closely with the Division and OPI to obtain prior approval on all retrospective and pre-payment audits and investigations prior to initiation. We will make all requests to retrospectively audit or place any Provider on pre-payment review by submitting reports to the OPI. We will confer with OPI and obtain prior approval before initiating any investigations requesting medical records or issuing audit findings and overpayment recoupment requests. At any point during an investigation, if a credible allegation of fraud is identified, we will stop the investigation and refer the matter to OPI. OPI will determine if the case should be referred to the State's MFCU. As part of an investigation, we will suspend payments to Providers when directed to do so by the OPI. We will comply with all reporting requirements, including using the most current version of the Division's standard operating procedure for referrals and reporting to the Division.

We propose the formation of a work group to collaborate with other MississippiCAN and CHIP CCOs to share best practices, lessons learned, and information on emerging schemes to maximize the impact of our shared duty to control FWA. We would be happy to serve in a leadership and facilitator role for this work group.

A.1.e. Other Components of the FWA Program

All of our employees are trained on and responsible for identifying and reporting suspected FWA and this responsibility is reinforced through our employee handbook, code of business conduct and ethics, annual required compliance training, and other ongoing communications.

Within 60 days of hire and annually thereafter, all employees, including our Compliance Officer, senior management, and members of our Board of Directors, participate in compliance training, which contains an extensive education module on FWA, equipping employees with information on identifying FWA red flags, applicable laws and regulations, and how to report suspect FWA. Our Mississippi Compliance Officer, in collaboration with our SIU team, may conduct targeted specialty training for team members requiring more in-depth education on a particular topic to further aid in identifying and reporting any suspected FWA.

Team members of our SIU participate in specialized, focused training for skill set building, current trends and patterns, and techniques throughout the year. Course types vary in scope and duration. Below are a sample of the organizations that support training:

- NHCAA
- Healthcare Fraud Prevention Partnership
- CMS Center for Program Integrity
- National Alliance of Medical Auditing Specialists

- Association of Certified Fraud Examiners
- American Academy of Professional Coders

We are active participants in industry associations, including NHCAA, Investigations Medicare Drug Integrity Contractor, and Healthcare Fraud Prevention Partnership. This helps keep our SIU abreast of current methods to combat FWA.

We also educate and train our Providers and Subcontractors on FWA during pre-delegation and annual delegation audits. Although we do not delegate FWA to our Subcontractors, Subcontractors are expected to have proactive FWA programs in place. The State delegation oversight team ensures the programs are robust and inclusive of best practices within the industry. Subcontractors work collaboratively and collectively with the health plan SIU team when instances of FWA are identified in their downstream networks to confirm the allegations are investigated, referred, and reported appropriately.

B. CLAIM DENIALS

Our denials review and reporting program will meet applicable requirements contained in the Draft Contract and ensure benefits are adjudicated and claims are paid in an accurate and timely manner, and with minimal administrative burden to Providers, Members, and the Division.

B.1.a. Denials Management Program

Managed collaboratively by our claims, Provider representative, and operations departments, our denials management program will include proactive Provider education and support, ongoing monitoring to ensure claims are submitted correctly and promptly, and accurate monthly reporting to the Division of denials processed. As stewards of public funds, our program will help prevent FWA, ensure Members have timely access to medically necessary care and services, and ensure Providers receive accurate and timely reimbursement.

All Provider-submitted claims will be immediately processed within our claims processing systems. Once we verify Member eligibility, edits will be systematically reviewed to determine if the claim meets payment criteria, ensure the Provider is enrolled with the State as a Medicaid Provider and is the appropriate type/specialty to perform the service, determine the claim is a covered service, and confirm services are billed appropriately. Once reviewed, we determine whether to pay or deny the entire claim or pay or deny at a line-item level. Regardless, the claim is stored in our system along with an overview of how the determination was made. A claim remittance file will be generated and sent electronically or mailed with all necessary claim payment information, including the HIPAA-compliant reason for any denial codes applied as part of our denial notification.

Denial Notifications. When we deny partial or full payment of a claim, our denial notification will include information detailing the reason for the denial so the Provider may address any or all issues with the claim at one time. If a claim is partially or totally denied on the basis the Provider did not submit any required information or documentation with the claim, our denial notification will specifically identify all such information and documentation. Providers can also access our Provider portal to view specific claims denial reasons or contact our Provider services call center for information on claims denials.

Denial Timelines. We will meet the Division's requirements for timeliness—from initial notification of claims denial, to expedited authorizations, to approvals for extensions sought due to Member or Provider needs or a lack of sufficient medical information to render a decision. We will respond to Provider inquiries and resolve Provider claims within 30 calendar days for incorrectly paid or incorrectly denied claims.

Denial Reports. We will submit to the Division a listing of denials processed in a time and manner as specified in the Division's Reporting Manual. We will provide reports by denial category, including those listed in Draft Contract § 16.2.4.

In addition to the Division-required reports, our claims, Provider representative, and operations departments will monitor denials weekly to quickly identify opportunities to institute follow-up around, for example, internal process improvement or Provider education. **Table 2** provides a description of the reports we generate and review.

Table 2. Claims Denials Reports. We use these reports to proactively monitor and address claims denials.

Report	Description	Frequency
Top 10 Providers with Claims Denials	This lists the top 10 Providers by volume of claims denied. The report includes the reasons for the denial (e.g., exact duplicate claim/service, precertification/authorization/notification/pretreatment absent) by individual Provider.	Weekly
Top 10 Claims Denial Reasons	This report lists the top 10 reasons for denial of claims. Under each individual reason, the report also details the top three Providers who had claims denied for that specific reason along with a count of claims denied.	Weekly

Our Provider representative and operations teams review these reports to identify trends, discrete Providers, and denial reasons where emerging trends are unfavorable to expectations or recent history. ***When such instances are identified, the team identifies underlying driver(s) of the variance, formulates action plans to address them, and monitors outcomes to confirm actions have been effective.*** We will also perform a deep dive into the claims denial reports we provide to the Division. If we identify a percentage of denials in excess of 2% for any individual denial category (e.g., prior authorization [PA], duplicate claims, timely filing), we will troubleshoot the issue and apply proactive root cause analysis and solution planning internally as well as with Providers and EDI vendors. A designated work group of health plan subject matter experts (SMEs) will provide outreach and education to the Provider to address the issue and decrease denials.

Our Provider network team will also monitor denials for out-of-network Providers. Upon identification, the team will contact the Provider, as appropriate, and invite them to join our MississippiCAN and CHIP Provider network. This will reduce Provider abrasion and enhance Member access to care.

B.1.b. Summary of Denials Criteria/Protocol

The foundation for our denial criteria is State FFS Medicaid edits and American Medical Association, Current Procedural Terminology, Health Resources and Services Administration, and NCCI guidelines. Building on that foundation, our claims prepayment auditing process (described in the following section) identifies frequent denial criteria, including duplicate claims; timely filing limits not being met by Providers; services requiring PA; non-covered services; Member ineligibility on the date of service; and incorrect coding.

B.1.c. Identifying Claims and/or Claims Lines That Meet Denial Criteria

Upon receipt of a claim, automated system edits determine if a claim meets predetermined denial criteria (described in our response to subsection “b” above). If the claim or individual claim line meets denial criteria, the remittance file will include the reason(s) for the denial. Providers will also be able to view specific claims denial reasons through the Provider portal or contact our Provider services call center for more information.

We audit claims daily using our claims audit tool, a web-based application that applies multiple filters when pulling claim samples. Filters include billed and approved amount, service code, claim age, and examiner. The tool allows auditors to review random claims. Sample claims and supporting documentation are compared to ensure proper processing. For each, the following are tested for accuracy: data entry (e.g., data entered correctly in the claims system versus the claims image), Member eligibility, contracted rate corroboration, proper authorization, duplicate payment has not occurred, denial reason appropriately applied, effect of modifier codes correctly applied, other insurance considered, and proper coding, including bundling/unbundling.

Regular internal audits ensure performance requirements and accuracy standards are met. Audits include verification of payment accuracy against Provider agreement terms and adherence to regulatory and internal guidelines and policies, ensuring all reimbursement requirements are implemented per our Contract. We use third-party vendors to provide post-payment reviews and inpatient hospital bill and DRG validation audits.

Provider requests for PA are reviewed by our clinical staff, which consists of certified and licensed nurses and physicians. Those claims that do not meet medical necessity or cost-effective care requirements are referred to our physicians who review the claim and medical data. The denial or approval decision is then made by the physicians.

B.1.d. Reconsideration Process

Providers will be able to resubmit claims that were filed within the appropriate time frame and subsequently denied for reconsideration within 90 calendar days from the date of denial. To request reconsideration of a denied claim, they can call our Provider services call center or complete our one-page reconsideration request form and fax it to our health plan.

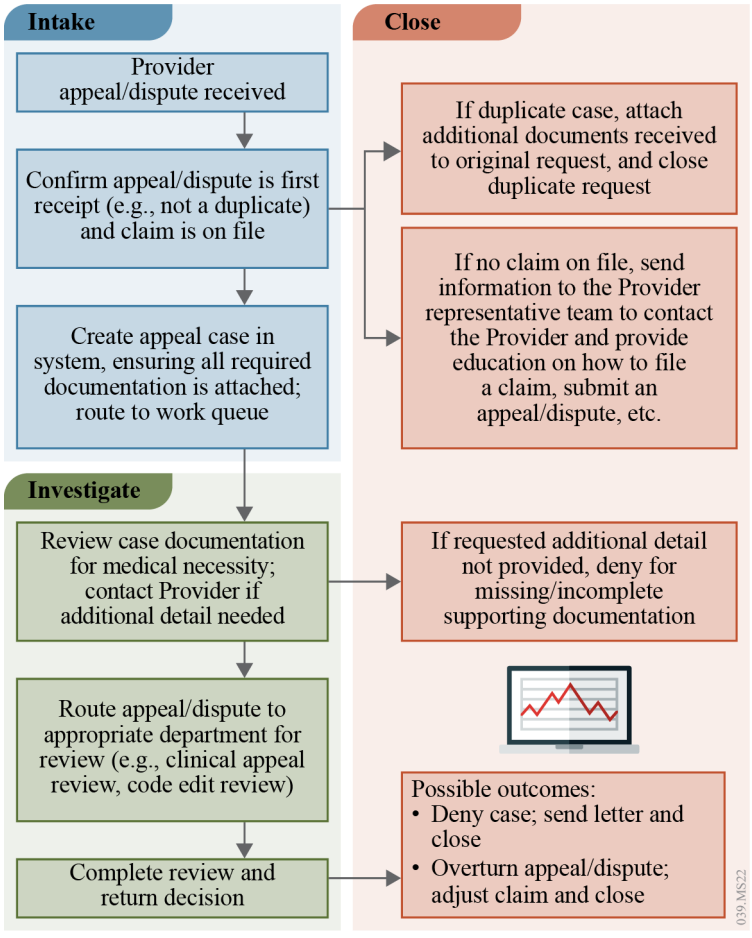
Providers will also be able to use the Provider portal, which is available 24/7/365, to submit requests for reconsideration, verify Member eligibility and paneled enrollment, submit electronic claims and query claims status, submit requests for PA and query the status of the request, and view HEDIS missed service alerts for their Members.

Proactive Provider Support

Through one-on-one support and education (telephonic, in-person, and live webinars), we work with Providers to promptly resolve claims disputes. We encourage Providers to contact their designated Provider Representative to work toward resolution. Designated Provider Representatives shepherd dispute resolution from beginning to end by coordinating with key health plan resources and departments, meeting with Providers to coordinate solutions, and sharing best practices to continuously refine our dispute resolution processes.

Exhibit 3 illustrates our process.

Exhibit 3. Reconsideration Process. A clearly defined workflow ensures prompt resolution.



We will promptly respond to Provider inquiries and resolve Provider claims within a 30-calendar-day period for incorrectly paid or incorrectly denied claims.

B.1e. Notifying and Educating Providers of Claims Denials

We will notify Mississippi Providers of claims denials through our denial notification, which includes information detailing the reason for the denial so the Provider may address any or all issues with the claim at one time. We will also explain the process for appealing the denial.

We provide training, technical assistance, and other activities to educate Providers and ensure proper PA, claims submission, and HIPAA compliance. Our Mississippi Provider manual also will contain detailed instructions that cover protocols for submitting accurate and timely PA requests and claims to prevent denials. Additionally, a dedicated Provider Services Manager and support team will work directly with our MississippiCAN and CHIP Providers to ensure transparent rules and timely and efficient claims payment. They will also conduct on-site and web-based educational meetings about online resources and various methods of electronic claims submission for our Provider network.

Providers Will Be Able to Use Our Reference Guides for Quick and Simple Pointers to Submit Accurate Claims and Avoid Denials

Specialized claims Provider, Member eligibility, BH Provider, and Provider network and call center reference guides will assist Mississippi Providers in submitting claims accurately to avoid denials.

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Our Mississippi-based Provider representative team will provide ongoing education to Providers regarding claims denials through in-person or virtual meetings, conversations, and email. We will also discuss claims denials during monthly meetings with PCPs, FQHCs, and hospital systems. We will notify Providers of the claims denials and provide instruction and guidance for how to correct these denials by referencing the following resources:

- Provider manuals
- Applicable health plan Provider forms
- PA lists, guides, and look-up tools
- Claims reconsideration request and appeals forms
- Provider reference guides
- Provider newsletters
- Non-participating Provider notification
- Claims denials and rejections billing tips
- COVID-19 vaccine billing
- Anesthesia modifiers
- Division billing handbook
- Mississippi Administrative Code
- Division fee schedule and rates
- Division Provider bulletins

Our locally based Provider representative and operations teams will meet monthly and review denial rates and trends for each Provider and by specialty type. The team will compare current and historical rates and Providers against their peers in the same specialty. A deep dive into the top 10 reasons for claims denials will pinpoint opportunities for Provider training, education, and technical assistance to improve accuracy and timeliness of submissions and reduce denials.

Finally, our delegation oversight team provides continuing education to delegated Provider entities to ensure accurate claims submission, including timely entering of credentialing roster updates. On average, we update newly credentialed Providers as participating within three business days of receipt from the delegated entity.

C. NATIONAL CORRECT CODING INITIATIVE (MississippiCAN)

C.1 Process to Comply with NCCI

We already comply with NCCI guidelines, developed and maintained by CMS, to ensure proper claims coding and payment. Our claims adjudication process includes a series of edits, including NCCI edits, and we have policies that we will submit for approval by the Division, which address manually priced claims, items, and services. Our processes are supported by industry-standard coding software that applies all NCCI edits, including Medically Unlikely Edits, procedure-to-procedure edits, and Add-On Codes.

For Medically Unlikely Edits, the entire line is denied if units exceed the Medically Unlikely Edits limit. In the event a State benefit limit (e.g., in Mississippi, the Provider submits a claim for 6 units for CPT® A7038) is more stringent or restrictive than a Federal Medically Unlikely Edit, we will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal Medically Unlikely Edit or State benefit limit, the professional organization standard may be used.

For the procedure-to-procedure bundling edits, we verify both the current claim submitted and claims previously submitted and available in claims history to ensure unbundling has not occurred on a single claim or across claims. If unbundling is found, the “column 2” code, as defined by CMS, is denied, whether on the current claim or the previously adjudicated claim. We follow procedure-to-procedure modifier bypass logic as defined by CMS.

Maintaining Compliance with NCCI

We employ measured steps to ensure we continue to comply with NCCI methodologies. ***We contractually require our claims editing software vendors to monitor State Medicaid changes for potential new rules, modifications of existing rules, or policy implementation.*** The process for reviewing and updating NCCI edits includes the following steps:

1. CMS publishes the quarterly update to Medicaid NCCI edit files.
2. Our coding software vendor's data team reviews, loads, and converts its data based on CMS' new replacement file.
3. The coding software vendor's clinical team conducts a quality assurance review of the file, including validation of data and testing of clinical accuracy.
4. All related NCCI edit rules are updated, including associated system lists, tables, correct coding initiatives, and Medically Unlikely Edit values.
5. Updated NCCI edit rules are delivered in the nearest quarterly updates to align with State and Federal updates.

This process ensures we will continue to meet NCCI policies and edit rules.

Applying MississippiCAN-specific Rules

A team of ***dedicated clinicians and subject matter experts (SMEs) will monitor Mississippi State regulatory updates using a proprietary website tracking application,*** which will provide us with immediate notification of updates to NCCI edit rules that are specific to MississippiCAN. Upon notification, the following steps will take place:

1. The SME will review the updates and determine if the update requires a change to an existing MississippiCAN NCCI edit, addition of a new NCCI edit, or deletion of an existing edit.
2. Policies and rules will be mapped to an identification in the claims processing system, which is also mapped to HIPAA-compliant claims adjustment reason codes and remittance advice remark codes.
3. Depending on the publishing date of the updates and bulletins, the edits will be delivered with the next quarterly release by the coding software vendor.

Our configuration department maintains current claims adjustment reason codes and remittance advice remark codes. We also monitor NCCI edits using various trending reports to ensure appropriateness.

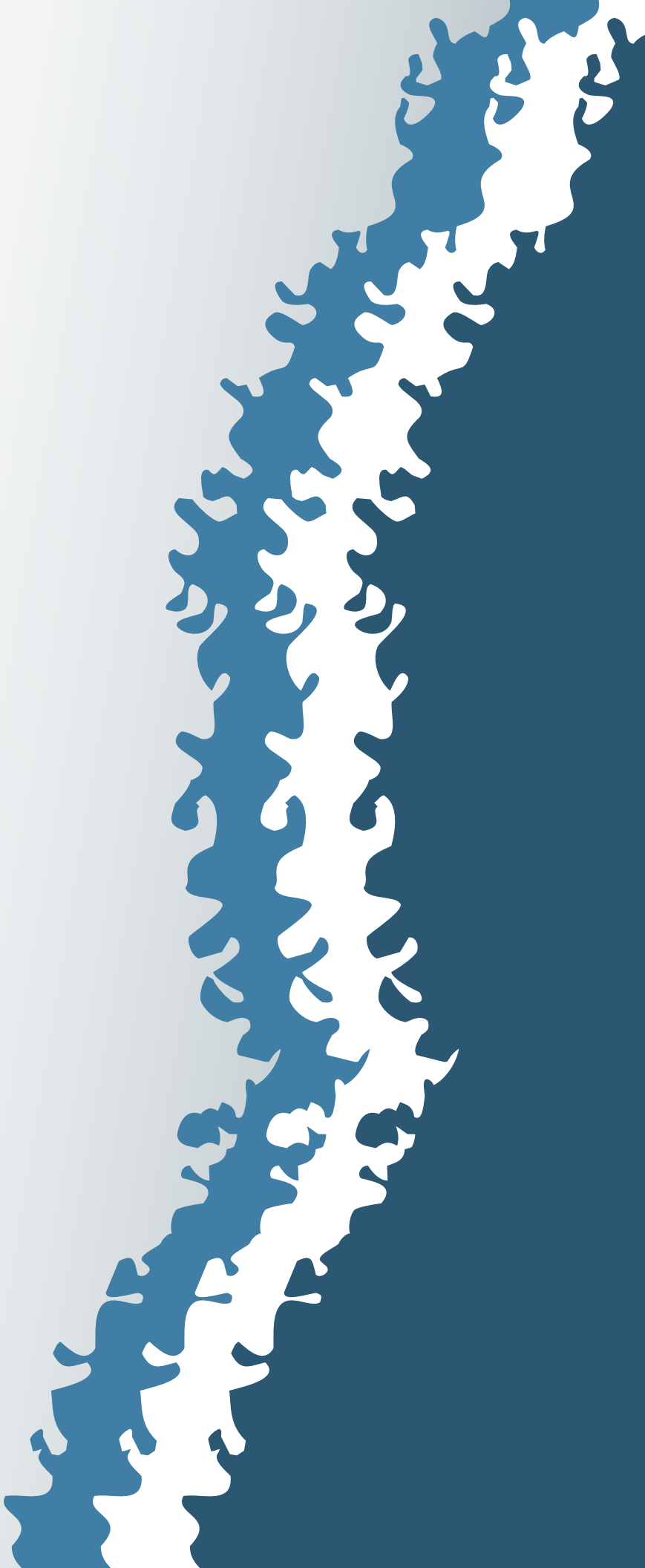
Working with Providers to Ensure Compliance

As part of our ongoing commitment to working proactively with MississippiCAN Providers to ensure proper coding, ***we will provide ongoing education through scheduled visits and encounters with Providers, including our monthly joint operating committee meetings with large Provider groups and health systems.*** We will identify compliance issues through a wide range of sources, including internally generated reports, staff input, Provider concerns, and review of code edit compliance and denied codes during visits with Providers. Any issues identified will be discussed with the Provider and their office staff to understand any contributing factors and discuss opportunities for improvement, which could range from additional training and education to a formal corrective action plan (CAP) to increase coding accuracy and best reflect the specific services delivered.

[END OF RESPONSE]

4.2.2.10

Subrogation and Third-Party Liability



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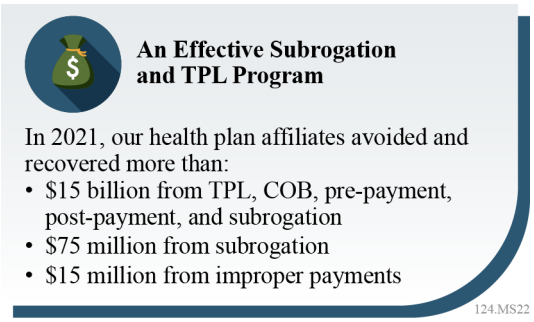
4.2.2.10: SUBROGATION AND THIRD-PARTY LIABILITY

A. APPROACH

A.1. Approach for Conducting Subrogation and Third-party Liability Activities

To maintain program integrity and conserve MississippiCAN and CHIP funds, we will diligently identify ways to avoid improper payments and recover amounts due from other sources of health insurance coverage. Tracking, monitoring, and reporting on our activities along the way, we draw on seasoned leadership as well as our fully integrated claims system and TPL and COB processes that identify, determine, and recover benefits or coordinate them with other payers. Our core administrative system supports full COB functionality and serves as the authoritative source of Member eligibility and enrollment data.



The extensive experience of our affiliated Medicaid/CHIP health plans with coordinating benefits, cost avoidance, and post-payment recoveries for subrogation and TPL enable us to maximize cost avoidance and cost recovery for claims in accordance with Federal and State requirements. We pay for covered services and make every possible effort to recover payments when other health insurance is in effect and care has been rendered.

Leveraging our dedicated payment integrity teams for our cost avoidance and TPL systems, we consistently and correctly identify Members' primary insurance. Enterprise wide, our Medicaid/CHIP health plan affiliates:

- Achieved $15,378,451 in combined savings in 2021 (TPL, COB, pre-pay, post-pay, subrogation)
- Achieved $75,025 in subrogation savings in 2021
- Avoided payments of approximately $14,943,285 in gross savings in 2021 compared to $12,206,672 in gross savings in 2019, an increase of 22%

We deploy resources and controls to ensure that we provide medically necessary covered services to Members and that Medicaid is the payer of last resort. **This includes our internal TPL investigative team that supplements the work performed by our TPL Vendors,** differentiating us from our competitors that solely rely on Subcontractors.

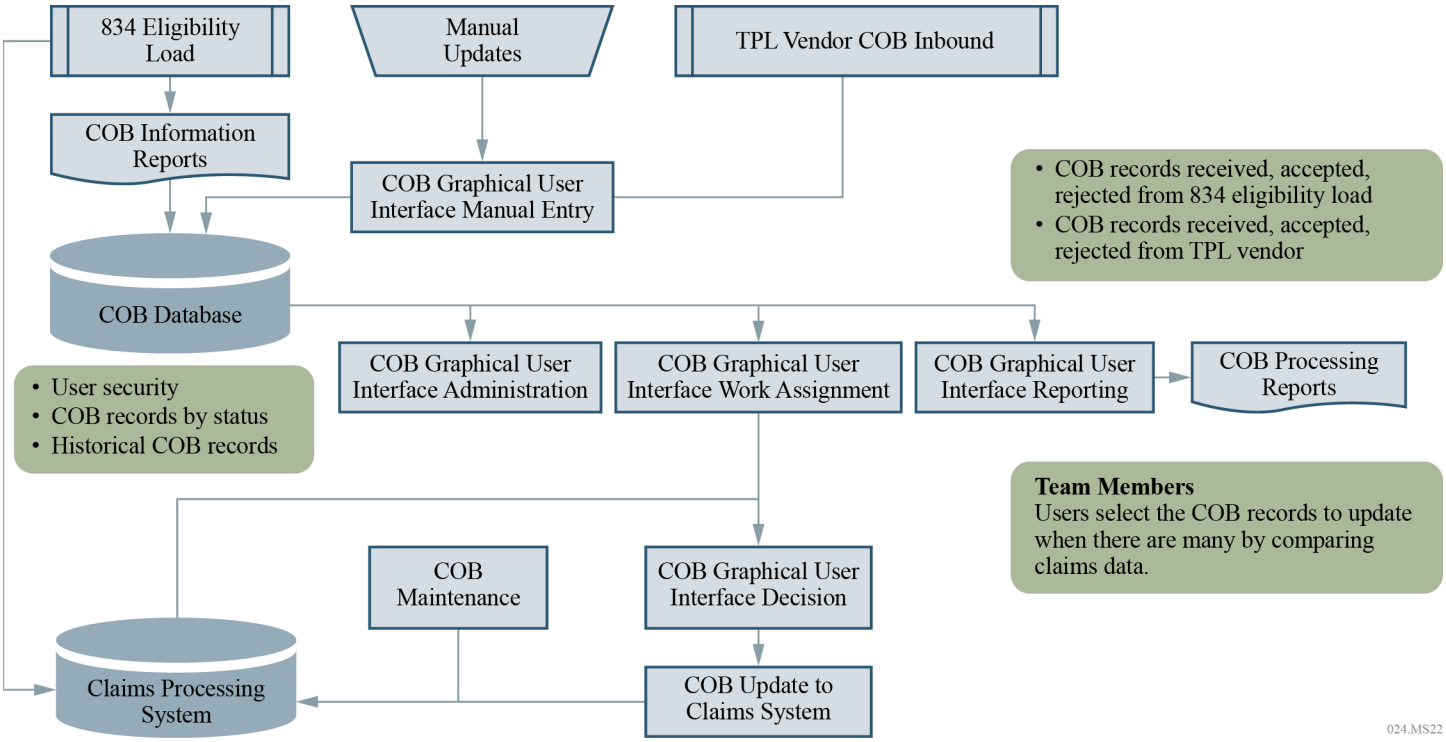
Our TPL/COB application allows real-time loading of the data received from multiple sources. This will include the Division's TPL daily file and our subrogation and TPL Vendors, as well as data manually created by our enrollment accounting department. Our system maintains the minimum historical TPL eligibility data online in accordance with Federal and State rules and regulations, which is currently for 72 months.

Supported by national resources and technologies, our Mississippi-based Chief Financial Officer (CFO) will oversee subrogation and TPL activities while our Mississippi-based Compliance Officer will serve as the single point of contact for the Division regarding subrogation and TPL. Our Compliance Officer will also ensure that we and our Subcontractors adhere to all Contract requirements and applicable Mississippi laws and regulations. Our CFO, Compliance Officer, and other staff involved in subrogation and TPL activities will be available to meet with the Division upon request.

Our Claims Administrator will lead a team of claims examiners and adjusters tasked with reviewing and investigating MississippiCAN and CHIP claims for possible recovery. The payment integrity team partners with our data analytics team to produce an accurate overpayment identification report that incorporates State-specific recovery timeframes, excludes non-covered services, and ensures the appropriate Medicaid allowed amount was fulfilled.

Our system posts recovered funds and applies those funds against the related claim. The team bills the primary insurance carrier to alleviate Provider abrasion and avoid any billing issues for the Provider of service. If the service Provider does not submit a requested refund, the claims processing system supports off-setting claims payments against monies to be recovered. **Exhibit 1** outlines the end-to-end COB application workflow, including exchanges with third parties.

Exhibit 1. COB Workflow. Defined workflows ensure accurate and timely capturing, processing, exchanging, and reporting of information.



Our policies and processes comply with Section 1902(a)(25) of the Social Security Act and 42 CFR § 433 Subpart D, and we will submit form letter templates and form document templates to the Division for advance written approval. We have reviewed and will comply with the requirements as detailed within the RFQ, including Draft Contract § 12, Third Party Liability.

A.1.a. Process for Capturing Third-Party Resource and Payment Information for Reporting to the Division

Processing State TPL Daily Files

Upon receipt and review of the State's TPL daily file, if there is new or updated COB information on it, the information will be added or updated in our claims processing system for appropriate cost avoidance. If we identify conflicting information, it will be updated by payment integrity or enrollment after validation.

We will report any discrepancies in TPL information supplied by the Division in the State TPL daily file in a daily file we will send to the Office of Third-Party Recovery. Our dedicated outbound eligibility extract team will also transmit any new COB information to the Division.

Identifying and Capturing Third-party Resources and Payment Information

We use sophisticated data-matching and file-search strategies to identify legally liable third parties, including group health and other health insurers, Medicare, liability insurance, and workers' compensation insurance. Data matching includes the Member's full name, date of birth, gender, and Social Security Number, as well as the period of coverage for the Member and their family members. Sources of data matching will include:

- The State's TPL daily file
- All commercial insurance carriers operating in the State of Mississippi and other governmental carriers
- Provider conversations and interactions
- Claims that include the presence of third-party resources or payment
- The National Eligibility Database
- Member COB/TPL information shared during the UM process
- COB vendors that provide new and updated information
- Member self-reporting at time of enrollment and during welcome calls, Health Risk Screenings, Comprehensive Health Assessments, and interactions with our staff

Verifying Information

Upon receiving proof of other coverage, we validate COB coverage by querying payer web portals and telephoning payer representatives. Upon verification, our enrollment team updates the system to reflect the other coverage information and eligibility dates, so we avoid paying as the primary payer. Urgent requests from Members and Providers are updated within 24 hours; non-urgent requests are loaded within 72 hours and validated information from program integrity is loaded in real time throughout the day. Claims received when there is other primary insurance—with the exception of certain Division-required services (e.g., EPSDT and Title IV-D services) covered under "pay and chase"—will be processed with our COB intelligence technology and will deny requesting a primary carrier explanation of benefits (EOB) to process as secondary.

Ensuring Subcontractor Compliance

We will contractually require our Subcontractors whose responsibilities include claims payment to meet all Mississippi TPL, subrogation, COB, cost avoidance, post-payment recovery, and reporting requirements. **Delegation oversight staff and account managers dedicated to each delegated Subcontractor monitor compliance through daily, monthly, and annual audits to ensure compliance**.

Ensuring Compliance with State Requirements

We monitor our subcontractor compliance through regular auditing to ensure they meet State requirements.

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We will share the State's TPL daily file with our Subcontractors that are responsible for tracking and pursuing recoveries. We will also exchange a file with our recovery vendors that includes all known COB in our claims processing system to facilitate post-payment recoupment efforts. We also share any additional TPL resources identified by the vendors in a daily file exchange.

Reporting to the Division

Our integrated reporting systems will enable us to produce intelligent, reliable, and compliant reports to meet Division requirements. Our TPL application captures all information on third parties, including TPL company name, collections, and collection attempts, for accurate monthly reporting to the Division.

We will continue to report all TPL resources identified for Members from all available sources, including delegated vendors.

A.1.b. Process for Retrospective Post-Payment Recoveries of Health-related Insurance

Upon payment of claims, we retrospectively analyze data to identify opportunities for post-payment recovery.

Using TPL and Recovery Subcontractors

To maximize the effectiveness of our subrogation and TPL efforts, we use industry leading TPL identification and recovery service vendors. We also combine proprietary internal data analytic reporting suites and supplemental vendor services to identify recovery opportunities.

Process for Recoveries

We use several methods to recover claims when other primary insurance is confirmed. In most cases, we submit claims directly to commercial insurance carriers and they send payment to us, and our recovery team processes the medical claim in our claims operating system, reflecting payment received.

If a recovery from a commercial carrier extends beyond the Division's lookback period (e.g., 180 days), the recovery team sends the Medicaid Provider a recovery letter with notification of other coverage eligibility within the State's regulatory requirements. If we do not receive a refund from the Provider, we process an "auto-deduct" within our system so these claims will be deducted from the Provider's future payment. All refunds received by the liable carrier or Medicaid Provider are processed in our claims operating system.

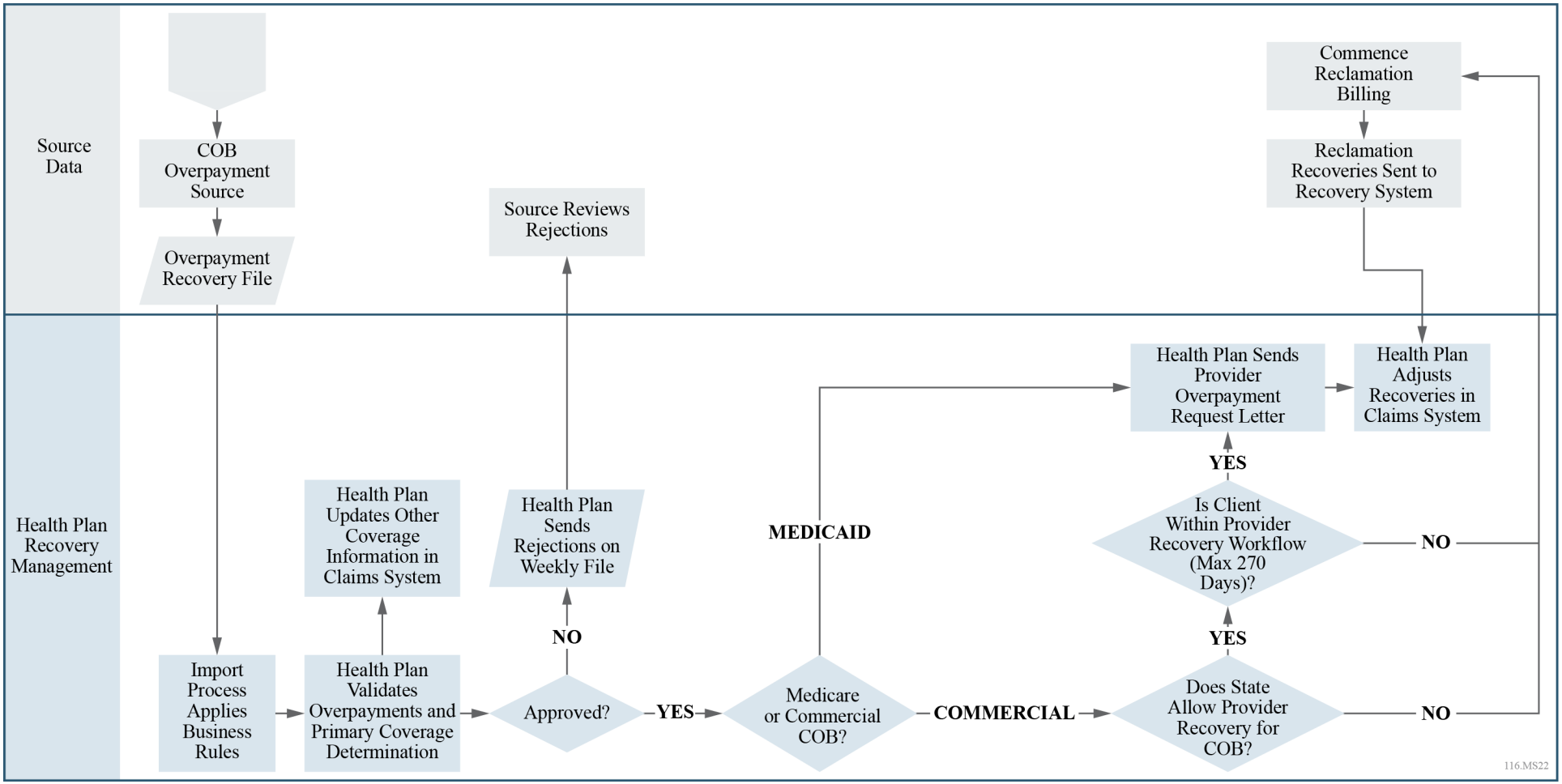
Once a claim is identified as overpaid or paid in error, the cost recovery unit verifies the validity of the overpayment, reviews State requirements to determine if an auto-debit or overpayment letter is required and creates the recovery record in our proprietary custom recovery application. Once we receive the refund, recovery staff process it and complete recovery retention activities within our proprietary recovery application. Developed in 2021, this application **improved our management of business controls to ensure that we adhere fully to all State recovery requirements**. We also enhanced our Provider communication process to make sure Providers have the knowledge they need to bill the appropriate carrier.

Our advanced inventory management system manages refunds, receipts, and recovery offset processing once Provider notification is appropriately aged. In 2021, we also enhanced automation around the offset process to systematically adjust claims and post Provider refunds, increasing accuracy and accountability.

In 2022, Providers will be able to view all post-payment recovery activities through our Provider portal.

Our recovery workflow process is shown in **Exhibit 2.**

Exhibit 2. Post-payment Recovery Workflow. Our end-to-end processes ensure recovery of appropriate TPL.



Reporting to the Division

We will report all third-party cost avoidance and recoveries for Members in accordance with the format specified by the Division. We will comply with Division reporting requirements and communicate cost avoidance, recoveries, and subrogation cases monthly.

A.1.c. Process for Adjudicating Claims Involving Third-party Coverage

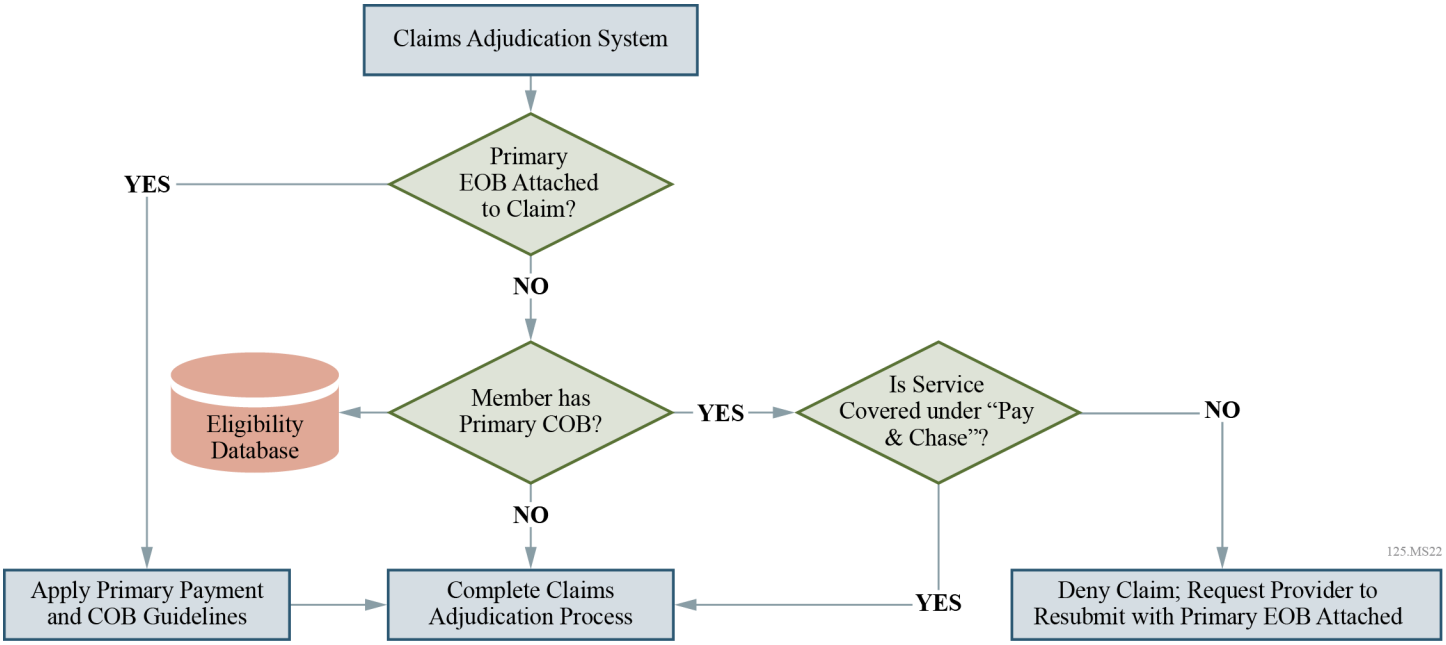
All TPL claims paying as secondary or denied will be processed and released in compliance with Contract requirements following our normal claims processing guidelines. At all times, we will adjudicate the claim and use post-payment recovery if the probable existence of TPL was not established by us or the Division prior to submission of the claim.

Our comprehensive order of benefits determination process ensures accurate determination of which carrier pays benefits as primary, secondary, and so forth. Some of the most common scenarios that will fall under the TPL umbrella include:

- Motor vehicle (automobile) accidents
- Medical malpractice
- Workers' compensation cases
- General liability

We will apply an extensive array of pre-payment review measures, including claims edits, system setup validation, and claims process improvements based on monthly trend analysis of leading and lagging quality indicators to ensure accurate and timely claims payments. We will also apply edits to ensure any identified TPL is billed before we pay a claim. **Exhibit 3** illustrates our claims adjudication workflow when TPL is identified.

Exhibit 3. Claims Workflow. Our tightly managed COB process ensures claims are paid appropriately.



For scenarios falling under TPL, we will pursue post-payment recovery in accordance with Federal and Mississippi requirements.

A.1.d. Process for Identifying, Recouping, and Releasing Claims

We employ multiple TPL controls to maintain the integrity of the programs we participate in and control program costs.

Identifying Claims

Our claims processing system identifies Members who have other available health insurance/TPL and whether the alternative insurance has been designated as "primary." **The system processes and coordinates claims using data from several sources, including the State, our COB and subrogation vendors, and our recovery**

team, to support full COB functionality. Once other insurance information is received from any of these sources, we will configure our claims system to recognize us as a secondary payer as defined by a Member's primary coverage.

Recouping Claims

We recognize Medicaid is the payer of last resort and pays for covered services only after any liable third-party sources have paid. We make every effort to recover payments when other insurance is in effect. We work with our COB and subrogation vendors to recover payments that have already been issued when we confirm another primary payer is liable for a claim. Our vendors provide up-to-date information captured on their platforms. We update our records in our claims system to reflect the presence of third-party insurance, and we submit recovery claims to commercial insurance carriers or other liable third-party insurers seeking repayment. Primary carriers send payment to us, which is reflected in our claims system. If the service Provider does not submit a refund as requested, our claims system supports offsetting claims payments against monies to be recovered.

Releasing Claims

We will release claims for payment immediately after investigation and determination that we are liable for such claims according to all Federal and Mississippi guidelines.

As an example of the process, to control costs in subrogation issues for the Mississippi CCO Program, we will flag TPL/third-party recovery cases associated with accidents/trauma via HCPCS codes. An automatic Member questionnaire meeting Mississippi regulations and requirements will be generated for the Member to complete, and the claim will be pended until further analysis determines liability. We will provide this lead to the Division's third-party unit and coordinate closely with the Division to determine a course of payment recovery for confirmed TPL. If it is determined that there is no TPL, the claim will be paid according to claims payment policy.

A.1.e. Process for Conducting Education for Attorneys and Insurers About MississippiCAN and CHIP

TPL team members and our recovery vendors receive training on COB/TPL when hired and at least annually thereafter, or more frequently if we enact major process changes. The training is either instructor-led or web-based, and staff can access current policies at any time.

Attorneys, whether they work for us or our recovery vendors, develop a direct relationship with the insurance carrier and/or law firm and seek to recover the maximum amount allowed for our health plan. **Attorneys receive additional training on the legal requirements related to COB/TPL, specific requirements of the States we do business in, and annual courses covering key case laws applicable to subrogation** (e.g., Arkansas Department of Health and Human Services v. Ahlborn and Wos v. E.M.A.).

In accordance with the Draft Contract, we will ensure our attorneys are aware that under no circumstances are we or our vendors allowed to imply that we are an Agent of the State or the Division, and that all form letters sent to third parties regarding COB/TPL include language provided by the Division.

We educate all Providers and Subcontractors specifically for the role or function they perform regarding program integrity. All educational material and training will be tailored to the State's requirements. Further, we provide oversight to ensure our Subcontractors have the information they need for success. Please refer to Section 4.2.2.7, Subcontractual Relationships and Delegation, in our proposal for more information about our approach to Subcontractor oversight.

A.1.f. Data Analytics and Informatics to Support Processes

We generate routine analytic reports to identify third-party coverage, look for certain types of accident/trauma diagnosis (e.g., via HCPCS codes, as detailed previously) and key clinical word indicators that would imply a potential TPL opportunity within our COB, authorization data, or claims data. This will identify claims indicative of car accidents, slips and falls, workers' compensation, severe burns, malpractice, and ER visits due to trauma.

In addition, our vendor uses a predictive analytics application to identify potential opportunities for recovery after receiving claims data from us. This application uses proprietary algorithms to analyze all paid claims and

review all levels of claim coding. It then completes data mining and generates a Member questionnaire within five business days of receipt. The vendor contacts selected Members to determine if the incident is eligible for subrogation and to obtain recovery source information. Members can respond with a prepaid envelope or call a toll-free number and speak to a Member advocate. A second questionnaire is sent if a response is not received within 21 days. This cycle is repeated until either a response is received, or four questionnaires have been sent. Responses are then reviewed by a team of attorneys with expertise in personal injury litigation, commercial litigation, nursing, and bankruptcy.

A.1.g. Process for Providing Supplemental Third-party Data and Files to the Division

We will track and report all COB/TPL activity in accordance with MississippiCAN and CHIP requirements.

We will report to the Division all TPL resources identified for Members from all available sources, including delegated vendors, and TPL discrepancies that is in the TPL information supplied by the Division.

To produce these reports, we will track and monitor TPL activities using the following methods:

- Our claims processing system tracks all primary coverage (e.g., commercial) for each Member through the COB module. This module can be updated manually or systematically through the Division discovery process under data matching.
- All recovery activities, including requests for refunds, Provider refunds, and/or recoupments from future claims, are tracked using our web-based recovery database application.
- Deductible and copayment information is stored in the claims processing system and can also be retrieved through the system.

Our Mississippi-based Compliance Officer will be responsible for ensuring the accuracy and timeliness of reported information, including providing supplemental third-party data and files to the Division.

A.1. h. Process for Reconciling TPL Payments for Submission to the Division's Actuaries

We will report overpayment recoveries for COB and subrogation to the Division monthly and submit encounter adjustments for reconciliation. All claim overpayments realized are managed through our proprietary recovery application, ensuring all claims are adjusted in our claims system timely and accurately for encounter adjustment. We will report all recoveries due to COB and subrogation to the Division monthly based on claims system reversals transacted within the reporting period and submit an annual report reconciling recovery amounts.

A.2. Internal Processes to Benchmark TPL Collections

We have internal processes in place to benchmark TPL collections against best practices to ensure we are optimizing TPL recoveries on behalf of all our clients. **This includes our internal TPL investigative team who supplements the work performed by our TPL vendors.** We continually build upon this valuable resource. For example, in 2021, we designed and implemented standard reports for our investigators to use to validate other coverage and pursue post-payment recovery; these reports streamlined activities and improved consistency of communications. In early 2022, we will launch an application to manage all internal investigations. This COB application will increase opportunity management, workflow automation, and serve as a source of truth for TPL data management for claim adjudication and cost avoidance. By increasing our ability to identify and validate Member TPL, this enhancement will improve cost avoidance and post-payment recovery.

On a monthly basis, our payment integrity team reviews a savings report that tracks COB and TPL pre-payment cost avoidance and post-payment recoveries in nominal amounts and provides a view of cost avoidance and recoveries on a PMPM basis. This allows us to compare each State's performance across our entire book of Medicaid/CHIP business to identify potential gaps in processes.

B. EFFECTIVENESS

B.1. Innovative Approaches to Ensure Our TPL Program Is Effective

We continually seek ways to improve maximize administrative efficiency and fiscal effectiveness of our subrogation and TPL program. This includes leveraging the best practices and lessons learned from our affiliate Medicaid and CHIP health plans across the nation. One innovation we have adopted is to **proactively generate leads to maximize cost savings.** Typically, health plans rely solely on vendors to identify TPL leads; instead, our approach casts a wider net and helps the proprietary algorithms train the underlying algorithms to more rapidly identify additional case types that may have been otherwise overlooked and not pursued. Some innovative approaches we have adopted across our health plans include:

- Transmitting monthly reports of suspected TPL cases to our recovery vendor. This will act as a control report to ensure the vendor is properly identifying all trauma- and accident-related diagnosis codes for TPL investigation (implemented Q4 2021).
- Expanding sources of TPL leads to include TPL information captured during the care management and UM review processes to identify any incremental cost avoidance and recovery opportunities that may be missed based on claim diagnosis algorithms (implemented Q4 2021).
- Employing the CAQH® COB validation tool to gather additional information to improve the accuracy and validity of TPL information (implemented Q1 2022).

We supplement this information with real-time data from our recovery vendors.

B.2. Additional Measurements We Employ to Measure the Efficacy of Our TPL Program

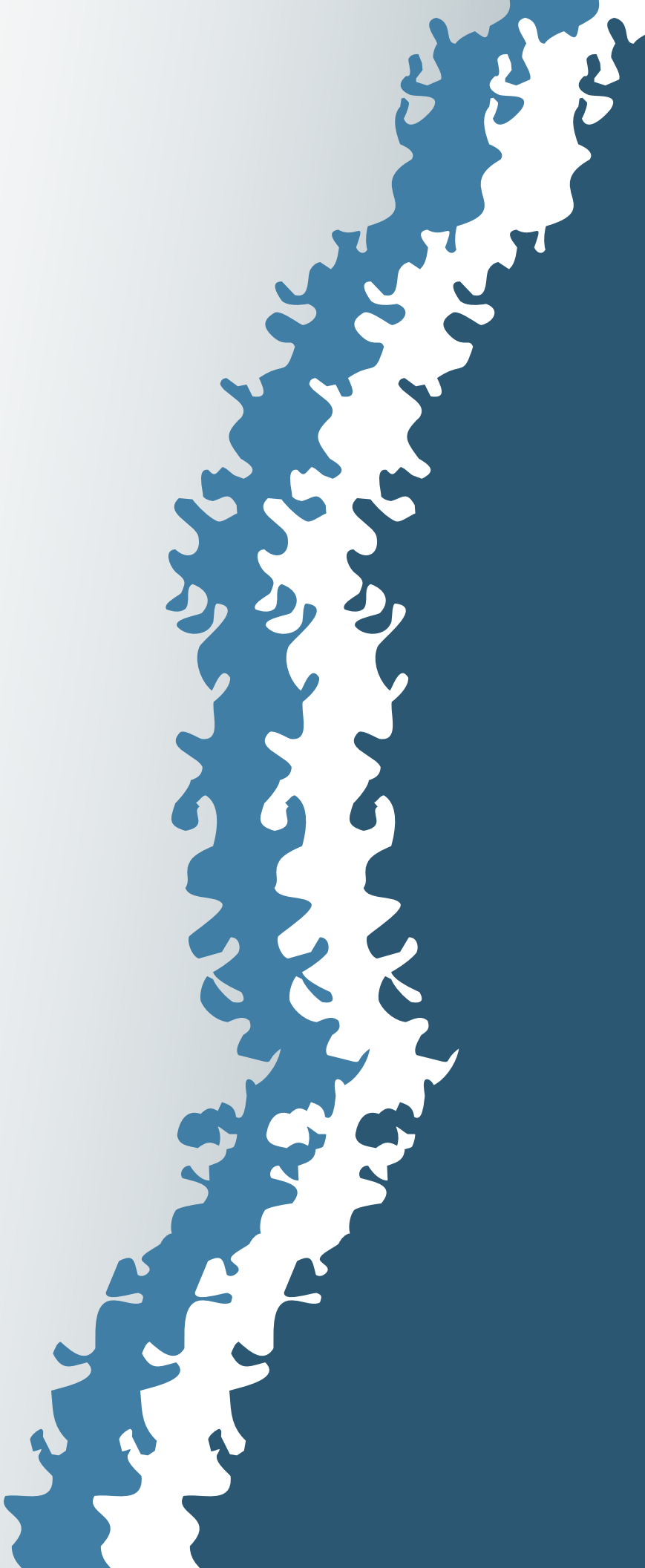
On a monthly basis, our payment integrity team reviews a report that tracks subrogation and TPL pre-payment cost avoidance and post-payment recoveries. The report will detail both nominal values and amounts on a PMPM basis for our MississippiCAN and CHIP Members compared to our entire Medicaid/CHIP book of business across the nation. Provided on a month-over-month basis, this will allow us to quickly identify potential gaps in our processes and employ mitigation strategies to address them.

We also review monthly TPL reports that indicate the percentage of Members with identified TPL compared to our entire book of Medicaid/CHIP business. This further ensures we use all available TPL sources.

[END OF RESPONSE]

4.2.2.11

Eligibility, Enrollment, and Disenrollment



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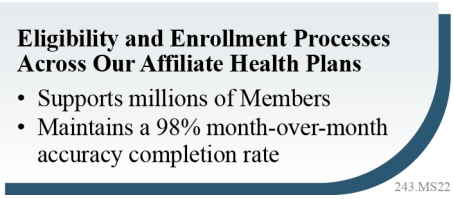
4.2.2.11: ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

A. FILE MANAGEMENT

A.1 How We Will Use the Division's Eligibility and Enrollment Files to Manage Membership

We are committed to the highest degree of transparency, collaboration, and partnership with the Division, especially when it comes to enrollment and sharing Member information. We leverage a next-generation, cloud-based platform, built on artificial intelligence technologies, which serves as our streamlined eligibility, enrollment, and disenrollment management and data exchange platform. Our system is a modular, interoperable functional technology that enables real-time, cloud-native, workflows-based artificial intelligence automation, which provides a highly configurable, modernized solution that will seamlessly interact with the Division's systems.

Our enrollment and eligibility life cycle management processes support millions of Members across our affiliated health plans nationwide. Our system's functionality supports and automates enrollment and eligibility processes. The following describes our system integration and processes, which will be deployed in compliance with all Contract requirements.



Eligibility. We recognize the Division as the source of truth for all Member eligibility and enrollment information. Our enrollment process is fully capable of systematically linking records for the same Members who are associated with different MississippiCAN or CHIP ID numbers, such as Members who are re-enrolled and assigned new ID numbers. Furthermore, our enrollment team updates our eligibility database whenever Members change names, phone numbers, addresses, or head of household/other status changes and notifies the State of such changes. We notify the Division if Member addresses are not accurate and encourage Members to contact the Division to also communicate name and address updates.

Our established eligibility data management methodology that coordinates between Member eligibility files and internal membership records is a fully automated process that drives downstream processes, including PCP auto-assignment (when applicable), ID card generation, and Member information packet generation through system jobs that download HIPAA-compliant 834 and/or proprietary eligibility data file(s). Our system accepts, processes, and loads HIPAA 5010 ASC X12 834 files daily, weekly, and monthly. The Member function processes electronic data transmission and adds, deletes, or modifies Member records with accurate begin and end dates based on data from the 834 files.

Enrollment. Our enrollment process begins upon receipt of daily or monthly enrollment files from the Division. Our eligibility validation engine processes the file through initial validation procedures that confirm file layout, record counts, and HIPAA compliance. Once validated, the information is processed within 24 hours and then stored in our core administrative system. The file is reconciled against internal Member information and, if a difference is found, the Member record is updated appropriately to match the Division's information. Once the record is updated, a new ID card is issued to the Member if any critical information has changed that affects the card (e.g., name or PCP).

The following processes ensure enrollment data loads accurately into our core admin system:

- **Enrollment record on eligibility file but not in our systems.** This process leverages an interactive dashboard to compare monthly full/audit eligibility file information against our system. Discrepancies are produced for review by our enrollment team; updates are entered to ensure accurate coverage.
- **Enrollment record in our systems but not on eligibility file.** This process uses an interactive dashboard to compare eligibility to enrollment files. If our system houses coverage not found on the full/audit file, we validate coverage for the Member and send discrepancies to the Division as required.
- **Other comparison reports.** We also employ processes involving interactive dashboards to generate reports and to compare daily eligibility files against full/audit files to identify discrepancies to report back to the Division.
- **Enrollment/eligibility data.** We securely transmit data to our Subcontractors upon receipt and loading of files.

HIPAA 834 monthly enrollment files are full replacement files and show the current status for each Member. Our process reads each record and validates the information currently in our system. If a change is found, the system is updated with the new information. Daily eligibility files contain new, changed, and terminated Members, whose information we load into our core admin platform before the next business day. As part of our standard process, we reconcile the data on each file with what is loaded in our eligibility and enrollment system, check for duplication, and report discrepancies to our enrollment team in an operational dashboard within our Member management system.

If exceptions are generated during any part of the enrollment data load, including 834 file load, PCP assignment, and vendor extracts, an exception is generated. The exceptions are then made available to the enrollment team and in our Member workflow to resolve the conflict and process the record. These exceptions are corrected within an average of two days for errors. An interactive digital view is available within our platform to monitor the enrollment file loads and vendor extracts.

Disenrollment. The termination of Member coverage is performed based on the information received in the eligibility file transmitted via the termination transaction (T3) or recoupment (X5) inbound process. The Member termination reason and transfer-out-of-plan information provided on the enrollment roster is loaded in the Member's record. This process is completed within 24 hours.

Data Exchange. We will work closely with the Division to establish schedules for each interface. We will interface with the State's MMIS for all the areas defined in the Contract as required and directed. We will receive enrollment data daily and monthly via customized 834 membership files from the Division. Across our affiliated health plans, daily 834 files are processed in approximately 5.5 hours. Based on this experience, we expect daily 834 transactions to be processed within 7 hours of receipt.

Reconciliation of Discrepancies Between the Division's Files and Our Internal Membership Records

Our eligibility and enrollment gateway processes the Division's file through initial validation procedures that confirm file layout, record counts, and HIPAA compliance. Once validated, the information is stored in our systems, and we will complete the processing within 24 hours. The file is reconciled against internal Member information, and we immediately report any anomalies in the initial validation to the Division, as required. Upon receipt and loading of the files, eligibility data is securely transmitted to subcontractors via Secure File Transfer Protocol sites.

Finding Member Content Information

We recognize that invalid Member addresses and other contact information are a significant pain point for the Division. To improve the Member experience and speed their access to care, we will go beyond the automated processes to find difficult-to-locate Members. When we identify invalid mailing addresses or enrollment materials are returned, we will activate a person-centered process that will set us apart from other CCOs.

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A.2 Our Process for Engaging Members Who Request to Disenroll

We respect Members and their right to choose healthcare Providers, and while we always strive for excellence, we understand that Members may request disenrollment from our plans for a variety of reasons.

A.2.a Process for Outreach and Engagement of Members

In addressing Member disenrollment requests, we strive to provide first-call resolution through our Member services call center at the time of the initial call. If a Member's concern is not fully resolved, a Member services call center employee communicates to the Member that we would like to elevate their concern and provides a warm transfer to an on-duty Member Services Supervisor for outreach and engagement with the Member. If the supervisor is able to resolve the issue, we document resolution and establish a follow-up time frame with the Member. If the supervisor is unable to resolve the issue and the Member still prefers to disenroll, we facilitate the disenrollment process and notify the Division for approval. If approved, we assist the Division with continuity of care and other transition issues that arise due to disenrollment. No matter the complaint, every effort is made to resolve the issue at the call center level and during the initial call. Documentation regarding incidents is forwarded to our grievances and appeals department via our core admin system. All grievances (both open and closed/resolved) are automatically "mapped" to the system's appeals and grievances application, which houses all appeals and grievances data, including those resolved by our call center staff. Average

turnaround time for complaint/grievance resolution across all our health plans in 2021 was approximately 28 calendar days.

We will not disenroll a Member or encourage a Member to disenroll because of their healthcare needs or a change in healthcare status; utilization of medical services; diminished capacity; or uncooperative or disruptive behavior resulting from special needs, except in cases in which a Member's continued enrollment seriously impairs our ability to furnish services to either the Member or other Members.

A.2.b Conducting Disenrollment Surveys and Using Results to Improve the Program

Whether the Member chooses to disenroll or not, we will follow up every request with a survey requesting details regarding their experience within five days of the request. Our brief disenrollment survey is designed to solicit valuable feedback on the reason for Member disenrollment. If the Member should self-select to transfer to another CCO, we will attempt to determine the reason and if there's an opportunity to improve. We use this valuable feedback to make improvements to the overall Member experience. Our survey is set up in a simple and brief way to collect the most feedback while being respectful of the Member's time and final experience with us.

Data from these surveys is reviewed by our QM committee when it meets each quarter. Issues identified in disenrollment surveys, other Member surveys, and Member complaints are often assigned CAPs by the QM committee. Those action plans are monitored for compliance by the committee and measured against subsequent survey information.

Additionally, we review all sources of Member feedback, including results from the CAHPS Experience of Care and Health Outcomes Survey, disenrollment information, complaints, and appeals. In Mississippi, we will establish regional Member and CBO councils to provide feedback on satisfaction and community needs. Member input provides a means to assess and improve Member satisfaction and accessibility to services, as well as enhance availability of the Provider network. Our quality assurance plan activities are based on CAHPS Experience of Care and Health Outcomes Survey results and the process for identification of improvement opportunities. Performance survey measures provide a critical means to evaluate the care and services we provide. These measures are at the core of our QI activities. Our staff, network Providers, quality teams, and committees review annual survey results to assess performance measured against benchmarks, compare them to performance thresholds, and trend to previous performance or goals to identify gaps and develop action plans.

We will also implement a new Member program, created in response to the need for supplemental feedback, which will strengthen and raise the voice of Members and families we serve. Through this innovative approach, we will seek Member feedback through a variety of untraditional means, including our relationships with community and government organizations; Member participation in our mobile health program; Member wellness calls and community engagement outreach calls; our Member and Provider satisfaction work groups; Member and family advisory councils; advocacy groups; and satisfaction surveys.

A.2.c Our Draft Disenrollment Survey

The following **Exhibit 1** is our proposed Member disenrollment survey.

B. ASSIGNMENT OF MEMBERS TO A PRIMARY CARE PHYSICIAN

B.1 Our Proposed Process to Assign Members to a PCP

The Member/Provider relationship is critical, guiding positive health choices and long-term outcomes. We focus foremost on keeping Members with their existing or preferred PCPs whenever possible to foster these relationships, connecting them with their trusted Provider to ensure continuity of care. Our core goal is to match Members to PCPs who best meet their needs through a coordinated, simple, and timely approach, as described in the following subsections. Our process is designed to ensure Members have a PCP assigned well within the Division's 60-day requirement, as detailed below.

We put Member choice first, collaborating with Members on PCP self-selection to match Members with appropriate PCPs who meet their holistic healthcare, cultural, and linguistic needs. Unlike many MCOs, we enable Members to change PCPs as often as they wish. We also permit Members to designate their specialist as their PCP, and this choice ensures the continuity of established relationships with doctors who uniquely understand the Member's healthcare needs.

We also use auto-assignment algorithms that match Members with appropriate PCPs. Our PCP assignment system leverages smart geographic technology to initiate a selection that is geographically proximate to the Member's home address, using five-mile increments, while also ensuring family members can stay with the same PCP. Our algorithm considers important factors such as Providers in our high-performing network of care VBP program that have demonstrated outcomes and are engaged with our health plan in a value-based arrangement. The algorithm also places priority on those Providers with open panels, and we incentivize our Providers to keep open panels.

A unique program we have successfully piloted in other States involves a CHW connecting with high-risk Members and families in person after they are first enrolled to ensure they get assigned a PCP and understand program benefits and the services we offer.

B.1.a Assisting Members with PCP Selection

All new Members, and/or their authorized representatives, receive a Member information packet prior to the first date of enrollment that includes information on how to choose a PCP and encourages Members to make a selection within 30 days. Members will have the ability to select PCP based on location, previous relationships, language, age, and access to ensure continuity of care. The materials also include our transitions of care policy and specific instructions on how to ensure continued access to their existing Provider. Our primary goals are to keep Members with their existing and/or preferred Providers whenever possible and to ensure timely authorizations and coordination of needed services during this critical period of adjustment.

Additionally, our Member welcome call program ensures we touch base with Members within that same time frame (the first 30 days of enrollment). Through this program, our affiliate health plans have contacted more than 60% of new Members within their first 30 days of enrollment. Our welcome call team contacts newly enrolled Members to share benefit information, answer questions, and emphasize the importance of scheduling the initial PCP appointment as well as assisting them with scheduling appointments. During the call, we also explain the importance of preventive health services and establishing a relationship with a PCP. Members are given the opportunity to change their assigned PCP to a PCP of their choice (if applicable). The call also encourages a well-check within 90 days of enrollment and establishes a relationship with us for access and support when the Member needs assistance.

We also inform Members they will be auto-assigned a PCP if they do not make a choice within 60 days of enrollment. If the Member's PCP information is not available within 60 days from enrollment, we employ our auto-assignment algorithm to assign PCPs to Members based on multiple business rules customized for each Mississippi requirement. The application can also assign PCPs to Members when enrollment information is submitted via a HIPAA 834 file or proprietary PCP assignment file. We will ensure the Division file assignment is given the highest order preference. The PCP auto-assignment application ensures Members are assigned to a Provider nearest their home, subject to the following:

- The Member's language preference
- The Provider's acceptance of new patients or patients by age and/or gender
- PCP specialty
- Prior Member grievances or complaints with a given Provider
- Age limits and regulatory restrictions set by the Division.

Wherever possible, the application assigns Members of the same family to the same PCP. This process is designed to run automatically whenever new Members are loaded into our system through new eligibility files.

Members have the option to change their PCP at any time by contacting our Member services call center employees, visiting our website, or accessing our Member mobile app to select a new PCP. Members' trust and comfort level with their PCPs is essential; therefore, we offer an array of PCPs from which Members may select, including linguistically diverse Providers representing threshold languages for general practice, family practice, internal medicine, pediatric, physician assistant, and nurse practitioner Provider types. Members also have access to our online and printed Provider directories, which include physical accessibility symbols to help Members select a Provider that meets any of their physical accessibility needs.

Members with known open authorizations will be contacted by our UM team to facilitate the transition of care. Physicians and service Providers who qualify, but are not part of our Provider network, are invited to join the network to help maintain long-term continuity of care for Members and keep them with their preferred Providers. We will work closely with Providers and/or other agencies to ensure that services for Members in an active course of treatment for acute or chronic health conditions are not disrupted or interrupted post enrollment. This includes requesting a data feed with all open authorizations to allow our UM staff to proactively identify and reach out to Members with continuity of care needs. Likewise, we will work directly with the Member's prior Provider and health plan in transitioning Members to preserve existing relationships whenever possible.

B.1.b Tracking Data to Confirm that Every Member Is Assigned

We generate reports at the end of the assignment process to ensure Members are assigned to a PCP. Our staff is notified of any required manual interventions for PCPs not assigned to Members due to certain exceptions. We also ensure that PCPs assigned to new Members are active and approved by the Division. The whole life cycle of Member enrollment, including PCP assignment, is ultimately recorded and managed through our information system, which integrates all Member information to identify a PCP who can best meet the Member's needs.

We also have an ongoing process to validate Member PCP assignments. We maintain a weekly validation check to ensure Members have not aged out of Providers, the Provider has not since had restrictions and/or updates that would render assignment invalid, and/or the Provider has terminated from the program.

B.1.c Informing PCPs/PCMHs of New Members Within Required Time Frames

We notify PCPs and PCMHs via our Provider portal of the Members assigned to them within five business days of the date on which we receive the Division's Member listing report. Within the portal is the Member roster page **Exhibit 2** provides a sample screen shot of the roster, which lists all Members assigned to a particular PCP along with their status, specifically designating new Members as "new." We provide Members with a written notice via regular mail within the contractually required time frame after the Member's enrollment that includes the date of enrollment, the name, telephone number, and address of the Member's PCP assignment, and options to select a PCP other than the PCP auto-assigned to the Member.

B.1.d Confirming PCPs/PCMHs Received the List of Assigned Members

We send PCPs and PCMHs a letter letting them know that this information is retrievable through the Provider portal. Providers acknowledge receipt of the list of Members assigned to them by accessing their Provider portal account. Through continued Provider education and training, we confirm these assignments are received.

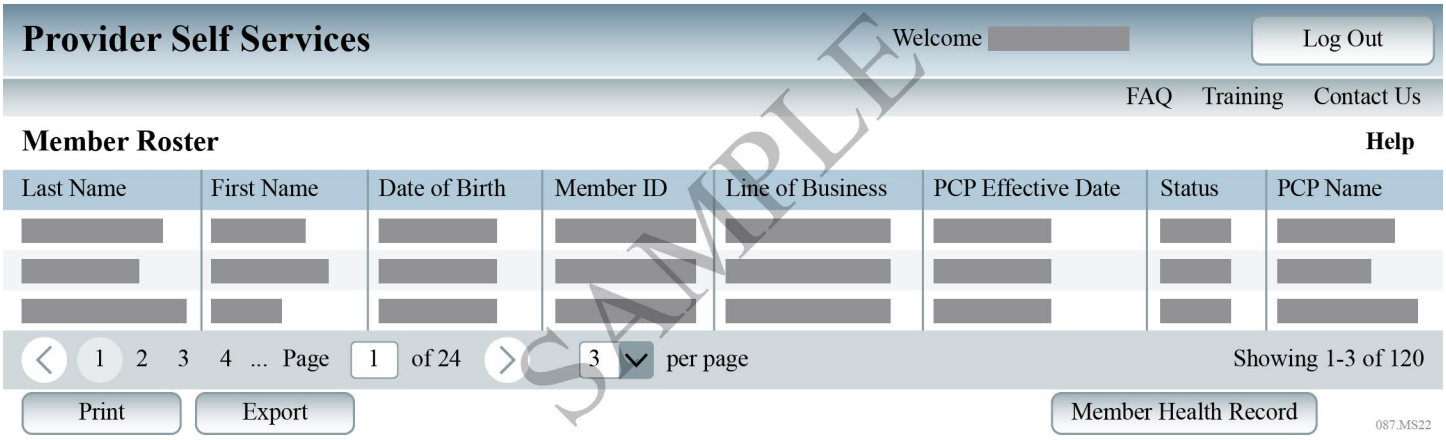
Innovative Solutions When Access to PCPs Is Challenging

We recognize that in some areas of the State, access to PCPs can present a significant challenge. In addition to helping Members overcome their barriers to care on a case-by-case basis, we are deploying strategies to increase access to PCPs through innovative new programs. These include:

- **Practice transformation strategy**. Our new practice transformation and technology enablement program will assist high-volume Providers serving Members in understanding the importance of Members to their practice, highlight opportunities for Providers to earn more through VBP arrangements, and ease Providers' administrative burdens. The program will provide increased data sharing and assistance from a dedicated Provider Representative who can sit in their clinic and work with the team to get Members onboarded and in for care.
- **FQHC VBP strategy.** Having strong relationships with FQHCs and rural health clinics (RHCs) is critical, especially in rural areas where traditional PCPs may not be available. We are prepared to negotiate expanded VBP arrangements with these important Providers to encourage their participation in improving outcomes for Members in these underserved areas.
- **PCMH indicator as part of tiering Providers**. Our VBP program will provide PCMHs with extra points, so their tier value is automatically higher. This means they will receive more auto-assignments of Members, and we will assist them with outreach to encourage Member visits. We will also provide increased Provider Representative assistance with Member outreach and other administrative tasks.

B.2 Sample of the Report We Will Use to Notify PCPs of Their Assigned Members

Exhibit 2. Sample Provider Portal Member Roster Will Notify PCPs of Their Newly Assigned Members



B.3 Process to Ensure New Members Have a PCP Appointment Scheduled Within 90 Calendar Days

It is imperative that Members can see their selected PCP as soon as possible following their enrollment. Our Member services and care management teams each play a part to ensure that happens well ahead of the State's 90-day requirement.

Member Services. Our new Member welcome call program ensures we touch base with Members within the first 30 days of enrollment and verifies they have received their Member information packet. Our Member Services welcome call team specifically stresses the importance of the PCP relationship, gives the Member the opportunity to select or change their assigned PCP, and encourages an appointment within 90 days. Beyond three attempts at new Member welcome calls, we also send a proactive welcome email in cases where we have a Member email address. In addition, we initiate a text campaign for those who have consented to receive texts. Furthermore, we complete welcome visits to high-risk Members to facilitate an optimal PCP assignment and ensure the Member and Provider are connected and engaged.

Care Management. After the initial welcome call, but also within those first 30 days, a Care Manager reaches out to conduct an HRA, verifies the new Member understands how their plan works, and answers any questions the Member may have regarding plan benefits, restrictions, rights, and responsibilities. The HRA also includes the assessment and identification of Members with special healthcare needs requiring special services assistance. The Care Manager reviews the Member's current care plan during this call and ensures that an appointment has been scheduled with the selected PCP. If necessary, the Care Manager assists in scheduling the appointment. If services have not yet been initiated, an assessment is completed, the Member's goals are identified, and a care plan is developed. The Care Manager then contacts the PCP to ensure Member information is properly recorded and that care plans are immediately reviewed. Our Care Managers serve as the primary-point-of-contact responsible for engaging Members, coordinating their care, and ensuring effective communication. Care Managers are individually assigned to Members based on their cultural, cognitive, and medical needs. After initial outreach, a Care Manager continues to work directly with a Member ***face-to-face and/or via phone as appropriate based on their specific needs.***

Maintaining Existing Relationships. Maintaining Provider/Patient relationships is fundamental to transitioning new Members. Those who transition into our plan with a non-participating Provider can continue to see that Provider for at least 90 days. We will work to establish a contract on a one-time or ongoing basis with these Providers when appropriate.

Member Engagement Process. The Member services call center and care management are closely aligned and in frequent communication to assist Members in establishing their PCP appointment. Our welcome call (Member services call center) team inputs data points from their contact with a new Member. Outreach and care management teams can then receive system alerts informing them of upcoming Member milestones, such as PCP appointment needs and dates, upcoming HRA review requirements, missing services, etc. They can work these queues with a full picture of Member needs, as well as with viable phone numbers pulled from various sources. They log this information if they are unable to reach a Member and, after four attempts, they send a

letter to the last known address. For at-risk Members whom we still cannot locate, our Care Managers mine data from multiple sources to find phone numbers and addresses, including talking to additional individuals who may help us reach the Member. CHWs search for contact information using internal and public databases, credit bureaus, white pages, and claims; reach out to Providers, pharmacies, and CBOs (such as emergency shelters the Member has previously accessed); and data mine sources such as HIE. Our care management staff seeks alternative contact information from Provider EHRs. If this process is unsuccessful, we dispatch one of our CHWs who lives and works in the area to go to the last known address and try to reach the Member while consciously abiding by PHI rules. Our systems are also flagged to alert any of our staff about the need for updated contact information when a Member contacts us.

Value-based Initiatives. The structure of these contracts encourages PCPs and PCMHs to proactively reach out to Members who are assigned to them.

Reporting. We will generate a report that identifies Members who have not seen their PCP within 90 days of enrollment. If a Member has not seen their PCP, we send the Member reminder letters and other notifications, and we will reach out to that Member to determine what barriers exist and how we can help establish an appointment for the Member. A priority is assigned to high-risk and vulnerable Members as identified by risk stratification.

B.4 Proposed Policies and Procedures for Designating a Specialist as a PCP/PCMH

The importance of specialty Provider relationships with Members with disabling conditions, special healthcare needs, or chronic illness cannot be overstated. Due to the complex needs of these Members, the choice of the Member to designate their specialist as their PCP ensures the continuity of established relationships with Providers who uniquely understand the Member's healthcare needs.

Policy to Designate a Specialist as a PCP. Our policy of having a specialty physician serve as a Member's PCP is straightforward: A Member with disabling conditions, chronic illnesses, or child(ren) with special healthcare needs and a Provider both need to agree to the arrangement, and the Provider must be a credentialed network Provider. Additionally, the arrangement needs to be approved by our care management team. This policy is standard in all our health plans, and we will apply it in support of MississippiCAN and CHIP.

Procedures to Designate a Specialist as a PCP When a Member Initiates the Request. Members can initiate a request by calling our Member services call center and providing the information regarding the network Provider they want as their PCP. Their request is logged into our systems and forwarded to our Provider representative team, which receives approval from the Member's Care Manager. The Provider representative team then contacts the specialist to discuss PCP responsibilities and ensure the specialist agrees to act as the Member's PCP. If the specialist agrees, the Provider representative team then coordinates with the Member services call center to assign the Member to the specialist in our processing system and communicate the change to the Member. If the specialist does not agree, the Member services call center notifies the Member and discusses options.

Specialist Initiates the Request. For a specialist to initiate a request to serve as a Member's PCP, the specialist notifies the Provider representative team, and submits the request. The Provider representative team provides an explanation of PCP responsibilities, ensures the specialist agrees to meet the additional responsibilities, and receives approval from the Member's Care Manager. The Provider representative team then coordinates outreach to the Member through the call center and ensures the Member agrees to the change. If the Member agrees, the Member is assigned to the specialist in our processing system. If the Member does not agree, we coordinate outreach to the specialist with the Provider representative team and advise the specialist that the Member has declined the change.

OB/GYN as PCP During Pregnancy. We designate OB/GYN Providers as PCPs when Members are pregnant, especially for high-risk pregnancies. This process allows the OB/GYN to participate in VBP and strengthens the relationship with the Member during their pregnancy and follow-up care.

The Care Manager's Role. After a specialist is designated as the Member's PCP, our clinical care management system is updated to reflect the specialist's dual role. The Care Manager coordinates with the specialty Provider to ensure the specialist has evidence-based PCP guidelines appropriate for the Member's plan of care and

ensures these services are provided. Data and analytics reports are generated to ensure that the specialist is fulfilling the dual role by identifying any gaps in care. The Care Manager follows up with the specialist if any gaps are identified and ensures they are addressed.

B.5 Proposed Process for Communicating with Members About Their PCP/PCMH Assignment

An important aspect of the services we provide Members is to help them stay proactive in their care and treatment plans. Communicating with Members regarding their PCP or PCMH assignment and encouraging a visit is one of our first priorities with a new Member.

Communicating with Members about their PCP/PCMH Assignment. New Members receive a Member information packet that includes information on benefits, such as periodic screenings. Members are made aware of their assigned PCP or PCMH through their Member ID letter that is included in the Member information packet. The Member ID card lists their assigned PCP or PCMH. They also receive a information guide and a Member handbook that highlights information on selecting or changing a PCP or PCMH, the importance of obtaining regular well-checks and getting immunized, current immunization schedules and charts, and what they should do or expect within 30–90 days after becoming a Member. Our Member information packet supports Provider practices by providing education and other resources to Members to assist them in achieving optimal self-management knowledge and skill. After the Member information packet is received, our new Member welcome call program ensures we touch base with Members within the first 30 days of enrollment. Our welcome call team also discusses the PCP/PCMH assignment when they reach newly enrolled Members.

Encouraging Members to Use Their Assigned PCP/PCMH. During the welcome call, we encourage all new Members to make a well-visit appointment with their assigned PCP within 90 days of enrollment. Additional proactive activities to encourage the Member to use their assigned PCP include written “birthday reminders” to Members about screenings that need to occur to follow the periodicity schedule. In addition to the birthday reminder, we regularly send written preventive services reminders encouraging Members to keep their scheduled appointments. A well visit is stressed as an important first step in establishing a medical home.

Additionally, EPSDT and well-child services are also promoted in educational documents, the Member handbook, newsletters, postcards, and brochures, which are mailed, distributed at outreach events, and available on our website. We systematically produce target lists of Members with gaps in care-related services. Our staff and Providers receive copies of these lists for targeted outreach. We conduct live reminder outreach calls to help make appointments. Our automatic voice response system, which supports telephone rules/services for Member and Provider contact, is also used to notify Members of gaps in care and provide preventive healthcare tips and information. Finally, we invite Members to sign up for our texting service, which sends reminders and follow-ups for missed appointments and overdue care.

Keeping Scheduled Appointments. In addition to proactive outreach, we engage in focused activities to assist Members in keeping scheduled appointments using the following outreach activities:

- Multiple outbound reminder calls
- Mailed reminders and education
- The Member mobile app, which pushes appointment reminders, based on evidence-based guidelines, to a Member’s cell phone or device
- Member incentives, such as gift cards for meeting specific goals, to increase compliance with needed services
- One-on-one collaboration between our QM specialists and the Provider focused on missed services

These missed services are also published on the secure online Provider and Member portals, available 24/7/365, and alerts are activated, so gaps in care are communicated both to Members and their Providers. In addition, a Member’s Care Manager can view a missed appointment in our integrated care management system and use this information to create targeted interventions and ensure appropriate services are delivered based on a Member’s entire health profile. We also use lists of Members with missed appointments to identify Members to target for mailing, email, text, and mobile app campaigns, and to identify neighborhoods and communities where we host certain community events and deploy our mobile health program resources, such as our mobile units and semi-permanent trailers. Member services call center employees will also remind the Member to obtain those services during incoming and outbound Member calls.

B.6 Proposed Process for Communicating with Members About PCP/PCMH Assignments and Assigned PCP/PCMH Utilization

Our focus is always on connecting Members to PCP/PCMHs. This starts with communicating with Members about assignments and utilization through direct Member communications, the care management process, and community engagement.

Targeted Member Communications. We send targeted reminder mailings to those within the identified population not on schedule with preventive health or chronic care screenings and tests. We also send missed appointment letters to Members if they miss a scheduled appointment. We can also add notifications to Providers.

Identifying and Resolving Member Barriers to Keeping Appointments. Care Managers are trained to identify and help eliminate any barriers preventing the Member from attending their scheduled appointments. Barriers such as transportation are discussed and resolved according to the Member's abilities and needs. For example, our Care Managers can engage our transportation vendor or use telehealth options to overcome any transportation barriers, particularly for those Members living in the State's more rural areas. In addition, our culturally competent staff is able to readily communicate with Members with language or other barriers that can sometimes impede services. Our CHWs, who live and work in the communities we serve, frequently provide valuable assistance in helping Members overcome SDOH such as food insecurity, lack of housing, and other needs that can make access to care more difficult.

Monitoring and evaluation of Member complaints related to accessibility, scheduling process, wait time, and delays are also conducted on an ongoing basis and reviewed by the operations committee to identify and resolve Member barriers to keeping appointments. Documentation of the Member's missed appointments and appropriate follow-up are documented in the Member's record. We also evaluate complaint trends, perform an annual access study, and administer the annual CAHPS satisfaction survey to identify access issues related to appointment standards. Gaps in performance are addressed by the Provider representative team in collaboration with our QM team.

Community Engagement. When we deploy our extensive mobile health program resources, such as our mobile units and semi-permanent trailers at community events, one of the most common points of contact occurs around the discussion of PCP selection and utilization. We always have a help desk at all community events. Whenever we have a presence in neighborhoods where Members reside, we encourage them to find a PCP they are comfortable with and seek preventive care, immunizations, and screenings. In Mississippi, we will also use our Provider Representatives and CHWs to provide help desk assistance at FQHCs and other Provider locations where Members might visit. Our staff at all levels are trained to have these conversations whenever they speak with Members.

C. MEMBER INFORMATION

C.1 Proposed Process for Providing Members with Information Packets

New Members receive a Member information packet that includes easy-to-understand information about covered services, such as physical health and behavioral health, and how to efficiently access healthcare services through our network of Providers, including telehealth-capable Providers, and presentation sites. The Member information packet, which includes the Member ID card, Member handbook, and a welcome guide, is distributed to Members simultaneously with notice of enrollment or within 14 calendar days of receiving the notice of enrollment.

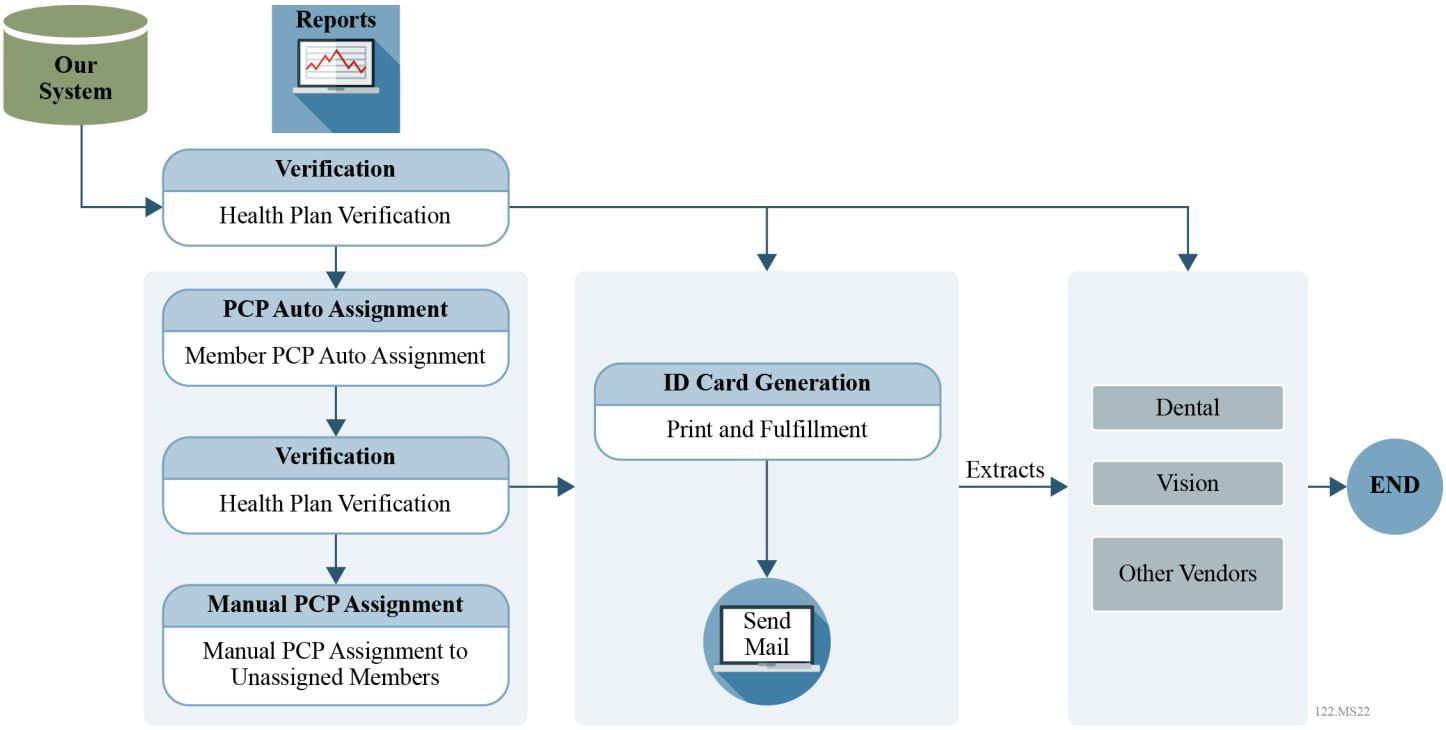
Welcome Guide

The welcome guide is a pamphlet that accompanies the Member handbook and is included in the Member information packet. It highlights the most vital information new Members must know to easily receive services, get started with their benefits, and take control of their health. The convenient tool was created so that the Member can easily understand the most essential information without having to search through an extensive handbook.

Providing Members with Information Packets and ID Cards

Upon receipt of the 834 Member eligibility file from the Division, our IT team processes the file and loads it into our centralized membership database. An enrollment extract is automatically generated, listing all the new Members in that transmission. That data is then transmitted to our print and fulfillment vendor to print Member ID cards, welcome letters, Member handbooks, welcome guides, and any other required Member information packet materials. These items are then mailed to new Members within three business days. All of these activities will occur well in advance of the Division's 14-day requirement as shown in **Exhibit 3**.

Exhibit 3. Eligibility/Enrollment Process Flow Occurs Within Three Business Days



Our content management team ensures quality, consistency, and compliance in all content intended for our Members. We develop all Member communications so that they will not exceed the third-grade reading level, per the Flesch-Kincaid index. Our materials reflect best practices by limiting the amount of text presented, using photos or graphics to reinforce the message, and choosing fonts and layout designs that simplify the content. We also field-test many health education brochures and booklets to verify their effectiveness with the target population.

Member materials are initially developed from State contract requirements and/or identified health education needs. Our clinicians and the quality department review all health education content to ensure it reflects the most current health information. Following internal review, which includes the Member advisory committee and the QM committee, we submit all Member materials to the Division for review and approval prior to publishing and distributing it for use. The materials and communications department track all materials through development and processes all print requests to ensure the Division has approved the materials. Any revisions to approved content result in resubmission to the Division for approval. All Member materials are 508 compliant and are available on our website and through our Member mobile app. They can also be requested in alternative formats and languages.

C.1.a. Language Alternatives That Will Be Available

All Member materials are in English and Spanish and provide information on how to request materials in another language or special format. Upon request, or identification of a Member's special needs, we provide materials in alternate formats such as audio, Braille, and large font. Additionally, we will translate Member materials into Spanish, Choctaw, and other threshold languages as identified by the Division. Highly qualified individuals will translate all written Member materials, such as the Member information packet, the Member ID card, the Member handbook, and health education materials as well as other vital Member documents. All

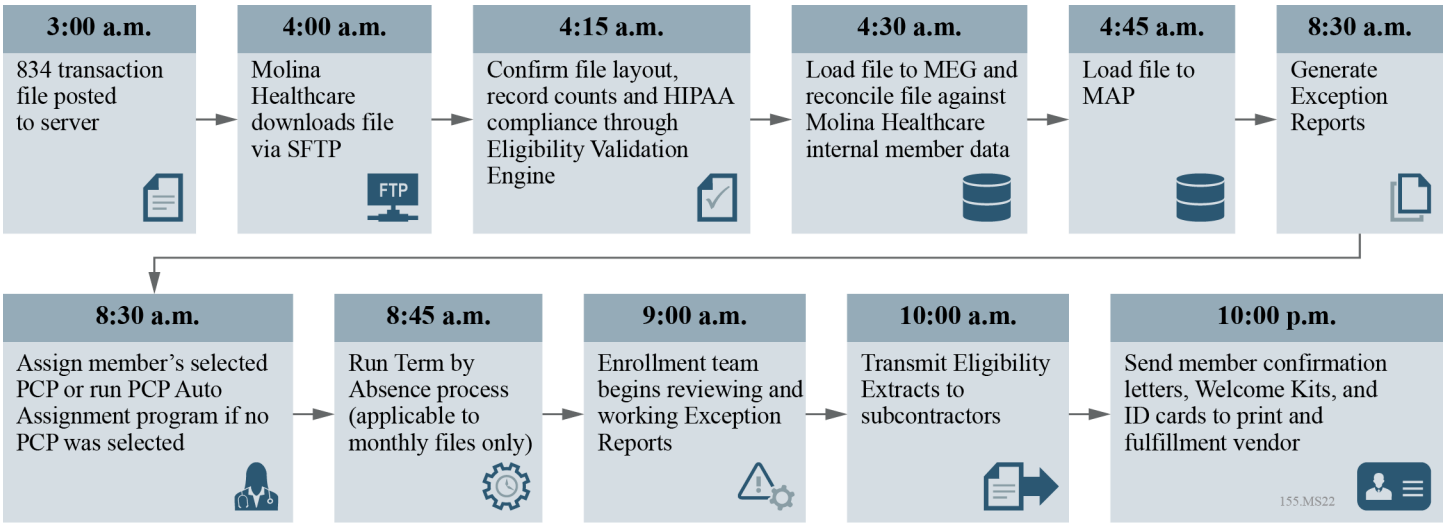
translated materials are certified by a professional translator to ensure content is accurately expressed in the target language with the appropriate terminology and cultural nuance.

C.1.b. How We Will Comply with Member Information Packet Requirements

We will comply with all requirements in Draft Contract, Section 3.2.6, Member Information Packet. In accordance with the Contract, we will provide each Member with an information packet indicating the Member's first effective date of enrollment. We will ensure the information is provided no later than 14 calendar days after the Contractor receives notice of the Member's enrollment. We will use standard mail, in envelopes marked with the phrase "Return Services Requested," as the medium for providing Member ID cards, in addition to electronic notification, if available. The Division will receive a copy of this packet on an annual basis for review and approval, or at any point when changes are made to the packet.

All materials from our Member information packets will be drafted by our materials and communications team and approved by the Division and our compliance team. Upon approval, the materials will be produced by our print and fulfillment vendor and shipped to Members (see **Exhibit 4** below). The materials will be reviewed annually or when any changes are made by either the Division or our compliance team. The Member information packet will contain a welcome guide, a MississippiCAN or CHIP program ID card, information about how to obtain a copy of a Provider directory in compliance with 42 CFR § 438.10(f)(6)(h), and a Member handbook. If an individual is re-enrolled within 60 calendar days of disenrollment, we will send the Member a new ID card. A new Member information packet will be supplied upon Member request.

Exhibit 4. Tightly Managed Process Ensures Timely Completion



C.1.c. Proposed Methods and Creative Approaches for Obtaining Correct Member Addresses

We recognize that invalid Member addresses and other contact information are a significant pain point for the Division. To improve the Member experience and speed their access to care, we go beyond automated processes to find difficult-to-locate Members. When we identify invalid mailing addresses or enrollment materials are returned, we will activate a person-centered process that sets us apart from other CCOs.

Our Member services call center employees, community engagement team, Care Managers, and CHWs will work together to find Members and their families. Because our CHWs live in the communities they serve, we can go to the Member's last-known address and speak with a family member to obtain the Member's new location. We will also collaborate with Providers, hospitals, and urgent care centers to check records for last-known addresses. Once we find the Member, our CHWs will visit, ensure they have received their enrollment materials, and talk with them about their PCP assignment, care management services, and other needs they may have. We will also encourage them to update their address and other contact information with the Division.

Once we identify and locate a Member and verify their correct address and other contact information, we will update our internal records and attempt to complete an HRA. We would be happy to collaborate with the Division to develop a process for providing feedback and reconciliation with State files based on our corrected

data. For example, in our affiliate health plans, we have a two-way file-sharing process that allows us to partner with those State agencies to update Member addresses.

C.1.d. Process for Following Up with Members Whose Information Packets Are Returned

Returned Information Packets and ID Cards

If the address information we have for a Member was incorrect and their Member information packet and ID card are returned, we make several attempts using various means to obtain accurate contact information. At the outset, we use claims details, if possible, to locate accurate data for Members. If contact cannot be made, we flag the Member's record to ensure their information is updated appropriately if they contact us.

C.1.e. Offeror May Choose to Include Sample Member Materials in Excess of the Page Limit

4.2.2.11 Appendix 1: Sample Member Materials provides two samples of Member materials:

- Member ID Card
- Welcome Letter

[END OF RESPONSE]

MCO LOGO

Welcome

Welcome to [MCO]

[MCO] provides high quality of service to people who qualify for Medicaid. Our goal is to help you and your family with your medical needs. We have employees ready to help you with questions or concerns. If you want to know about the structure and operations of the plan, call us toll free at [phone] or TTY/TDD 711.
As a new member it's important that you:

Verify your Member ID card. Your Member ID card is included in this mailing. You should take a moment to review your ID Card. Each member of the family will get a separate ID Card. If you didn't get your ID card you may obtain one online after registering at [member portal website] or contact our Member Services Department to request one.

Verify your Primary Care Provider (PCP). A PCP is a health care professional who helps you when you are sick and can also help you stay healthy. If you need help getting an appointment call our Member Service Department. You will receive your ID card along with information regarding your PCP. If the doctor assigned is the wrong PCP, call our Member Service Department. You may also change your PCP on our website at [member portal webiste].

You may have a copay. If you are with [MCO] and the services are approved, covered, or from a [MCO] provider, depending on your coverage, you may have a co-pay. The co-pay will be listed on your ID card. Don't pay for a bill until you have talked to us. We will help you with this matter.

Read Your Member Handbook. It is important that you read your Member Handbook. The handbook has important information about your benefits. If you need a copy of the Handbook you can visit our website at [MCO website], or call our Member Service Department to request one. Re view Your Provider Directory. The provider directory is a list of all the providers that are part of [MCO]. You can find information such as office hours, telephone numbers, and address. You can also look up providers on our online provider directory on our website at [MCO website]. If you need a copy of the provider directory you can call our Member Service Department to request one. You can also get a copy at our website at [MCO website].

We Provide Benefits to Help Keep You and Your Family Healthy. Some of these services include over-the-counter prescriptions, adult well care, dental care, and children's health. To find a complete list of benefits, please visit our website at [MCO website].

Member Services Department

The Member Services Department can answer all your questions. You may call us toll free at [MCO phone] or TTY/TDD 711, Monday to Friday, 7:30 a.m. to 8:00 p.m., and from 8:00 a.m. to 5:00 p.m. on Saturday and Sunday, the second weekend of each month. We are closed on state approved holidays. We can help you in English or Spanish. We are ready to talk to you in another language. This is at no cost to you.

When you call us, please have your ID card so we can help you with:

- Your benefits
- PCP changes
- How to get care
- Info on doctors
- Wellness programs
- Your concerns
- Doctor Appointments
- More information about [MCO] doctors.
  - Board Certification
  - Performance Measures
  - Medical school they went to
  - Where they did their training

If you call when we are closed, please leave a message. We will call you back the next working day. If you have an urgent question, you may call our 24 Hour Nurse Advice Line toll free at [MCO p] or TTY/TDD 711. Our nurses are able to help you 24 hours a day and 7 days a week.

Translation Services

If you need to speak in your own language, we can help. A translator will be ready to talk to you. They can also help you talk to your doctor or provider. A translator can help you:

- Make an appointment
- Talk with your doctor or nurse
- Get emergency care
- File a complaint, grievance, or appeal
- Get help about taking medicine
- Follow up about prior approval you need for a service
- With sign language

[Member Portal]

Check out our online tool. This service can assist you in managing your health services. It can also help you save time. To access [member portal] you will need access to the internet. With [member portal] you will be able to:

- Print a temporary Member ID card
- Request a new card be sent to you if you have lost yours
- Change your PCP
- Check your eligibility
- Update your contact information
- Get reminders for health services that you need.
- You can also get information on why these services are important
- You can find more information about our doctors. You can find out about board certification. You can find out what language they speak. You can also find out about your doctor’s qualifications

To sign up, visit [member portal]. The registration process is easy and simple. Make sure to have your ID card handy. Stay in touch with [MCO] with just the touch of a button!

Where to Get Care

The chart below tells you where to go for medical services.

Possible Problem	Where to go/Who to call
Emergency Care	An emergency needs to be taken care of right away. You don't need approval for an emergency. Call 911 or go to an emergency room near you. You can go to any emergency room. You can get care (24) hours a day, (7) days a week.
Out-of-Service Area	You might not be in any of our services areas. If this happens and you need care, call our Member Services Department. You must call us for approval before you get care in other areas. You can also call your PCP. *Emergency care* is covered while you are away. You can go to any hospital for emergency services. If it's not an emergency; you must get care in our service area.
Urgent Care	Call your PCP. You can also call our (24) Hour Nurse Advice Line at [Phone], TTY/TDD 711. [MCO] Nurse Advice Line can help you understand and get the medical care you need. They can help you: • If you need to see a doctor right away • Get Care • Find an urgent care center that is part of [MCO]. You can also find this information on our website at [MCO Website]
Primary Care Physician (PCP)	Go to your [MCO] PCP for check-ups, test & results, illnesses, shots, and/or prescriptions. It's important for you to have your regular check-ups, tests, and shots. This will help you stay healthy.
Hospital	Your PCP or specialist might need to send you to a hospital. They might send you for inpatient or outpatient services. Your doctor will take care of these needs. They will get any needed prior approval so you can get the care you need.
Specialist	You may want to call your PCP first. Make sure you go see a specialist that is part of the [MCO] Plan. You don't need a referral to see a specialist.

Prescription Drugs

You must go to a pharmacy that is part of the [MCO] plan. You may need help finding a pharmacy. If so, call our Member Service Department or visit our website at [MCO website]. The Pharmacist will need your prescription from your doctor and [MCO] ID card when filling your prescription.

Preferred Drug List

The Preferred Drug List (PDL) is a list of covered drugs. Most generic drugs are included in the PDL. There are drugs that may have a limit on how much you can get at one time and its strength. Sometimes you have to try other drugs first before we approve a drug that is on the PDL. This is called Step-Therapy.

Some drugs need to be approved by [MCO] before you can get them. This approval is called a prior authorization or prior approval (PA). Your doctor will get a PA for drugs that need it. You can ask if there is a different drug you can take that doesn't need a PA. Your doctor may want to give you a drug that is not on the PDL. For a complete list of the drugs that are covered or not covered, call our Member Service Department. You can also get a copy at
our website at [website]

Access to Behavioral Health Services

[MCO] can help you get behavioral health services you and your family need. You must use a provider that is part of our network.

Your benefits cover:

- Inpatient Services
- Outpatient Services
- Doctor Visits

Nurse Advice Line

[MCO] has a 24-Hour Nurse Advice Line to help you know and get the medical care you need. You may call our 24 Hour Nurse Advice Line at [Phone]or TTY/TDD 711. Our nurses are able to help you (24) hours a day and (7) days a week.

They can help you:

- If you need to see a doctor right away
- Get Care
- Find an urgent care center close to home

Complaints, Grievances and Appeals

We hope that [MCO] will serve you well. If you have a concern or complaints about the coverage under the Plan, you should contact our Member Service Department. A Member Service Representative will help answer any questions you may have. They can also help you to resolve a complaint, or help filing your grievance or appeal. Your provider can also file a grievance or appeal on your behalf.

How to File a Complaint, Grievance, or Appeal

If you are not happy with services [MCO] has provided, you can file a grievance. Grievances can be for things like the care you get from a provider or hospital, the time it takes to get an appointment, or not being able to find a provider in your area.

If you are not happy with a decision we made, you can file an appeal. An appeal can be filed when you do not agree with our decision to stop, change, suspend, reduce or deny a service; or we denied a whole or partial payment of a service (claims are denied).

You can file a complaint, grievance, or appeal by calling our Member Service Department. You could also send us a letter to the address below:

[MCO]
Grievance & Appeals Unit
[Address]
Fax: Fax Number

Check our website, [MCO Website] or review your Member Handbook to read about:

- Grievance & Appeal processes and rights
- Grievance & Appeal timeframes
- Who can file a grievance/appeal?

If you need a copy of the Handbook you can also call our Member Service Department at [Phone].

Enrollment and Disenrollment

Check our website, [MCO website] or review your Member Handbook to read about:

- Enrollment Period
- Lock-In
- Disenrollment

If you need a copy of the Handbook you can also call our Member Service Department at [Phone] or TTY/ TDD 711.

Fraud and Abuse

[MCO]'s Fraud and Abuse Plan benefits [MCO], its employees, members, providers, payers and regulators by increasing efficiency, reducing waste, and improving the quality of services. [MCO] takes the prevention, detection, and investigation of fraud and abuse seriously, and complies with state and federal laws. [MCO] investigates all suspected cases of fraud and abuse and promptly reports to government agencies when appropriate. [MCO] takes the appropriate disciplinary action, including but not limited to, termination of employment, termination of provider status, and/or termination of membership.

You can report potential fraud and abuse without giving us your name.

To report suspected Medicaid fraud, contact [MCO] AlertLine toll-free at [Phone] or complete a report form online at MCO.alertline.com

You can also report to the state. To report suspected fraud and/or abuse in Medicaid, call the Consumer Complaint Hotline toll-free at [Phone].

Evaluating New Technology

[MCO] uses a medical evaluation process to review whether a new drug, medical device, surgical, or other therapies are proven to be safe and effective for a particular condition when compared to other alternative. If
[MCO] denies coverage for a drug, device, or procedure that is new technology as not medically necessary, you or your provider can ask for more information on [MCO]'s covered procedures. Please call our [MCO] Member Services Department at [Phone] or TTY/TDD 711.

Your Member Rights & Responsibilities

Your Rights

- To be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy
- To request and obtain information on any limits of your freedom of choice among network providers
- To a prompt and reasonable response to questions and requests
- To know who is providing medical services and who is responsible for your care

Your Responsibilities

- For providing to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health
- For reporting unexpected changes in your condition to the health care provider
- For reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you
- To follow the care plan that you have agreed on with your provider

Please visit our website at [MCO website] or view pages 44-45 of your Member Handbook for a complete list of member rights and responsibilities.

Questions?

Feel free to call our Member Services Department at [Phone] or TTY/TDD 711, Monday to Friday from 7:30 a.m. to 8:00 p.m, and 8:00 a.m. to 5:00 p.m., Saturday and Sunday the second weekend of each month.

We look forward to serving you!

CHIP Value Added Services

Unlimited office visits – Copay may apply
1 pair of glasses each calendar year and one (1) eye exam per year; In addition to standard Medicaid coverage limit for frames and lenses, we provide an additional $100 credit per calendar year for frames or lenses, or contact lenses.

Community Navigator Program – These community health workers assist in navigating the healthcare system and accessing community-based programs that promote healthy development, independent living, and physical and mental well-being for members.
Personal Care Managers available in clinics.
24-hour Nurse Advice Line (NAL) – [Phone], TTY/TDD 711

Enhanced Incentives

Well Child Care Rewards • Members' ages 0-18 that receive all childhood immunizations on schedule receive a $20 gift card. • Members that receive all scheduled childhood immunizations before 18 months of age receive a $20 gift card. • Take kids ages 1-13 to scheduled checkups to get a $25 gift card.
Prenatal Rewards • New members who complete an early prenatal exam within 42 days of enrollment are eligible for a $20 gift card after verification by their OB/GYN or PCP. • Existing members who complete an early prenatal exam in the first trimester are eligible for a $20 gift card. • Expecting moms who have their first trimester visit within 42 days of joining [MCO] and have a second trimester visit scheduled receive a $25 gift card for each visit.
Health Management Programs – If your child lives with a chronic condition, our free programs can help through any treatment.
Asthma Program – Complete our 3-month program and get an allergy-free pillowcase and mattress cover.
Community Baby Showers – Held throughout the state where expecting and new mothers can receive information about having a healthy pregnancy, postpartum care and infant care, and membership in Mom and Baby program.
No-cost Cell Phone – Get access to a smartphone to use 24/7 that allows communication with [MCO] care managers, access to transportation and community organizations, our Member Mobile app for access to covered services and appointment reminders, and more.
Farmer's Market Program – Eat your veggies. They're good for you! To make it easy, we distribute fresh vegetables to members through local churches and community organizations.
Weight Watchers™ – If you qualify, [MCO] will enroll eligible members with up to 12 weeks of online Weight Watcher access.

FRONT

MCO LOGO **MCO ADDRESS**

Member: <Member_Name_1>
Member ID #: <Member_ID_1>
Program: <Program_Name_1>

Primary Care Provider (PCP)
Name: <PCP_Name_1>
Phone: <PCP_Phone_Number_1>

RxBIN: 004336
RxPCN: MCAIDMSCP
RxGRP: RX6949

Effective Date of Coverage: <Member_effective_date_1>
Copay: Office/ER
Out of Pocket maximum: $xxx

MCOPortal.com

230A.MS22

BACK

EMERGENCY SERVICES: Call 911 or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider (PCP). Follow up with your PCP after all emergency room visits.

MEMBERS

Member Services: (Phone)
24-Hour Nurse Advice Line: (Phone)
24-Hour Behavioral Health Crisis Line: (Phone)

For Dental, Transportation, Vision: (Phone)
For Deaf and Hard of Hearing: TTY/TDD 711

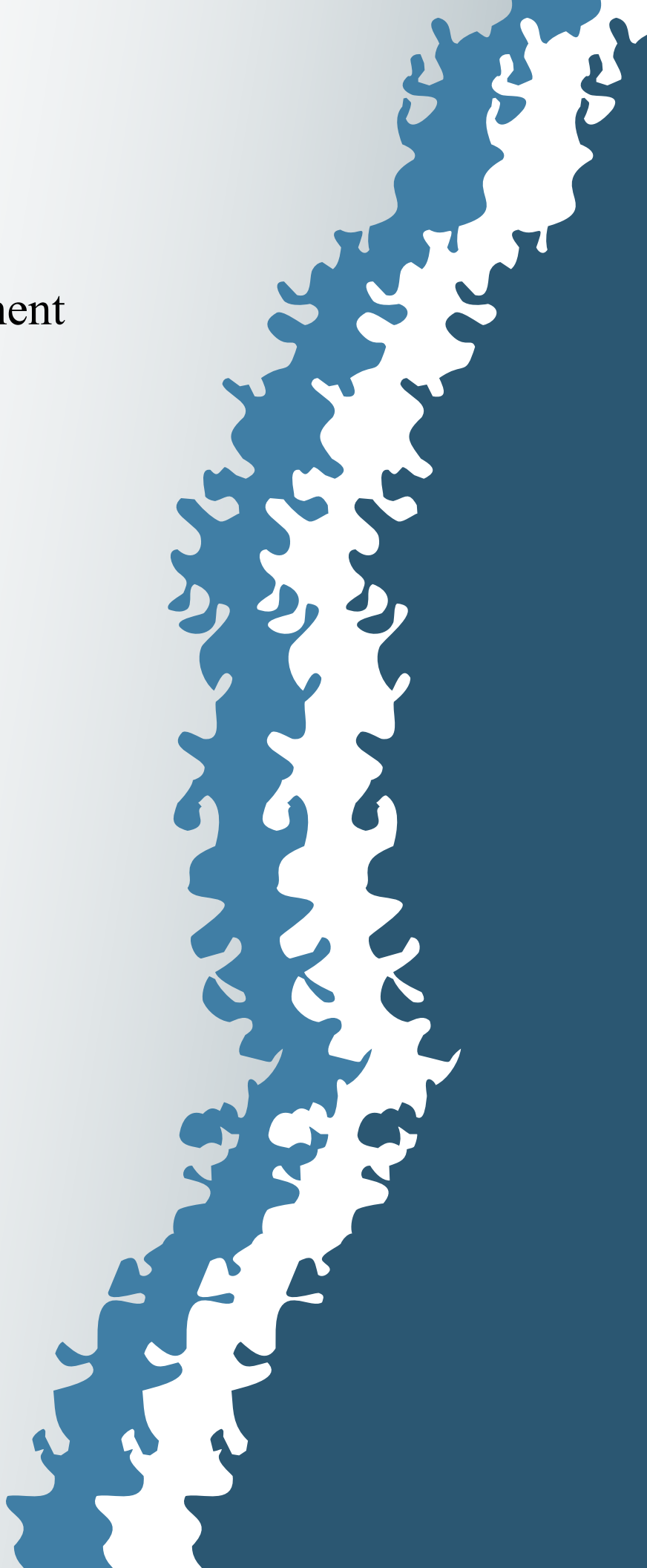
MCO.com

PROVIDERS Medical Claims: ADDRESS
For prior authorization, eligibility, claims or benefits call [MCO Phone] or visit the Provider Portal at provider.MCO.com.

230B.MS22

4.2.3

Innovation and Commitment



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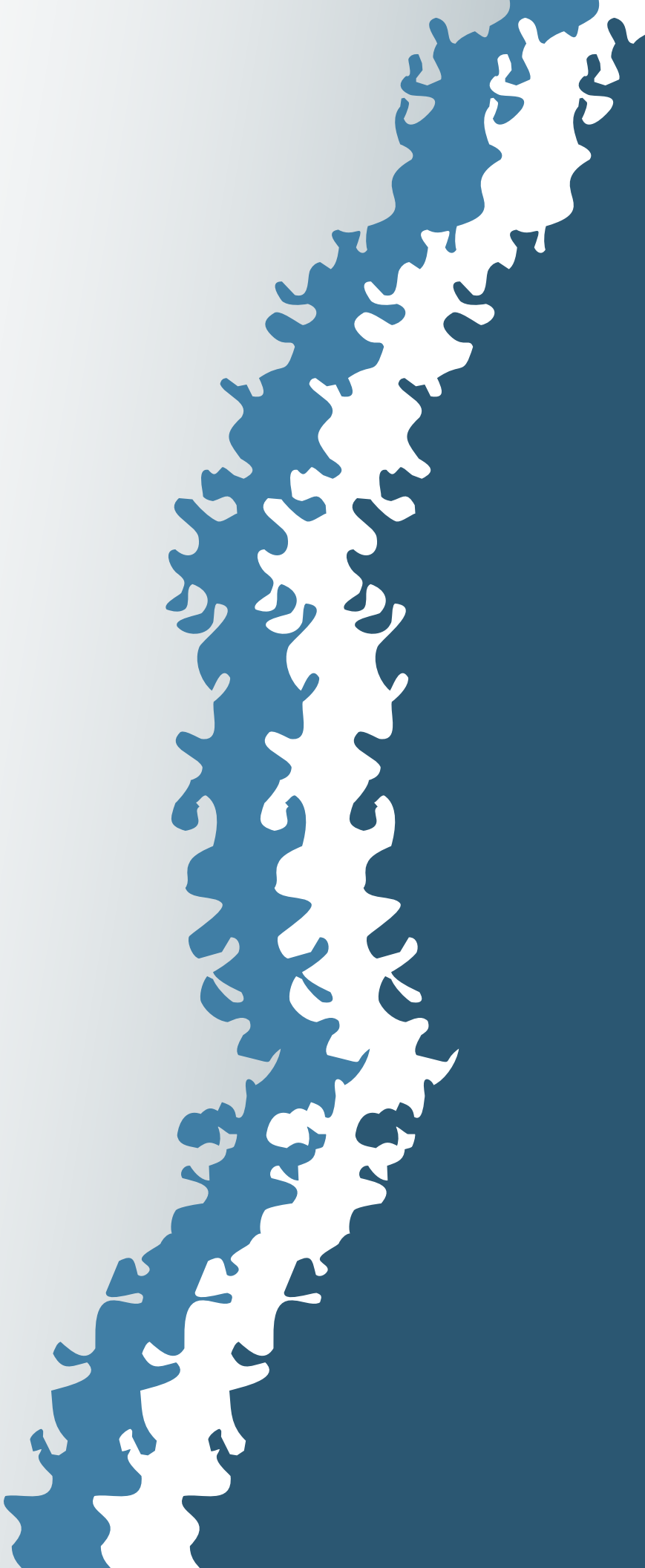
4.2.3.1

Value-Based Purchasing



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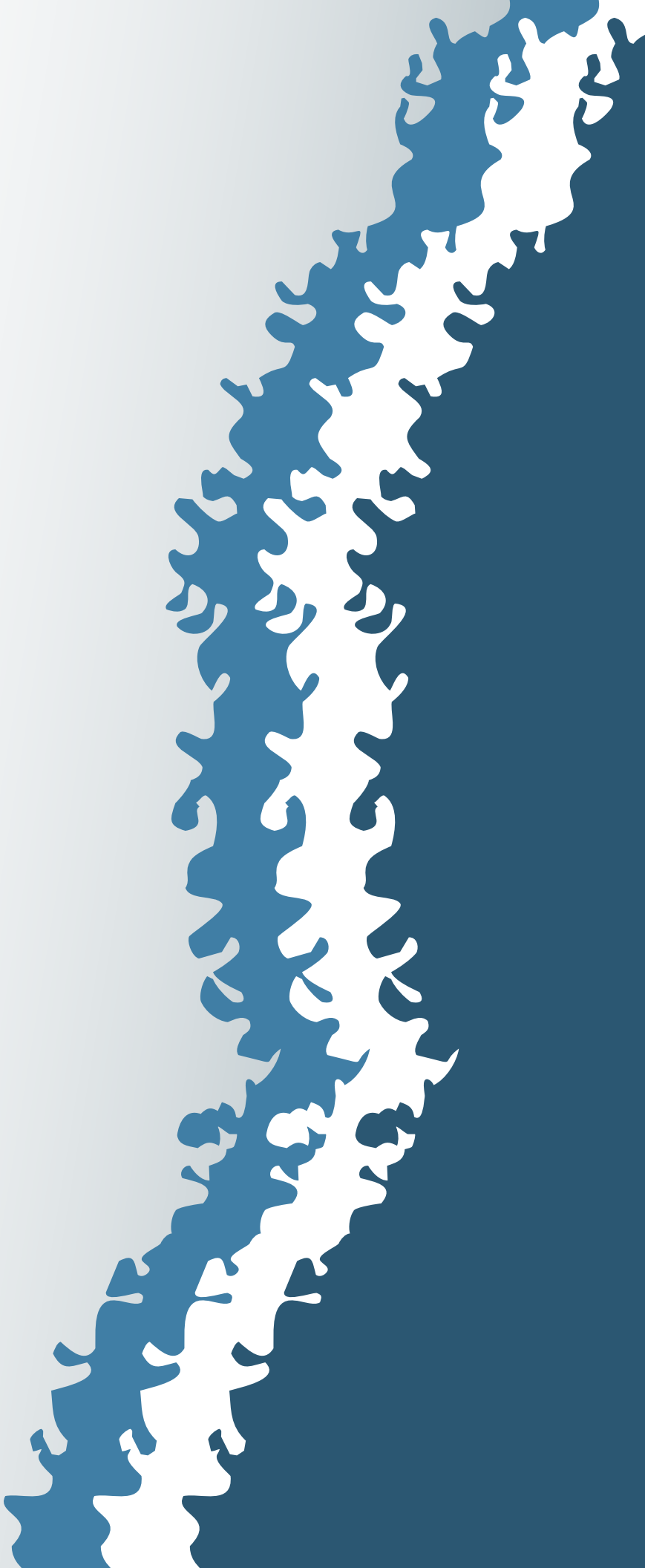
4.2.3.2

Patient-Centered Medical Home (PCMH)



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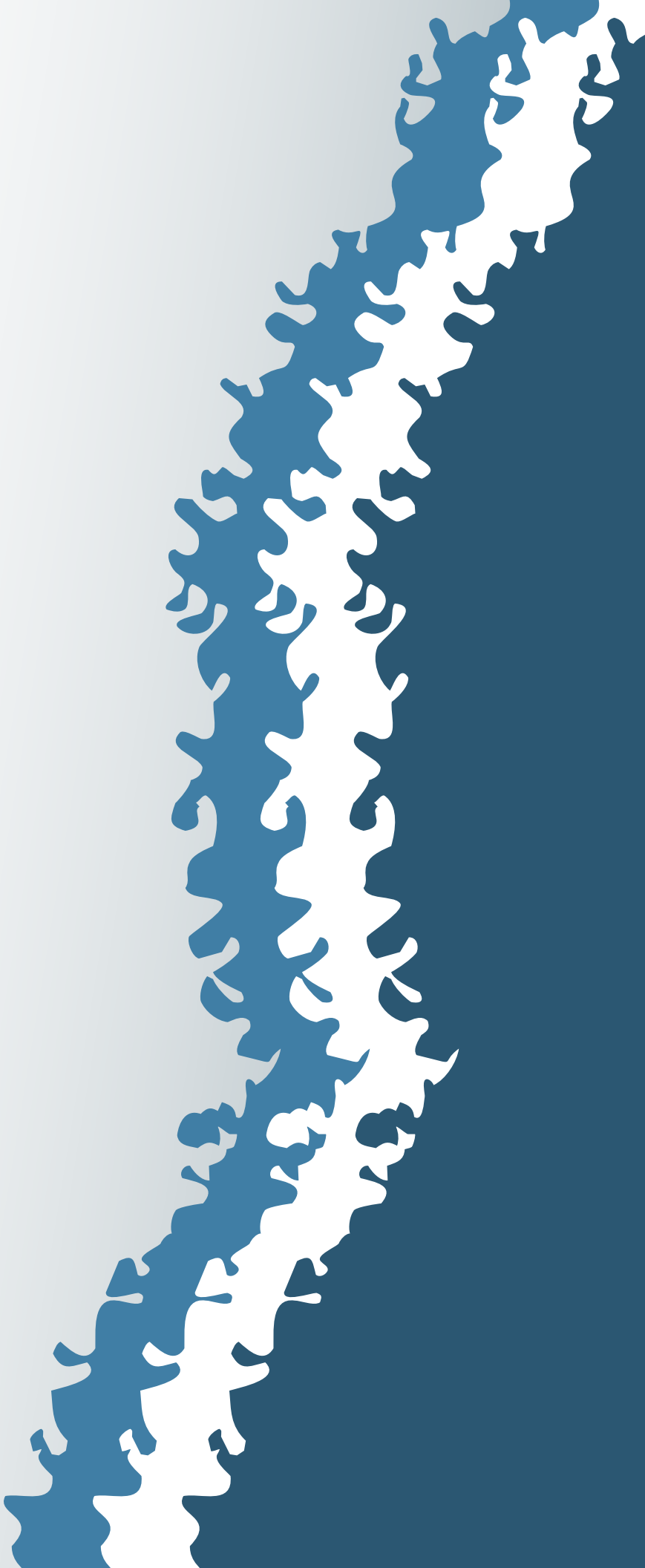
4.2.3.3

Social Determinants of Health (SDOH)



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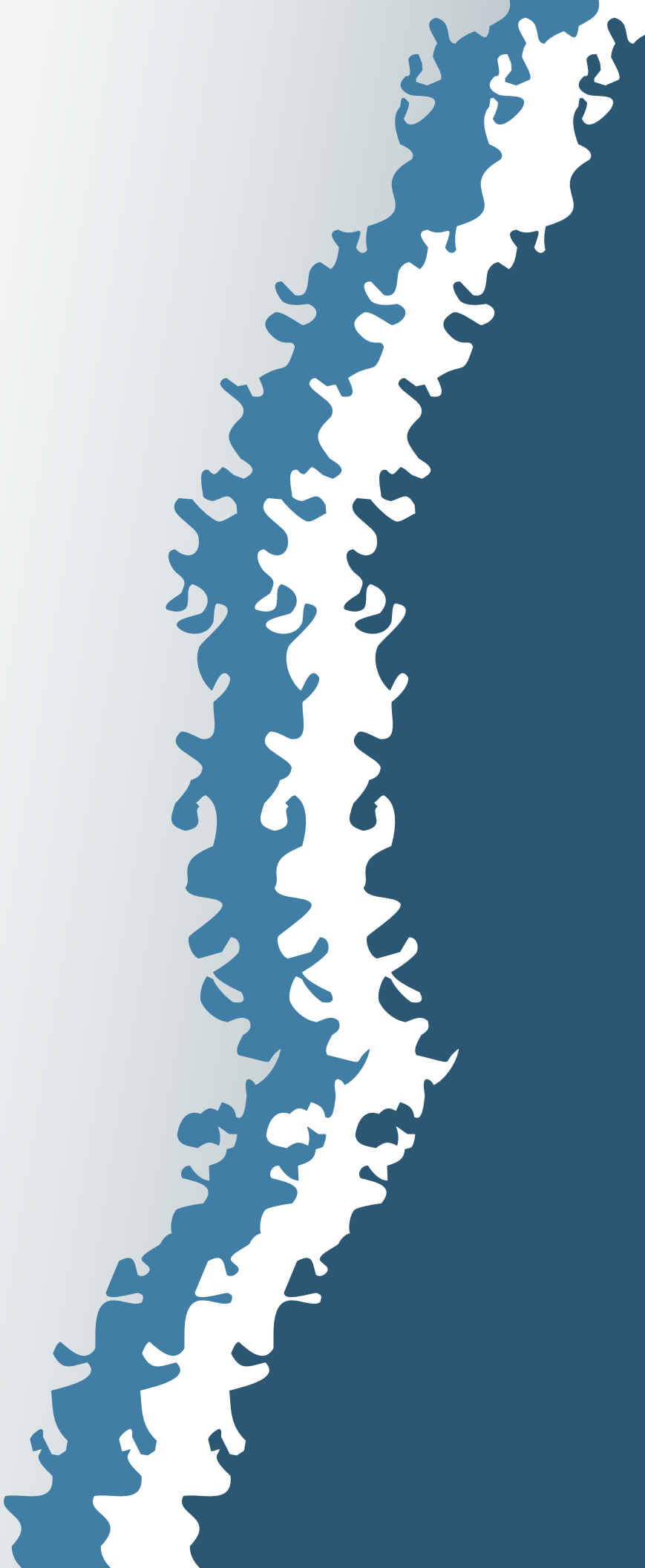
4.2.3.4

Value Added Benefits (Value-Adds)



UNMARKED

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.

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Proposed Value-Added Benefit: Summary Chart	
Benefit Name: CPR and Parenting Classes for Parents/Caregivers	
Target Beneficiary Population(s): Parents and caregivers in MississippiCAN and CHIP	
Benefit description, including any limitations and prior authorization requirements: **Division-Curated Value-Add for CCO Contract:** Perinatal We will provide CPR and parenting classes for parents and caregivers. This benefit is open to Members in all programs. Parenting and co-parenting classes will be made available via an online program that allows participants to learn at their own pace during any time of the day or evening. Classes are available in Spanish. Topics will include: • How to handle anger and stress • The cost of poor parenting • Understanding the legal process • How to make a parenting plan • Establishing appropriate boundaries • Consequences and rewards • How to help build your child's self-esteem • How to more effectively communicate with kids and ex-spouses • Blended families—issues and concerns with stepfamily members CPR classes are available to Members via an online healthcare education company that specializes in training courses that lead to certifications in CPR, first aid, and other emergency response areas. We will also provide CPR training and teach Members and their families how to respond when someone is having a cardiac emergency. We will provide educational materials and CPR kits for Members in attendance who have airway problems and may need a CPR kit at home. Pregnant Members and mothers will have the opportunity to learn how to administer basic CPR for infants. **Goals:** Increase in Members taking an active role in their health. Work with communities to promote best practices of healthy living. Strengthen person and family engagement as partners in their care.	
Projected utilization in year one (total units): 3,244	**Price per unit:** $210
Gross value: $681,2400	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $681,240	**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: Wound Care Management and Diabetic Health Education	
Target Beneficiary Population(s): Pregnant Members, those who recently delivered their babies, and Members who are diagnosed with diabetes and are pregnant or recently delivered	
Benefit description, including any limitations and prior authorization requirements: **Division-Curated Value-Add Category:** Perinatal Category In alignment with the Division's curated list of desired value-adds, we will provide postpartum wound care management support as part of our care management offerings for Members who recently have had a cesarean section or have slow-healing vaginal lacerations. Our Care Managers will work directly with Members, providing education and support to ensure proper healing, such as wound cleansing, timely dressing change, and appropriate dressing. Our Care Managers will help Members who are new mothers schedule appointments and transportation to complete their postpartum visits. **Goals:** Promote effective prevention and treatment of chronic disease. Work with communities to promote best practices of healthy living.	
Projected utilization in year one (total units): Provided as a part of care management	**Price per unit:** $0
Gross value: $0	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $0	**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: Vision Benefits for Members Age 21 Years and Older	
Target Beneficiary Population(s): Members age 21 years and older	
Benefit description, including any limitations and prior authorization requirements: **Division-Curated Value-Add Category:** Extended Services We will provide an additional $100 above the standard benefit for medically necessary and appropriate services (e.g., corrective lenses), which reflects established parameters for frequency of services and level of required vision correction or change. This benefit covers frames, lens type, and materials for Members with a new prescription. Coverage includes contact lenses or glasses. This benefit is for coverage of one pair of corrective lenses per year. **Goals:** Work with communities to promote best practices of healthy living. Strengthen person and family engagement as partners in their care.	
Projected utilization in year one (total units): 3,558	**Price per unit:** $100
Gross value: $355,800	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $355,800	**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: Nutrition Assistance	
Target Beneficiary Population(s): All Members	
Benefit description, including any limitations and prior authorization requirements: **Division-Curated Value-Add Category:** SDOH We will provide nutrition assistance and additional nutrition resources for Members, including those who receive SNAP or WIC benefits. Following a $25 allowance per Member, we will also provide nutrition assistance, education, and training for Members regarding nutritious foods and food preparation via the following planned efforts: **Baby shower** events provide opportunities for pregnant Members and new mothers to receive educational lessons and materials regarding nutrition for mom and baby. **Our farmers market** events offer Members tokens they can exchange for fruit and vegetables at local farmers markets across the State. We will provide educational materials and cooking lessons for children and their guardians to promote lifelong healthy habits. We will provide nutritional food items and household and personal hygiene supplies for Members via special events in partnership with schools and local CBOs. We also will provide a four-part education series for mothers and their children in Head Start to pre-K regarding dental health, mental health, and other key health topics for new moms. The **perinatal health management** program promotes healthy pregnancies and improved birth outcomes by focusing on the risk of preterm birth among Black women and other women of color. As part of the program, a nutritionist and on-site advocate will deliver an intervention program that consists of group meetings, a tailored meal plan, nutritional supplements, healthy lifestyle coaching, and a personal counselor throughout each trimester of the pregnancy and in the postpartum period. **Text reminder program for pregnant women and new moms** provides appointment reminders and personalized information on prenatal care, signs of labor, breastfeeding, infant growth and development, and nutrition sent directly to Members' phones at no cost. **Goals:** Work with communities to promote best practices of healthy living. Strengthen person and family engagement as partners in their care. Address and improve food insecurity.	
Projected utilization in year one (total units): 3,742	**Price per unit:** $25
Gross value: $93,550	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $93,550	**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: Transition Meals	
Target Beneficiary Population(s): Members who have food insecurity and have recently been discharged from the hospital and/or those who just delivered a baby	
Benefit description, including any limitations and prior authorization requirements: **Division-Curated Value-Add Category:** SDOH We will provide up to 56 medically tailored meals over four weeks to high-risk Members discharging from inpatient care or pregnant/postpartum women upon transitioning from the hospital who are experiencing food insecurity. **Goals:** Provide nutrition assistance to Members experiencing food insecurity at a time where healthy meals are critical to recovery.	
Projected utilization in year one (total units): 704	**Price per unit:** $394.80
Gross value: $277,939	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $277,939	**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: Controlling Asthma	
Target Beneficiary Population(s): Available to high-risk Members who have an asthma diagnosis	
Benefit description, including any limitations and prior authorization requirements: **Division-Curated Value-Add Category:** SDOH We will provide **pest control, bed bug treatment, or dust mite treatment**, as needed, with a $250 maximum allowance per year per Member with an asthma diagnosis. Our CHWs, who work directly with Members to address SDOH, will complete home assessments and arrange for services aimed to improve the home environment. The CHW will address any additional barriers facing Members by using our closed-loop referral system to connect to social service partners. We will follow National Asthma Education and Prevention Program guidelines for integrated pest management, which call for identification of pest problems through monitoring and inspection; blocking entry points; removing pests' food, water, and shelter; and using low-toxicity pesticides only as needed. According to the National Asthma Education and Prevention Program, cockroaches and mice are the top cause of asthma-related events in the home, and guidelines aim to reduce allergens and triggers. We will provide education for Members regarding these and other triggers, such as smoke from cigarettes, dust, pollen, pets, or strong perfume odors, with tips that families can take to prevent asthma-related complications. We also will focus education and support efforts on medication adherence through videos, educational brochures, and one-one-one, in-person coaching. **Goals:** Increase medication adherence. Decrease ER utilization for acute asthma in Medicaid beneficiaries with respiratory illness. Promote effective prevention and treatment of chronic disease. Work with communities to promote best practices of healthy living.	
Projected utilization in year one (total units): 797	**Price per unit:** $250
Gross value: $199,250	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $199,250	**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: Education and Employment Supports	
Target Beneficiary Population(s): Benefit available to all Members	
Benefit description, including any limitations and prior authorization requirements: **Division-Curated Value-Add Category:** SDOH We will provide education and employment support for Members, including GED testing with employment support for those who successfully complete GED testing. Our CHWs specializing in employment will work with Members one-on-one, using our closed-loop referral system to help connect them to employment support and resources. Additionally, we will collaborate with CBOs, such as the Family Resource Center of North Mississippi, to provide financial education and literacy classes to Members in 16 counties in the State. Our Interfaith Manager and our community engagement team will collaborate with CBOs and faith-based organizations, such as churches, to provide Members with community learning collaboratives that offer students free Internet connection and a quiet place to study. We will also provide workforce training through our future partnership with the Workforce Investment Network Job Centers and their affiliates like Climb CDC and Northwest Mississippi Community College. **Goals:** Work with the community to promote best practices of healthy living. Strengthen person and family engagement as partners in their care.	
Projected utilization in year one (total units): 998	**Price per unit:** $120
Gross value: $119,760	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $119,760	**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: Prenatal Reward: Gift Card and Car Seats	
Target Beneficiary Population(s): Pregnant Members	
Benefit description, including any limitations and prior authorization requirements: **Division-Curated Value-Add Category:** Children We will provide gift card reward incentives for Members who complete their prenatal checkups. Members will receive the following rewards: • $25 gift card for completing the first trimester prenatal visit • $25 gift card for completing the second trimester prenatal visit • Car seat when completing six total prenatal visits. We will include education, training, and resources that show new parents how to use car seats to ensure safety. Our Lactation Specialist will work with pregnant Members and new moms to refer them to receive an electric breast pump, with education, training, and support prior to giving birth and after delivery. Members will be able to use gift cards to purchase diapers, baby wipes, and other supplies for newborns. **Goals:** Reduce preterm births in Medicaid beneficiaries. Increase the rate of maternity visits during the first 16 weeks of pregnancy.	
Projected utilization in year one (total units): 6,632 gift cards 237 car seats	**Price per unit:** $50 gift cards $80 car seat
Gross value: $350,560	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $184,760	**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: Unlimited Office Visits	
Target Beneficiary Population(s): All Members	
Benefit description, including any limitations and prior authorization requirements: We will provide unlimited physician office visits beyond the 16 visits offered under traditional Medicaid for all Members. This value-add does not apply to inpatient consults and ER visits. **Goals:** Work with community to promote best practices of healthy living. Strengthen individual and family engagement as partners in Member care. Promote effective prevention and treatment of chronic disease.	
Projected utilization in year one (total units): 2484	**Price per unit:** $118.40
Gross value: $294,105.60	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $294,105.60	**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: No Copays	
Target Beneficiary Population(s): All Members under the MississippiCAN program	
Benefit description, including any limitations and prior authorization requirements: We will provide MississippiCAN Members with no copayment responsibilities or other charges for covered medical services. **Goals:** Work with community to promote best practices of healthy living. Strengthen person and family engagement as partners in their care. Promote effective prevention and treatment of chronic disease.	
Projected utilization in year one (total units): 474,221	**Price per unit:** $4.13
Gross value: $1,958,533	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $1,958,533	**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: Postpartum Care	
Target Beneficiary Population(s): New mothers (women of childbearing age)	
Benefit description, including any limitations and prior authorization requirements: We will provide a $25 gift card as an incentive for Members who complete their postpartum visits for early detection of medical issues, are screened for postpartum depression, receive education, and connect with community services within 21-to-56 days after delivery. This value-add supports meeting HEDIS benchmarks. Members will be able to use gift cards to purchase diapers, baby wipes, and other supplies for newborn babies. **Goals:** Increase the completion rates for postpartum maternal visits. Work with communities to promote best practices of healthy living. Strengthen person and family engagement as partners in their care.	
Projected utilization in year one (total units): 4,336	**Price per unit:** $25
Gross value: $108,400	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $108,400	**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: Electric Breast Pump Program	
Target Beneficiary Population(s): Members who are new mothers with newborn babies up to 12 months of age	
Benefit description, including any limitations and prior authorization requirements: We will provide electric breast pumps at no cost to Members who recently delivered their babies, up to their child's first birthday. The initiative includes ongoing education and support for six months after receiving the electric breast pump. We will also work with Members to help them schedule postpartum visits and well-child visits for newborn babies. **Goals:** Promote postpartum health visits and EPSDT or well-child visits, and increase the rate of mothers who breastfeed.	
Projected utilization in year one (total units): 1,898	**Price per unit:** $100
Gross value: $189,800	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $189,800	**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: Annual Well-child and EPSDT Incentives	
Target Beneficiary Population(s): Members younger than 21 years old in the MississippiCAN program; Members up to 19 years old in the Mississippi CHIP program	
Benefit description, including any limitations and prior authorization requirements: We will provide a $25 gift card to Members who complete their annual, age-appropriate visits for early detection of medical issues and reduced hospitalizations. This enhanced benefit supports meeting HEDIS benchmarks, Child and Adolescent Well-Care Visit (ages 3–21), and Well-Child Visits in the First 30 Months of Life (ages 0–30 months) measures. Members will be able to use the incentive to purchase over-the-counter drugs and diapers. **Goals:** Increase adolescent immunizations for vaccine-preventable diseases. Increase well-child visits. Work with communities to promote best practices of healthy living.	
Projected utilization in year one (total units): 26,766	**Price per unit:** $25
Gross value: $669,150	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $669,150	**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: Diabetic Exams	
Target Beneficiary Population(s): Members ages 18–64 who are diagnosed with diabetes	
Benefit description, including any limitations and prior authorization requirements: We will provide a $25 gift card to Members who are 18–64 years old when they complete their yearly Comprehensive Diabetes Care eye exam for early detection of diabetic retinopathy and associated medical issues. This benefit supports meeting HEDIS benchmarks. We will also provide a $25 gift card to Members who are 18–64 years old and diagnosed with diabetes when they complete their HbA1c test. Members will be able to use gift cards to purchase over-the-counter drugs. **Goals:** Promote effective prevention and treatment of chronic disease. Work with communities to promote best practices of healthy living.	
Projected utilization in year one (total units): 379	**Price per unit:** $25
Gross value: $9,475	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $9,475	**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: Mammogram Screening	
Target Beneficiary Population(s): Female Members 40–75 years old	
Benefit description, including any limitations and prior authorization requirements: We will provide a $50 gift card for female Members ages 40–75 who complete their annual mammogram screening for early detection of medical issues. This benefit supports meeting HEDIS benchmarks. Members will be able to use gift cards to purchase over-the-counter drugs. **Goals:** Increase the completion rate for mammogram screenings among female Members ages 50–75. Work with communities to promote best practices of healthy living.	
Projected utilization in year one (total units): 173	**Price per unit:** $50
Gross value: $8,650	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $8,650	**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: Mobile Device Access Program	
Target Beneficiary Population(s): Adult Members who are actively enrolled and participating in our care management program and have communication access barriers	
Benefit description, including any limitations and prior authorization requirements: We will provide an enhanced program for those who are receiving care management to receive a free cell phone if needed. This program will be available at no cost for Members. Program features include: • Free phone (smartphone or better) • The phone comes loaded with our apps that apply to the Member's needs • Unlimited talk, text, and data • Free voicemail, three-way calling, call waiting, caller ID, and access to 911 • Free international calling to select countries • Free calls to mobile device access program support • Free calls to our Member services call center **Goals:** Improve appropriate healthcare utilization, address SDOH barriers, and improve access via telehealth and mobile app.	
Projected utilization in year one (total units): 1,747	**Price per unit:** $84
Gross value: $146,748	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $146,748	**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: Adult Annual Wellness Visit	
Target Beneficiary Population(s): Members 19 years and older	
Benefit description, including any limitations and prior authorization requirements: We will provide a $25 gift card for Members age 21 and older when they complete their annual wellness visit with a PCP. Members will be able to use gift cards to purchase over-the-counter drugs. **Goals:** Promote effective prevention and treatment of chronic diseases.	
Projected utilization in year one (total unit): 1,822	**Price per unit:** $25
Gross value: $45,550	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $45,550	**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: Scheduled Immunizations	
Target Beneficiary Population(s): MississippiCAN and CHIP Members younger than 19 years old	
Benefit description, including any limitations and prior authorization requirements: We will provide a $25 gift card per year for Members younger than 19 who complete their recommended age-appropriate immunizations. One gift card per calendar year. Members or legally authorized representatives/caregivers will be able to use gift cards to purchase items needed to support a healthy lifestyle. **Goals:** Increase childhood and adolescent immunizations for vaccine-preventable diseases. Increase well-child visits. Promote effective prevention and treatment of chronic disease.	
Projected utilization in year one (total units): 8,500	**Price per unit:** $25
Gross value: $212,500	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $212,500	**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: Flu Vaccination	
Target Beneficiary Population(s): All Members in MississippiCAN and CHIP	
Benefit description, including any limitations and prior authorization requirements: We will provide a $10 Walmart gift card as an incentive for Members who receive the flu vaccination. This benefit supports meeting CAHPS. Members will be able to use gift cards to purchase over-the-counter drugs. **Goals:** Flu vaccinations are the best way to protect our Members and their families against flu and its potentially serious complications.	
Projected utilization in year one (total units): 8,771	**Price per unit:** $10
Gross value: $87,710	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $87,710	**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: WW	
Target Beneficiary Population(s): Members age 18 years and older in the MississippiCAN or CHIP programs	
Benefit description, including any limitations and prior authorization requirements: Upon referral from a Care Manager, PCP, or PCMH, we will provide up to 12 weeks of WW online program membership for Members 18 years and older to help combat obesity. **Goals:** Promote the adoption of lifelong healthy habits for the prevention of obesity. Promote effective prevention and treatment of chronic disease.	
Projected utilization in year one (total units): 286	**Price per unit:** $45
Gross value: $12,870	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $12,870	**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: Kurbo by WW	
Target Beneficiary Population(s): Members 15–17 years of age	
Benefit description, including any limitations and prior authorization requirements: We will provide up to 12 weeks of the Kurbo by WW online program for Members ages 15–17 years old who are in the 95th percentile or more in body weight. **Goals:** Promote the adoption of lifelong healthy habits for the prevention of obesity. Promote effective prevention and treatment of chronic disease.	
Projected utilization in year one (total units): 71	**Price per unit:** $180
Gross value: $12,780	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $12,780	**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: Storybook Heroes/Ready to Read	
Target Beneficiary Population(s): Members ages 5–10 years old and their parents/caregivers	
Benefit description, including any limitations and prior authorization requirements: We will collaborate with FQHCs, rural health clinics, and Head Start programs to install book libraries and provide new books each year to replace worn-out books for young readers. We will work with local organizations, such as libraries and the Mississippi Children's Museum, to create opportunities to offer books for elementary school-aged Members to take home with them at no cost. Another effort is our Head Start program, which, in collaboration with Boys and Girls Clubs, teaches families to read nutrition labels to empower them to make healthy choices. **Goals:** Promote health education and health literacy by engaging children and their parents/guardians with education regarding health-oriented topics.	
Projected utilization in year one (total units): 12	**Price per unit:** $1,500
Gross value: $18,000	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $18,000	**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: Family Farm Days	
Target Beneficiary Population(s): All Members	
Benefit description, including any limitations and prior authorization requirements: We will partner with local farmers to provide tokens to Members that they will be able to exchange for fruit and vegetables at local farmers markets in various communities across the State. Additionally, we will offer children's cooking lessons to empower families to prepare smart (healthy) snacks and encourage the preparation of nutritious meals. Our program will also focus on education and activities that promote physical activity. **Goals:** Address SDOH barriers related to food insecurity. Work with communities to promote best practices of healthy living.	
Projected utilization in year one (total units): 7,485	**Price per unit:** $17.50
Gross value: $130,988	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $130,988	**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.**

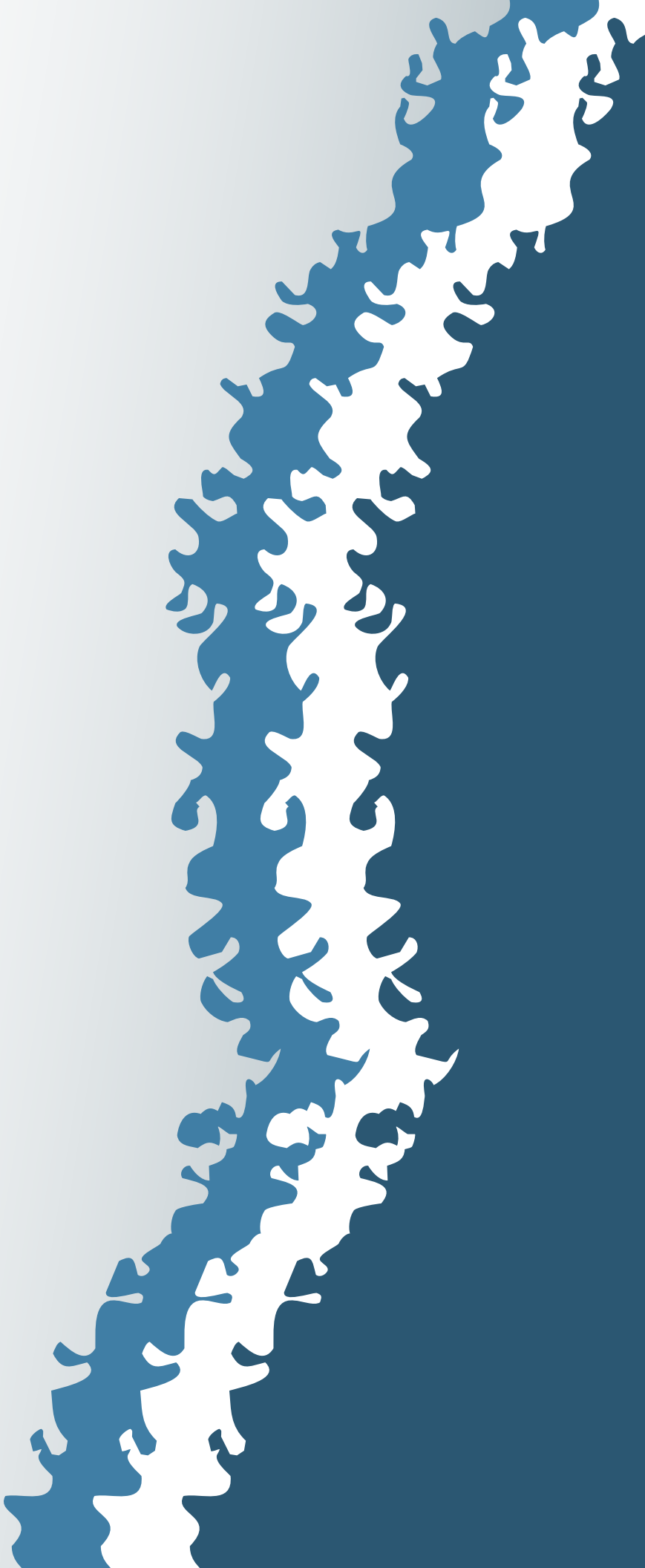
Proposed Value-Added Benefit: Summary Chart	
Benefit Name: Dental Cleanings	
Target Beneficiary Population(s): All adult Members	
Benefit description, including any limitations and prior authorization requirements: We will cover two dental cleanings per year for all adult Members. Further, through our community events, we will share the availability of this value-add to our pregnant Members and mail special brochures to Members actively in prenatal treatment. **Goals:** Engage with communities to improve dental health. Promote maternal dental health.	
Projected utilization in year one (total units): 6,616	**Price per unit:** $34.72
Gross value: $229,708	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $229,708	**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: COVID-19 Immunization	
Target Beneficiary Population(s): All Members who meet recommended criteria for COVID-19 vaccination	
Benefit description, including any limitations and prior authorization requirements: Members who complete a two-dose mRNA series or one dose of Johnson & Johnson's Janssen COVID-19 vaccines will receive a $25 gift card incentive. We will provide transportation to vaccination appointments, and we will bring vaccination events directly to communities via our pop-up and mobile help centers. Members will be able to use gift cards to purchase over-the-counter drugs. **Goals:** To lower our Members' risk of getting and spreading the virus that causes COVID-19. Vaccines can also help prevent serious illness and death.	
Projected utilization in year one (total units): 9,356	**Price per unit:** $25
Gross value: $233,900	**Offsetting costs (provide amount and basis for estimate):** $0
Net Value (gross value minus offsetting costs): $233,900	**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: Staffing	
Title of Position: Senior Specialist, Quality Improvement (RN)	
Value-Add to which Position will be Linked: This position will be linked to all our proposed Member value-adds.	
Description of Position: The required occupational knowledge and specific technical and professional skills and abilities to perform the essential duties of this job are as follows: • Acts as a lead specialist to provide project, program, and/or initiative-related direction and guidance for other department specialists and/or collaboratively with other departments. • Implements key quality strategies that require a component of near real-time clinical decision-making. These activities may include initiation and management of interventions (e.g., removing barriers to care); preparation for QI compliance surveys; preparation and review of potential quality of care and critical incident cases; review of medical record documentation for credentialing and model of care oversight; and any other Federal- or State-required quality activities. • Monitors and ensures that key quality activities that involve clinical decision-making are completed on time and accurately in order to present results to key departmental management. • Writes narrative reports to interpret regulatory specifications, explain programs and results of programs, and document findings and limitations of department interventions. • Creates, manages, or compiles the required documentation to maintain critical QI functions that have a component of clinical decision-making. • Leads QI activities, meetings, and discussions with and between other departments within the organization. • Alerts Manager and Director of any gaps in processes that may require remediation. In particular, the Senior Specialist may be asked to focus on parts of the process where a clinician's perspective would be valuable to uncover process gaps or limitations. • Performs the lead role in the coordination and preparation of the HEDIS medical record review, which includes ongoing review of records submitted by Providers and the annual HEDIS medical record review. The Senior Specialist will be asked to perform duties where clinical decision-making may be necessary. • Participates in meetings with vendors for the medical record collection process. • Assists Manager and Supervisor(s) in training and takes the lead role in these activities. • Collects medical records and reports from Provider offices, loads data into the HEDIS application, and compares the documentation in the medical record to specifications to determine if preventive and diagnostic services have been performed correctly. • Works with the corporate HEDIS team to monitor accuracy of abstracted records as required by specifications. • Participates in scheduled meetings with the corporate HEDIS team, vendors, and HEDIS auditors. • Assists the QI staff with Provider and Member interventions and incentive efforts as needed through review of medical records documentation. • Provides data collection and report development support for QI studies and PIPs. • Assists as needed in support of accreditation activities, such as NCQA reviews, CAHPS, and State audits by reviewing clinical documentation.	
Number of Staff Expected to Fill this Position/Staffing Need: One	
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): Salary between $49,430–$91,799	**Expected Location of Employee:** **[X] Mississippi [ ] Out-of-State**

4.2.3.5

Performance Improvement Projects



UNMARKED

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.

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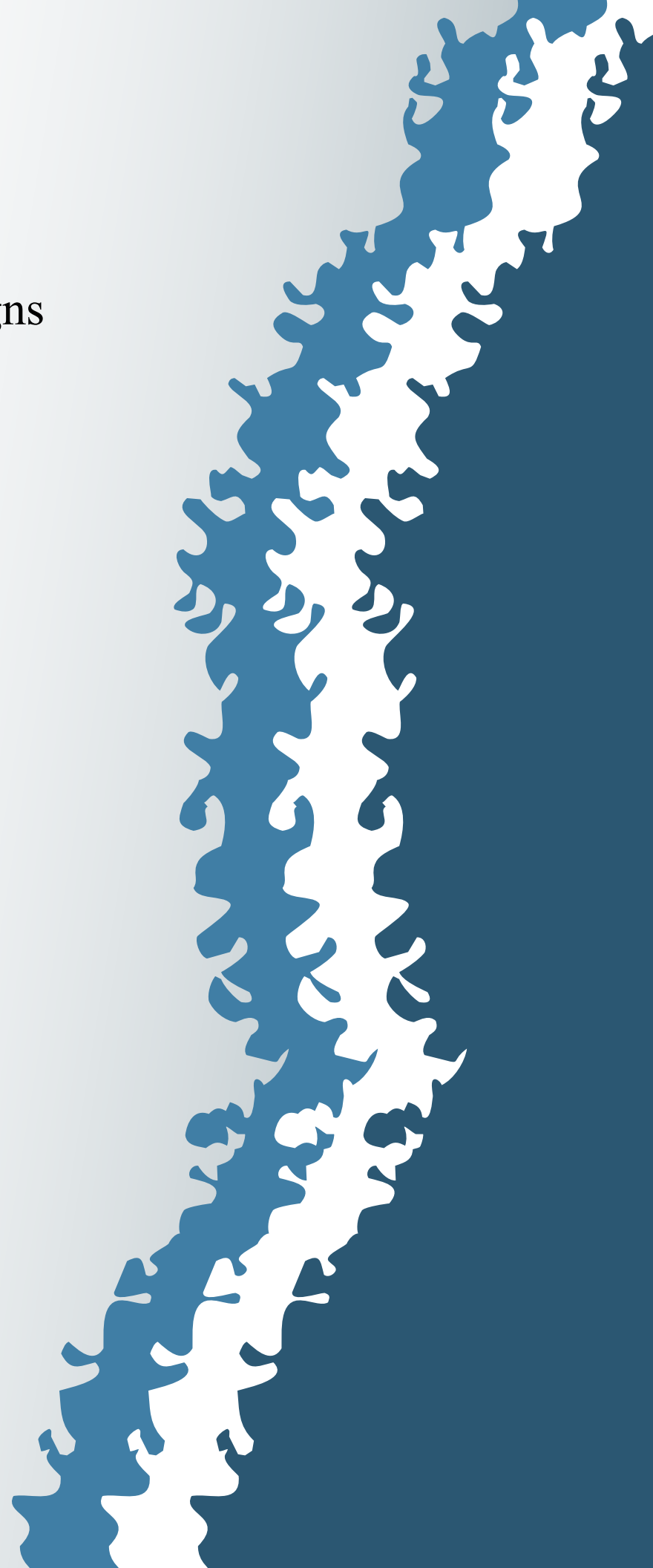
4.2.3.6

Health Literacy Campaigns



UNMARKED

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: Healthy Mom, Healthy Baby
Target Beneficiary Population(s): Pregnant Members; women of childbearing age and their families
Overview of Campaign Strategy and Goals: Our **Healthy Mom, Healthy Baby** pregnancy education and health literacy campaign will seek to increase Member understanding and empower them to make informed decisions regarding important pregnancy milestones; develop healthy habits during pregnancy; complete prenatal, postpartum, well-child visits, and recommended vaccinations; quit smoking using cessation tips and support; and access SDOH supports. Our Manager, Health Equity and SDOH, will develop materials for pregnant women in underserved communities to help them navigate the medical system during pregnancy, delivery, and postpartum. We will collaborate with Tougaloo College/Delta HealthPartners Healthy Start Initiative; and other CBOs, Members and Providers via our Member and Provider stakeholder committees; and Mississippi State organizations and the Division.
Reason for choosing this Campaign: The CDC's Pregnancy Risk Assessment Monitoring System's 2019 maternal health data shows only 60.9% of women in Mississippi performed healthcare visits in the 12 months before pregnancy; 83% began prenatal care in the first trimester; and 89% had a maternal postpartum checkup. Mississippi also had the highest **preterm birth rate** in the nation with Black mothers experiencing higher **infant mortality rates** versus White mothers in 2019**.**
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): Our **social media** channels will provide Members with a series of educational videos, while our Member website and mobile app will host a robust library of articles, brochures, and key health reminders. Our **modes of delivery** will include one-on-one Member education via our high-touch care management, targeted Member mailings, important on-hold messages, transitions of care packets for new moms, and educational flyers, brochures, and in-person lessons. We will host community events to deliver education, such as baby showers, and via our mobile health program using mobile units and semi-permanent trailers to meet Members in the community, as well as disburse information via partners, such as Providers, CBOs, and State agencies.
Tools for measuring engagement: We will track engagement via social media monitoring tools, such as views, likes, and shares. We will track our published media articles, including readership and viewership estimates. We will track successful Member outreach, including delivered mailings, completed outreach calls, and utilization of gift card and car seat value-add incentives for completion of prenatal and postpartum visits.
Tools for measuring impact: We will track and analyze completion rates for prenatal and postpartum visits. Our Member survey will assess each Member's level of understanding related to campaign topics and how many visits were completed as a result of our campaign.
Will a staffing investment be made for this Campaign? [X] Yes [ ] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

Health Literacy Campaign: Summary Chart
Campaign Title: Lactation Education
Target Beneficiary Population(s): Pregnant Members and those who recently delivered their babies, and their families
Overview of Campaign Strategy and Goals: Our **Lactation Education** health literacy campaign will seek to increase Member understanding of the importance of nursing their babies and empower them to make informed decisions for themselves. The campaign will encourage Members to use their covered benefits and value-adds, including nutrition assistance, our gift card and car seat incentives, and electric breast pump enhanced benefit. Our Manager, Health Equity and SDOH, in collaboration with our Certified Lactation Specialist, will develop campaign materials using stakeholder input, including Mississippi Lactation Specialists and other CBOs via our CBO councils; Members and Providers via our Member and Provider stakeholder committees; and Mississippi State organizations and the Division.
Reason for choosing this Campaign: The CDC's Pregnancy Risk Assessment Monitoring System's 2019 maternal health data shows that only 68.6% of mothers in Mississippi ever breastfed, and only 39.7% did any breastfeeding at 8 weeks.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): Our **social media** channels will provide Members with a series of educational videos, while our Member website and mobile app will host a robust library of articles, brochures, and key health reminders. Our **modes of delivery** will include one-on-one Member education via our high-touch care management, targeted Member mailings, important on-hold messages, transitions of care packets for new moms, and educational flyers, brochures, and in-person breastfeeding education lessons. We will host community events to deliver education, such as lactation group or on-on-one education events, and via our mobile health program using mobile units and semi-permanent trailers to meet Members in the community, as well as disburse information via partners, such as Providers, CBOs, and State agencies, such as WIC sites.
Tools for measuring engagement: We will track engagement via social media monitoring tools, such as views, likes, and shares. We will track our published media articles, including readership and viewership estimates. We will track successful Member outreach, including delivered mailings and participation in our electric breast pump value-add.
Tools for measuring impact: We will track and analyze participation in our electric breast pump program. Our Member survey will assess each Member's level of understanding related to breastfeeding and how many new moms breastfed their babies as a result of our campaign.
Will a staffing investment be made for this Campaign? [X] Yes [ ] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

Health Literacy Campaign: Summary Chart
Campaign Title: Healthy Active Lifestyle
Target Beneficiary Population(s): All Members
Overview of Campaign Strategy and Goals: Our **Healthy Active Lifestyle** multigenerational education campaign will seek to engage Members of all ages and their families to increase their understanding of best practices for healthy living, including healthy recipes for every age, outdoor wellness and fun activity guides, and eating guides for those with a diagnosis, such as diabetes or hypertension. In addition to our targeted Member mailings and school-based partnerships, our plan includes in-person lessons, such as our family wellness program, farmers market events and cooking classes, and our fitness-in-education program. We will promote participation in our value-adds, including WW® membership for adults and Kurbo® by WW membership for children ages 8–17. Our Manager, Health Equity and SDOH, in collaboration with our Manager, Community Engagement, Care Managers, and Quality Management Director, will develop campaign materials using stakeholder input, including CBOs via our CBO councils; Members and Providers via our Member and Provider stakeholder committees; Mississippi State and local organizations, such as head start programs and regional pre-kindergarten schools; and the Division.
Reason for choosing this Campaign: Obesity in adults, children, and adolescents can lead to increased susceptibility to a host of diseases, chronic health conditions, psychological disorders, and premature death, which in turn, adds to major healthcare costs. According to a 2018 MSDH report, 41.8% of school-aged children and adolescents are overweight or obese. And at 37.3%, Mississippi ranks second highest in the nation for adult obesity.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): Our **social media** channels will provide Members with a series of educational videos, while our Member website and mobile app will host a robust library of articles, brochures, and key health reminders. Our **modes of delivery** will include one-on-one Member education via our high-touch care management, targeted Member mailings, important on-hold messages, educational flyers, brochures, and in-person lessons. We will host community events to deliver education, including via our mobile health program using mobile units and semi-permanent trailers to meet Members in the community, as well as disburse information via partners, such as Providers, CBOs, and State agencies.
Tools for measuring engagement: We will track engagement via social media monitoring tools, such as views, likes, and shares. We will track our published earned media articles, including readership and viewership estimates. We will track successful Member outreach, including delivered mailings, completed outreach calls, and utilization of value-adds.
Tools for measuring impact: We will track and analyze participation in our WW® and Kurbo® by WW value-add, including highlighting Member success stories. Our Member survey will identify each Member's lifestyle goals and assess their level of understanding.
Will a staffing investment be made for this Campaign? [X] Yes [ ] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

Health Literacy Campaign: Summary Chart
Campaign Title: Member Empowerment
Target Beneficiary Population(s): All Members
Overview of Campaign Strategy and Goals: Our **Member Empowerment** education and literacy campaign seeks to provide all Members with education on the following topics: • Best way to use Member benefits • Member rights and responsibilities • Tools for self-referral for SDOH services, including our closed-loop referral system • How to keep Member benefits, specifically the redetermination process, including redetermination reminders • Selecting or changing a PCP assignment • When to seek help from an urgent care facility or ER • Which questions to ask their PCP, including how to ask for help with SDOH needs • Where to get help understanding medication instructions • How to prepare for and participate in telehealth appointments • How to request translation services and schedule transportation for medical appointments • Importance of completing all recommended, age-appropriate wellness visits: flu shots, EPSDT, well-child visits, adult well-visits, mammograms, etc. • How to access incentives and value-adds
Reason for choosing this Campaign: Individuals who are equipped with knowledge and information make better informed health decisions. An increase in Members' health education, literacy, and know-how for accessing and using Medicaid benefits is key to improving health outcomes and quality of life.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): Our **social media** channels will provide Members with a series of educational videos, while our Member website and mobile app will host a robust library of articles, brochures, and key health reminders. Our **modes of delivery** will include one-on-one Member education via our high-touch care management, targeted Member mailings, important on-hold messages, and educational flyers, brochures, and in-person lessons. We will host community events to deliver education, such as Member information assistance events, and via our mobile health program using mobile units and semi-permanent trailers to meet Members in the community, as well as disburse information via partners, such as Providers, CBOs, and State agencies.
Tools for measuring engagement: We will track engagement via social media monitoring tools, such as views, likes, and shares. We will track successful Member outreach, including delivered mailings, completed outreach calls, and participation in our community events.
Tools for measuring impact: We will track utilization of our gift card program, translations requested, Member mobile app downloads, active users in our SDOH closed-loop referral system, and Z codes submitted by Providers. Our Member survey will assess each Member's level of understanding related to campaign topics and ask how many are engaged in their healthcare as a result of our campaign.
Will a staffing investment be made for this Campaign? [X] Yes [ ] No **If yes, use the Health Literacy Campaign: Staffing Chart to provide details.**

Health Literacy Campaign: Staffing

Title of Position: Health Literacy Specialist

Campaign to which Position will be Linked: Healthy Mom, Healthy Baby; Lactation Education; Healthy Active Lifestyle; Member Empowerment

Description of Position:

The following are technical and professional skills and abilities required for this position:

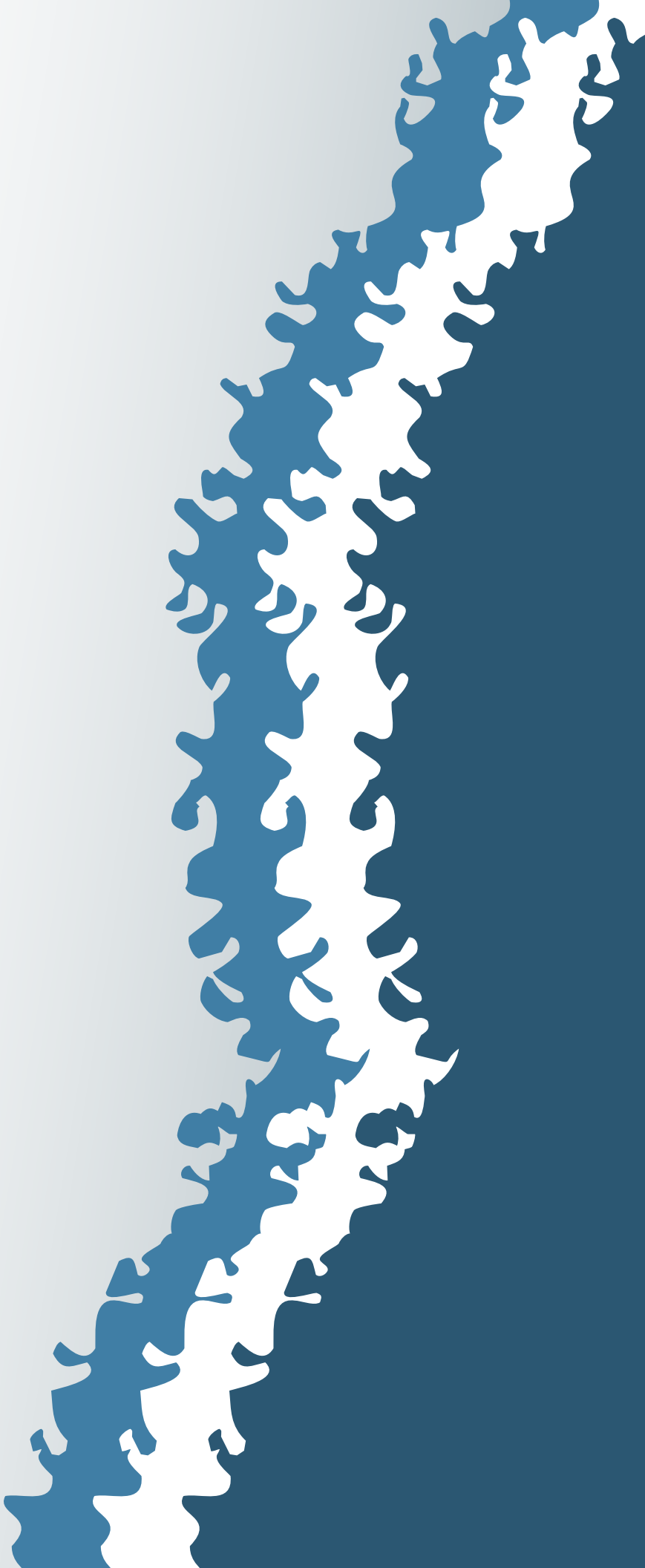
- Serves as a community-based Member advocate and resource, using knowledge of the community and available resources to engage and assist Members in managing their healthcare needs through our health literacy campaign efforts.
- Collaborates with and supports the healthcare services, Member engagement, and community engagement teams by providing nonclinical paraprofessional assistance in the field, including health education campaign efforts for Members in their communities, nursing homes, shelters, doctor's offices, and more.
- Empowers Members by helping them navigate health literacy materials and maximize their health plan benefits via health education events, classes, and other educational opportunities. Assistance may include proving educational materials in alternate languages and formats, such as large print or Braille.
- Assists Members in accessing social services such as community-based resources for housing, food, employment, and more, via educational opportunities at in-person events, Member mailings, and Member electronic communications, such as notifications on the Member mobile app.
- Participates in ongoing or project-based activities to support Member education that may require extensive Member outreach (telephonically and/or face-to-face).
- Local travel within Mississippi may be required for attending community Member events.

Number of Staff Expected to Fill this Position/Staffing Need: One

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): Hourly rate between $14.75 to $27.40	**Expected Location of Employee:** **[X] Mississippi [ ] Out-of-State**

4.2.3.7

Telehealth



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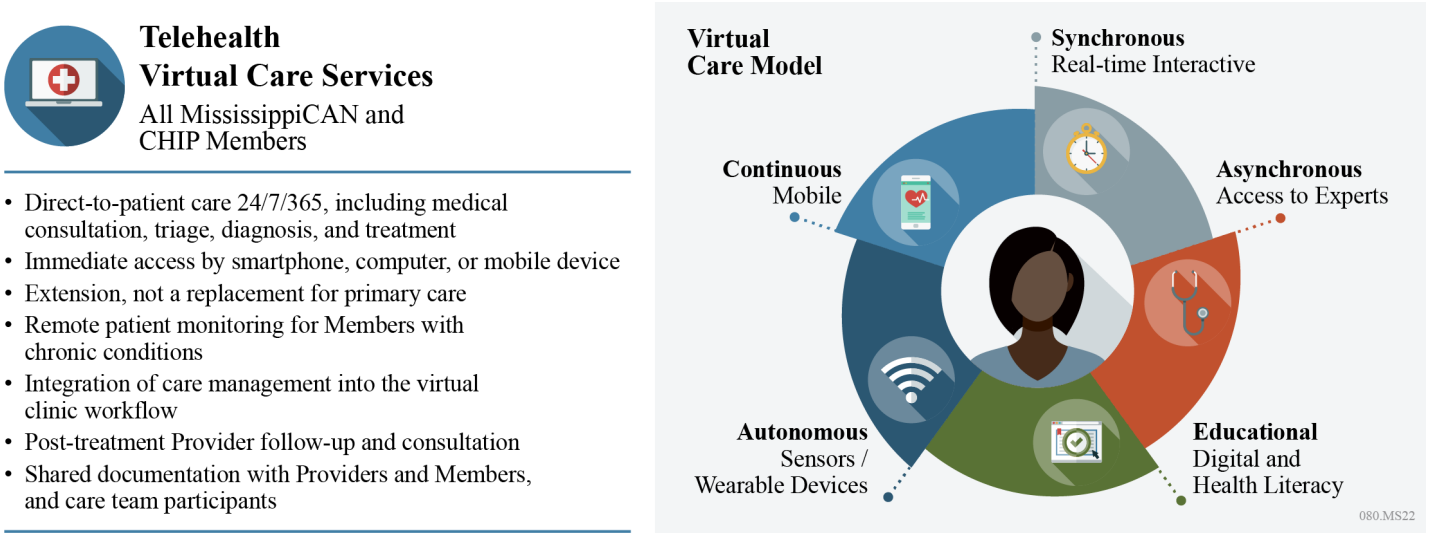
4.2.3.7: TELEHEALTH

One of the emerging results of the ongoing COVID-19 pandemic is expanded and accepted use and innovation in the area of telehealth. Telehealth has evolved over the past few years from a traditional term for using two-way electronic communications to improve a patient's health to encompass a broader meaning, including leveraging various remote technologies to support the delivery of or access to health care services across a wide spectrum of health disciplines. With emerging and expanding use, telehealth has also rapidly spread to include Member and Provider education and solutions.

As an experienced CCO and recognized industry leader in the use of innovative technology, we rapidly expanded our telehealth capabilities in response to the pandemic, as well as the easing of restrictions by States on the use of virtual conferencing for medical care, normally classified at a level commensurate with primary care and urgent care. As we continue to live within the confines of the pandemic and anticipate a gradual and eventual transition into the post-pandemic era, the Division has indicated a desire to continue offering payment for consumer-direct telehealth services as a means of expanding access to care, reducing unnecessary emergency and inpatient utilization/hospitalization, and enhancing overall health among the population.

Our proposed telehealth program leverages a broad range of remote technologies and methodologies to provide and deliver Member and Provider access to telehealth virtual care services across a wide spectrum of health disciplines, as shown in **Exhibit 1** and further detailed below. We will provide access to virtual healthcare services ***through future partnerships with the University of Mississippi Medical Center (UMMC***) and our national telehealth Provider.

Exhibit 1. Telehealth Virtual Care Services. We will provide all MississippiCAN and CHIP Members access to telehealth virtual care services through our partnerships with a UMMC and our national telehealth Provider.



With the recently revised rules, we are aligning our telehealth offerings to include certain synchronous and asynchronous activities, such as remote patient monitoring, e-visits, and telephone calls. Our telehealth offering will include access to physical health, BH, and select specialty services and accommodate different aspects of telehealth, such as urgent care visits, follow-up Provider visits, post-hospitalization visits, mental health counseling, and prenatal and postnatal care, to name a few. We will also allow other Provider types to deliver telehealth as defined by the revised rules, including BH Providers, supervised practitioners, audiologists, speech–language pathologists, occupational therapists, physical therapists, speech–language pathology aides, audiology aides, occupational therapy assistants, physical therapist assistants, dentists, and dietitians.

As an essential part of our telehealth approach in Mississippi, our mobile health program will advance telehealth awareness in rural communities and provide Members with direct access to technology, including computers and Internet access, and other resources to help get them "connected." With a primary focus on the Mississippi Delta, our mobile health program will provide Members with essential program benefit information and service access assistance, promote health and digital literacy, and offer support and resources for accessing additional community-based and government-sponsored programs.

We will also encourage Providers to use telehealth technologies by educating them on virtual health care delivery capabilities, reimbursement, and other incentive opportunities. For example, ***as part of our Provider transformation and technology enhancement program, we will provide grant funding to incentivize Providers to expand, enhance, and further develop their telehealth capabilities***.

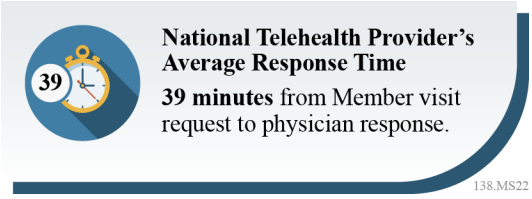
The following details our experience and proposed innovative approach to telehealth service delivery as an integral part of the CCO Program.

Our Ability to Support and Ensure the Most Efficient Use of Telehealth

We bring solid experience successfully providing telehealth services for Medicaid recipients and the Providers who serve them. In fact, we currently facilitate telehealth programs in all our health plans. Further, and underscoring our enterprise-wide commitment to deploying nationally recognized telehealth protocols, the Chief Medical Officer at one of our affiliate health plans was instrumental in the development of the national guidelines for telemedicine.

Our experience prior to and during the ongoing COVID-19 pandemic confirms that telehealth provides a valuable option for Members with certain non-emergency conditions and concerns, and for Members with limited mobility and those who are participating in remote learning, under quarantine, or dealing with other challenges that limit or inhibit face-to-face interaction. We have also seen how telehealth has addressed transportation challenges for Members, especially those living in rural and underserved areas where access to primary and specialty care can be limited and other factors, such as SDOH, can serve as barriers to equitable health access.

Exhibit 2. Average Telehealth Response Time. Our national telehealth Provider's average response time in 2021 was 39 minutes from initial request to Provider contact with the Member.



Telehealth is a welcome option for Members, who have expressed their satisfaction with our telehealth virtual service offering, **with 77% of participants rating their satisfaction as "excellent" according to our Q4 2021 survey**. Due to the COVID-19 pandemic, we experienced a dramatic 866% initial increase in telehealth utilization across our health plans in 2020, and telehealth utilization has remained significantly above pre-pandemic levels through 2021 and into 2022. As shown in **Exhibit 2, our national telehealth Provider's average response time in 2021 was 39 minutes from initial request to Provider contact with the Member.** We expect these trends to continue, which puts even more emphasis on the importance of helping Members get "connected" for access to telehealth services, such as through our mobile health program.

In compliance with Draft Contract § 4.4.2, Telehealth, we will facilitate the administration of telehealth services as dictated by the Mississippi Administrative Code, Mississippi Division of Medicaid State Plan, and communications issued by the Division. We will ensure constant compliance with the Division's policies so that program Members have access to telehealth services as needed.

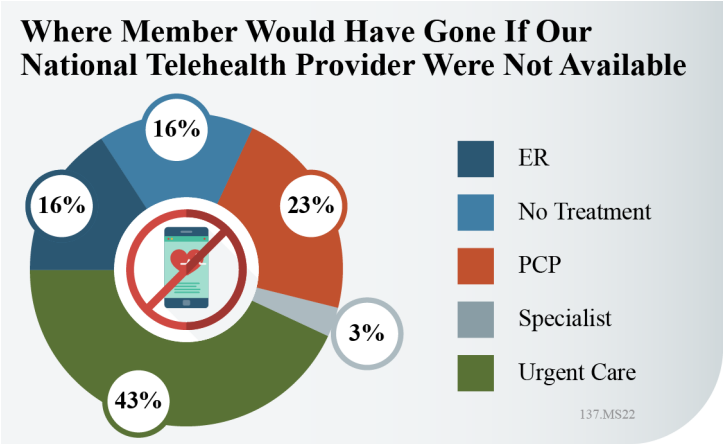
Increasing Access to Virtual Care Services Through Improvement in Telehealth Delivery Options

We recognize the wide range of barriers that Members face in accessing healthcare services. For example, we are aware of the digital divide that exists among Mississippians and understand that 19.4% of the State's population does not have consistent access to broadband Internet, compared with the national average of 6.3%. We also acknowledge that 51% of Mississippi's residents live in rural areas and that it is ranked as the fourth-most rural State in the nation.

Telehealth is an important component of our rural health strategy in which we commit to increasing access to virtual health services and benefits, improving health outcomes and quality of life for MississippiCAN and CHIP populations, specifically those residing in rural areas or experiencing other social and equitable barriers that inhibit their ability to access health benefits and services. We leverage telehealth as a tool for facilitating Member access to needed services in a clinically appropriate manner that are not available locally without considerable time and cost.

Our organization has effectively used telehealth to facilitate virtual access to needed services, reducing costs by providing an alternative option to expensive urgent care and ER visits. As shown in **Exhibit 3**, our data shows that our telehealth service offerings have provided efficient means of access for the 16% of individuals who would not have sought health services if they were not available through virtual technologies.

Exhibit 3. Where Members Would Have Gone. We use telehealth to enable Members to access care at an appropriate level.



We will use telehealth to increase access to physical health and BH services through two primary delivery options:

- **Local Providers in the Mississippi network.** We are already in discussions with local telehealth resources, such as UMMC Project ECHO (Extension for Community Healthcare Outcomes) and other major health systems within the Mississippi network to increase Member telehealth access to Mississippi-based Providers.
- **Certified national Providers.** We will partner with other certified telehealth Providers, such as our national telehealth Provider and our specialty e-consult solution, to offer telehealth and on-demand, virtual access to board-certified physicians and specialists to support Provider collaboration on specialty services.

Web links for telehealth services will be provided on our website to UMMC, St. Dominic, and any other network Provider from which telehealth services are offered, such as Baptist Health, North Mississippi Medical Health System, and Forest General in collaboration with Hattiesburg Clinic, as well as our national telehealth Provider.

Our Innovative Approach to Improving Telehealth Access in Rural Areas of Mississippi

While all MississippiCAN and CHIP Members will be eligible for our telehealth services, ***our innovative approach for meeting the health access needs of Members residing in rural Mississippi is to bring the technology and services to them where they live***. In preparation for the CCO Program, we have already invested and intend to continue to invest heavily in our programs to make the Delta healthier. These are comprised of multiple initiatives designed to improve health outcomes by enabling a greater level of access to health services and benefits, including telehealth, specifically within the Mississippi Delta region. For the CCO Program, we will develop innovative telehealth plans and policies for Members and present them to the Division for approval within 60 days of award of this Contract.

Our proposed multifaceted approach to make the Delta healthier will reach rural communities and address the wide range of barriers to care that Members face while also enhancing support available from Providers. The program focuses on the Mississippi Delta, a rural area with the most severe health disparities and outcomes. Members in care management who live in the Delta can benefit from these programs, including the following:

- **Our mobile health program (mobile units and semi-permanent trailers)**, which will provide the technology, resources, and assistance necessary for Members to access telehealth Providers
- **Our specialty e-consult solution,** which provides Members direct telehealth access to specialty care through their PCP/PCMH when the PCP/PCMH participates in the program
- **Unique and specialty telehealth solutions,** which combine solutions for technology access with remote patient monitoring and will help Members connect to their PCP/PCMH for urgent care services and post-discharge follow-up visits

Also wrapped within the greater programs are educational and support resources and initiatives to help get and keep CCO Program Members "connected," which is a key part of supporting program Members and Providers throughout Mississippi and a major part of improving health outcomes in rural areas, and specifically in the Mississippi Delta region.

Increasing Member Access to Care by Bringing Technology Directly to Them

Because Mississippians in rural and remote areas face barriers to access and care, ***we will provide Mississippi-specific initiatives, services, resources, and technology solutions to mitigate the challenges of access and***

sustainability for rural Members. As further described below, our program designed to make the Delta healthier includes our mobile units and semi-permanent trailers, standard and specialty telehealth solutions, and our mobile device access program. Through these programs, we demonstrate our health plan's ability and commitment to supporting and ensuring the most efficient use of telehealth for Members and Providers, with consideration for the rural nature of much of the MississippiCAN and CHIP populations.

Mobile Units

Since not every Member can travel to urban areas, nor can every condition be treated via telehealth, we will deploy our mobile units in rural Delta communities to bolster Member access to the specialists they need. Our mobile units are large and fully equipped to provide Members another opportunity to engage with us and access direct health care and telehealth virtual care services. The mobile units will also be staffed by nurse practitioners who can provide preventive services and population health education. These units will be stationed near community centers, faith-based centers, food banks, homeless shelters, school events, sporting events, and public social service offices, improving access to in-person and telehealth services in diverse, underserved communities, including rural areas, that struggle with health disparities.

We will identify high-performing Providers and practitioners in urban areas and offer them incentives, such as enhanced payments and day rates, to meet Members where they are in rural neighborhoods and communities. We will assist these practitioners to establish mobile clinics and coordinate care with the Member's local PCP/PCMH. If necessary, follow-up care can then be performed via one of our telehealth solutions or through subsequent mobile clinics. We do not consider telehealth a solution that replaces the in-person PCP/PCMH visit, but instead expands access to high quality primary care into the communities that lack sufficient access to it.

Semi-permanent Trailers

Our semi-permanent trailers will provide flexible Member solutions and innovative healthcare services aimed at closing clinical care gaps within the rural Delta region. Our semi-permanent trailers will give Members the opportunity to visit with Care Managers, attend Member orientation sessions, participate in health and digital literacy initiatives, and get help and information regarding covered and value-added benefits, as well as other programs available to them. Members will be able to make an appointment or walk in to receive help. Members, their caregivers, and authorized representatives can receive in-person assistance regarding their covered benefits and health navigation, submit complaints and/or grievances, and access an array of ancillary services, including but not limited to:

- **Access to technology and virtual services,** such as:
  - Private rooms with **telehealth capabilities to attend private appointments**
  - Complimentary use of **computers and Wi-Fi**
  - Access to **personalized assistance for help getting connected** through our mobile device access program and other government benefits and programs
  - **Assistance logging on to their telehealth virtual visit,** to ensure a successful appointment
- Access to other programs and services, such as employment assistance, local events, community resource guides, access to housing specialists, and meeting spaces with conference rooms and other amenities

Unique and Specialty Telehealth Solutions

Telehealth has taken center stage in healthcare delivery, especially in response to the COVID-19 pandemic. We stand apart from other health plans with the sophistication of our telehealth virtual solutions, including advantages such as:

- **Allowing *any* medically necessary service to be provided by contracted Providers via telehealth,** when possible
- **Increasing Member access through our mobile health program,** to provide Members with access to a wide range of telehealth services, advance digital and health literacy, and help them get connected through community-based programs
- **Offering 24/7/365 access to telehealth physicians** through direct access via desktop, smartphones, and tablet devices provided to Members as needed

- **Providing remote patient monitoring capabilities** to provide PCP/PCMHs with actionable, condition-specific trending data to help monitor patients and improve Member health outcomes before the Member goes to urgent care, the ER, or requires inpatient admission
- **Ensuring unique BH telehealth options are available on demand**, such as our social isolation solution, which offers 24/7/365 engagement and support to address Members with mental health needs

Additionally, we will offer specialist telehealth solutions aligned to the Division's health priorities.

Access to Specialists at the Click of a Button. We will offer rural Providers access to **specialists via our specialty e-consult solution,** a telehealth platform that provides contracted PCP/PCMHs access to top specialists in a variety of fields. Using text-based conversations, PCP/PCMHs will receive feedback on a diagnosis or care plan, gain insights on how to support Members waiting for their specialist appointments, or receive help interpreting labs or diagnostic tests. The focus of the consult will be to enable Providers to make informed clinical decisions and enable equitable access to specialty care, regardless of where a Member lives. Our specialty e-consult solution will provide contracted PCP/PCMHs with access to more than 120 specialists through a HIPAA-compliant app or their integration options within the Provider's EHR. Consultations will offer same-day insights, enabling Providers to meet Members' needs in the moment.

Expanding Access to Prenatal and Postnatal Care. Through our ***proposed partnership with the Mississippi State Department of Health WIC nutrition program, we will offer free access to our infant feeding support technology platform*.** The platform is a mobile app that can connect Members to live, virtual video support from board-certified lactation consultants and nurses 24/7/365. It also enables them to directly call their Care Manager. Postnatal support will help families learn about newborn concerns, such as digestion problems or diaper rash, promoting peace of mind while avoiding unnecessary ER visits. As an extension of the program, moms with babies in the NICU will receive a care package that includes a gift box, burp cloth, and membership card.

Our Mobile Device Access Program. We will offer Members who are actively engaged in care management access to our mobile device access program, which provides free wireless service, Internet access, and mobile phones or tablets to Members who do not already have access to a mobile phone, enabling them to access care through our telehealth solutions described below. Through this program, Members will receive free text messaging, broadband Internet/data packages, and voice services. Further, we will pre-program the mobile device with our Member services call center number, our Member mobile app and any other apps appropriate for the Member, such as the infant feeding support app previously referenced.

Offering Telehealth Services to MississippiCAN and CHIP Members

We offer telehealth services through a range of vehicles to meet the individual needs of Members and Providers with the goal of reducing unnecessary ER and inpatient utilization/hospitalization. As further described below, we will encourage, educate, and promote Member accessibility to our telehealth virtual care services, which will be provided in partnership with a UMMC and our national telehealth Provider.

UMMC 2 You. Staffed by board-certified nurse practitioners, UMMC 2 You's capabilities will enable Members to talk to a Provider 24/7/365 via online virtual modalities, including smartphone, tablet, or personal computer. Practitioners are certified in family medicine and trained to provide virtual care. The UMMC 2 You application is available from anywhere in Mississippi where Internet access is available or where smartphones work. In general, same-day appointments are available and typically last approximately 15 minutes. If necessary, practitioners can schedule in-person appointments for Members and prescribe common medications.

UMMC Project ECHO. We are already in discussions to create a partnership with the UMMC Center for Telehealth's Project ECHO to increase capacity in Mississippi rural areas. Currently, UMMC coordinates with, and their specialists participate in, various Project ECHO efforts throughout Mississippi. Project ECHO virtually links expert specialist teams at an academic "hub" with PCPs/PCMHs in local communities for consultation and case review. Specialists serve as mentors and colleagues, share expertise, and create ongoing learning communities where PCPs/PCMHs receive support, develop skills to treat particular conditions, and provide comprehensive care to Members with complex conditions.

Our National Telehealth Provider. Program Members can connect with a physician 24/7/365 through our mobile app, telephone, or Member website, making it simple for them to connect to a doctor from anywhere. All physicians accessed through our national telehealth Provider are board certified and appropriately licensed, average 20 years of experience, and are enrolled with Mississippi Medicaid. Translation services are currently available in 250 languages. Physicians follow our national telehealth Provider's internal and evidence-based clinical guidelines to diagnose and treat Members and refer those with more complex needs to their PCP/PCMH as appropriate. Our national telehealth Provider will send telehealth visit summaries to a Member's PCP/PCMH upon their request. Members may also view the EHR of their visit through our national telehealth Provider's portal or our mobile app, and/or request a copy by phone.

Promoting Telehealth Services to Members and Providers

As a steadfast supporter of telehealth, we take advantage of every opportunity to promote telehealth virtual care services to Members and Providers. We will educate them about the availability of telehealth, considerations for using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.

Members. Across all our affiliate health plans, we educate Members about the benefits of telehealth and how to access virtual care services through various means. We intend to leverage these means in Mississippi, including:

- **Health plan staff.** Our staff, including Care Managers, CHWs, Member Services Representatives, and a Transitions of Care Coordinator, will educate Members on telehealth and how they can use it at home, school, or a Provider's office.
- **Mobile health program.** We will educate Members on telehealth services at our mobile units and semi-permanent trailers. This will include facilitating targeted health and digital literacy campaigns and initiatives to ensure Members are aware of services and the benefits available to them.
- **Member materials.** We have developed and will distribute printed Member materials, such as flyers, pamphlets, tips, and guides. We will post materials to our Member website and our staff will reference available resources during Member interactions as appropriate.
- **Provider directory.** We will include indicators of telehealth capabilities in our print and online Provider directories.
- **Website postings**. We will promote telehealth through our Member website, to encourage Members to use telehealth, as shown in **Exhibit 4.**
- **Social media platforms.** We will also promote telehealth options and post tips and how-to videos on our social media platforms.

Exhibit 4. Promoting Telehealth on Our Website. We will promote telehealth through our Member website.

To reinforce the benefits of telehealth and promote its use, our ER diversion team will identify Members with elevated utilization levels and remind them about UMMC's and our national telehealth Provider's availability and how to access telehealth services during outreach calls. Our ER diversion team will also educate Providers on the availability of telehealth services and the benefits they offer Members and Providers. In all Member education and outreach activities, we will ensure telehealth does not replace Provider choice and/or Member preference for in-person service delivery.

Providers. We will promote the use of telehealth virtual services to Providers by increasing awareness and comfort with telehealth and educating them on its benefits, including reduced missed appointments and reimbursement opportunities. Our core administrative system is configured to reimburse Providers appropriately and accurately for telehealth services. We will educate Providers on how to engage and use telehealth services, including proper coding of telehealth claims. Our methods for promoting telehealth services to Providers include:

- **Provider transformation and technology enhancement program.** ***Through our commitment to invest $3 million over the 4 years of the Contract, we will use a portion of that to provide grant funding to incentivize Providers to expand, enhance, and further develop their telehealth capabilities***, helping to address health equity and disparities by providing greater access to care in rural communities. For example, we have a

partnership with the University of Mississippi School of Nursing to extend their practitioner program through the summer months. We will also invest in Provider education opportunities and initiatives to encourage a greater level of telehealth adoption.

- **Encouraging and incentivizing Providers.** We will proactively encourage further Provider adoption of telehealth by educating them on virtual health care delivery capabilities, reimbursement, and opportunities through incentives, such as VBP programs.
- **Provider representative team outreach.** Our Provider representative team will regularly communicate with Providers, including meeting one-on-one, leading virtual trainings, or attending association meetings. During these encounters, they will inform Providers and their office staff on the availability of telehealth and its benefits, how to employ it, and billing and reimbursement policies.
- **Provider manual.** Our Provider manual will include detailed policies and instructions on telehealth, including compliance with Federal and State laws and regulations.
- **Provider newsletters and website postings.** We will frequently distribute Provider newsletters and post Provider website updates on the rapid expansion of telehealth benefits. We are committed to keeping Providers informed of the rapidly evolving breadth of telehealth coverage.
- **Telehealth resource guide and policy.** We recommend CCOs partner to create a unified telehealth policy and a resource guide that serves as a how-to guide on the technical requirements, workflows, coding, and billing aspects of telehealth. We will also present this information at our comprehensive closed-loop Member and Provider feedback program.

Supporting Meaningful Use of Telehealth Through Technical Assistance for Members and Providers
We will continue to take actions to support appropriate and timely use of telehealth by Members and Providers. As we do in all our States, we will solicit feedback from Members and Providers on using telehealth effectively, barriers they face, and opportunities for improvement. We will use this feedback, paired with assessments of disparities in care and emerging telehealth best practices, to continue to advance our approach. We will provide technical assistance for Members and Providers through the following:

Helping Members Get Connected. We know MississippiCAN and CHIP Members experience challenges, such as lack of technology, digital literacy, and reliable broadband Internet coverage. We will address these barriers by educating Members on the services available to them through mailing campaigns; by posting content to our website and social media platforms; and through our mobile health program, where we will have pamphlets available and staff helping at our semi-permanent trailers. During their interactions and communications with Members, Care Managers and Transitions of Care Coordinators will educate and help Members in applying for a smartphone and service plan through our mobile device access program, and in accessing and using our telehealth technologies offered by their Mississippi PCP/PCMH Providers or national telehealth Provider app. Further, through our mobile health program and our healthy lifestyle community events, we will coordinate with CBOs and other public and social entities to put on a fun and informal play day for the whole family, while also providing information on available services.

Helping Providers Expand Capabilities and Use. We will support our network Providers in practice transformation and will collaborate with Providers to identify challenges and offer resources to assist in the use and the expanded adoption of telehealth. We will educate Providers on how to engage and use telehealth services, including proper coding of claims. Methods will include outreach from our Provider representative team, who regularly communicate with Providers and offer one-on-one meetings, virtual trainings, and association meetings. They will also inform Providers and office staff of telehealth availability, benefits, use, and billing and reimbursement policies. Our Provider manual will include detailed telehealth policies and instructions, and we will frequently post updates to our Provider portal on the rapid expansion of telehealth virtual benefits to keep Providers informed of the evolving breadth of telehealth coverage. We are also proactively contacting with Providers who offer telehealth services to confirm they are appropriately licensed and enrolled with the Division.

Direct Telehealth Technical Support
Member and Provider direct telehealth technical support will be provided through the following methods:

- **Health plan technical support.** We will provide support links and resource information on our mobile app and website along with our toll-free number for our Member and Provider services for additional support 24/7/365. Members can also call our call center for information on our mobile device access program.
- **UMMC technical support.** UMMC provides 24/7/365 in-house technical support through a toll-free number, which is listed on their website and mobile app.
- **National telehealth Provider technical support.** For anytime technical assistance and support, our national telehealth Provider provides 24/7/365 access to a customer service team member through a toll-free number, which is also listed on their website and mobile app.

Expanding Telehealth Program Services

With the recently revised rules, we will align our telehealth offerings to include certain asynchronous activities:

Remote Patient Monitoring. We will partner with UMMC, an organization that provides chronic illness monitoring equipment and tools, and other national services Providers to facilitate a remote patient monitoring program. As shown in **Table 1,** we will cover remote patient monitoring for at-risk Members and those with chronic conditions as well as high-risk pregnancies.

Table 1. Potential Conditions for Remote Patient Monitoring. Through strategic partnerships, we will cover remote patient monitoring for at-risk Members and those with chronic conditions.

Disease/Condition	Metrics	Frequency
Asthma	Pulse Oximeter; Heart Rate; Spirometry	Daily
Bone Marrow Transplant	Blood Pressure; Weight; Heart Rate; Pulse Oximeter; Temperature	Daily
Congenital Heart Disease	Weight; Pulse Oximeter; Heart Rate	Weekly
Congestive Heart Failure	Weight; Blood Pressure; Heart Rate	Daily
COPD	Pulse Oximeter; Heart Rate; Spirometry	Daily
Diabetes	Blood Glucose Levels	Three Times Daily
End-stage Renal Disease Hypertension	Blood Pressure; Heart Rate	Daily
Home-based Cardiac Rehab (In Development)	Blood Pressure; Heart Rate	TBD
Hypertension	Blood Pressure; Heart Rate	Daily
Maternal Hypertension	Blood Pressure; Heart Rate	Weekly
Pediatric Obesity	Activity; Weight	Daily

We will leverage digital technologies, such as wearables, apps, and other mobile monitoring devices, that capture data from Members and transmit information to Providers for insight, recommendations, and action planning. This will enhance Members' access to care and allow them to actively engage in their healthcare by improving adherence to treatment plans and health outcomes. We will also proactively engage Members through health literacy campaigns through multiple methods, such as in-person through our mobile health program and through traditional mail and virtual outreach methods.

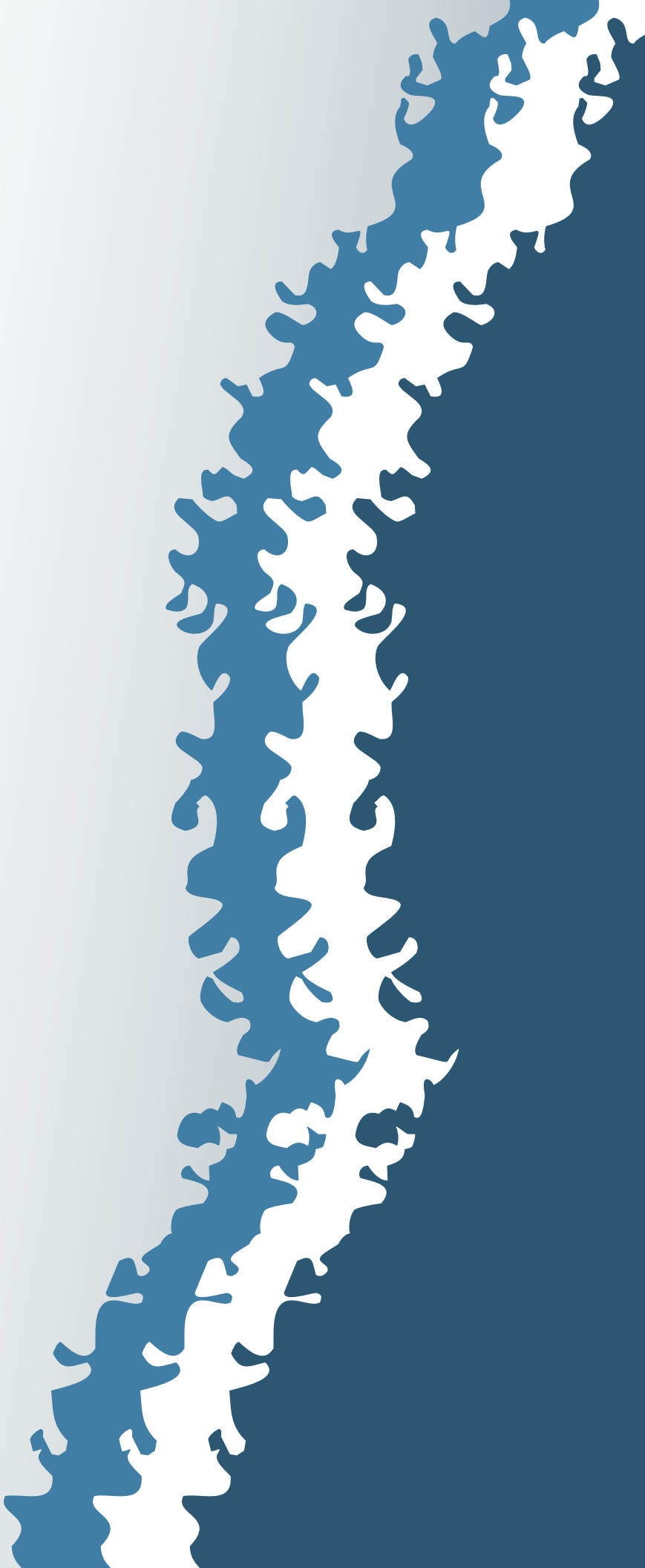
Tele-vision. We are planning to offer a tele-vision solution in partnership with our vision subcontractor. Through this option, Members would be able to speak with a licensed, fully credentialed vision care Provider in real time through interactive audio and video communication equipment. Members would simply call the Provider's office or go online to the practice's website to schedule an eye appointment and request a virtual visit. The Provider would then provide the Member with instructions on the next steps for an appointment. The virtual exam could involve the Member going into the office where an exam room is set up for virtual visits. Another option is for the Member and the Provider to be in remote or different locations.

Tele-psych. We will also engage with UMMC and other national Providers to address BH accessibility and integrated care delivery through general and specialized psychiatric services. Delivered through interactive online video tools, mental health services will be available to Medicaid and CHIP recipients and supported by psychiatrists, psychologists, therapists, and other mental health Providers.

[END OF RESPONSE]

4.2.3.8

Use of Technology



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4.2.3.8: USE OF TECHNOLOGY

We are committed to partnering with the Division through a shared mission to better the lives of Mississippians by ensuring CCO Program Members have access to quality health services. As part of **our commitment, we will proactively support and encourage a high level of ongoing mutual engagement and innovative collaboration with the Division.** This includes working in partnership to determine how the Division can leverage and use our health information technologies and solution capabilities to provide a greater level of program insight and transparency in support of the CCO Program.

By contracting with us, the Division can be confident in the choice to collaborate with a health plan at the forefront of advanced health technology. **Our technology investments provide innovative and modern solutions to our State partners by amplifying the stability, security, and scalability of our platforms and elevating service delivery processes.**

As shown in **Table 1,** we have identified technologies and solutions that could be used to the benefit of the Division in the areas requested. All technology solutions that we propose in response to this RFQ to support program functional areas will comply with the State of Mississippi's Enterprise Security Policy.

Table 1. Technologies that Could Benefit the Division. We have identified the following technologies that we can leverage to provide the Division with more insight and transparency into the CCO Program.

Technology Solutions	Overview	Data Gathering and Analysis	Efficacy of Initiatives and Programs	Transparency	Stakeholder Collaboration
Mississippi Partner Portal	A HIPAA-compliant CCO Program dashboard with a user-friendly self-service option customized to the Division's interests	✓	✓	✓	✓
Enhanced HIE Model	A future-state HIE Model for Mississippi that enhances the State's goal for HIE for all Mississippians	✓	✓	✓	✓
Advanced Health Information Solutions	Superior systems and solutions configured specifically to support the Division's CCO Program needs across the care continuum	✓	✓	✓	✓

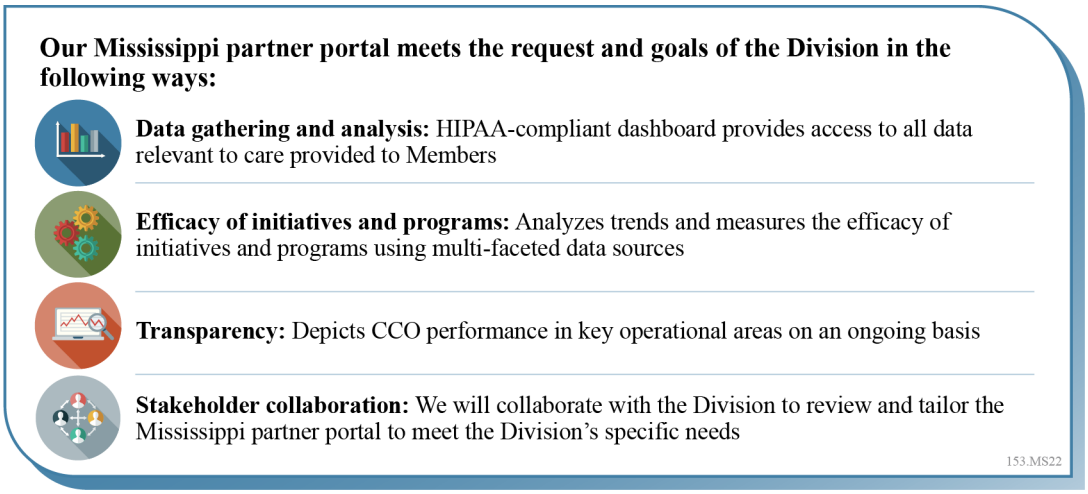
The following sections describe our commitment to supporting the CCO Program leveraging innovated, industry-leading technology and provide detailed descriptions of the technologies that can be leveraged by the Division.

Mississippi Partner Portal

As part of our commitment to data gathering and program transparency, we will design a customized Mississippi partner portal based on the Division's interest in using such an interface to depict CCO performance in key operational areas, as well as our extensive Medicaid managed care experience.

Exhibit 1 provides an overview of our Mississippi partner portal.

Exhibit 1. Mississippi Partner Portal Synopsis. In partnership with the Division, we will design a Mississippi partner portal accessible via a secure and compliant web-based interface customized to the Division's interests.



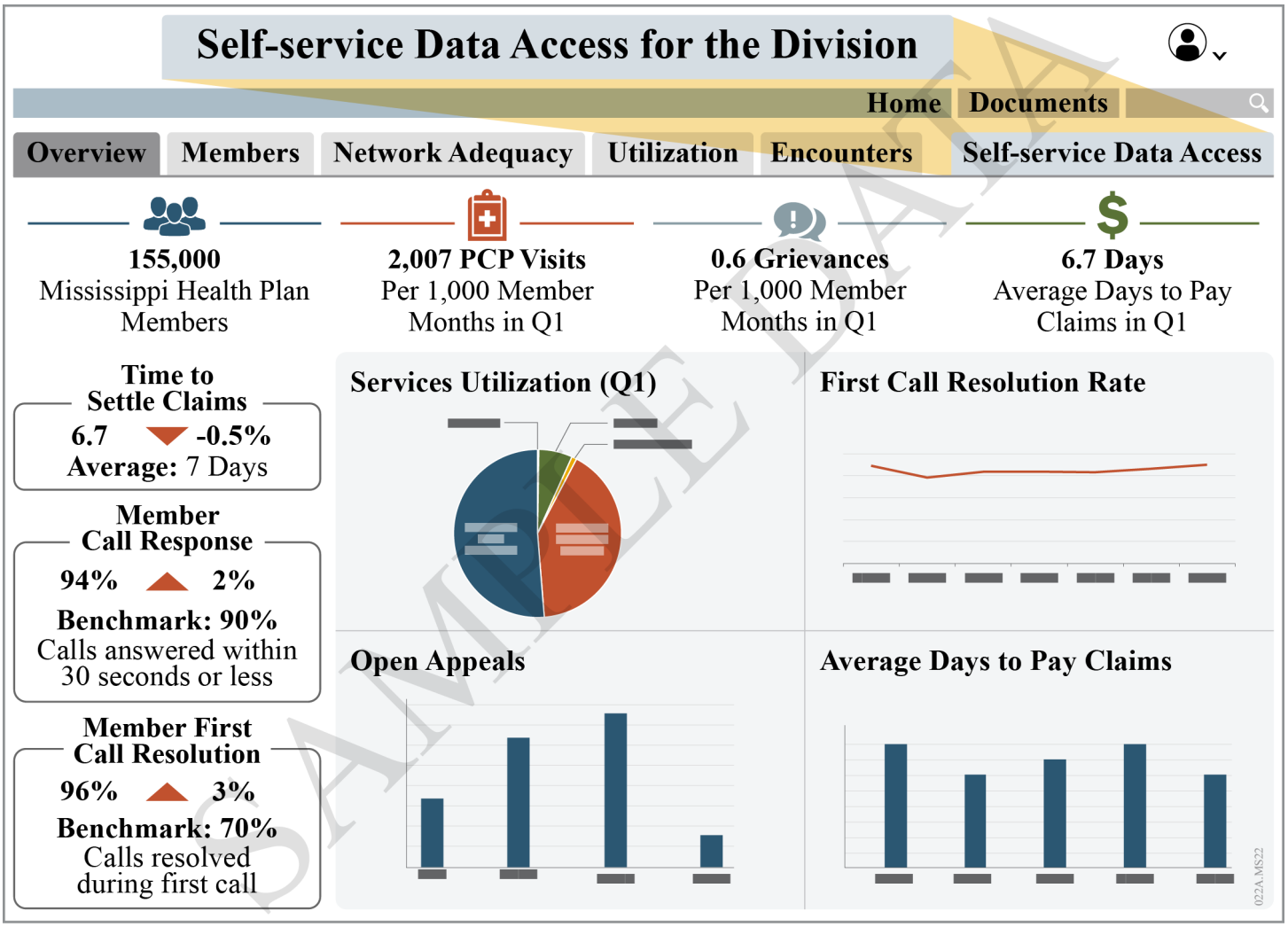
To help in analyzing trends and the improving the efficacy of initiatives and programs, authorized Division staff can view snapshots of key program data through a user-friendly interface accessible through our secured HIPAA-compliant Mississippi partner portal. Our goal is to make key areas of State reporting readily available and easily accessible in real time. **The Mississippi partner portal will leverage the same advanced and powerful technology as our internal executive dashboard, which our health plan leadership will use for complete oversight of CCO Program operations**.

We will work with the Division directly to ensure that we are addressing specific CCO Program needs. For example, if the Division would like to have data insights to monitor care for maternal and neonatal Members, we can create a dashboard so that the Division can view quality and cost of care data for these Members.

As shown in **Exhibit 2, *within the Mississippi partner portal the Division can access options that will provide access to all data relevant to care provided to Members***, including encounters, care management, population health management, utilization management, and quality data along with subcontractor data, which will be limited to and associated with the Division.

We welcome feedback from the Division on the Mississippi partner portal and would like to partner with the Division to review and tailor it, so we can further meet your needs.

Exhibit 2. Mississippi Partner Portal for the Division. We will deploy a customizable Mississippi partner portal that will enable the Division to access relevant program data through a web-based interface.



To support the Division in maximizing the value and capabilities of this tool, we will provide training to appropriate Division staff.

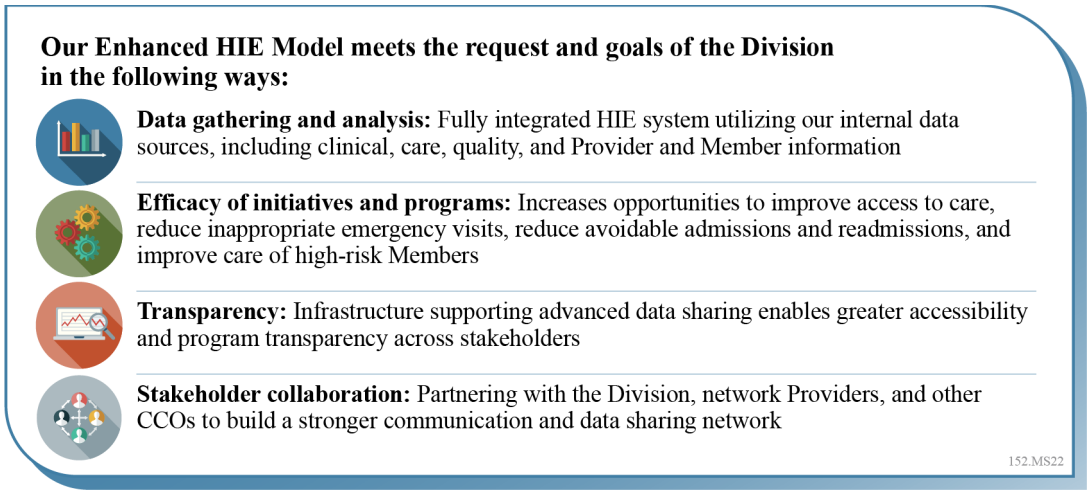
Enhanced HIE Model

In recognizing the strides that the Division is making to advance data exchange in Mississippi, we will extend our expertise, capabilities, and resources to develop a collaborative enhanced HIE model with the Division and other CCO Program stakeholders. To help facilitate improved interoperability of clinical data across the State, we will participate in both the statewide HIE and a regional HIE at no additional cost to the Division, as required by the Draft Contract.

Well versed in the promotion and use of electronic HIE, we have a comprehensive understanding of the current state of the Mississippi HIE. In partnership and collaboration with the Division, our technology and capabilities can be used to drive the future of innovation in the Mississippi HIE space and provide a greater level of program insight and transparency in support of the CCO Program.

Exhibit 3 provides an overview of our enhanced HIE model for Mississippi.

Exhibit 3. Enhanced HIE Model for Mississippi Synopsis. We will extend our expertise, capabilities, and resources to develop a collaborative Enhanced HIE Model with the Division and other CCO Program stakeholders.



We recognize the effort, investment, and resources required from the Division to support this project. In committing to a true partnership approach with the Division, we welcome the opportunity to engage with the Division to discuss the future state of the HIE and how we can best support an enhanced model that meets the specific needs of Mississippi.

The following demonstrates our understanding of and capabilities to support the current Mississippi HIE model. We also delve deeper into our extensive experience in the HIE space and detail how our innovative technologies can enhance the current Mississippi HIE model described below.

Current HIE Configuration for the CCO Program

To support technology requirements of the CCO Program, we will provide Member enrollment and clinical summary data to the Division. This exchange of health information is required to ensure that CCO Program Members receive continuity of care as they enroll or disenroll from health plans managed by us and other trading partners serving the MississippiCAN and CHIP populations in Mississippi. The scope of data for this project will include the following:

- Preparing and sending Member demographic information to the Division
- Receiving and processing clinical summary responses sent by the Division
- Preparing and sending clinical summary information to the Division

The following demonstrates our experience and technological capabilities that can support the advancement of data exchange in Mississippi thorough our enhanced HIE model.

Future-state Enhanced Mississippi HIE Model

Our advanced HIE integration platform and architectural capabilities enable us to transmit clinical data to the Division either directly to the Division's interoperability platform or through the Mississippi HIE. We can also interface with other operational systems, such as the MES/MMIS operated by the Division, as required by the Division, to access, inquire, and bidirectionally share information such as Member eligibility and enrollment, claims and encounters data, and Provider profiles and demographic data.

Encouraging HIE Participation

- Proven collaboration with state partners, HIEs, Providers and other CCOs
- Proactive solutions to address technological and financial barriers Providers may face
- Experience with incentive programs that reward Providers for connecting to HIEs

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The HIE integration platform is an aggregated intelligence application that provides real-time Member health data from different source systems and HIEs. The Member data in this platform can be amalgamated from different sources to support proactive Member care. Our internal HIE integration platform ingests HIE data and operationalizes it, providing real-time Member health information and integrating SDOH and population health systems into an actionable whole-person model of care. Our platform consumes data files, such ADT HL7 and Consolidated Clinical Documents, in real time to proactively facilitate and support Members.

Care management teams leverage our HIE integration platform for targeted Member interventions with the goal of improving population health outcomes, such as addressing level-setting of care and ensuring appropriate courses of treatment are provided to Members. As an example, over the last year, our affiliate health plans have tracked specific Member cohorts, such as those with high ER and hospital utilization. One of our affiliates tracked more than 3,000 emergency and hospital visits in the State, with 14.5% of visits showing a BH diagnosis. They used this data for Member outreach initiatives and transitions-of-care activities to determine appropriate level-of-care options. **As a result, our affiliate reduced ER visits by 70% and 30-day readmissions by 50% within these Member cohorts.** We will implement similar data initiatives in Mississippi.

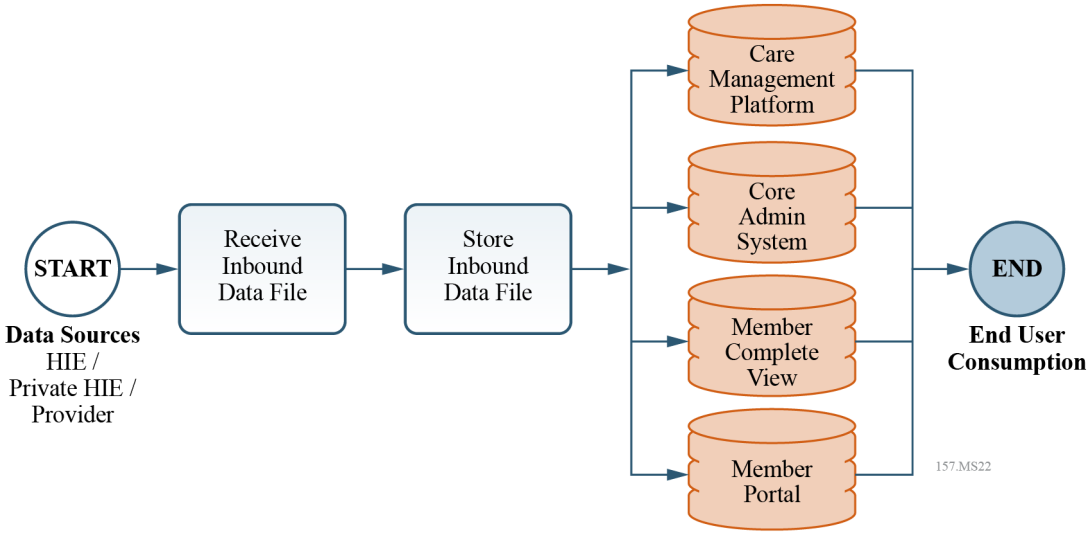
HIE Best Practices and Initiatives. Our affiliate health plans participate in State HIEs to support best practices and strategic initiatives that produce successful outcomes. **Table 2** provides examples of best practices and strategic initiatives our affiliates have led in partnership with HIEs that we anticipate extending within the Mississippi HIE.

Table 2. HIE Best Practices and Initiatives. As a leader and innovator in the HIE space, our affiliate health plans participate in State HIEs to support best practices and strategic initiatives that produce successful outcomes.

State	Best Practices / Strategic Initiatives and Outcomes
State HIE 1	Inclusion of Member social history data points in the clinical summary. **Outcome:** Supports SDOH State initiatives.
	Real-time notifications when patients are admitted, released, or transferred from ERs or hospitals to Providers to better manage care. **Outcome:** Enables HIE participation through VBP.
	Automated push of consolidated clinical documents when a PA request is received related to key diagnosis. **Outcome:** Timely response ensures the right care is delivered at the point of care.
State HIE 2	Community information exchange hosting a "shared care plan" accessible to authorized clinical and community partners across most accountable health communities. **Outcome:** Enhances care planning, timely access to data, and better health outcomes.
	Lead HIE data-sharing relationship established with prison system. **Outcome:** Provides historical medical insight on population to support treatment and care.

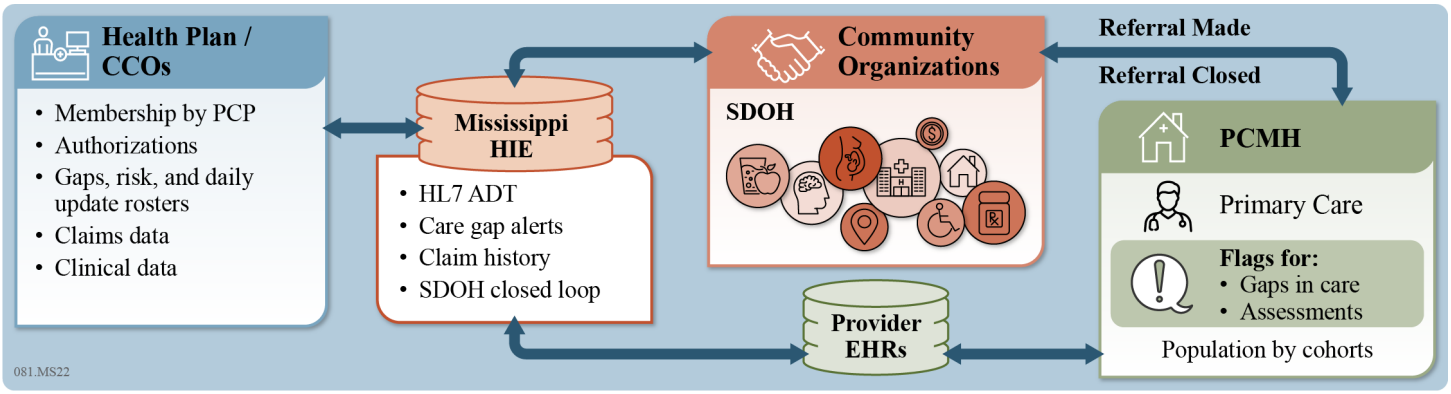
Exhibit 4 demonstrates the high-level inbound data business process diagram supporting our enhanced HIE model. This represents multiple HIE data sources we can consume, normalize, and make accessible across all aspects of the healthcare continuum.

Exhibit 4. High-level Inbound Data Business Process Diagram. Our enhanced HIE model is supported by a streamlined inbound data process that will enable us to consume, normalize, and make data accessible from multiple HIE data sources.



We will share data with the HIE and work diligently to encourage and incentivize further adoption of Member data exchange among Providers. Our enhanced HIE model, shown in **Exhibit 5**, will eliminate the need for multiple CCO registry applications from payers for Providers to log into; improve the ability to refer and track SDOH; reduce unnecessary ER utilization; and improve health outcomes for Members.

Exhibit 5. Enhanced HIE Model. The enhanced HIE model will share information at the point of care based on Provider needs, thereby encouraging HIE adoption and enabling VBP models.

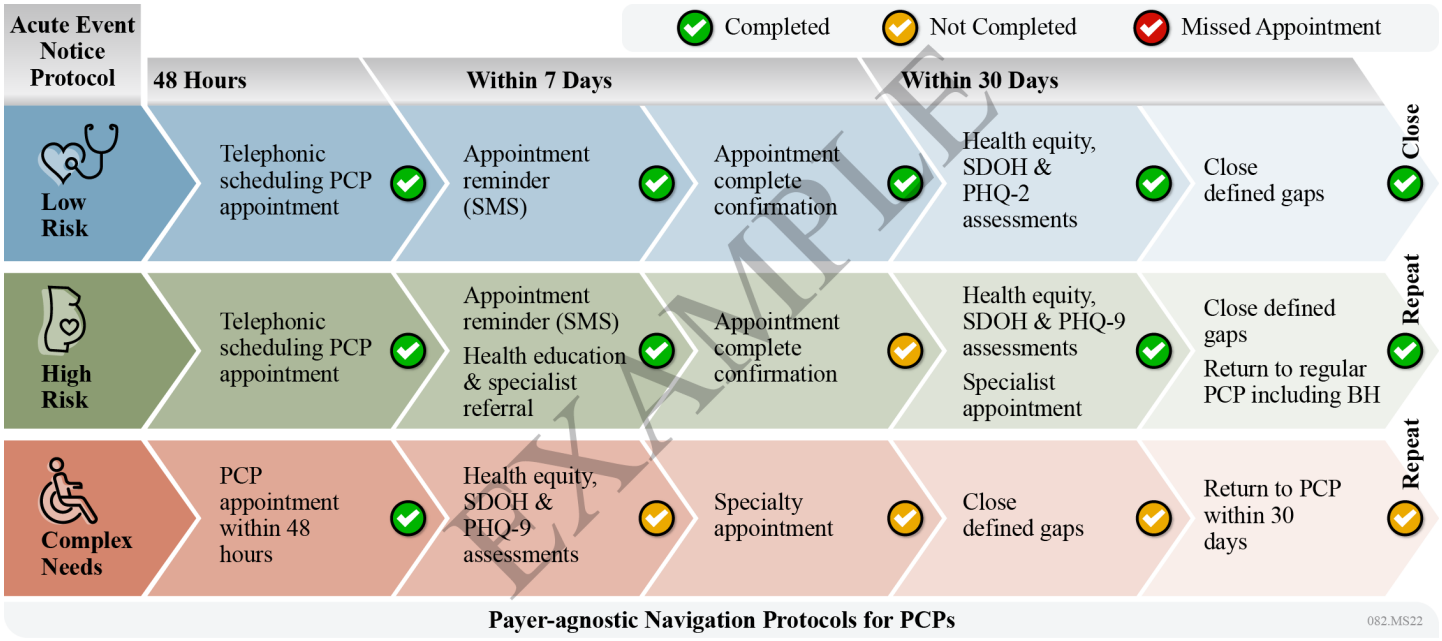


Our enhanced HIE model is informed by evidenced-based care transition models that have proven successful in reducing potentially preventable events and improving care quality. The model enables health equity principles, training, support, and accountability through single sign-on of third-party SDOH Providers and our SDOH referral system. This strategic solution will enable a closed-loop SDOH referral system for all Members to the Provider automatically through the HIE, thus increasing HIE adoption and utilization. We are also able to use other referral systems used by the State, such as the My Resources referral system put in place by MDHS.

The Mississippi enhanced HIE model will focus on the four pillars of performance that are critical for improving community health outcomes: improving access to care, reducing inappropriate ER visits, reducing avoidable admissions and readmissions, and improving care of high-risk Members. The model's core principles include ongoing measurement and refinement of processes and outcomes against goals defined within our VBP Provider programs. We will incorporate measures to ensure network Providers continue to, or initiate measures to, contribute Members' clinical data to the HIE according to policies and standards set forth by the HIE. All Providers can participate in a baseline post-acute care navigation protocol under either a low-risk or a high-risk navigation model that is supported with VBP.

Exhibit 6 is an example that demonstrates the relationship with PCPs and provides suggested activity post-acute event within a specific time frame. This example is based on national best practices that reduce potentially preventable events and improve quality.

Exhibit 6. Example Acute Event Notification Protocol. Under the Mississippi enhanced HIE model, Providers can participate in a navigation protocol that provides recommended actions and timelines for suggested activity post-acute event.



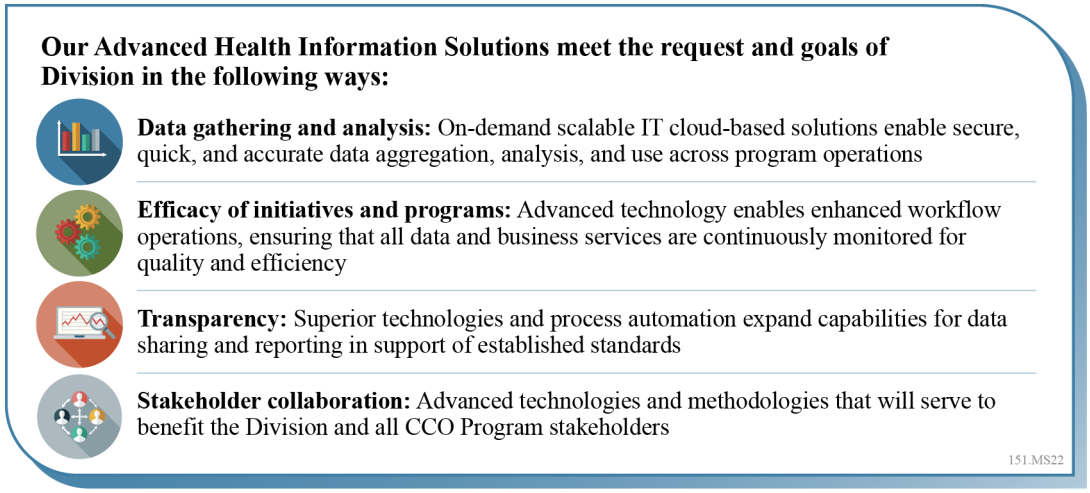
As an innovator in health technology, we are strong advocates for the promotion and use of HIE across program stakeholders. We are dedicated and committed to increasing capabilities for timely access to and transmission of available information to help improve health outcomes and reducing unnecessary utilization. Our organization is highly experienced in the HIE space and our affiliates have collaborated to define and implement HIE technology and data exchanges. We will bring these innovations and proven practices to Mississippi.

Advanced Health Information Solutions

Our investments in our **ongoing IT digital journey** has transformed our technology solutions. In support of the CCO Program, we will deploy and leverage advanced technologies and methodologies that serve to benefit all stakeholders. In this way, we will consistently demonstrate to the Division our commitment to collaboration and innovation.

Exhibit 7 provides an overview of our advanced health information solutions for Mississippi.

Exhibit 7. Advanced Health Information Solutions Synopsis. Our advanced health information solutions meet or exceed State and Federal requirements, supporting the Division's CCO Program needs across the care continuum.



Our advanced health information solutions enable us to deliver services securely, quickly, and accurately within embedded development processes, such as robotic process automation and DevSecOps, effectively removing manual, repetitive operational processes. This ensures the stability and security of our operations and bolsters our ability to deliver operational and service excellence leveraging our advanced health information solutions. **As a result, our 12-month average availability for major systems is 99.99%, with a recovery time objective of 0-to-24 hours.**

We are proud to showcase that our advanced health information solutions meet or exceed State and Federal requirements, fully supporting the Division's CCO Program needs across the care continuum. As detailed in **Table 3,** our technology solutions for the CCO Program truly differentiate us from other CCOs and add measurable value to the Division, Members, Providers, and other key stakeholders.

Table 3. Advanced Health Information Solutions. We proudly showcase that our advanced health information solutions meet or exceed State and Federal requirements, fully supporting the Division's CCO Program needs across the care continuum.

Innovative Technological Methods	Description of Key Innovation	Benefit to Program
IT Cloud	In 2020, **we began hosting all core technology systems and operations on an IT cloud.** We distribute technology systems and services across our IT cloud regions, which are composed of multiple geographic locations, meaning users will not experience outages outside of scheduled maintenance periods. Our IT cloud enables us to quickly and reliably implement our systems and services.	• Systems built for resiliency, stability, and scalability • Enables a greater level of security, such as our zero-trust security model • Expanded capabilities for data sharing
API Gateway	Our FHIR-enabled API gateway is a single, unified platform for data aggregation. It uses industry-leading technology to govern real-time integrations with built in security controls at the application layer in our zero-trust security fabric, which maintains strict access controls, thereby promoting greater security throughout the network. We have deployed an API gateway in the IT cloud, which ensures that both data and business services are highly reliable, secure, integrated, and monitored, 24/7/365. All systems and services are linked to identity management and OAuth 2.0 security for both individual and system-to-system authorization.	• Helps ensure Members have timely access to care from program day one • Enables us to pay claims accurately, timely, and within State guidelines • Reduces risk by ensuring all systems have been thoroughly reviewed for security and compliance considerations • Allows us to scale our infrastructure in an agile, efficient, and cost-effective manner, ultimately providing program savings to the Division through reduced administrative costs
Zero Trust Security Model	We actively and continuously strengthen our security posture and underlying security fabric. As a result, we have incorporated an advanced and contemporary security model known as zero trust, which, by default, maintains strict access controls that question the presence of even those who already have access to a network.	• Enables greater overall network security and data privacy and decreases the likelihood of data breaches • Closes potential vulnerabilities and more stringently controls authorized access to data and at level of access
Client Relationship Management Platform	Our integrated solution enables us to deliver a superior Member journey by delivering individualized services tailored to their specific needs. It provides a digital Member experience leveraging multiple channels of inbound and outbound communication that take into consideration fully integrated system Member views. Our team leverages our client relationship management platform as a source of real-time data to personalize the Member experience when assisting them in finding a Provider based on individual need.	• Connected, high-touch Member experience, through the following: – **Omni channels**. mobile, web, voice, chat, and social – **Digital self-service.** Automatic voice response and voice and chat bots – **Actionable engagement insights and cognitive intelligence.** Customer personas, natural language recognition, and speech-to-text • Enables cross-functional teams access to crucial data to make smarter, faster decisions
Eligibility & Enrollment Gateway	Our AI-driven, on-cloud eligibility & enrollment gateway leverages next-generation software to transform Member enrollment business processes while reducing administrative costs and improving Member access to care. Our eligibility & enrollment gateway serves as a master system of record, fully supporting and automating all elements of the enrollment and eligibility process, including automated file management, Member coverage determination, premium reconciliation activities, rules management, and reporting.	• HIPAA compliant to ensure highest information and data security • Predictive analytics targeted toward driving actionable insights and reporting • API integration through microservice-based scalable architecture allowing for tightly integrated services with our State partners

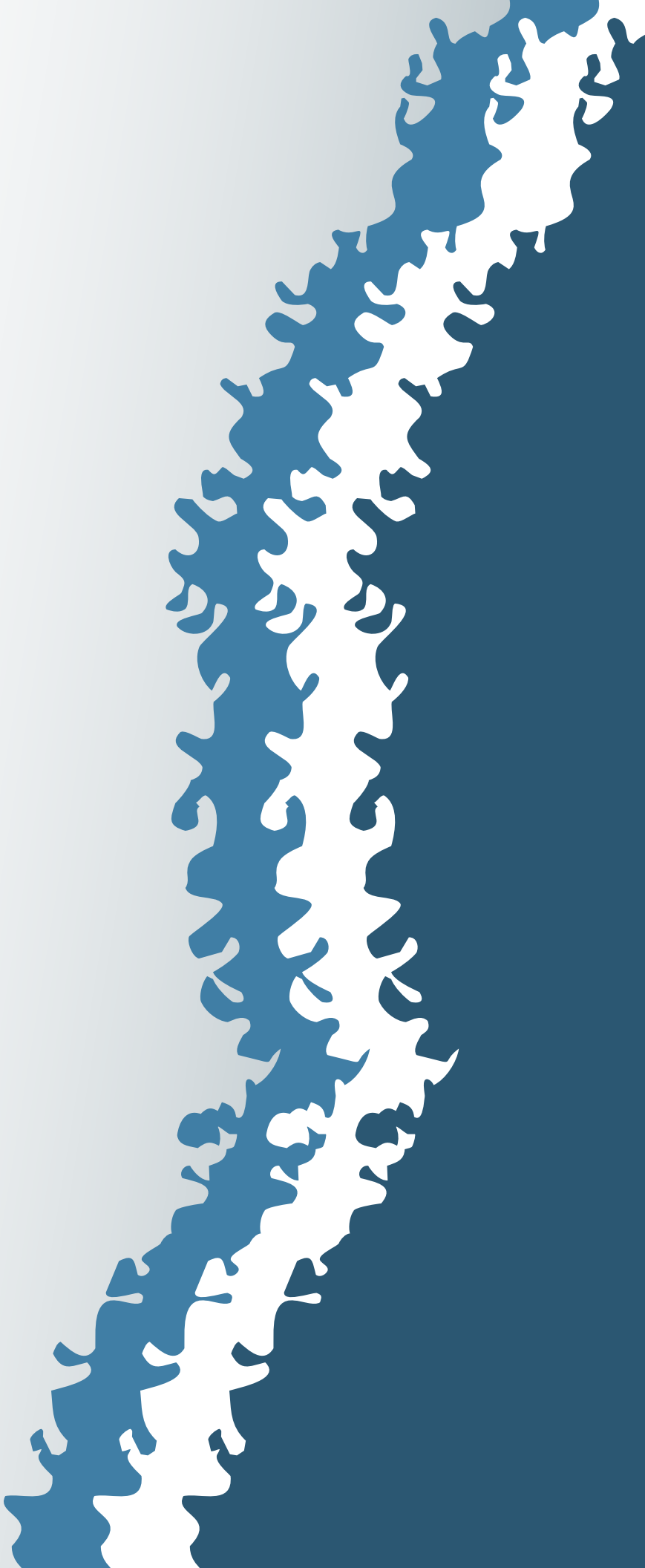
Innovative Technological Methods	Description of Key Innovation	Benefit to Program
Claims KPI, Accuracy and Improvement	In support of the CCO Program, we will implement an expedited quality and accuracy process to ensure our claims KPI standards exceed requirements. With this process in place from receipt of an auto-adjudicated claim to Provider payment, **our claims processing system and operations will enable us to pay more than 99% of clean claims within 30 calendar days, and more than 99.9% of clean claims within 90 calendar days.**	• Expedited quality and accuracy process ensures we will greatly exceed program KPI requirements and maintain stringent compliance • Enhanced workflow and process monitoring significantly reduce the potential for processing errors and delay

All applications and systems are currently implemented and integrated, and will be operational by readiness review.

[END OF RESPONSE]

4.2.3.9

Potential Partnerships



UNMARKED

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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Mississippi Division of Medicaid Coordinated Care Organization Program

MANAGEMENT QUALIFICATION

Response to: RFQ # 20211210

March 4, 2022 at 2:00 PM CT

Submitted by:

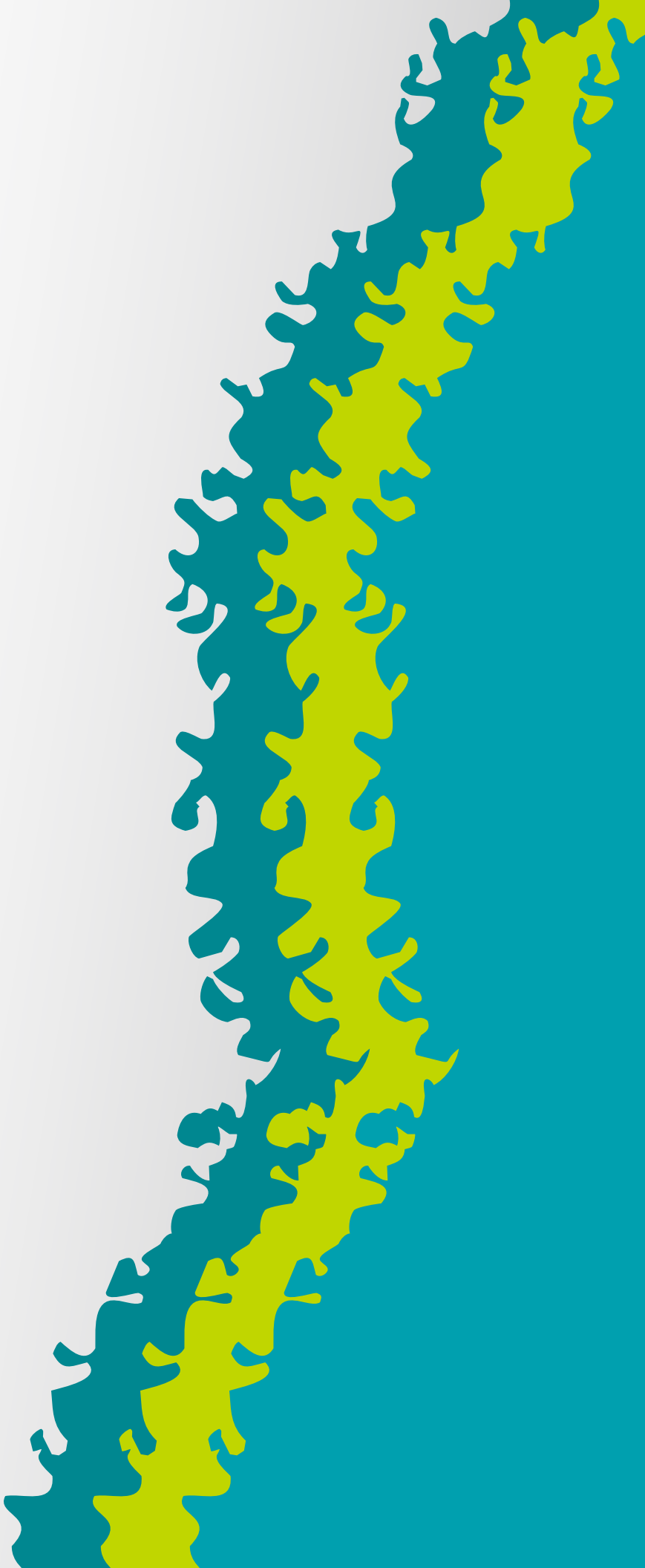
Molina Healthcare of Mississippi, Inc.

TABLE OF CONTENTS

4.3 Management Factors (Marked)

4.3.1

Corporate Background and Experience



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4.3.1 CORPORATE BACKGROUND AND EXPERIENCE

Molina Healthcare of Mississippi, Inc. (Molina), is a wholly owned subsidiary of Molina Healthcare, Inc. (Molina Healthcare), an experienced leader in providing quality healthcare for government-sponsored healthcare programs. Molina Healthcare and its affiliated Medicaid health plans manage Member-centered, community-focused, and cost-effective plans that have consistently shown meaningful gains in Member access to care and health outcomes for nearly 30 years. What began in 1980 as a single clinic has blossomed into a Fortune 500 healthcare leader serving approximately 5.2 million Members in 19 States.

For the Division's CCO Program, Molina Healthcare will provide resources and support to us as a Subcontractor with delegated services ranging from legal affairs and finance to centralized clinical utilization management (UM) services and call center overflow. Details about Molina Healthcare and its prior experience as our Subcontractor are presented in our response to RFQ §§ 4.3.2.1, Information to Be Disclosed, and 4.3.3.5, Subcontractors (forms provided in Appendix H).

The Division's decision to integrate MississippiCAN and CHIP services into a single CCO Program signals their desire for a collaborative partnership with CCOs to improve Member health, quality of life, and equity while maximizing the use of finite taxpayer dollars. As a current MississippiCAN and CHIP health plan that is deeply aligned with the Division's goals, we are that partner. Over the past five years, we have achieved multiple successes, such as building robust Provider networks and establishing relationships with hundreds of community-based organizations (CBOs) across the State. We have executed contracts with urgent care centers, allowing them to provide primary care to Members, and we have expanded telehealth services to use video conferencing for medical care normally classified at a level commensurate with primary care and urgent care. We count the following among our most significant achievements since beginning services delivery in the State:

- Our comprehensive Neonatal Care Management program, which focuses on high-risk pregnancy detection with the goal of a healthy and safe return home for mother and baby together, has reduced readmission rates and emergency room (ER) visits by more than 50% and sustained program participation of 65% through the first year of the baby's life.
- Our response to the COVID-19 public health crisis has been swift, multifaceted, ongoing, and responsive to the Division's request for assistance.
- The successful rollout of our Pay-for-Performance program, which began in Q1 of 2021 with just two Providers and increased to almost 1,100 Providers by Q2 2021, has resulted in opportunities for Providers to begin to address gaps in care for the more than 90,000 Members assigned to them through the program.

Our commitment to Mississippi is much more than rhetoric. We are resolute in our mission to improve the lives and health of Mississippians and, as described throughout this response, we have the background, experience, and passion to be of service to the Division, Members, and Providers in the new Contract.

[END OF RESPONSE]

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.

Biographical Information				
General Background Information				
Date Business was Established: 03/02/2009				
Legal Business Name as Reported to the Internal Revenue Service: Molina Healthcare of Mississippi, Inc.				
Doing Business As Name (if applicable): N/A		**Tax Identification Number (required):** 26-4390042		
Ownership Type (public company, partnership, subsidiary, etc.): Wholly owned subsidiary of Molina Healthcare, Inc.				
Number of Personnel Currently Engaged in Operations: 172		**Total Number of Employees:** 172		
Professional accreditations pertinent to the services provided by this RFQ: NCQA Interim Health Plan Accreditation since August 2020; renewal survey scheduled for February 2022 to achieve NCQA Health Plan Accreditation for three years				
Location of the Principal Place of Business				
Address Line 1 (Street Name and Number): 188 E. Capitol St.				
Address Line 2 (Suite, Room, etc.): Ste. 700				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Mailing Address (P.O. Box): 188 E. Capitol St.	**City:** Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds
Location of place of performance of the proposed Contract				
Address Line 1: 188 E. Capitol St.				
Address Line 2: Ste. 700				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Contractual Termination				
Has the Offeror been a party to any contractual termination within the past five (5) years? [ ] Yes [X] 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]

4.3.1.1.2 CORPORATE RESOURCES

As a subsidiary of a Fortune 500 company fully dedicated to government assistance programs such as Medicaid and CHIP, Molina brings an unparalleled breadth and depth of national knowledge and best practices to the CCO Program. Our company name and established presence in Mississippi are invaluable assets as we continue our partnership with the Division. And, as a current health plan for MississippiCAN and CHIP, we have the experience, locally based staff, and strong relationships with Providers, CBOs, hospitals, and educational institutions to ensure a seamless implementation of the new Contract.

In this response, we are pleased to have the opportunity to describe the range of resources, products, and services that position us as a successful CCO Program health plan. Our computer and technological resources are best-in-class, and our current products and services support the same populations as the CCO Program does. We offer the Division an impressive array of unique and/or innovative resources—namely, our people, our financial commitment to Mississippi, a variety of key products and services, and assets such as Member- and Provider-facing IT apps and platforms. Finally, we point to our parent company, Members, Providers, the Division, and program stakeholders as the critical additional resources that allow us to do what we do best: meet Members where they live, work, and raise their families, so we can help them improve their health and lives.

Computer and Technological Resources

Molina Healthcare's computer and technology investments alone have exceeded $1 billion over the past four years, demonstrating a corporate commitment to amplifying the stability, security, and scalability of IT platforms and helping each affiliate health plan elevate service delivery processes. As an organization focused on government-sponsored programs, we have the infrastructure and expertise to quickly integrate IT apps and platforms to better respond to the needs of Members and Providers.

This section summarizes our IT solutions for the CCO Program. In addition, we provide an overview of our IT asset management, computer services, and workforce connectivity initiatives designed to prevent any disruption to employees that could affect service delivery to Members.

Our computer and technology resources are designed to prevent any disruption to our workforce that could affect Members.

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Technology that Meets the Needs of the New Contract

Molina's existing IT systems will fully support CCO Program goals by:

- Identifying and stratifying populations by specific needs to drive effective, quality-based, targeted interventions and support cross-system collaboration
- Addressing health disparities and barriers to access, whether geographic or based on social determinants of health (SDOH)
- Delivering quality-focused analytics, actionable insights, and data transparency to drive value through and transformation across the health system
- Empowering stakeholders with broad data sets to ensure active engagement in Members' health
- Providing consistency and easing administrative burden for both Providers and Members
- Supporting our high-performing value-based purchasing (VBP) program for our network of care
- Leveraging our technological capabilities to support a unified health service delivery system through collaboration with the Division, Members, Providers, and other stakeholders

Our experience and commitment to ongoing technological innovation differentiates us from our competitors. In **Exhibit 1**, we give examples of IT solutions and how they will benefit Members, Providers, and the Division. For a complete list of our IT resources for the new Contract, see our response to RFQ § 4.2.2.6, Information Technology.

Exhibit 1. Examples of IT Resources. We leverage our vast array of IT solutions to enhance service delivery to Members and Providers.

IT Innovation	Description	Benefits
Expanded Telehealth Services	Our telehealth program leverages a broad range of various remote technologies and methods to provide Member access to healthcare services across a wide spectrum of health disciplines. We will use telehealth to increase access to physical health and behavioral health (BH) services through local telehealth resources, major health	• Expanded access to care, reducing unnecessary ER and inpatient utilization, and enhancing overall health among Members • Greater range of virtual health services by increasing Provider types

IT Innovation	Description	Benefits
	systems within the Mississippi network, and certified telehealth Providers.	
Remote Patient Monitoring	We will cover ***remote patient monitoring*** for Members with chronic conditions. such as asthma, diabetes, hypertension, heart disease, COPD, and cancer, as well as high-risk pregnancies. This will allow Members to actively engage in their healthcare and improve adherence to treatment plans and health outcomes.	• Improved health outcomes for Members with complex conditions • Improved self-management and adherence to care plans • Improved data-driven clinical decision-making
SDOH Closed-loop Referral System	Our SDOH referral system provides ***closed-loop referrals to connect Members to services and social programs that address SDOH issues*** in our communities, such as access to food, housing, and transportation. It also allows us to monitor and ensure appropriate delivery of services to Members.	• Closed-loop SDOH referral system to connect Members to services • Population health program services
Automated Criteria-based Prior Authorization (PA) Process	Through an enhanced, auto-expedited workflow and already established protocol, our automated, criteria-based PA process allows specific CPT®/DX codes to be reviewed and approved more quickly and efficiently. Once a PA is received from a Provider with a select PA code identified, a care reviewer processor is allowed to check for all the required supporting documentation. Once verified, the care review processor can authorize the PA based on the already established protocol guidance.	• Reduced turnaround time for quicker PA decisions • Data to determine over/underutilization of services
Automated Electronic Health Record (EHR) Access for 278 PA Transactions	This process allows for ***electronic transfer of information between the Provider and CCO digital platforms***, which enables both organizations to streamline the PA process and lay a foundation for future automation of the process.	• Moves a greater volume of PA transactions from fax to electronic data transmission • Reduces turnaround time for quicker PA decisions
VBP	We will incorporate VBP payments to enhance performance by healthcare Providers. VBP holds healthcare Providers accountable for both the cost and quality of care they provide, reducing inappropriate care and identifying and rewarding the best-performing Providers. ***The VBP program will incentivize the Provider with a flat payment per episode of an agreed-upon, measurable metric.*** We will adjudicate claims and send value-based reimbursement directly to the Provider.	• VBP opportunities for Providers • Reduces inappropriate care • Identifies and incentivizes best-performing Providers
Mississippi Partner Portal	As a part of our commitment to program insight and data transparency, our Mississippi Partner Portal is a secure and compliant web-based interface customized to the Division's interests. ***The Division will be able to access data relevant to care provided to Members, including encounters, care management, UM, and quality data, along with Subcontractor data, which will be limited to and associated with the Division.*** We welcome feedback on the dashboard from the Division and would like to partner with the Division to review and tailor it so we can further meet your needs.	• Authorized Division staff can view snapshots of key program data and performance indicators 24/7/365, extending program transparency • Makes key areas of program reporting readily available and easily accessible as a supplement to our State-mandated reports • Greater program insight through data access and transparency
Health Information Exchange (HIE) Integration Platform	Our advanced platform and architectural capabilities enable the transmission of clinical data to the Division through either direct transmission to the Division's interoperability platform or through the HIE. We can interface with other operational systems—such as MES/MMIS operated by the Division—as required by the Division to access, inquire, and bidirectionally share information, such as Member eligibility and enrollment, claims and encounters data, and Provider profiles and demographic data. We also can partner with the Division to establish an enhanced HIE model that ***will eliminate the need for multiple CCO registry applications, improve the ability to refer to and track SDOH, reduce unnecessary ER utilization, and improve health outcomes for Members.***	• Interoperability • Care coordination • Supports current-state HIE requirements • Enhanced future-state HIE model
Reporting Enhancement Initiative	We will implement an expanded internal quality process to enhance reporting. Each reporting type will have a team responsible for generating the report and adding data, with oversight from a department head. We leverage an internal dashboard for tracking areas of inconsistency and expediting the correction process.	• Expanded internal quality process to improve reporting • Minimizes the potential for errors in reporting • Enhanced reporting workflow

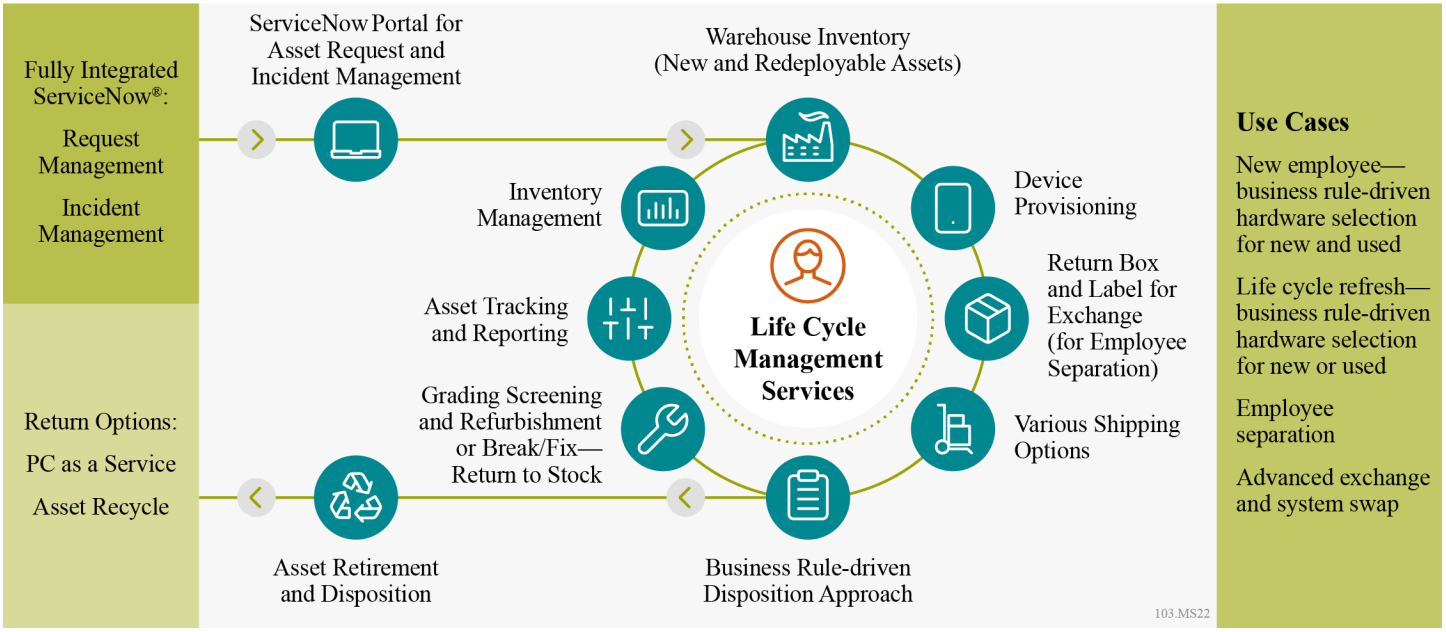
Best-in-Class Asset Management and Computer Services

Molina Healthcare has made significant investments to establish best-in-class asset management and computer services for employees across the enterprise. Through a partnership with our supply chain vendor, Dell Technologies—***the first and only such partnership in managed care***—Molina Healthcare has created a fully integrated Life Cycle Service Delivery and Personal Computer (PC) as a Service deployment model (see **Exhibit 2**) to support data collection and the delivery of information to decision-makers. Enterprise-wide benefits of this model include:

- The ability to burst fulfillment capabilities up to 1,000 computer shipments per week
- Increased warehouse capacity to stock more than 3,000 computers and more than 6,000 monitors
- Shipment of computers and monitors to the employee's home address within one business day of request
- Tracking and management of employee computer systems with a 3-year refresh cycle to ensure employees have the most current Windows -based laptops and accessories

For the CCO Program, this model gives us the ability to quickly meet the demands of onboarding new employees to support delivery of services to Members, Providers, the Division, and other stakeholders.

Exhibit 2. Life Cycle Services Built by Molina. Technology processes are aligned with the asset life cycle to enable data collection and deliver relevant information to decision-makers.



At the foundation of all computer technology—and always our first consideration with any computer in the environment—is the ability to meet our stringent internal security protocols and Federal/State requirements. Molina Healthcare ensures every computer in the environment is secure from external threats by deploying world-class security tools and Federal Information Processing Standard 140-2 protocols for encryption at the computer bios layer to every computer. Leveraging the robust features of endpoint/zero trust security software from Absolute® Software Corporation, ***we maintain total control over all computer data and endpoints to protect Members' PHI and personal identifiable information.*** We can view and manage each computer for encryption and anti-malware, and we can remotely freeze or completely wipe hard drives regardless of the device's connectivity (or lack thereof) to the Internet.

Molina Healthcare's Service Desk provides same-day resolution of computer and IT issues more than 90% of the time, which is well above industry standards.

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Computer technology governance oversight is well established through corporate policies and procedures and is led by Molina Healthcare's Chief Compliance Officer; Chief Information Security Officer; Chief Information Officer; Director, HIPAA and Privacy Officer; and Director, Security Services. For the CCO Program, oversight is the responsibility of our Compliance Officer, who is fully supported by the computer and technology resources and leadership/staff at Molina Healthcare.

Enhanced Service Desk Access and Support. Molina Healthcare has further transformed our ability to support our computer environment with a Service Desk operation staffed completely onshore in all time zones for all affiliate health plans. To support quick resolution of computer and IT issues, the Service Desk is staffed during normal business hours and even during holidays. Our access to this level of IT support provides assurance to our staff and the Division that technical issues will not create delays in access to care, care coordination activities, UM, PAs, and other program functions.

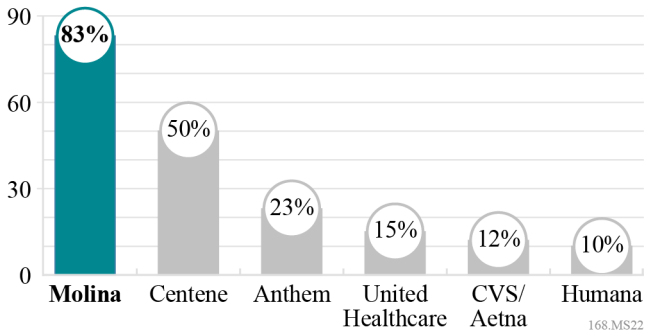
Connectivity from Outside the Office

To ensure connectivity outside the office—and to support staff efficiency and collaboration regardless of staff location—our employees have secure web-based access to Molina's systems through secure VPN connectivity. We also provide company-issued cell phones with "hot spot" Internet connectivity, so staff can easily communicate with Members and Providers while in the field.

Current Products and Services

State governments and Federal agencies trust Molina Healthcare to provide a wide range of quality services to families and individuals enrolled in Medicaid (including CHIP), Medicare, and Marketplace health plans. Unlike its healthcare competitors with both commercial and government books of business (see **Exhibit 3**), Medicaid is Molina Healthcare's primary focus. More than 83% of Molina Healthcare's business is dedicated to serving vulnerable populations (per year-end 2021 public earnings data).

Exhibit 3. Comparison of Health Plans' Focus on Government-sponsored Healthcare Programs. More than 83% of our business is dedicated to serving vulnerable populations.



In this response, we describe our current products and services in Mississippi and those of our affiliate health plans across the US. Through this diverse portfolio of products and services, we help Members manage existing conditions and, most importantly, provide them with the tools, information, and resources to proactively self-manage and focus on preventive measures that deliver results.

MississippiCAN

We have been a MississippiCAN health plan since October 2018. We provide or arrange for healthcare services to Medicaid Members eligible for TANF and CHIP services. The scope of benefits includes coordination and approval of all medically necessary services, preventive care, claims processing, Member services, Provider relations, and network development. As of December 31, 2021, we serve 80,899 MississippiCAN Members.

Mississippi CHIP

We have been a Mississippi CHIP health plan since November 2019. The scope of benefits we provide or arrange for eligible CHIP Members includes coordination and approval of all medically necessary services, preventive care, claims processing, Member services, Provider relations, and network development. As of December 31, 2021, we serve 14,125 CHIP Members.

Affiliate Health Plans

Molina and our affiliate health plans in 19 States deliver risk-based managed care services to approximately 3.8 million Medicaid and CHIP Members and a total of 5.2 million combined Medicaid (including CHIP), Medicare, and Marketplace Members. Products and services are described below.

Medicaid

Our parent company and affiliate health plans serve approximately 3.8 million Medicaid Members through TANF; ABD; CHIP; Medicaid Expansion; Intellectually and Developmentally Disabled; Serious Mental Illness (SMI); LTSS; and Medicare-Medicaid Plan (MMP) programs.

Medicare

Our parent company serves 683,000 Medicare Members through Medicare Advantage; Dual Eligible Special Needs Plans (D-SNPs); MMPs; and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs). In the

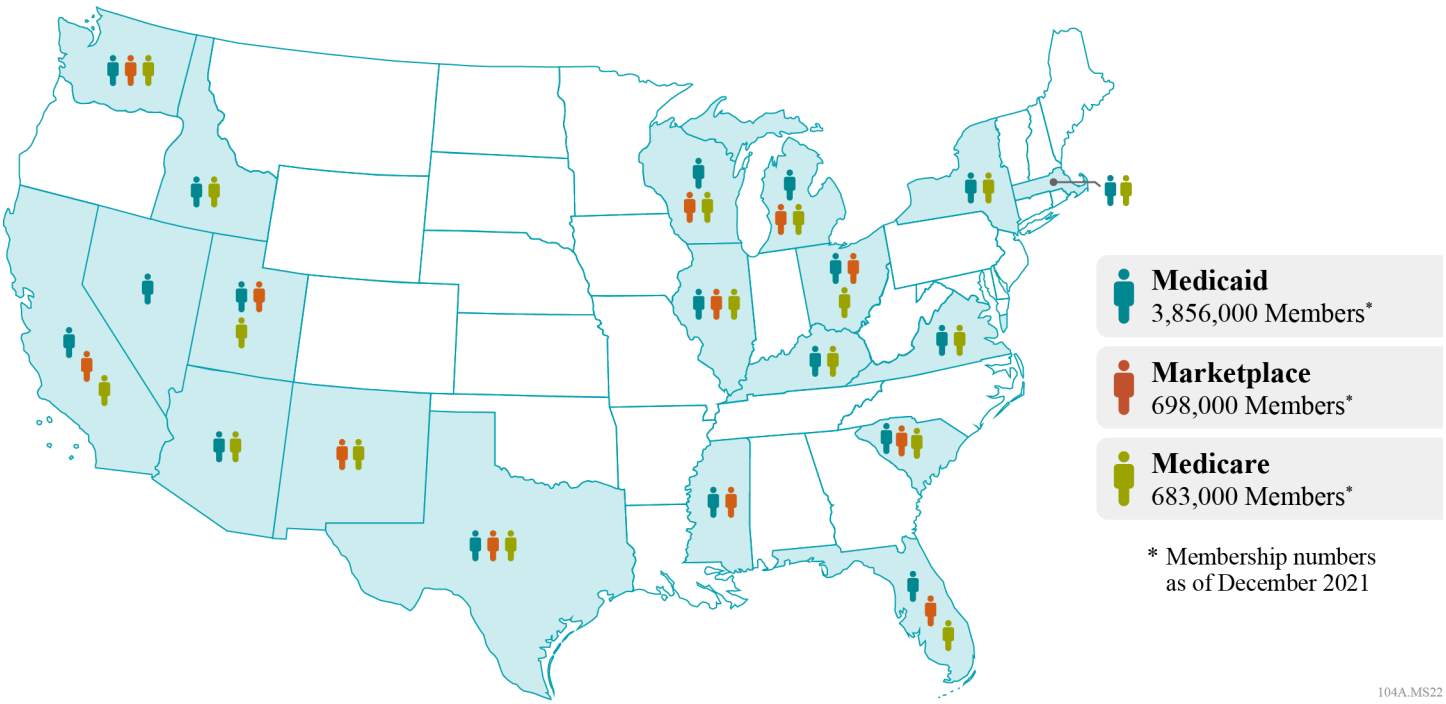
MMP and FIDE-SNP programs, our affiliates administer all Medicare- and Medicaid-covered services, including State programs such as home- and community-based services, and use a model of care that integrates healthcare to address Members' physical health, BH, and SDOH needs.

Marketplace

Our organization serves 698,000 Members through Marketplace plans in 14 States where it has Medicaid health plans, remaining fully committed to these strategically important programs to serve Members and extend our company's mission.

Exhibit 4 illustrates the States with current Molina Healthcare subsidiary health plans and total membership in Medicaid, Marketplace, and Medicare plans.

Exhibit 4. Molina Healthcare's Membership and Program Coverage. *Nationwide, we serve 5.2 million Members in 19 States.*



Intangible Assets

The US Generally Accepted Accounting Principles (GAAP) definition of intangible assets ***is identifiable nonmonetary assets without physical substance, such as customer lists, brand name, data, and workforce.*** Consistent with GAAP, we do not record internally generated intangible assets on our balance sheet—and our organization has not been involved in a business combination/acquisition that would require us to assign a fair value to our assets. From the accounting perspective, Molina Healthcare has no intangible assets on its balance sheet.

We do, however, have multiple resources—all with no physical substance—that we categorize as intangible assets because they have long-term value for our business. These assets are described in the following paragraphs.

Company Name and Reputation. When Dr. C. David Molina, an ER physician, noted an influx of ER patients for common illnesses, such as a sore throat, because they were being turned away by doctors who would not accept Medicaid insurance, he established his first primary care clinic. That was more than 40 years ago. His goal was to treat the lowest income patients regardless of their ability to pay, and that goal remains the primary focus of Molina Healthcare and its affiliate health plans to this day. Our Molina name in Mississippi and our relationship with Molina Healthcare are synonymous with that commitment.

Company Organizational Structure. Molina's horizontal organizational structure reflects the value we place on teamwork, collaboration, creativity, and open channels of communication. Unlike a vertical organization's multiple management levels and strict chains of command, our company's structure has just one management

level between our Chief Executive Officer (CEO) and the directors, managers, supervisors, and other skilled staff who will administer the CCO Program. This organizational structure works for Molina because of our size and the quality of our staff. With more than 170 employees as of January 2022, we are small enough that our teams function effectively, yet large enough to hire and retain individuals with highly specialized skills and qualifications. Our screening and hiring processes for new employees ensure the selection of individuals who can work both collaboratively and independently, while ongoing staff training reinforces the value we place on flexibility and creativity. ***The value of our organizational structure is reflected in our low staff turnover rate of just 4.3% in 2021 compared to an industry average of 25%.***

Contracted Provider Network. As of January 2022, we have networks of 18,461 unique MississippiCAN and 17,636 unique CHIP Providers. Our Provider Services Agreements with network Providers will continue uninterrupted into the new Contract. Provider satisfaction with Molina is high, with the results of a 2021 survey indicating that more than 4 out of 5 Providers would recommend us.

Relationships with Mississippi Hospital Systems and Educational Institutions. As of January 2022, we have Hospital Services Agreements with 185 hospitals for MississippiCAN and 170 hospitals for CHIP, all of which will continue uninterrupted into the new Contract. (The hospital counts include additional hospital units such as psychiatric and inpatient rehabilitation units.) We also have initiatives in place to collaborate with hospitals and educational institutions to improve access to care and Member health outcomes. Examples include:

- Care Management RNs working with NICU units at the University of Mississippi Medical Center (UMMC), North Mississippi Medical Center, and Le Bonheur Children's Hospital to provide education and support to the families of NICU babies during their hospitalization and after discharge
- Partnering with UMMC and our national telehealth Provider to deliver Member access to telehealth virtual care services across a wide spectrum of health disciplines
- Partnering with UMMC's Center for Telehealth Project ECHO® (Extension for Community Healthcare Outcomes) to virtually link expert specialist teams at academic hubs to mentor, share expertise, and create ongoing learning communities where PCMHs receive support, develop skills, and provide comprehensive care to Members with complex conditions
- Partnering with UMMC and the University of Mississippi School of Nursing to provide access to healthcare for families where they live by funding the university's mobile clinics for nine weeks during the summer, when school-based clinics are normally closed

Company's Incorporation in Mississippi. Molina was incorporated in Mississippi as Molina Healthcare of Mississippi, Inc., on March 2, 2009. We are a for-profit corporation in good standing, and we file annual reports in compliance with Mississippi Secretary of State requirements. Incorporation status gives us benefits, such as asset protection through limited liability and a corporate identity.

Active Insurance License in Mississippi. Molina was issued a Health Maintenance Organization insurance license by MID on January 19, 2018. This license allows us to provide healthcare services in Mississippi in compliance with applicable State laws and regulations.

NCQA Accreditation. Molina has achieved interim NCQA Health Plan Accreditation for an 18-month period, which was based on policy and procedure review. We will be going through our renewal survey in February 2022 to achieve Health Plan Accreditation for three years. NCQA accreditation is a significant asset because it provides an impartial opinion about the quality of our services and a determination that our health plan's practices meet national standards.

Mississippi Leadership and Staff. All current Mississippi-based leadership and staff will transition to the new Contract. Our local presence, in-depth knowledge of MississippiCAN and CHIP, and established working relationship with the Division create an environment in which implementation of the CCO Program will occur efficiently and with no disruption to Members.

Collaborations with CBOs and Public Agencies. We have forged partnerships with public agencies and CBOs throughout the State and will continue to build on those relationships for the CCO Program. Initiatives for the new Contract include working with the:

- Community Foundation of Northwest Mississippi to provide nutrition education/literacy and help ensure children and their families have access to healthy, fresh, and nutritious food
- MSDH WIC to increase Member access to coordinated, culturally competent care by leveraging an infant feeding support technology platform that offers breastfeeding support with lactation consultants and on-demand video visits with nurses
- Mississippi Department of Employment Security's Workforce Investment Network Job Center to provide much-needed funding to deliver workforce development, on-the-job training, and scholarships to young adults

Expertise in State of Mississippi and Federal Policy Approaches to MississippiCAN and CHIP. As a current health plan for MississippiCAN and CHIP and a Molina Healthcare subsidiary, we are experts in State and Federal policies that affect government-sponsored healthcare programs. Our depth of knowledge enables us to analyze the impact of proposed policy changes and react/respond quickly in situations such as the COVID-19 public health emergency. For example, we understand the impact of the American Recovery and Reinvestment Act's Maintenance of Effort requirement on Medicaid eligibility protections, State waivers, and executive orders.

Access to the Resources and Institutional Knowledge of Our Parent Company. We benefit from Molina Healthcare's knowledge and expertise administering government-sponsored health plans across the country, and from their ongoing leadership and the support we receive as a Molina Healthcare subsidiary health plan. Molina Healthcare has been a proven partner and Subcontractor for MississippiCAN and CHIP, providing a variety of delegated services that allows our local team to focus on Member-, Provider-, and community-facing services and relationships. As a Subcontractor for the CCO Program, Molina Healthcare will support us in the following areas:

- Human resources and training
- Facilities
- IT
- Legal
- Marketing and public relations support
- Corporate finance
- Claims
- Quality
- Member/Provider call center overflow
- Administrative clinical program support
- Clinical telephony
- Network management support
- Healthcare services support
- Subcontractor oversight

Access to the Successes and Lessons Learned from Our Affiliate Health Plans. Our affiliate health plans work continuously—both independently and with Subcontractors, vendors, and suppliers—to identify, evaluate, and implement strategies and technologies to improve Member experiences. The overarching goal in their health plans is the same as ours: to increase access to services and provide ever-higher quality of care while focusing on cost-effectiveness, program compliance, and minimal FWA. Their successes, best practices, and lessons learned provide a wealth of information we can access as we evaluate and mitigate the risks of potential programs/services/initiatives targeted at improving the lives and health of Mississippians.

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 an explanation. Acceptance of the explanation provided is at the discretion of the Division.

Corporate Experience: Current and/or Recent Client				
Client's Name: Arizona Health Care Cost Containment System				
Client Location				
Address Line 1: 801 E. Jefferson St.				
Address Line 2:				
City: Phoenix	**State:** AZ	**Zip Code:** 85034	**County:** Maricopa	
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Dawn Sica				
Title: Operations Compliance Officer				
Phone Number: (602) 417-4568	**Email Address:** Dawn.Sica@azahcccs.gov			
Work Details				

Number of covered lives: 47,600

- Medicaid: 46,600 total
  - 24,000 TANF
  - 18,000 Medicaid Expansion
  - 3,100 Aged, Blind, and Disabled (ABD) Dual Eligible/Non-Dual Eligible
  - 1,500 CHIP
- Medicare: 1,000 Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP)

Time period of contract:

- Medicaid: 10/01/2018–9/30/2022

Total number of staff hours expended during time period of contract: 31,140

Personnel requirements:

Individuals directly responsible for day-to-day operations of the Arizona Health Care Cost Containment System (Medicaid) program contract:

- Administrator/Chief Executive Officer
- Chief Medical Officer
- Senior Medical Director
- Adult Healthcare Administrator
- Children's Healthcare Administrator
- Chief Financial Officer
- Pharmacy Coordinator/Pharmacy Director

- Dental Director
- Corporate Compliance Officer
- Contract Compliance Officer
- Quality Management Manager
- Performance/Quality Improvement Manager
- Credentialing Coordinator
- Maternal Child Health/EPSDT Coordinator
- Member Liaison Coordinator
- Individual and Family Affairs Administrator
- Medical Management Manager
- Transition Coordinator
- Transplant Coordinator
- Justice System Liaison
- Court Coordinator
- Employment/Vocational Administrator
- Network Administrator
- Member Services Manager
- Provider Services Manager
- Claims Administrator
- Encounter Manager
- Provider Claims Educator
- Dispute and Appeal Manager
- Information Systems Administrator
- Continuity of Operations and Recovery Coordinator
- Cultural Competency Coordinator
- Communications Administrator
- Management Services Agreement Administrator
- Tribal Coordinator

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid: Statewide
- Medicare: Region 1, Central (Maricopa, Pinal, and Gila counties)

Population Coverage

- Medicaid: TANF, CHIP, ABD, Medicaid Expansion
- Medicare: Adults 65 and older, younger adults on Social Security Disability Insurance (SSDI), individuals with end stage renal disease (ESRD)

Publicly funded contract cost: $11,113,076,871

Description of work performed under this contract

Molina Complete Care is contracted to provide managed care services for the Arizona Complete Care Program (Central Region geographic service area), which provides integrated care addressing physical health and behavioral health needs for Title XIX/XXI populations, including adults with general mental health/substance use disorder needs.

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:				
City: Sacramento	**State:** CA	**Zip Code:** 95814	**County:** Sacramento	
Mailing Address (P.O. Box): P.O. Box 997413 MS 0000	**City:** Sacramento	**State:** CA	**Zip Code:** 95899	**County:** Sacramento
Direct Contact for Client				
Name: Katryna Fific				
Title: Contract Manager				
Phone Number: (916) 633-0162	**Email Address:** Katryna.Fific@dhcs.ca.gov			
Work Details				

Number of covered lives: 661,000

- Medicaid (Medi-Cal): 589,000
  - 326,000 TANF
  - 186,000 Medicaid Expansion
  - 71,000 ABD (Long-Term Care Dual Eligible/Non-Dual Eligible, Medicare-Medicaid Plan [MMP] opt-out)
  - 6,000 ABD (Dual Eligible)
- Medicare: 11,000
  - 8,000 MMP (Dual Eligible)
  - 3,000 Dual Eligible Special Needs Plan (D-SNP)
- Marketplace: 61,000

Time period of contract:

- Medi-Cal Geographic Managed Care, Sacramento County: 01/01/2008–12/31/2022
- Medi-Cal Geographic Managed Care, San Diego County: 10/01/2018–12/31/2022
- Medi-Cal Two-Plan, Imperial County: 11/01/2018–12/31/2022
- Medi-Cal Two-Plan, Riverside/San Bernardino counties: 08/01/2018–12/31/2022
- Medi-Cal Two-Plan, Los Angeles County, Secondary (Medicaid) (Molina is a subcontracted health plan under HealthNet in Los Angeles County): 02/01/2018–Present

Total number of staff hours expended during time period of contract: 3,731,520

Personnel requirements:

Individuals directly responsible for day-to-day operations of the Medi-Cal (Medicaid) program contract:

- Medical Director
- Compliance Officer
- Marketing Representatives
- General staff (Care Management, Quality Management, Member Services, Provider Services, Network Management, and unspecified positions mentioned throughout contract)

Geographic and population coverage requirements:

Geographic coverage

- Medicaid (Medi-Cal): Serves Members in six counties (Imperial, Los Angeles, Riverside, Sacramento, San Bernardino, and San Diego)
- Medicare-Medicaid Plan (MMP) and D-SNP: Serves Members in five counties (Imperial, Los Angeles, Riverside, San Bernardino, and San Diego)
- Marketplace: Serves Members in five counties (Imperial, Los Angeles, Riverside, San Bernardino, and San Diego)

Population coverage

- Medicaid (Medi-Cal): TANF, Medicaid Expansion, ABD (Dual Eligible/Non-Dual Eligible, and ABD long-term care (including Dual Eligible/Non-Dual Eligible, and Medicare-Medicaid Plan opt-out)
- Medicare: Individuals enrolled in Medicare and Medicaid (Dual Eligible), adults 65 and older, younger adults on SSDI, and individuals with ESRD
- Marketplace: US citizens (ages 19–64) and foreign nationals legally residing in US with annual household income at or below the Medicaid standard

Publicly funded contract cost: $42,964,082,751

Description of work performed under this contract

Molina Healthcare of California is contracted to provide managed care services to the following Medi-Cal (Medicaid) programs:

- **California Medi-Cal (Geographic Managed Care Plan Contract, Sacramento and San Diego counties)** provides healthcare services to eligible Medi-Cal recipients, including ABD, TANF, Expansion, and ABD Dual-Covered populations within the scope of benefits, including coordination and approval of all medically necessary services, claims processing, Member services, Provider relations, and network development
- **California Medi-Cal (Two-Plan Contract, Imperial, Los Angeles, and Riverside/San Bernardino counties)** provides healthcare services to eligible Medi-Cal recipients, including ABD, TANF, Expansion, and ABD Dual-Covered populations within the scope of benefits, including coordination and approval of all medically necessary services, claims processing, Member services, Provider relations, and network development

Corporate Experience: Current and/or Recent Client				
Client's Name: Florida Agency for Health Care Administration				
Client Location				
Address Line 1: 2727 Mahan Dr.				
Address Line 2:				
City: Tallahassee	**State:** FL	**Zip Code:** 32308		**County:** Leon
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Pam Hull				
Title: Chief of Medicaid Plan Management Operations				
Phone Number: (850) 412-4299	**Email Address:** Pamela.Hull@ahca.myflorida.com			
Work Details				

Number of covered lives: 177,000

- Medicaid: 129,000 total (108,000 TANF, 20,000 ABD, 1,000 Medicaid D-SNP)
- Medicare: 2,000 D-SNP
- Marketplace: 46,000

Time period of contract:

- Medicaid—Florida Statewide Medicaid Managed Care (SMMC): 12/01/2018–12/31/2023

Total number of staff hours expended during time period of contract: 1,004,640

Personnel requirements:

Individuals directly responsible for day-to-day operations of the Florida SMMC program contract:

- Contract Manager
- Medical Director
- Compliance Manager
- Fraud Investigative Unit Manager
- Designated staff for the following functional areas:
  - Medicaid quality
  - Medicaid recipient/Provider assistance
  - Medicaid policy
  - Medicaid data analytics

- Medicaid finance
- Claims and encounter data
- Program integrity
- Subcontractor oversight

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid: SMMC Regions 6, 8, and 11
- Medicare: Regions 5, 6, 9, and 11
- Marketplace: Regions 4, 5, 6, 7, 9, and 11

Population Coverage

- Medicaid: TANF, ABD (Dual Eligible/Non-Dual Eligible, long-term care, Medicaid D-SNP)
- Medicare: Adults 65 and older, younger adults on SSDI, individuals with ESRD
- Marketplace: US citizens (ages 19–64) and foreign nationals legally residing in US with annual household income at or below the Medicaid standard

Publicly funded contract cost: $15,929,216,538

Description of work performed under this contract

Molina Healthcare of Florida is contracted to provide managed care services for the Florida SMMC Program, which provides or arranges for healthcare services to eligible Medicaid Members (TANF and ABD) residing in the service area. The scope of benefits includes coordination and approval of all medically necessary services, preventive care, claims processing, Member services, Provider relations, and network development. The contract also includes providing and arranging long-term care services for Members residing in the service area. Long-term care scope of benefits includes coordination and approval of home, community-based, and institutional services, claims processing, Member services, Provider relations, and network development.

Corporate Experience: Current and/or Recent Client				
Client's Name: Idaho Department of Health & Welfare				
Client Location				
Address Line 1: 1720 Westgate Dr.				
Address Line 2:				
City: Boise	**State:** ID	**Zip Code:** 83704	**County:** Ada	
Mailing Address (P.O. Box): P.O. Box 83720	**City:** Boise	**State:** ID	**Zip Code:** 83720	**County:** Ada
Direct Contact for Client				
Name: Alexandra (Ali) Fernández				
Title: Bureau Chief, Bureau of Long-Term Care				
Phone Number: (208) 287-1179	**Email Address:** Alexandra.Fernandez@dhw.idaho.gov			
Work Details				
Number of covered lives: 11,000 • Medicaid: 6,000 ABD, (long-term care Dual Eligible) • Medicare: 5,000 D-SNP				
Time period of contract: • Medicaid: 01/01/2018–12/31/2022				
Total number of staff hours expended during time period of contract: 42,465				
Personnel requirements: Individuals directly responsible for day-to-day operations of the Idaho Medicaid program contract: • Administrator/Program Director • LTSS Specialist • Behavioral Health Clinical Director • Compliance Officer				
Geographic and population coverage requirements: **Geographic Coverage** • Medicaid: Statewide • Medicare: Statewide **Population Coverage** • Medicaid: ABD (Long-Term Care Dual Eligible) • Medicare: Adults 65 and older, younger adults on SSDI, individuals with ESRD				
Publicly funded contract cost: $514,882,858				

Description of work performed under this contract
Molina Healthcare of Idaho is contracted to provide managed care services for the Idaho Medicare Medicaid Coordinated Plan FIDE-SNP and Idaho Medicaid Plus (Molina secondary payer only) programs that provide or arrange for healthcare services to eligible Medicaid Members (TANF, ABD) residing in the service area. Scope of benefits includes coordination and approval of all medically necessary services, preventive care, claims processing, Member services, Provider relations, and network development. The contract includes providing and arranging long-term care services for Members residing in the service area. Long-term care scope of benefits includes coordination and approval of home, community-based, and institutional services, claims processing, Member services, Provider relations, and network development.

Corporate Experience: Current and/or Recent Client				
Client's Name: Illinois Department of Human Services				
Client Location				
Address Line 1: 100 South Grand Ave. E.				
Address Line 2:				
City: Springfield	**State:** IL	**Zip Code:** 62762		**County:** Sangamon
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Kelly Cunningham				
Title: Medicaid Administrator				
Phone Number: (217) 782-2570	**Email Address:** Kelly.Cunningham@illinois.gov			
Work Details				

Number of covered lives: 344,000

- Medicaid: 326,000 total (210,000 TANF, 88,000 Medicaid Expansion, 28,000 ABD)
- Medicare (MMP): 18,000

Time period of contract:

- Medicaid: 01/01/2018–12/31/2025

Total number of staff hours expended during time period of contract: 3,527,680

Personnel requirements:

Individuals directly responsible for day-to-day operations of the HealthChoice Illinois (Medicaid) program Contract:

- Chief Executive Officer
- Chief Financial Officer
- Chief Operating Officer
- Chief Medical Officer
- Medical Director
- Chief Psychiatrist
- Member Services Director
- Provider Services Director
- Management Information System Director
- Care Management Manager
- LTSS Program Manager
- Community Liaison
- Quality Management Coordinator
- Utilization Management Coordinator
- Compliance Officer

- Registered Pharmacist
- Transition Officer

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid: Statewide
- Medicare (MMP): Statewide

Population Coverage

- Medicaid: TANF, Medicaid Expansion, ABD (Dual Eligible (LTSS)/Non-Dual Eligible, Children)
- Medicare: MMP (Dual Eligible)

Publicly funded contract cost: $14,996,585,543

Description of work performed under this contract

Molina Healthcare of Illinois is contracted to provide managed care services for the HealthChoice Illinois Medicaid program, providing a comprehensive system of medical and healthcare delivery, including preventive, primary, specialty, and ancillary health services for Members (TANF, CHIP, and adults eligible for Medicaid under the Affordable Care Act (ACA) expansion, excluding individuals eligible for Medicare) in Medicaid and those eligible through the ACA. Services include network access and availability, utilization management, quality of care, Member services, grievances and appeals, benefit administration, and oversight and monitoring.

Corporate Experience: Current and/or Recent Client				
Client's Name: Kentucky Cabinet for Health and Family Services, Department for Medicaid Services				
Client Location				
Address Line 1: 275 E. Main St.				
Address Line 2:				
City: Frankfort	**State:** KY	**Zip Code:** 40621		**County:** Franklin
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Veronica Judy-Cecil				
Title: Senior Deputy Commissioner, Kentucky Department for Medicaid Services				
Phone Number: (502) 564-4321		**Email Address:** Veronica.Judycecil@ky.gov		
Work Details				
Number of covered lives: 327,000 • Medicaid: 327,000 (172,000 TANF, 124,000 Medicaid Expansion, 31,000 ABD)				
Time period of contract: • Medicaid: 01/01/2021–12/31/2024				
Total number of staff hours expended during time period of contract: 44,980				
Personnel requirements: Individuals directly responsible for day-to-day operations of the Kentucky Medicaid program contract: • Chief Executive Officer • Chief Financial Officer • Compliance Officer • Medical Director • Pharmacy Director • Dental Director • Behavioral Health Director • Provider Network Director • Quality Improvement Director • Population Health Management Director • Management Information System Director • Member Services Manager and staff • Provider Services Manager and staff • Claims Processing staff • Utilization Management Director				

- EPSDT Coordinator
- Guardianship Liaison
- Program Integrity Coordinator

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid: Serves Members in all eight Kentucky Medicaid Managed Care Regions

Population Coverage

- Medicaid: TANF, Medicaid Expansion, ABD (Dual Eligible/Non-Dual Eligible, Children)

Publicly funded contract cost: $7,694,822,270

Description of work performed under this contract

Molina Healthcare of Kentucky is contracted to provide managed care services for the Kentucky Medicaid program, which provides or arranges for healthcare services to eligible Medicaid Members (TANF and ABD) residing in the service area. Scope of benefits includes coordination and approval of all medically necessary services, preventive care, claims processing, Member services, Provider relations, and network development. Contract also includes providing and arranging long-term care services for Members residing in the service area. Long-term care scope of benefits includes coordination and approval of home, community-based, and institutional services, claims processing, Member services, Provider relations, and network development.

Corporate Experience: Current and/or Recent Client				
Client's Name: Executive Office of Health and Human Services, MassHealth Program				
Client Location				
Address Line 1: One Ashburton Place				
Address Line 2:				
City: Boston	**State:** MA	**Zip Code:** 02108		**County:** Suffolk
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Christine Smith				
Title: Contract Manager				
Phone Number: (617) 573-1600	**Email Address:** Christine.l.Smith@state.ma.us			
Work Details				

Number of covered lives: 15,000

- Medicaid: 1,500 ABD (Non-Dual Eligible)
- Medicare: 13,500 FIDE-SNP

Time period of contract:

- Medicaid: 01/01/2022–12/31/2022

Total number of staff hours expended during time period of contract: 449,280

Personnel requirements:

Individuals directly responsible for day-to-day operations of the Senior Care Options (Medicaid) program contract:

- Director of the Contractor's Senior Care Options Program
- Quality Management Director
- Medical Director
- Geriatrician
- Behavioral Health Clinician

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid: Statewide; serves Members in Boston and non-Boston MassHealth (Medicaid) regions
- Medicare: Serves Members in eight counties (Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester)

Population Coverage

- Medicaid: ABD (Non-Dual Eligible)
- Medicare: Adults 65 and older, younger adults on SSDI, individuals with ESRD, and individuals in institutional/transitional settings

Publicly funded contract cost: $6,276,403,217

Description of work performed under this contract

Senior Whole Health by Molina Healthcare is contracted to provide services for the Massachusetts Senior Care Options Program (FIDE-DSNP), which provides or arranges healthcare services for individuals 65 and older who are eligible for Medicare and/or MassHealth standard-eligible Members residing in the service area. Scope of benefits includes coordination and approval of all medically necessary behavioral health services, preventive care, claims processing, Member services, Provider relations, and network development. The contract includes providing and arranging long-term care services for Members residing in the service area. Long-term care scope of benefits includes coordination and approval of home, community-based, and institutional services, claims processing, Member services, Provider relations, and network development.

Corporate Experience: Current and/or Recent Client				
Client's Name: Michigan Department of Health and Human Services				
Client Location				
Address Line 1: 333 S. Grand Ave.				
Address Line 2:				
City: Lansing	**State:** MI	**Zip Code:** 48909		**County:** Ingham
Mailing Address (P.O. Box): P.O. Box 30195	**City:** Lansing	**State:** MI	**Zip Code:** 48909	**County:** Ingham
Direct Contact for Client				
Name: Kim Hamilton				
Title: Director, Managed Care Plan Division				
Phone Number: (517) 284-1145	**Email Address:** hamiltonk@michigan.gov			
Work Details				

Number of covered lives: 428,000

- Medicaid: 388,000 (220,000 TANF, 117,000 Medicaid Expansion, and 51,000 ABD)
- Medicare: 28,000 (15,000 D-SNP and 13,000 Medicare-Medicaid Plan Dual Eligible)
- Marketplace: 12,000

Time period of contract:

- Medicaid: 10/1/2021 – 9/30/2023

Total number of staff hours expended during time period of contract: 58,128

Personnel requirements:

Individuals directly responsible for the day-to-day operations of the Michigan Comprehensive Health Care Program (Medicaid) contract:

- Executive Director/Chief Executive Officer
- Medical Director
- Quality Improvement Director
- Chief Financial Officer
- Management Information System Director
- Compliance Officer
- Member Services Director
- Provider Services Director
- Grievance and Appeals Coordinator
- Medicaid Liaison
- Management Information System Liaison
- Privacy Officer
- Security Officer

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid: Serves Members in nine of ten Michigan Medicaid regions
- Medicare-Medicaid Plan: Regions seven and nine
- Medicare: D-SNP, Medicare Advantage Prescription Drug (MAPD) Plan: Serves 49 counties
- Marketplace: Serves eight counties

Population Coverage

- Medicaid: TANF, CHIP, ABD, Children's Special Health Care Services, children in foster care (transitional age), Medicaid Expansion
- Medicare-Medicaid Plan (Dual Eligible): Individuals enrolled in Medicare and Medicaid
- Medicare (D-SNP/MAPD Plan): Adults 65 and older, younger adults on SSDI, and individuals with ESRD
- Marketplace: US citizens (ages 19–64) and foreign nationals legally residing in US with annual household income at or below the Medicaid standard

Publicly funded contract cost: $8,355,524,013

Description of work performed under this contract

Molina Healthcare of Michigan is contracted to provide managed care services for the Michigan Comprehensive Health Care Program (Medicaid), which provides comprehensive healthcare services, including physical outpatient behavioral health services, and pharmacy to Medicaid Members in the service area. Scope of work includes managing the provision of comprehensive healthcare services, including physical and behavioral health, to Medicaid, including CHIP, beneficiaries in the service area. Scope of work also includes coordination and approval of all medically necessary services, preventive care, vision care, hearing aids, dental care for pregnant women and Healthy Michigan plan Members, claims processing, Member services, and Provider contracting, including credentialing and network development. Molina Healthcare of Michigan delegates the authority to perform some plan functions and services while maintaining oversight responsibility for delegated and non-delegated activities.

Corporate Experience: Current and/or Recent Client				
Client's Name: Nevada Department of Health and Human Services, Division of Health Care Financing and Policy				
Client Location				
Address Line 1: 1100 E. William St.				
Address Line 2: Ste. 102				
City: Carson City	**State:** NV	**Zip Code:** 89701	**County:** Washoe	
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Theresa Carsten				
Title: Social Services Chief III				
Phone Number: (775) 684-3655	**Email Address:** Theresa.Carsten@dhcfp.nv.gov			
Work Details				
Number of covered lives: 134,000 • Medicaid: 134,000 total (130,000 TANF/Medicaid Expansion, 4,000 CHIP)				
Time period of contract: • Medicaid: 01/01/2022–12/31/2022				
Total number of staff hours expended during time period of contract: 11,591				
Personnel requirements: Individuals directly responsible for the day-to-day operations of the Nevada Medicaid Program contract: • Chief Executive Officer • Chief Financial Officer • Chief Information Officer • Chief Medical Director • Behavioral Health Medical Director • Nevada Medicaid/CHIP Operations Manager • Compliance Officer • Provider Network/Provider Services Director • Utilization Management/Quality Management/Improvement Director • Program Integrity Unit Manager • Member Services/Call Center Director • Grievances and Appeals Coordinator • Claims/Encounters Manager • Nevada Department of Corrections Coordinator • Population Health Program Director				

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid managed care service areas: Washoe County and Clark County

Population Coverage

- Medicaid: TANF, CHIP, and Children with Special Health Care Needs

Publicly funded contract cost: $1,708,923,238

Description of work performed under this contract

Molina Healthcare of Nevada is contracted to provide managed care services to the Nevada Medicaid program, which provides or arranges healthcare services for eligible Medicaid Members residing in the managed care service areas of Clark and Washoe counties. Scope of benefits includes coordination and approval of all medically necessary services, preventive care, claims processing, Member services, Provider relations, and network development.

Corporate Experience: Current and/or Recent Client				
Client's Name: New Mexico Human Services Department, Centennial Care Program				
Client Location				
Address Line 1: 39b Plaza La Prensa				
Address Line 2:				
City: Santa Fe	**State:** NM	**Zip Code:** 87507		**County:** Santa Fe
Mailing Address (P.O. Box): P.O. Box 2348	**City:** Santa Fe	**State:** NM	**Zip Code:** 87504	**County:** Santa Fe
Direct Contact for Client				
Name: Nicole Comeaux, JD, MPH				
Title: New Mexico State Medicaid Director				
Phone Number: (505) 827-7750		**Email Address:** Nicole.Comeaux@state.nm.us		
Work Details				
Number of covered lives: 25,200 • Medicare (MAPD Plan): 2,200 • Marketplace: 23,000				
Time period of contract: • Molina Healthcare of New Mexico does not currently hold a Centennial Care 2.0 (Medicaid) contract; prior Medicaid contract ran 01/01/2014–12/31/2018				
Total number of staff hours expended during time period of contract: 176,800				
Personnel requirements: • None (no current contract)				
Geographic and population coverage requirements: **Geographic Coverage** • Medicare (MAPD Plan): Serves Members in 24 of 33 counties in New Mexico • Marketplace: Statewide **Population Coverage** • Medicare (MAPD Plan): Adults 65 and older, younger adults on SSDI, and individuals with ESRD • Marketplace: US citizens (ages 19–64) and foreign nationals legally residing in US with annual household income at or below the Medicaid standard				
Publicly funded contract cost: $5,044,606,455				

Description of work performed under this contract
Molina Healthcare of New Mexico does not currently hold a Centennial Care 2.0 (Medicaid) contract with the New Mexico Human Services Department. Molina's prior Medicaid contract ran 01/01/2014–12/31/2018, through which the health plan provided or arranged medically necessary services for physical health, behavioral health, long-term care, dental, vision, and transportation for Medicaid Members, including TANF, ABD, Alternative Benefit Plan (ABP), Full Dual Eligible, and long-term care populations.

<table>
<tr><th colspan="5">Corporate Experience: Current and/or Recent Client</th></tr>
<tr><td colspan="5">Client's Name: New York State Department of Health, Office of Health Insurance Programs</td></tr>
<tr><td colspan="5">Client Location</td></tr>
<tr><td colspan="5">Address Line 1: One Commerce Plaza</td></tr>
<tr><td colspan="5">Address Line 2:</td></tr>
<tr><td>City: Albany</td><td colspan="2">State: NY</td><td colspan="2">Zip Code: 12210</td><td>County: Albany</td></tr>
<tr><td>Mailing Address (P.O. Box):
Same as above</td><td>City:</td><td>State:</td><td>Zip Code:</td><td>County:</td></tr>
<tr><td colspan="5">Direct Contact for Client</td></tr>
<tr><td colspan="5">Name: Maureen Schips</td></tr>
<tr><td colspan="5">Title: Medicaid Redesign Analyst II/Plan Manager</td></tr>
<tr><td colspan="2">Phone Number:
(518) 408-1102</td><td colspan="3">Email Address:
Maureen.Schips@health.ny.gov</td></tr>
<tr><td colspan="5">Work Details</td></tr>
<tr><td colspan="5">Number of covered lives: 403,100
Medicaid: 403,000
293,000 TANF
52,000 Medicaid Expansion (Essential Plan)
18,000 CHIP
40,000 ABD Long-Term Care, Non-Dual Eligible, Non-Dual Eligible/Long-Term Care, and Health and Recovery Plan program (behavioral health)
Medicare: 100 D-SNP</td></tr>
<tr><td colspan="5">Time period of contract:
Medicaid: 03/19/2019–02/29/2024</td></tr>
<tr><td colspan="5">Total number of staff hours expended during time period of contract: 3,619,200</td></tr>
<tr><td colspan="5">Personnel requirements:
Individuals directly responsible for day-to-day operations of the New York State Medicaid program contract:
Plan President/CEO
Government Affairs/Regulatory Affairs Director
Compliance Officer
Behavioral Health Medical Director for Adult Services
Behavioral Health Medical Director for Children's Services
Medical Director Designated for Medically Fragile Children
Behavioral Health Clinical Director for Adult Services
Behavioral Health Clinical Director for Children's Services
Health and Recovery Plan Behavioral Health Medical Director for Adult Services
Health and Recovery Plan Behavioral Health Clinical Director for Adult Services</td></tr>
</table>

- Health and Recovery Plan Medical Director, General Medicine
- Medicaid MCO Liaison for Medically Fragile Children
- Medicaid MCO Foster Care Liaison
- Behavioral Health Care Management Director
- Behavioral Health Utilization Management Director
- Member Services Director
- Network Development Director
- Provider Relations Director
- Training Director
- Quality Management Director
- Information Systems Director
- Governmental/Community Liaison Director

Geographic and population coverage requirements:

Geographic Coverage:

- Medicaid: Molina Healthcare of New York (18 counties in Western New York, Affinity by Molina Healthcare and 10 counties in metro New York City)
- Medicare (D-SNP): Senior Whole Health (6 counties in metropolitan New York City)

Population Coverage:

- Medicaid: TANF, Child Health PLUS (CHIP), ABD (Dual Eligible/Non-Dual Eligible), Health and Recovery Plan (HARP), and Expansion (Essential Plan)
- Medicare (D-SNP): Adults 65 and older, younger adults on SSDI, and individuals with ESRD

Publicly funded contract cost: $42,655,501,554

Description of work performed under this contract

Molina Healthcare of New York is contracted to provide managed care services for the following Medicaid programs:

- **New York Medicaid Managed Care** provides comprehensive coverage for all Members, including pregnant women and children as well as childless adults and individuals who are 65 and older and not eligible for Medicare. Covered benefits include, but are not limited to, smoking cessation agents; treatment and preventive health and dental care (doctors and dentists); hospital inpatient and outpatient services; laboratory and X-ray services; care in a nursing home; care through home health agencies and personal care; treatment in psychiatric hospitals (for persons under 21 or those 65 and older), mental health facilities, and facilities for the intellectually or developmentally disabled; family planning services; EPSDT for children under 21 years of age under the Children's Health Insurance Program; medicine, supplies, medical equipment, and appliances (wheelchairs and more); clinic services; transportation to medical appointments, including public transportation and car mileage; emergency ambulance transportation to a hospital; and prenatal care.
- **New York Child Health PLUS** is an insurance plan for any child who is domiciled in New York and not Medicaid eligible. The program provides comprehensive coverage for qualifying children from birth to 19 years to ensure that all children in New York State have health coverage. Coverage includes medical, dental, vision, well-child visits, and the following: well-child care; physical exams; immunizations; diagnosis and treatment of

illness and injury; X-ray and lab tests; outpatient surgery; emergency care; prescription and non-prescription drugs; inpatient hospital medical or surgical care; short-term therapeutic outpatient services (chemotherapy, hemodialysis); inpatient and outpatient treatment for alcoholism, substance use disorder (SUD), and mental health; speech and hearing; durable medical equipment (DME); emergency ambulance transportation to a hospital; and hospice.

- **New York Essential Plan** provides comprehensive coverage for Members ages 19–64. It includes smoking cessation agents; treatment and preventive health and dental care (doctors and dentists); hospital inpatient and outpatient services; laboratory and X-ray services; care in a nursing home; care through home health agencies and personal care; treatment in psychiatric hospitals (mental health facilities and facilities for individuals with intellectual/developmental disabilities); family planning services; early periodic screening, diagnosis, medicine, supplies, medical equipment, and appliances (wheelchairs and more); emergency ambulance transportation to a hospital; and prenatal care.
- **New York Healthcare Plus – HARP** assigns Members based on claims encounters. Members who qualify typically are chronically addicted and/or have behavioral health issues. HARP is focused on recovery and helping participants become productive members of society even if they have a mental disability or struggle with severe addiction. The program also offers job placement and coaching and non-medical transportation (for example, transportation to rehabilitation appointments). After successfully completing HARP, Members may be eligible to transition seamlessly back into Medicaid managed care.

Corporate Experience: Current and/or Recent Client				
Client's Name: Ohio Department of Medicaid				
Client Location				
Address Line 1: 50 W. Town St.				
Address Line 2: #400				
City: Columbus	**State:** OH	**Zip Code:** 43215		**County:** Franklin
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Roxanne Richardson				
Title: Deputy Director of Managed Care				
Phone Number: (614) 752-0503	**Email Address:** Roxanne.Richardson@medicaid.ohio.gov			
Work Details				

Number of covered lives: 388,000

- Medicaid: 345,000 total (195,000 TANF; 107,000 Medicaid Expansion; 28,000 ABD adults/children; 11,000 MMP opt-out, Medicaid only; 4,000 children in adoption/foster care services)
- Medicare: 19,000 total (17,000 MMP; 2,000 D-SNP)
- Marketplace: 24,000

Time period of contract:

- Medicaid: 07/01/2018–06/30/2024

Total number of staff hours expended during time period of contract: 110,720

Personnel requirements:

Individuals directly responsible for day-to-day operations of the Ohio Medicaid program contract:

- Administrator/Chief Executive Officer/Chief Operating Officer
- Medical Director/Chief Medical Officer
- Chief Compliance Officer
- Behavioral Health Administrative Director
- Behavioral Health Clinical Director
- Quality Improvement Director
- Community Engagement Coordinator
- Care Management Director
- Utilization Management Director
- EPSDT/Maternal Child Health Manager
- Provider Services Representatives
- Contract Compliance Officer

- Transition Coordinator

Geographic and population coverage requirements:

Geographic Coverage:

- Medicaid: Statewide (West, Northeast, Central Southeast Medicaid regions)
- Medicare (MMP): 13 counties (Butler, Clark, Clermont, Clinton, Delaware, Franklin, Greene, Hamilton, Madison, Montgomery, Pickaway, Union, and Warren)
- Marketplace: Serves Members in 64 of 88 counties statewide (West, Northeast, and Central Southeast regions)

Population Coverage:

- Medicaid: Populations include those identified by Ohio Administrative Code 5160-28-02, covered families and children (includes children, families, and pregnant women), Aid to the Aged, Blind, and Disabled (AABD) children under 18, ABD adults 18 to 64, adoption and foster care children, Adult Extension (Group VIII), and children with special health care needs receiving services
- Medicare: Adults 65 and older, younger adults on SSDI, and individuals with ESRD
- Marketplace: US citizens and foreign nationals legally residing in the US

Publicly funded contract cost: $15,618,453,626

Description of work performed under this contract

Molina Healthcare of Ohio is contracted to provide managed care services for the following Medicaid programs:

- **Ohio Medicaid Managed Care** provides or arranges medically necessary physical, preventive health, dental, vision, and mental healthcare services for ABD, covered families and children, children with special health care needs, and adult extension plan Members.
- **Ohio Molina MyCare Ohio Medicaid** is a contract that specifies the requirements for care coordination and payment of MyCare Medicaid-only Members. The contract does apply to both dual-benefit Members and Medicaid Members unless specified, and according to the order of precedence.

Corporate Experience: Current and/or Recent Client				
Client's Name: South Carolina Department of Health and Human Services				
Client Location				
Address Line 1: Jefferson Square				
Address Line 2: 1801 Main St.				
City: Columbia	**State:** SC	**Zip Code:** 29201		**County:** Richland
Mailing Address (P.O. Box): P.O. Box 8206	**City:** Columbia	**State:** SC	**Zip Code:** 29201	**County:** Richland
Direct Contact for Client				
Name: Kathie Reed Wanket, MPA, PAHM				
Title: Program Manager I				
Phone Number: (803) 898-2801	**Email Address:** Reed@scdhhs.gov			
Work Details				
Number of covered lives: 215,000 • Medicaid: 176,000 total (162,000 TANF, 14,000 ABD Non-Dual Eligible) • Medicare: 5,000 (4,000 MMP and Dual Eligible and 1,000 D-SNP) • Marketplace: 34,000				
Time period of contract: • Medicaid: 07/01/2021–06/30/2024				
Total number of staff hours expended during time period of contract: 32,780				
Personnel requirements: Individuals directly responsible for day-to-day operations of the South Carolina Healthy Connections (Medicaid) program contract: • Administrator • Chief Financial Officer • Contract Account Manager • Medical Director • Pharmacy Director • Quality Improvement Director • Utilization Management Coordinator • Claims and Encounter Manager/Administrator • Compliance Officer • Provider Services Manager • Member Services Manager • Legal • Interagency Liaison • Other Medical Personnel (licensed/certified)				

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid: Statewide
- Medicare (MMP, D-SNP): Statewide

Population Coverage

- Medicaid: TANF, CHIP, ABD
- Medicare-Medicaid Plan (Dual Eligible): Individuals enrolled in Medicare and Medicaid
- Medicare (D-SNP): Adults 65 and older, younger adults on SSDI, and individuals with ESRD
- Marketplace: US citizens and foreign nationals legally residing in the US

Publicly funded contract cost: $3,142,823,869

Description of work performed under this contract

Molina Healthcare of South Carolina is contracted to provide managed care services for the South Carolina Healthy Connections program, which provides or arranges healthcare services for eligible traditional Medicaid Members residing in the service area. Scope of work includes coordination and approval of all medically necessary covered services, preventive care, claims processing, Member services, Provider relations, and network development.

Corporate Experience: Current and/or Recent Client				
Client's Name: Texas Health and Human Services Commission				
Client Location				
Address Line 1: 4601 W. Guadalupe St.				
Address Line 2:				
City: Austin	**State:** TX	**Zip Code:** 78711		**County:** Travis
Mailing Address (P.O. Box): P.O. Box 13247	**City:** Austin	**State:** TX	**Zip Code:** 78711	**County:** Travis
Direct Contact for Client				
Name: Shannon Kelley				
Title: Associate Commissioner, Managed Care				
Phone Number: (512) 565-5099	**Email Address:** Shannon.Kelley@hhs.texas.gov			
Work Details				

Number of covered lives: 427,000

- Medicaid State of Texas Access Reform (STAR) CHIP: 138,000 total (126,000 TANF, 12,000 CHIP/CHIP Perinate)
- Medicaid (Texas STAR+PLUS: 135,000 total (80,000 ABD Dual Eligible Long-Term Care; 55,000 ABD Non-Dual Eligible Long-Term Care)
- Medicare: 15,000 (12,000 MMP; 3,000 D-SNP, MAPD)
- Marketplace: 139,000

Time period of contract:

- Medicaid (STAR CHIP): 09/01/2021–08/31/2022
- Medicaid (STAR+PLUS): 09/01/2021–08/31/2022
- Medicaid (STAR+PLUS): 01/01/2022–08/31/2022 (assignment of Cigna STAR+PLUS contracts via acquisition of Cigna's Medicaid line of business in Texas)

Total number of staff hours expended during time period of contract: 368,836

Personnel requirements:

STARCHIP (Medicaid)

- Executive Director
- Medical Director
- Member Services
- Management Information Systems
- Claims Processing

- Provider Network Development and Management
- Benefit Administration and Utilization and Care Management
- Quality Improvement
- Behavioral Health Services
- Financial Functions
- Reporting
- Security Officer
- Privacy Officer

STAR+PLUS (Medicaid)

Key personnel are those with management responsibility or principal technical responsibility for the following functional areas for each MCO program included within the scope of the contract:

- Executive Director
- Medical Director
- Member Services
- Management Information Systems
- Claims Processing
- Provider Network Development and Management
- Benefit Administration and Utilization and Care Management
- Quality Improvement
- Behavioral Health Services
- Financial Functions
- Reporting

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid (STAR-CHIP): STAR serves Members in 5 of 13 managed care service areas (Bexar, Dallas, El Paso, Harris, and Hidalgo); CHIP/CHIP Perinate serves Members in 7 of 13 managed care service areas (Dallas, Harris, Hidalgo, Jefferson, MRSA Central TX, MRSA Northeast TX, and MRSA West TX)
- Medicaid (STAR+PLUS): Serves Members in 6 of 13 managed care service areas (Bexar, Dallas, El Paso, Harris, Hidalgo, and Jefferson)
- Medicare (MMP, D-SNP): Serves Members in 5 service areas (El Paso, Hidalgo, Harris, Dallas, and Bexar)
- Marketplace: Serves Members in 6 service areas (Bexar, Dallas, El Paso, Harris, Hidalgo, and Jefferson)

Population Coverage

- Medicaid (STAR-CHIP): TANF, CHIP, and CHIP Perinate
- Medicaid (STAR+PLUS): ABD, Intellectual and Developmental Disability (I/DD), and Dual Eligible
- Medicare (MMP, D-SNP): Individuals enrolled in Medicare and Medicaid (Dual Eligible), adults 65 and older, younger adults on SSDI, and individuals with ESRD
- Marketplace: US citizens (ages 19–64) and foreign nationals legally residing in US with annual household income at or below the Medicaid standard

Publicly funded contract cost: $24,463,265,442
Description of work performed under this contract
Molina Healthcare of Texas is contracted to provide managed care services for two Texas Medicaid programs: • **STAR** provides or arranges comprehensive healthcare services through a managed care delivery system for eligible STAR and CHIP Members. Scope of work includes coordination of all medically necessary covered services, preventive care, utilization management, claims processing, Member services, Provider relations, and network development. • **STAR+PLUS with LTSS** provides comprehensive healthcare services through a managed care delivery system for the STAR+PLUS program (Medicaid ABD). Scope of work includes coordination of all medically necessary covered services, preventive care, utilization management, claims processing, Member services, Provider relations, and network development.

Corporate Experience: Current and/or Recent Client				
Client's Name: Utah Department of Health, Utah Medicaid Integrated Care Program				
Client Location				
Address Line 1: Cannon Health Building				
Address Line 2: 288 N. 1460 W.				
City: Salt Lake City	**State:** UT	**Zip Code:** 84116	**County:** Salt Lake	
Mailing Address (P.O. Box): P.O. Box 141010	**City:** Salt Lake City	**State:** UT	**Zip Code:** 84116	**County:** Salt Lake
Direct Contact for Client				
Name: Gregory Trollan				
Title: Assistant Director, Medicaid and Health Financing				
Phone Number: (801) 538-6358	**Email Address:** Gtrollan@utah.gov			
Work Details				

Number of covered lives: 130,000

- Medicaid: 91,000 total (62,000 TANF, 18,000 Medicaid Expansion, and 11,000 ABD Dual Eligible/Non-Dual Eligible)
- CHIP: 3,000
- Medicare: 11,000
- Marketplace: 25,000

Time period of contract:

- Medicaid: 11/01/2018–12/31/2022

Total number of staff hours expended during time period of contract: 2,895,360

Personnel requirements:

Individuals directly responsible for day-to-day operations of the Utah Medicaid/CHIP program contract:

- Chief Executive Officer
- Chief Financial Officer
- Compliance Officer
- Nondiscrimination Coordinator
- Additional personnel: Health plan agrees to furnish its staff and services as necessary for the satisfactory performance of the services as enumerated in this Agreement (Contract)

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid: Statewide
- CHIP: Statewide
- Medicare: Statewide
- Marketplace: Statewide

Population Coverage

- Medicaid: TANF, ABD
- CHIP: Children over 18 years of age or primary caregiver with child(ren) over 18 years of age
- Medicare (MAPD, D-SNP): Adults 65 and older, younger adults on SSDI, individuals with ESRD
- Marketplace: US citizens and foreign nations legally residing in the US

Publicly funded contract cost: $1,141,239,020

Description of work performed under this contract

Molina Healthcare of Utah is contracted to provide managed care services for the following Medicaid programs:

- **Utah Medicaid** provides or arranges healthcare services for eligible traditional Medicaid Members residing statewide. Scope of work includes coordination and approval of all medically necessary covered services, preventive care, claims processing, Member services, Provider relations, and network development.
- **Utah CHIP** provides or arranges healthcare services for eligible CHIP Members. Scope of work includes coordination and approval of all medically necessary covered services, preventive care, claims processing, Member services, Provider relations, and network development.

Corporate Experience: Current and/or Recent Client				
Client's Name: Virginia Department of Medical Assistance Service				
Client Location				
Address Line 1: 600 E. Broad St.				
Address Line 2:				
City: Richmond	**State:** VA	**Zip Code:** 23219	**County:** Henrico	
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Karen Kimsey				
Title: Agency Director				
Phone Number: (804) 786-8099	**Email Address:** Karen.Kimsey@dmas.virginia.gov			
Work Details				

Number of covered lives: 126,500

- Medicaid: 126,000 (46,000 TANF, 48,000 Medicaid Expansion, 28,000 Commonwealth Coordinated Care Plus, 4,000 CHIP)

Time period of contract:

- Medicaid Medallion 4.0: 07/01/2021–6/30/2022
- Medicaid Commonwealth Coordinated Care Plus: 07/01/2021–6/30/2022

Total number of staff hours expended during time period of contract: 196,355

Personnel requirements:

Individuals directly responsible for day-to-day operations of the Medallion 4.0 (Medicaid) program contract:

- Project Director
- Project Manager
- Medical Director/Chief Medical Officer
- Behavioral Health/Addiction Recovery Treatment Clinical Director
- Care Coordination Manager
- Compliance Officer
- Provider Network Manager
- Program Integrity Lead
- Encounter Data Manager
- Children and Youth with Special Health Care Needs Care Coordinator

Individuals directly responsible for day-to-day operations of the Commonwealth Coordinated

Care Plus (Medicaid) program contract:

- Project Director
- Project Manager
- Chief Medical Officer/Medical Director
- Pharmacy Director
- Medical Behavioral Health Director
- Behavioral Health Director
- Director of LTSS
- Chief Financial Officer
- Chief Operating Officer/Director of Operations
- Quality Director
- Senior Manager of Clinical Services
- Claims Director
- Information Technology Director
- Compliance Officer
- ADA Compliance Director

Geographic and population coverage requirements:

Geographic Coverage

- Medallion 4.0 and Commonwealth Coordinated Care Plus: Serve 6 of 7 managed care regions (Southwest, Roanoke/Allegheny, Charlottesville, Central, Northern/Winchester, and Tidewater)

Population Coverage

- Medallion 4.0: TANF, CHIP, I/DD, Medicaid Expansion
- Commonwealth Coordinated Care Plus: Medicaid managed care LTSS, ABD, Medicare-Medicaid Dual Eligible, home- and community-based services, I/DD, and qualified Medicaid Expansion

Publicly funded contract cost: $8,193,976,665

Description of work performed under this contract

Molina Complete Care is contracted to provide managed care services for two Virginia Medicaid programs:

- **Virginia Medallion 4.0** is Virginia's Medicaid program for infants, children, pregnant women, and adults in low-income families with children. It provides acute and primary healthcare services, prescription drug coverage, and behavioral health services.
- **Virginia Coordinated Care Plus** provides or arranges healthcare services for eligible Medicaid Members who are 65 or older, children or adults with disabilities, skilled nursing facility residents, and those receiving LTSS residing in the service area.

Corporate Experience: Current and/or Recent Client				
Client's Name: Washington State Health Care Authority				
Client Location				
Address Line 1: 626 8th Ave. SE				
Address Line 2:				
City: Olympia	**State:** WA	**Zip Code:** 98501		**County:** Thurston
Mailing Address (P.O. Box): P.O. Box 45531	**City:** Olympia	**State:** WA	**Zip Code:** 98501	**County:** Thurston
Direct Contact for Client				
Name: Dr. Charissa Fotinos				
Title: Acting Medical Director				
Phone Number: (360) 725-9822	**Email Address:** Charissa.Fotinos@hca.wa.gov			
Work Details				

Number of covered lives: 1,060,000

- Apple Health Integrated Managed Care (Medicaid): 993,000 total (502,000 TANF, 359,000 Medicaid Expansion, 51,000 State-funded behavioral health services only), 42,000 ABD (Non-Dual Eligible), 39,000 CHIP
- Medicare: 13,000 D-SNP
- Marketplace: 54,000

Time period of contract:

- Medicaid: 01/01/2020–12/31/2023

Total number of staff hours expended during time period of contract: 906,880

Personnel requirements:

Individuals directly responsible for day-to-day operations of the Apple Health Integrated Managed Care (Medicaid) program contract:

- Chief Executive Officer
- Chief Financial Officer
- Healthcare Authority Government Relations Contact
- Healthcare Authority Account Executive
- Compliance Officer
- Medical Director
- Behavioral Health Medical Director
- Behavioral Health Clinical Director

- Program Integrity/Special Investigations: 1 FTE dedicated to Washington for every 50,000 Members
- Designated managerial positions with the following behavioral health responsibilities:
  - Behavioral Health Children's System Administrator
  - Behavioral Health Addictions Administrator
  - Behavioral Health Utilization Management Administrator
  - Behavioral Health Network Development Manager
  - Behavioral Health Provider Relations Manager

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid: Statewide (serves Members in all ten regions)
- Medicare: Statewide
- Marketplace: Statewide

Population Coverage

- Medicaid: TANF, CHIP, ABD, I/DD, Dual Eligible (behavioral health only)
- Medicare (D-SNP): Adults 65 and older, younger adults on SSDI, and individuals with ESRD
- Marketplace: US citizens (ages 19 to 64) and foreign nationals legally residing in US with annual household income at or below the Medicaid standard

Publicly funded contract cost: $10,650,340,040

Description of work performed under this contract

Molina Healthcare of Washington is contracted to provide managed care services for the Washington State Apple Health Integrated Managed Care program, which provides the full continuum of comprehensive Medicaid services, including primary care, pharmacy, mental health, and SUD treatment through collaborative care coordination and the integration of services under a single entity.

Corporate Experience: Current and/or Recent Client				
Client's Name: Wisconsin Department of Health Services				
Client Location				
Address Line 1: One W. Wilson St.				
Address Line 2:				
City: Madison	**State:** WI	**Zip Code:** 53703		**County:** Dane
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Linda Kaestner				
Title: Managed Care Analyst				
Phone Number: (608) 722-8524	**Email Address:** Linda.Kaestner@dhs.wisconsin.gov			
Work Details				

Number of covered lives: 98,000

- Medicaid (Badger Care Plus + SSI): 73,000 total (55,000 TANF, 15,000 childless adults, and 3,000 ABD Non-Dual Eligible)
- Medicare: 1,000 (D-SNP)
- Marketplace: 24,000

Time period of contract:

- Medicaid (Badger Care Plus + SSI): 01/01/2022–12/31/2022

Total number of staff hours expended during time period of contract: 5363

Personnel requirements:

Individuals directly responsible for day-to-day operations of the Badger Care Plus + SSI (Medicaid) program contract:

- Plan President
- Chief Medical Officer
- Chief Financial Officer
- Compliance Officer
- Medical Director
- Quality Improvement/State Quality Compliance Director
- Healthcare Services Director
- Behavioral Health Director
- Provider Contracting and Network Operations Director
- Pharmacy Director

- Contract Management Director

Geographic and population coverage requirements:

Geographic Coverage

- Medicaid (Badger Care Plus + SSI): Statewide
- Medicare: Statewide
- Marketplace: Statewide

Population Coverage

- Medicaid: TANF, CHIP, ABD, Dual Eligible, childless adults
- Medicare (D-SNP): Adults 65 and older, younger adults on SSDI, individuals with ESRD
- Marketplace: US citizens (ages 19 to 64) and foreign nationals legally residing in US with annual household income at or below the Medicaid standard

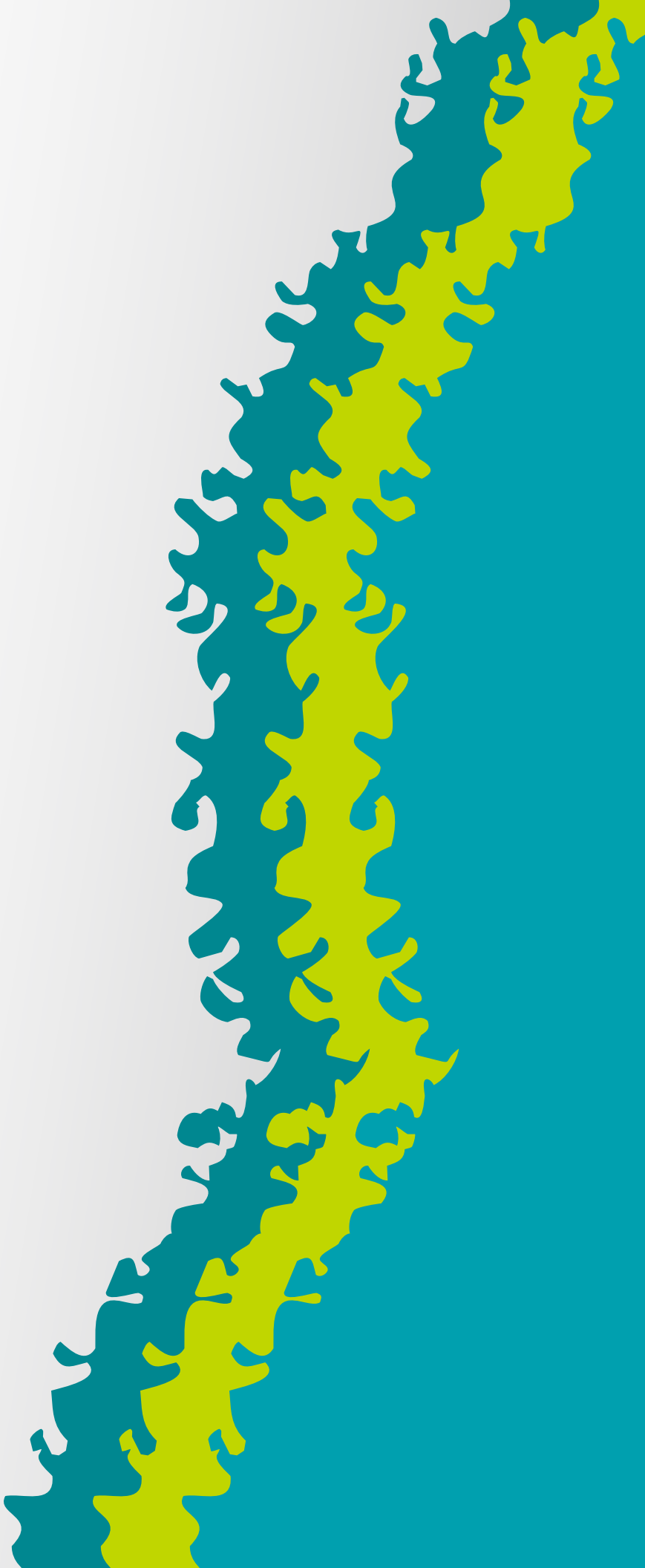
Publicly funded contract cost: $2,591,793,904

Description of work performed under this contract

Molina Healthcare of Wisconsin is contracted to provide managed care services for the Wisconsin BadgerCare Plus program, which provides comprehensive healthcare services to Members enrolled in Molina under the State of Wisconsin BadgerCare Plus (TANF/CHIP) and/or Medicaid SSI program. BadgerCare Plus is a Medicaid program that provides healthcare coverage for children and pregnant women up to 300% of the Federal Poverty Level and qualifying adults up to 100% of the Federal Poverty Level. Medicaid SSI provides healthcare coverage for SSI Members and the ABD population. We provide services for promoting coordination and continuity of preventive health services and other medical care, including prenatal care, emergency care, and HealthCheck services. Recently, Wisconsin has required that Molina provide narcotic treatment services to Members.

4.3.2

Ownership and Financial Disclosure Information



MARKED

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.

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 [X] 5% or More Ownership Interest(percentage owned:100%)				
Effective Date of Ownership: 3/2/2009				
Legal Business Name as Reported to the Internal Revenue Service: Molina Healthcare, Inc.				
Doing Business As Name (if applicable):	Tax Identification Number (required): 13-4204626			
Primary Business Address				
Line 1 (Street Name and Number): 200 Oceangate,				
Address Line 2 (Suite, Room, etc.): Suite 100				
City: Long Beach	State: CA	Zip Code: 90802	County: Los Angeles	
Mailing Address (P.O. Box): 200 Oceangate, Suite 100	City: Long Beach	State: CA	Zip Code: 90802	County: Los Angeles
Business Location				
Address Line 1: 100 Oceangate				
Address Line 2: 15th Floor				
City: Long Beach	State: CA	Zip Code: 90802	County: Los Angeles	
Business Location				
Address Line 1: 604 Pine Ave.				
Address Line 2:				
City: Long Beach	State: CA	Zip Code: 90802-1329	County: Los Angeles	
Business Location				
Address Line 1: 650 Pine Ave.				
Address Line 2:				
City: Long Beach	State: CA	Zip Code: 90802-1320	County: Los Angeles	
Business Location				
Address Line 1: 2180 Harvard Street				
Address Line 2: Suite 400				
City: Sacramento	State: CA	Zip Code: 95815	County: Sacramento	

Business Location			
Address Line 1: 1660 N. Westridge Circle			
Address Line 2:			
City: Irving	State: TX	Zip Code: 75038	County: Dallas
Business Location			
Address Line 1: 70 E 55th Street			
Address Line 2: 8th & 9th Floors			
City: New York	State: NY	Zip Code: 10022	County: New York
Business Location			
Address Line 1: 3959 Pender Drive			
Address Line 2: Suite 240			
City: Fairfax	State: VA	Zip Code: 22030	County: Fairfax
Business Location			
Address Line 1: 1330 North Washington Street			
Address Line 2: Suite 4000			
City: Spokane	State: WA	Zip Code: 99201	County: Spokane

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 Barlow	First Name Jeff	MI D	Suffix
Title Secretary	Social Security Number (required) [redacted]	Date of Birth (MM/DD/YYYY) [redacted]	Gender (M/F) M
Home Address Line 1 [redacted]			
Address Line 2			
City Sacramento	State CA	Zip Code 95864	County Sacramento
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): <text>			
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
[x] Director/Officer	07/29/2010	[ ] Managing Employee (W-2)	<text>
[ ] Contracted Managing Employee	<text>	[ ] Agent	<text>
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): <text>			

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 Wolf	First Name Matthew	MI D	Suffix
Title Director	Social Security Number (required) [redacted]	Date of Birth (MM/DD/YYYY) [redacted]	Gender (M/F) M
Home Address Line 1 [redacted]			
Address Line 2			
City Downers Grove	State Illinois	Zip Code 60516	County DuPage
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): <text>			
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
[x] Director/Officer	10/29/2019	[ ] Managing Employee (W-2)	<text>
[ ] Contracted Managing Employee	<text>	[ ] Agent	<text>
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): <text>			

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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.			
Last Name Galatas	First Name Bridget	MI L	Suffix
Title Director / President	Social Security Number (required) [redacted]	Date of Birth (MM/DD/YYYY) [redacted]	Gender (M/F) F
Home Address Line 1 [redacted]			
Address Line 2			
City Destrehan	State LA	Zip Code 70047	County St. Charles Parish
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): <text>			
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
[x] Director/Officer Director (top); President (bottom)	10/08/2018 12/11/2017	[ ] Managing Employee (W-2)	<text>
[ ] Contracted Managing Employee	<text>	[ ] Agent	<text>
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): <text>			

[REST OF PAGE INTENTIONALLY LEFT BLANK]

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 Lynam	First Name Benjamin	MI E	Suffix
Title Director	Social Security Number (required) [redacted]	Date of Birth (MM/DD/YYYY) [redacted]	Gender (M/F) M
Home Address Line 1 [redacted]			
Address Line 2			
City Huntington Beach	State CA	Zip Code 92648	County Orange 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): <text>			
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
[x] Director/Officer	3/29/2021	[ ] Managing Employee (W-2)	<text>
[ ] Contracted Managing Employee	<text>	[ ] Agent	<text>
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): <text>			

[REST OF PAGE INTENTIONALLY LEFT BLANK]

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 LeBlanc	First Name Caroline	MI R	Suffix
Title Chief Financial Officer	Social Security Number (required) [redacted]	Date of Birth (MM/DD/YYYY) [redacted]	Gender (M/F) F
Home Address Line 1 [redacted]			
Address Line 2			
City Flowood	State MS	Zip Code 39232	County Rankin
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): <text>			
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
[x] Director/Officer	5/29/2020	[ ] Managing Employee (W-2)	<text>
[ ] Contracted Managing Employee	<text>	[ ] Agent	<text>
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): <text>			

[REST OF PAGE INTENTIONALLY LEFT BLANK]

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 Joiner	First Name Thomas	MI E	Suffix M.D.
Title Chief Medical Officer	Social Security Number (required) [redacted]	Date of Birth (MM/DD/YYYY) [redacted]	Gender (M/F) M
Home Address Line 1 [redacted]			
Address Line 2			
City Brandon	State MS	Zip Code 39047	County Rankin
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): <text>			
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
[x] Director/Officer	1/30/2018	[ ] Managing Employee (W-2)	<text>
[ ] Contracted Managing Employee	<text>	[ ] Agent	<text>
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): <text>			

[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 [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): Molina Healthcare, Inc.			
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: <text>			
Effective Date of Ownership and/or Management Control:			
Legal Business Name of Subcontractor as Reported to the Internal Revenue Service: Molina Healthcare, Inc.			
Doing Business As Name (if applicable):	Tax Identification Number (required): 13-4204626		
Primary Business Address			
Line 1 (Street Name and Number): 200 Oceangate, Suite 100			
Address Line 2 (Suite, Room, etc.):			
City: Long Beach	State: CA	Zip Code: 90802	County: Los Angeles
Mailing Address (P.O. Box): 200 Oceangate, Suite 100	City: Long Beach	State: CA	Zip Code: 90802	County: Los Angeles
Additional Business Location(s): Duplicate this page to provide all locations if necessary.			
Address Line 1: 100 Oceangate			
Address Line 2: 15th Floor			
City: Long Beach	State: CA	Zip Code: 90802	County: Los Angeles
Business Location			
Address Line 1: 604 Pine Ave.			
Address Line 2:			
City: Long Beach	State: CA	Zip Code: 90802-1329	County: Los Angeles
Business Location			
Address Line 1: 650 Pine Ave.			
Address Line 2:			
City: Long Beach	State: CA	Zip Code: 90802-1320	County: Los Angeles
Business Location			
Address Line 1: 2180 Harvard Street			
Address Line 2: Suite 400			
City: Sacramento	State: CA[72]	Zip Code: 95815	County: Sacramento

Business Location			
Address Line 1: 1660 N. Westridge Circle			
Address Line 2:			
City: Irving	State: TX	Zip Code: 75038	County: Dallas
Business Location			
Address Line 1: 70 E 55th Street			
Address Line 2: 8th & 9th Floors			
City: New York	State: NY	Zip Code: 10022	County: New York
Business Location			
Address Line 1: 3959 Pender Drive			
Address Line 2: Suite 240			
City: Fairfax	State: VA	Zip Code: 22030	County: Fairfax
Business Location			
Address Line 1: 1330 North Washington Street			
Address Line 2: Suite 4000			
City: Spokane	State: WA	Zip Code: 99201	County: Spokane

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.**
Molina Healthcare, Inc.	• Molina Healthcare of Arizona, Inc. • Molina Healthcare of California • Molina Healthcare of Florida, Inc. • Molina Healthcare of Georgia, Inc. • Molina Healthcare of Illinois, Inc. • Molina Healthcare of Iowa, Inc. • Molina Healthcare of Kentucky, Inc. • Molina Healthcare of Michigan, Inc. • Molina Healthcare of Mississippi, Inc. • Molina Healthcare of Nevada, Inc. • Molina Healthcare of New Mexico, Inc. • Molina Healthcare of New York, Inc. • Molina Healthcare of Ohio, Inc. • Molina Healthcare of Oklahoma, Inc. • Molina Healthcare of Puerto Rico, Inc. • Molina Healthcare of South Carolina, Inc. • Molina Healthcare of Texas Insurance Company • Molina Healthcare of Texas, Inc. • Molina Healthcare of Utah, Inc. • Molina Healthcare of Virginia, LLC • Molina Healthcare of Washington, Inc. • Molina Healthcare of Wisconsin, Inc. • Senior Whole Health, LLC	Ownership	100%

	• Senior Whole Health of New York, Inc.		
Barlow, Jeff D.	• 2028 West Broadway, LLC • Alpha Care Holdings, Inc. • Florida MHS, Inc. (dba Magellan Complete Care of Florida) • Molina Care Connections, LLC • Molina Clinical Services, LLC • Molina Healthcare, Inc. • Molina Healthcare Data Center, LLC • Molina Healthcare of Arizona, Inc. • Molina Healthcare of California • Molina Healthcare of Florida, Inc. • Molina Healthcare of Illinois, Inc. • Molina Healthcare of Iowa, Inc. • Molina Healthcare of Kentucky, Inc. • Molina Healthcare of Michigan, Inc. • Molina Healthcare of Mississippi, Inc. • Molina Healthcare of Nevada, Inc. • Molina Healthcare of New Mexico, Inc. • Molina Healthcare of New York, Inc. • Molina Healthcare of Ohio, Inc. • Molina Healthcare of Puerto Rico, Inc. • Molina Healthcare of Rhode Island, Inc. • Molina Healthcare of Texas, Inc. • Molina Healthcare of Texas Insurance Company • Molina Healthcare of Utah, Inc. • Molina Healthcare of Virginia, LLC • Molina Healthcare of Washington, Inc. • Molina Healthcare of Wisconsin, Inc. • Molina Pathways, LLC • Oceangate Reinsurance, Inc. • Senior Health Holdings, Inc. • Senior Health Holdings, LLC • Senior Whole Health Management Company, Inc. • Senior Whole Health of New York, Inc. • Senior Whole Health, LLC. • SWH Holdings, Inc. • The Management Group, LLC.	Management	N/A
Galatas, Bridget L.	• Molina Healthcare of Mississippi, Inc.	Management	N/A

Joiner, Thomas E.	• Molina Healthcare of Mississippi, Inc.	Management	N/A
LeBlanc, Caroline R.	• Molina Healthcare of Mississippi, Inc.	Management	N/A
Lynam, Benjamin E.	• Florida MHS, Inc. • Molina Healthcare of Arizona, Inc. • Molina Healthcare of California • Molina Healthcare of Florida, Inc. • Molina Healthcare of Illinois, Inc. • Molina Healthcare of Kentucky, Inc. • Molina Healthcare of Michigan, Inc. • Molina Healthcare of Mississippi, Inc. • Molina Healthcare of Nevada, Inc. • Molina Healthcare of New Mexico, Inc. • Molina Healthcare of New York, Inc. • Molina Healthcare of Ohio, Inc. • Molina Healthcare of Puerto Rico, Inc. • Molina Healthcare of South Carolina, Inc. • Molina Healthcare of Texas Insurance Company • Molina Healthcare of Texas, Inc. • Molina Healthcare of Utah, Inc. • Molina Healthcare of Virginia, LLC • Molina Healthcare of Washington, Inc. • Molina Healthcare of Wisconsin, Inc. • Oceangate Reinsurance, Inc. • Senior Whole Health of New York, Inc. • Senior Whole Health, LLC • The Management Group, LLC	Management	N/A
Wolf, Matthew D.	• Molina Healthcare of Illinois, Inc. • Molina Healthcare of Mississippi, Inc. • Molina Healthcare of Nevada, Inc.	Management	N/A

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.

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.

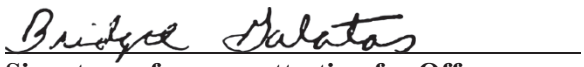
In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency.

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.

Molina Healthcare of Mississippi, Inc.
Name of Offeror

Bridget L. Galatas
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror


Signature of person attesting for Offeror

March 3, 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.

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: Molina Healthcare, Inc.	
TIN/SSN (as applicable): 13-4204626	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 200 Oceangate, Ste. 100, Long Beach, CA 90802	
Date of Transaction: 10/2018–12/2021	**Amount of Transaction:** $131,528,662.00
Name of Entity with Whom the Transaction Took Place: March Vision Care Group, Incorporated	
TIN/SSN (as applicable): 95-4874334	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 6601 Center Dr. W., Ste 200, Los Angeles, CA 90045	
Date of Transaction: 10/2018–12/2021	**Amount of Transaction:** $13,753,792
Name of Entity with Whom the Transaction Took Place: SKYGEN, USA	
TIN/SSN (as applicable): 81-0762694	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: W140 N8981 Lilly Rd., Menomonee Falls, WI 53051	
Date of Transaction: 09/2021–12/2021	**Amount of Transaction:** $5,373,284.00

Name of Entity with Whom the Transaction Took Place: Medical Transportation Management, Inc.	
TIN/SSN (as applicable): 43-1719762	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary**
Address of Subcontractor: 635 Maryville Centre, Ste. 300, St. Louis, MO 63141	
Date of Transaction: 09/2020–12/2021	**Amount of Transaction:** $1,794,812.00

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:

[X] 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.

Molina Healthcare of Mississippi, Inc.
Name of Offeror

Bridget L. Galatas
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror

Bridget Galatas
Signature of person attesting for Offeror

March 3, 2022
Date

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.

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.

Molina Healthcare of Mississippi, Inc.
Name of Offeror

Bridget L. Galatas
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror

Bridget Galatas
Signature of person attesting for Offeror

March 3, 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.

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.

Molina Healthcare of Mississippi, Inc.
Name of Offeror

Bridget L. Galatas
Printed name of person attesting for Offeror

Chief Executive Officer
Title of person attesting for Offeror

Bridget Galatas
Signature of person attesting for Offeror

March 3, 2022
Date

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.

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,
2. Three (3) year financial pro forma. Appendix G provides a link to the pro forma template to be completed by the Offeror.

The Division reserves the right to request any additional information to assure itself of an Offeror's financial status.

In response to this requirement, Molina provides audited financial statements, documentation of available lines of credit, and our three-year financial pro forma.

4.3.2.6 Appendix 1: Audited Financial Statements. Statutory-Basis Financial Statements and Report of Independent Certified Public Accountants for Molina Healthcare of Mississippi, Inc., are provided for the three years ending December 31, 2020 and 2019; December 31, 2019 and 2018; and December 31, 2018 and 2017. Each statement includes, at a minimum, a statement of income, balance sheet, statement of changes in financial position during the last three years, statement of cash flow, auditors' reports, notes to financial statements, and summary of significant accounting policies.

4.3.2.6 Appendix 2: Documentation of Available Lines of Credit. Our parent company, Molina Healthcare, Inc. (Molina Healthcare), is a Fortune 500 corporation whose common stock is publicly traded on the New York Stock Exchange under the symbol MOH. As a publicly traded company, our parent has access to a wide range of financing sources, including publicly traded equity securities, publicly traded debt securities, revolving bank lines of credit, bank loans, and lease financing.

We have full access to the financial resources of Molina Healthcare, including a line of credit. This line of credit is part of a credit agreement that includes a $1.0 billion revolving credit facility with an available borrowing capacity of $1.0 billion as of February 15, 2022. The credit facility has a term of 5 years, and all amounts outstanding become due and payable on June 8, 2025. Our line of credit and the maximum credit amount is documented in Molina Healthcare's Form 10-K for the fiscal year ended December 31, 2021, which was filed with the US Securities and Exchange Commission on February 14, 2022. See Attachment 4.3.2.6-2, Form 10-K Extract, Notes to Consolidated Financial Statements, Note 11, Debt, Credit Agreement, page 74. As of December 31, 2021, no amounts were outstanding under the revolving credit facility, and there have been no changes to that status through February 15, 2022.

4.3.2.6 Appendix G: Financial Pro Forma. We have completed the pro forma template in RFQ Appendix G.

[END OF RESPONSE]

4.3.2.6 AUDITED FINANCIAL STATEMENTS AND PRO FORMA FINANCIAL TEMPLATE

Appendix 1

Audited Financial Statements

Statutory Basis Financial Statements and Report of Independent Certified Public Accountants

Molina Healthcare of Mississippi, Inc.

December 31, 2020 and 2019

Contents

GRANT THORNTON LLP
100 E. Wisconsin Ave., Suite 2100
Milwaukee, WI 53202

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REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

Board of Directors and Stockholder
Molina Healthcare of Mississippi, Inc.

We have audited the accompanying statutory-basis financial statements of Molina Healthcare of Mississippi, Inc. (a Mississippi corporation), which comprise the statutory-basis statement of admitted assets, liabilities, capital and surplus as of December 31, 2020 and 2019, and the related statutory-basis statements of revenues and expenses, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory-basis financial statements.

Management's responsibility for the financial statements
Management is responsible for the preparation and fair presentation of these statutory-basis financial statements in accordance with accounting practices prescribed or permitted by the Mississippi Insurance Department; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of statutory-basis financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility
Our responsibility is to express an opinion on these statutory-basis financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the statutory-basis financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory-basis financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the statutory-basis financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the statutory-basis financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory-basis financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for adverse opinion on generally accepted accounting principles
We draw attention to Note A of the statutory-basis financial statements, the statutory-basis financial statements are prepared by Molina Healthcare of Mississippi, Inc. on the basis of the financial reporting provisions prescribed or permitted by the Mississippi Insurance Department, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Mississippi Insurance Department.

The effects on the statutory-basis financial statements of the variance between the regulatory basis of accounting described in Note A and accounting principles generally accepted in the United States of America, although not reasonably determinable are presumed to be material.

Adverse opinion on generally accepted accounting principles
In our opinion, because of the significance of the matter discussed in the Basis for Adverse Opinion on Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly the financial position of Molina Healthcare of Mississippi, Inc. as of December 31, 2020 and 2019, or changes in financial position or cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Opinion of statutory-basis of accounting
In our opinion, the statutory-basis financial statements referred to above present fairly, in all material respects, the financial position of Molina Healthcare of Mississippi, Inc. as of December 31, 2020 and 2019, and the results of its operations and its cash flows for the years then ended in accordance with the basis of accounting practices prescribed or permitted by the Mississippi Insurance Department, described in Note A.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the statutory-basis financial statements as a whole. The summary investment schedule and the supplementary investment risks interrogatories as of December 31, 2020, are presented for the purpose of additional analysis and are not a required part of the statutory-basis financial statements. Such supplementary information is the responsibility of the management and was derived from and relates directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. The information has been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures. These additional procedures included comparing and reconciling the information directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary information is fairly stated in all material respects, in relation to the statutory-basis financial statements as a whole.

Grant Thornton LLP

Milwaukee, Wisconsin
May 13, 2021

Molina Healthcare of Mississippi, Inc.
Statements of Admitted Assets, Liabilities, Capital and Surplus
As of December 31,

ASSETS	2020	2019
Cash and invested assets		
Cash and cash equivalents	$ 136,056,103	$ 57,365,392
Short-term investments	-	314,860
Bonds	24,571,393	13,712,436
Total cash and invested assets	160,627,496	71,392,688
Investment income due and accrued	174,395	140,104
Premiums due and unpaid	9,461,222	37,853,768
Amounts recoverable from reinsurers	752,053	-
Amounts receivable relating to uninsured plans	1,286,497	98,744
Current federal and foreign income tax recoverable and interest thereon	971,488	-
Net deferred tax asset	1,624,082	-
Health care and other amounts receivable	1,399,687	547,514
Premium taxes recoverable	258,270	-
TOTAL ASSETS	$ 176,555,190	$ 110,032,818
LIABILITIES, CAPITAL AND SURPLUS		
Liabilities		
Claims unpaid	$ 44,422,604	$ 53,228,732
Unpaid claims adjustment expenses	773,445	930,060
Aggregate health policy reserves	37,001,392	-
Premiums received in advance	1,116,466	196,896
General expenses due and accrued	7,677,014	5,958,128
Federal income tax payable	-	28,509
Amounts due to Parent and affiliates	3,272,326	2,252,386
Payable for securities	-	284,941
Reinsurance in unauthorized and certified companies	752,053	-
Liability for amounts held under uninsured plans	829,823	-
Amounts due to government agencies	8,524,122	3,703,520
Total liabilities	104,369,245	66,583,172
Capital and surplus		
Common stock, no par value (10,000 shares authorized and 100 shares issued and outstanding)	-	-
Special surplus funds	-	6,600,000
Paid-in surplus	60,000,000	60,000,000
Surplus notes	10,000,000	13,000,000
Unassigned surplus	2,185,945	(36,150,354)
Total capital and surplus	72,185,945	43,449,646
TOTAL LIABILITIES, CAPITAL AND SURPLUS	$ 176,555,190	$ 110,032,818

The accompanying notes are an integral part of these statutory basis financial statements.

Molina Healthcare of Mississippi, Inc.
Statements of Revenue and Expenses
Years ended December 31,

	2020	2019
Revenue		
Net premium income	$ 481,557,247	$ 338,350,855
Change in unearned premium reserves and reserve for rate credits	(35,730,634)	-
Total revenue	445,826,613	338,350,855
Expenses		
Hospital and medical benefits	216,036,787	223,875,305
Other professional services	23,020,880	17,672,583
Outside referrals	4,605,780	8,689,436
Emergency room and out-of-area	39,567,027	43,388,244
Pharmacy	53,442,817	31,028,647
Net reinsurance recoveries	(752,053)	-
Total hospital and medical expenses	335,921,238	324,654,215
Claims adjustment expenses	10,472,915	7,180,765
General administrative expenses	58,282,023	35,976,297
Total expenses	404,676,176	367,811,277
Net underwriting gain (loss)	41,150,437	(29,460,422)
Other income (expense)		
Net investment income earned	798,787	1,278,143
Net realized capital gains, less capital gains tax expense of $43 and $14, respectively	161	51
Other expense	(99,544)	(26,100)
Total other income	699,404	1,252,094
Aggregate write-ins for other income		
Net income (loss) before federal income taxes	41,849,841	(28,208,328)
Federal income taxes incurred	10,049,960	(5,278,144)
NET INCOME (LOSS)	$ 31,799,881	$ (22,930,184)

The accompanying notes are an integral part of these statutory basis financial statements.

Molina Healthcare of Mississippi, Inc.
Statements of Changes in Capital and Surplus
Years ended December 31,

	2020	2019
Capital and surplus, beginning of year	$ 43,449,646	$ 28,915,372
Net income (loss)	31,799,881	(22,930,184)
Change in net deferred income tax	1,624,082	-
Change in nonadmitted assets	(935,611)	(2,535,542)
Change in unauthorized and certified reinsurance	(752,053)	-
Change in surplus notes	(3,000,000)	13,000,000
Capital contributions	-	27,000,000
Capital and surplus, end of year	$ 72,185,945	$ 43,449,646

The accompanying notes are an integral part of these statutory basis financial statements.

Molina Healthcare of Mississippi, Inc.
Statements of Cash Flows
Years ended December 31,

	2020	2019
Operations		
Net premiums and revenues collected	$ 516,960,722	$ 308,523,815
Net investment income received	1,019,922	1,151,137
Benefit and loss-related payments	(347,431,592)	(284,667,791)
General administrative payments	(67,485,939)	(37,972,104)
Federal income taxes paid	(11,050,000)	5,205,000
Net cash provided by/(used in) operations	92,013,113	(7,759,943)
Investment activities		
Proceeds from bonds sold or matured	1,358,483	795,007
Cost of bonds acquired	(12,757,602)	(13,717,809)
Net cash used in investment activities	(11,399,119)	(12,922,802)
Financing and miscellaneous activities		
Surplus notes	(3,000,000)	13,000,000
Capital contributions	-	27,000,000
Other cash provided (applied)	761,857	2,195,242
Net cash (used in)/provided by financing and miscellaneous activities	(2,238,143)	42,195,242
Net increase in cash, cash equivalents and short-term investments	78,375,851	21,512,497
Cash, cash equivalents and short-term investments, beginning of year	57,680,252	36,167,755
Cash, cash equivalents and short-term investments, end of year	$ 136,056,103	$ 57,680,252

The accompanying notes are an integral part of these statutory basis financial statements.

Note 1 – Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

Molina Healthcare of Mississippi, Inc. (the Plan) was incorporated under the laws of the state of Mississippi on March 2, 2009. The Plan is a wholly owned subsidiary of Molina Healthcare, Inc. (Molina, or the Parent), a multi-state managed care organization that arranges for the delivery of healthcare services to persons eligible for Medicaid, Medicare, the state insurance marketplace (the Marketplace), and other government-sponsored health care programs for low-income families and individuals.

The Plan is a health maintenance organization (HMO), licensed in the state of Mississippi, that provides comprehensive health care services to Medicaid enrollees under contracts with the state of Mississippi, Office of the Governor, Division of Medicaid (Division). The Plan's Medicaid contract with the Division is effective through June 30, 2022. The Plan also serves individuals through the state's Marketplace. In some instances, the Marketplace allows individuals to purchase health insurance that is federally subsidized. Such contracts represent the majority of the Plan's source of premium income for the years ended December 31, 2020 and 2019.

The Plan contracts with independent physician associations, hospitals and other providers to provide medical services to its members. As an HMO, the Plan is at risk for all covered outpatient and inpatient claims incurred by its beneficiaries.

The financial statements of the Plan are presented on the basis of accounting practices prescribed or permitted by the Mississippi Insurance Department (the Department). The Department practices differ from accounting principles generally accepted in the United States of America (GAAP) as follows:

Certain assets designated as "nonadmitted assets" are excluded from the statutory basis statements of admitted assets, liabilities, capital and surplus, and the change in such assets is credited or charged directly to unassigned surplus. Assets considered to be non-admitted were as follows as of December 31, 2020 and 2019:

	2020	2019
EDP equipment and software, furniture, and equipment	$ 766,721	$ 930,923
Health care receivable	3,772,005	2,672,005
Prepaid and other assets	-	187
	$ 4,538,726	$ 3,603,115

For other significant differences from GAAP refer to Note 1.C below.

The Department recognizes only statutory accounting practices prescribed or permitted by the state of Mississippi for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under the Mississippi insurance law. The National Association of Insurance Commissioners' *Accounting Practices and Procedures Manual* (NAIC SAP) has been adopted as a component of prescribed or permitted practices by the state of Mississippi.

Such prescribed accounting practices have no effect on the Plan's statutory basis financial statements for the periods presented.

B. Use of Estimates in the Preparation of the Financial Statement

The preparation of financial statements in conformity with Statutory Accounting Principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. It also requires disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

C. Accounting Policy

The Plan applies the following accounting policies:

(1) Basis for Short-Term Investments: Short-term investments consist primarily of U.S. treasury notes and investments in corporate debt securities with maturity dates of greater than three months but less than one year at the time of acquisition. The basis of short-term investments is the same as for bonds as stated in Note C(2) below.

(2) Basis for Bonds and Amortization Schedule: Bonds include U.S. government and other debt securities with maturity dates of greater than one year at the time of purchase. Bonds not backed by other loans are principally stated at amortized cost using the scientific method. Bonds with NAIC designations of one or two are stated at amortized cost. Bonds with NAIC designations of three or higher are stated at the lower of amortized cost or fair value. Amortization of bond premium or accretion of discount is computed using the scientific (constant-yield) interest method. Realized capital gains and losses are determined using the specific- identification method and were not significant for the years ended December 31, 2020 and 2019. There were no significant unrealized gains or losses on investments, and the Plan recognized no losses from other-than-temporary impairments for the years ended December 31, 2020 and 2019.

(3) Basis for Loan-Backed Securities and Adjustment Methodology: Loan-backed securities are stated at amortized cost or lower of amortized cost or fair value. The Plan's investments in loan-backed securities consist of asset-backed securities and mortgage-backed securities. Prepayment assumptions using a prospective approach were obtained from broker-dealer survey values or internal estimates.

(4) Anticipated Investment Income Used in Premium Deficiency Calculation: The Plan assesses the profitability of its medical care policies to identify groups of contracts where current operating results or forecasts indicate probable future losses. The Plan anticipates investment income as a factor in the premium deficiency calculation, in accordance with Statement of Statutory Accounting Principles (SSAP) No. 54, *Individual and Group Accident and Health Contracts*. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. The Plan has not recorded any premium deficiency reserves as of December 31, 2020 or 2019.

(5) Management's Policies and Methodologies for Estimating Liabilities for Losses and Loss/Claim Adjustment Expenses for Accident & Health Contracts: Claims unpaid are based on actual historical experience and estimates of medical expenses incurred but not paid (IBNP). The Plan employs its own actuaries to estimate IBNP monthly. The estimation of the IBNP liability requires a significant degree of judgment in applying actuarial methods, determining the appropriate assumptions and considering numerous factors. Of those factors, the Plan considers estimated completion factors and the assumed healthcare cost trend to be the most critical assumptions. Other relevant factors also include, but are not limited to, healthcare service utilization trends, claim inventory levels, changes in membership, product mix, seasonality, benefit changes or changes in Medicaid fee schedules, provider contract changes, prior authorizations and the incidence of catastrophic or pandemic cases. Because of the significant degree of judgment involved in estimation of the IBNP liability, there is considerable variability and uncertainty inherent in such estimates. Each reporting period, the recognized IBNP liability represents the Plan's best estimate of the total amount of unpaid claims incurred as of the balance sheet date using a consistent methodology in estimating the IBNP liability. The Plan believes its current estimates are reasonable and adequate; however, the development of the estimate is a continuous process that is monitored and updated as more complete claims payment information and healthcare cost trend data becomes available. Actual hospital and medical expenses may be less than previously estimated (favorable development) or more than previously estimated (unfavorable development), and any differences could be material. Any adjustments to reflect favorable development would be recognized as a decrease to hospital and medical expenses, and any adjustments to reflect unfavorable development would be recognized as an increase to hospital and medical expenses, in the period in which the adjustments are determined. Refer to Note 15, "Change in Incurred Claims and Claim Adjustment Expenses," for further information.

(6) Changes in the Capitalization Policy and Predefined Thresholds from Prior Period: The Plan has not modified its capitalization policy from the prior period.

Electronic data processing (EDP) equipment and software, which is non-admitted, is depreciated using the straight-line method over the lesser of its useful life or three years. Depreciation expense related to EDP equipment and operating system software totaled $19,125 for both years ended December 31, 2020 and 2019.

Furniture and equipment and leasehold improvements, which are non-admitted, are generally depreciated using the straight-line method over the estimated useful lives of the assets. Depreciation expense related to furniture and equipment and leasehold improvements totaled $145,078 and $145,409 for the years ended December 2020 and 2019, respectively.

(7) Method Used to Estimate Pharmaceutical Rebate Receivables: Amounts receivable for pharmaceutical rebates are estimated based upon historical and current utilization of prescription drugs and contract terms. Income from pharmaceutical rebates is reported as a reduction of hospital and medical expenses in the statutory basis statements of revenue and expenses. The Plan admits estimated pharmaceutical rebate receivables relating to the three months immediately preceding the reporting date in accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans*. Refer to Note 16, "Health Care Receivables" for further information.

The Plan has also deemed the following to be significant accounting policies and/or differences between statutory practices and GAAP:

Cash and Invested Assets

Cash and cash equivalents are defined as cash and short-term highly liquid investments that are both readily convertible into known amounts of cash and so near maturity that they represent insignificant risk of changes in value because of changes in interest rates. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP cash overdraft balances would be classified as liabilities. Only investments with original maturities of three months or less when purchased qualify under this definition with the exception of money market mutual funds (MMMF) registered under the Investment Company Act of 1940 (the Act) and regulated under rule 2a-7 of the Act as described in SSAP No. 2R, *Cash, Cash Equivalents, Drafts and Short-Term Investments*. Under GAAP, the corresponding caption of cash, cash equivalents, and short-term investments include cash balances and investments that will mature in one year or less from the balance sheet date. MMMF are reported at fair value or net asset value (NAV) as a practical expedient.

Investments in bonds are reported at amortized cost or fair value based on their NAIC designation. Under GAAP, investments in bonds are grouped into three separate categories for accounting and reporting purposes: available-for-sale securities, held-to-maturity securities, and trading securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. Trading securities are recorded at fair value, and holding gains and losses are recognized in net income.

Premiums Due and Unpaid

Premiums due and unpaid at December 31, 2020 and 2019, consist primarily of amounts due from the Division. Premiums due and unpaid balances are stated at net realizable value based on management's judgment of the ultimate collectibility of the accounts. Collection trends are monitored and any adjustments required are reflected in current earnings. Premiums due and unpaid balances outstanding greater than 90 days due, with the exception of premiums due from governmental agencies, are non-admitted in accordance with NAIC SAP.

Net Deferred Tax Assets or Liabilities

The Plan follows the guidance of SSAP No. 101, *Income Taxes,* for deferred income taxes. Deferred tax assets and liabilities are recorded for temporary differences between the tax basis of assets and liabilities and their amounts reported on the financial statements, using statutory rates in effect for the year in which the differences are expected to reverse. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as a change in surplus in the period that includes the enactment date. SSAP No. 101 includes a valuation allowance criterion whereby only gross deferred tax assets that are more likely than not (defined as a likelihood of more than 50%) to be realized are potentially admissible, subject to certain limitations and admissibility tests. Under GAAP, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets not realizable.

Accrued Retrospective Premiums and Contracts Subject to Redetermination and Aggregate Health Policy Reserves

Accrued retrospective premiums and contracts subject to redetermination, and aggregate health policy reserves relate to amounts recorded under various programs and contractual provisions discussed in Note 14, "Retrospectively Rated Contracts and Contracts Subject to Redetermination".

Net Deferred Tax Assets or Liabilities

The Plan follows the guidance of SSAP No. 101, *Income Taxes*, for deferred income taxes. Deferred tax assets and liabilities are recorded for temporary differences between the tax basis of assets and liabilities and their amounts reported in the financial statements, using statutory rates in effect for the year in which the differences are expected to reverse. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as a change in surplus in the period that includes the enactment date. SSAP No. 101 includes a valuation allowance criterion whereby only gross deferred tax assets that are more likely than not (defined as a likelihood of more than 50%) to be realized are potentially admissible, subject to certain limitations and admissibility tests. Under GAAP, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets not realizable.

Receivables from or Amounts Due to Parent and Affiliates

The Plan has various transactions with Molina and the Plan's affiliates. In the statutory basis statements of admitted assets, liabilities, capital and surplus, the Plan reports any unsettled amounts due from Molina and affiliates as "Receivables from Parent and affiliates." The Plan reports unsettled amounts owed to Molina and affiliates as "Amounts due to Parent and affiliates." Refer to Note 5, "Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties" for further information.

Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held Under Uninsured Plans

The Plan reports amounts receivable relating to uninsured plans due from and liability for amounts held under uninsured plans due to Medicaid agency for the administrative activities the Plan performs for which it has no underwriting risk.

Under the Medicaid program, the receivables or payables relate to Medicaid pass-throughs. The Plan receives certain amounts from the Medicaid agency, which are fully passed through to designated providers. The Plan therefore serves as a fiscal intermediary between the state and providers and does not assume underwriting risk in such arrangements. The Plan received pass-through payments amounting to $46,528,971 and $29,073,724 in 2020 and 2019, respectively, which are not reflected as revenue or expense in the statutory-basis statement of revenue and expenses. Refer to Note 10, " Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans", for further information.

Net Premium Income and Change in Reserve for Rate Credits

Premium revenue is recognized in the month that members are entitled to receive healthcare services. Premiums collected in advance of a coverage period are recorded as premiums received in advance. Premium revenue is generally received based on per-member per-month rates established in advance of the periods covered, except as described below and in Note 14, "Retrospectively Rated Contracts and Contracts Subject to Redetermination".

Medicaid Program

Medical Cost Floors (Medical Loss Ratio or MLR) and Corridors: For certain Medicaid premiums, amounts may be returned to the Division if certain minimum amounts are not spent on defined medical care costs, or the Plan may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Additionally, sanctions may be levied by the Division if the amounts spent on medical care costs as a percentage of premiums are not within a specified range. These sanctions include the requirements to file a corrective action plan as well as an auto assignment freeze.

In 2020, Mississippi enacted temporary premium refunds and related actions in response to the reduced demand for medical services stemming from COVID-19, which resulted in a reduction of the Plan's medical margin. In some cases, these premium actions were retroactive to earlier periods in 2020, or as early as the beginning of the states' fiscal years in 2019. Beginning in the second quarter of 2020, we have recognized retroactive premium actions that we believe to be probable, and where the ultimate premium amount is reasonably estimable. The Plan recognized approximately $28,600,000 related to these retroactive premium adjustments.

Marketplace Program

Risk Adjustment: Under this program, the Plan's composite risk scores are compared with the overall average risk score for the state and market pool. Generally, the Plan will make a risk adjustment payment into the pool if its composite risk scores are below the average risk score (risk adjustment payable), and will receive a risk adjustment payment from the pool if their composite risk scores are above the average risk score (risk adjustment receivable). The Plan estimates its ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to net premium income in the statutory basis statements of revenues of expenses. See Note 14, "Retrospectively Rated Contracts and Contracts Subject to Redetermination" for further information.

Minimum MLR: The ACA has established a Minimum MLR of 80% for the Marketplace. If the Minimum MLR is not met, the Plan may be required to pay rebates to its Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. The Plan recognizes estimated rebates under the Minimum MLR as an adjustment to net premium income in the statutory basis statements of revenues of expenses.

Hospital and Medical Expenses

Hospital and medical expenses include primarily fee-for-services expenses: Hospital and medical expenses are recognized in the period in which services are provided and include fee-for-service claims, pharmacy benefits, capitation payments to providers, and various other medically-related costs. Under fee-for-service claims arrangements with providers, the Plan retains the financial responsibility for medical care provided and incurs costs based on actual utilization of hospital and physician services. Such hospital and medical expenses include amounts paid by the Plan as well as estimated medical claims and benefits payable for costs that were IBNP as of the reporting date. Pharmacy benefits represent payments for members' prescription drug costs, net of rebates from drug manufacturers. The Plan estimates pharmacy rebates based on historical and current utilization of prescription drugs and contractual provisions. Capitation payments represent monthly contractual fees paid to providers, who are responsible for providing medical care to members, which could include medical or ancillary costs like dental, vision and other supplemental health benefits. Such capitation costs are fixed in advance of the periods covered and are not subject to significant accounting estimates. Other hospital and medical expenses include all medically-related administrative costs, amounts due to providers pursuant to risk-sharing or other incentive arrangements, provider claims, and other healthcare expenses.

Reinsurance

Beginning in 2020, the Plan has an excess of loss reinsurance agreement with Oceangate Reinsurance, Inc., an affiliate, which provides unlimited coverage of 90% of individual claims above deductibles of $1,000,000 for Medicaid business and $1,000,000 for Marketplace business. In 2019 the Plan had an excess of loss reinsurance agreement with a non-affiliated company. Reinsurance expense is reported as a reduction of net premium income, and amounted to $451,515 and $397,303 for the years ended December 31, 2020 and 2019, respectively.

Reinsurance contracts do not relieve the Plan from its obligations to subscribers. The Plan remains liable to its subscribers for the portion reinsured to the extent that the reinsurance company does not meet the obligations assumed under the reinsurance contract.

Concentrations

The Plan has cash and invested assets deposited in financial institutions in which the balances exceed the Federal Deposit Insurance Corporation insured limit. The Plan has not experienced any losses in such accounts and management believes it is not exposed to any significant credit risk. The Plan's investments and a portion of its cash are managed by professional portfolio managers operating under documented investment guidelines.

Concentration of credit risk with respect to receivables is limited because the Plan's primary payor is the Division.

Risks and Uncertainties

The Plan's sole Medicaid customer is the Division. The loss of its contract with the Division would have a material adverse effect on the Plan's financial position, results of operations or cash flows. The Plan's ability to arrange for the provision of medical services to its members is dependent upon its ability to develop and maintain adequate provider networks. The inability to develop or maintain such networks could, in certain circumstances, have a material adverse effect on the Plan's financial position, results of operations or cash flows.

The Plan's profitability depends in large part on accurately predicting and effectively managing medical care costs. Management continually reviews the Plan's medical costs as well as its underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond the Plan's control and could adversely affect its ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on the Plan's financial condition, results of operations or cash flows.

The Plan is subject to thorough and extensive regulations by multiple state and federal agencies. Its failure to comply with various regulations and requirements could limit the Plan's revenue or increase costs. In certain circumstances, a failure to comply with regulations or the cost incurred in complying with regulations could have a material adverse effect on the Plan's financial position, results of operations or cash flows.

Cash Flow

The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition; whereas under GAAP, the statements of cash flow reconcile the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting.

Comprehensive Income

The presentation of the statutory basis statements of admitted assets, liabilities, capital and surplus is not in conformity with GAAP with respect to the reporting of other comprehensive income.

Minimum Capital and Surplus

The Plan is subject to minimum capital and surplus requirements prescribed by the Title 83-41-325 of the Mississippi Insurance Code. At December 31, 2020 and 2019, the Plan's capital and surplus was in compliance with such minimum capital and surplus requirements.

The NAIC adopted Risk Based Capital (RBC) standards to measure the minimum amount of capital appropriate for a managed care organization to support its overall business operations. The state of Mississippi has passed legislation to adopt RBC. At December 31, 2020 and 2019, the Plan was in compliance with the minimum RBC requirement.

Recent Accounting Pronouncements

Recent accounting pronouncements issued by the NAIC did not have, nor does the Plan expect such pronouncements to have, a significant impact to the Plan's present or future financial statements

D. Going Concern

The Plan is not aware of any relevant conditions or events that raise substantial doubt about its abilities to continue as a going concern.

Note 2 – Investments

The following tables summarize the Plan's investments including gross unrealized gains and losses as of the dates indicated:

	12/31/2020			
	Cost or amortized cost	Unrealized gains	Unrealized losses	Fair value
Industrial & miscellaneous	$ 11,060,983	$ 443,944	$ -	$ 11,504,927
Open depositories	(1,180,799)	-	-	(1,180,799)
Other money market mutual funds	125,987,353	-	-	125,987,353
Special revenue and special assessments	9,352,867	361,000	-	9,713,867
States, territories, and possessions	1,031,056	56,269	-	1,087,325
Political subdivisions	2,615,257	120,196	-	2,735,453
U.S. Government	11,760,779	2,914	-	11,763,693
Totals	$ 160,627,496	$ 984,323	$ -	$ 161,611,819

	12/31/2019			
	Cost or amortized cost	Unrealized gains	Unrealized losses	Fair value
Industrial & miscellaneous	$ 1,629,383	$ 1,740	$ (1,329)	$ 1,629,794
Open depositories	(6,035,055)	-	-	(6,035,055)
Other money market mutual funds	37,422,634	-	-	37,422,634
Special revenue and special assessments	8,966,166	5,928	(26,604)	8,945,490
States, territories, and possessions	782,251	1,165	(3,876)	779,540
Political subdivisions	2,649,496	479	(15,663)	2,634,312
U.S. Government	25,977,813	-	-	25,977,813
Totals	$ 71,392,688	$ 9,312	$ (47,472)	$ 71,354,528

The amortized cost and fair value of the Plan's investments by contractual maturities were as follows:

	12/31/2020	
	Amortized cost	Fair value
Due in one year or less	$ 13,284,245	$ 13,327,652
Due in over one year through five years	16,458,211	17,067,536
Due after five years through ten years	5,879,191	6,201,076
Due after ten years through twenty years	187,995	197,016
Due after twenty years	11,298	11,982
Totals	$ 35,820,940	$ 36,805,262

A. Loan-Backed Securities

(1) Description of Sources Used to Determine Prepayment Assumptions

Prepayment assumptions for mortgage-backed securities, collateralized mortgage obligations and other structure securities were generated using a purchased prepayment model. The prepayment model uses a number of factors to estimate prepayment activity including the time of year (seasonally), current levels of interest rates (refinancing incentive), economic activity (including housing turnover) and term and age of the underlying collateral (burnout, seasoning). On an ongoing basis, the rate of prepayment is monitored and the model is calibrated to reflect actual experience, market factors and view point.

(2) Because the decline in the market values of the securities was not due to the credit quality of the issuers, and because the Plan does not intend to sell nor does it expect to be required to sell these securities before a recovery in their cost basis, the Plan does not consider the securities to be other-than-temporary impaired at December 31, 2020.

B. Restricted Assets

As of December 31, 2020 and 2019, bonds included $522,734 and $523,258 that were restricted for certain purposes as required by the Department.

Note 3 – Investment Income

The Plan had no investment income that was excluded in 2020 or 2019. All of the Plan's investments and the income derived from such investments meet the criteria for admitted receivables.

Note 4 – Income Taxes

A. Deferred Tax Assets/(Liabilities)

1. Components of Net Deferred Tax Asset/(Liability)

	2020			2019			Change		
	1	2	3	4	5	6	7	8	9
	Ordinary	Capital	(Col. 1 + 2) Total	Ordinary	Capital	(Col. 4 + 5) Total	(Col. 1 - 4) Ordinary	(Col. 2 - 5) Capital	(Col. 7 + 8) Total
a. Gross deferred tax assets	$ 2,088,395	$ -	$ 2,088,395	$ 1,967,667	$ -	$ 1,967,667	$ 120,728	$ -	$ 120,728
b. Statutory valuation allowance adjustment		-	-	1,410,450	-	1,410,450	(1,410,450)	-	(1,410,450)
c. Adjusted gross deferred tax assets (1a - 1b)	2,088,395	-	2,088,395	557,217	-	557,217	1,531,178	-	1,531,178
d. Deferred tax assets nonadmitted		-	-	-	-	-	-	-	-
e. Subtotal net admitted deferred tax assets (1c - 1d)	2,088,395	-	2,088,395	557,217	-	557,217	1,531,178	-	1,531,178
f. Deferred tax liabilities	464,313	-	464,313	557,217	-	557,217	(92,904)	-	(92,904)
g. Net admitted deferred tax assets / (net deferred tax liabilities) (1e - 1f)	$ 1,624,082	$ -	$ 1,624,082	$ -	$ -	$ -	$ 1,624,082	$ -	$ 1,624,082

2. Admission Calculation Components SSAP No. 101, *Income Taxes*

	2019			2019			Change		
	1	2	3	4	5	6	7	8	9
	Ordinary	Capital	(Col. 1 + 2) Total	Ordinary	Capital	(Col. 4 + 5) Total	(Col. 1 - 4) Ordinary	(Col. 2 - 5) Capital	(Col. 7 + 8) Total
a. Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,834,180	$ -	$ 1,834,180	$ -	$ -	$ -	$ 1,834,180	$ -	$ 1,834,180
b. Adjusted gross deferred tax assets expected to be realized (exduding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below.)	153,559	-	153,559	-	-	-	153,559	-	153,559
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	153,559	-	153,559	-	-	-	153,559	-	153,559
2. Adjusted gross deferred tax assets allowed per limitation threshold	-	-	10,584,279	-	-	6,517,447	-	-	4,066,832
c. Adjusted gross deferred tax assets (exduding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	100,656	-	100,656	557,217	-	557,217	(456,561)	-	(456,561)
d. Deferred tax assets admitted as the result of application of SSAP 101. Total 2(a)+2(b)+2(c)	$ 2,088,395	$ -	$ 2,088,395	$ 557,217	$ -	$ 557,217	$ 1,531,178	$ -	$ 1,531,178

3. Other Admissibility Criteria

	2020	2019
a. Ratio percentage used to determine recovery period and threshold limitation amount	516.2%	325.7%
b. Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)2 above	$ 70,561,863	$ 43,449,646

4. Impact of Tax Planning Strategies

(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets, by tax character as a percentage.

	2020		2019		Change	
	1	2	3	4	5 (Col. 1 - 3)	6 (Col. 2 - 4)
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
1. Adjusted gross DTAs amount from Note 4A1(c)	$ 2,088,395	$ -	$ 557,217	$ -	$ 1,531,178	$ -
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax planning strategies	%	%	%	%	%	%
3. Net admitted adjusted gross DTAs amount from Note 4A1(e)	$ 2,088,395	$ -	$ 557,217	$ -	$ 1,531,178	$ -
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax planning strategies	%	%	%	%	%	%

(b) Does the Plan's tax planning strategies include the use of reinsurance? No.

B. Deferred Tax Liabilities Not Recognized: None.

C. Current and Deferred Income Taxes

1. Current Income Tax

	2020	2019	Change
a. Federal	$ 10,034,583	$ (5,464,115)	$ 15,498,698
b. Foreign	-	-	-
c. Subtotal	$ 10,034,583	$ (5,464,115)	$ 15,498,698
d. Federal income tax on net capital gains	43	14	29
e. Utilization of capital loss carry-forwards	-	-	-
f. Other	15,377	185,971	(170,594)
g. Federal and Foreign income taxes incurred	$ 10,050,003	$ (5,278,130)	$ 15,328,133

2. Deferred Tax Assets

	2020	2019	Change
a. Ordinary:			
1. Discounting of unpaid losses	$ 526,571	$ 594,999	$ (68,428)
2. Unearned premium reserve	-	-	-
3. Policyholder reserves	-	-	-
4. Investments	-	-	-
5. Deferred acquisition costs	-	-	-
6. Policyholder dividends accrual	-	-	-
7. Fixed assets	127,984	266,068	(138,084)
8. Compensation and benefits accrual	67,367	41,358	26,009
9. Pension accrual	-	-	-
10. Receivables - nonadmitted	887,290	446,995	440,295
11. Net operating loss carry-forward	-	-	-
12. Tax credit carry-forward	-	-	-
13. Other (items <=5% and >5% of total ordinary tax assets)	479,183	618,247	(139,064)
	-	-	-
99. Subtotal	$ 2,088,395	$ 1,967,667	$ 120,728
b. Statutory valuation allowance adjustment	-	1,410,450	(1,410,450)
c. Nonadmitted	-	-	-
d. Admitted ordinary deferred tax assets (2a99-2b-2c)	$ 2,088,395	$ 557,217	$ 1,531,178
e. Capital:			
1. Investments	-	-	-
2. Net capital loss carry-forward	-	-	-
3. Real estate	-	-	-
4. Other (items <=5% and >5% of total capital tax assets)	-	-	-
99. Subtotal	$ -	$ -	$ -
f. Statutory valuation allowance adjustment	-	-	-
g. Nonadmitted	-	-	-
h. Admitted capital deferred tax assets (2e99-2f-2g)	$ -	$ -	$ -
i. Admitted deferred tax assets (2d+2h)	$ 2,088,395	$ 557,217	$ 1,531,178

3. Deferred Tax Liabilities

	2020	2019	Change
a. Ordinary:			
1. Investments	$ -	$ -	$ -
2. Fixed assets	-	-	-
3. Deferred and uncollected premium	-	-	-
4. Policyholder reserves	-	-	-
5. Other (items <=5% and >5% of total ordinary tax assets)	464,313	557,217	(92,904)
99. Subtotal	$ 464,313	$ 557,217	$ (92,904)
b. Capital:			
1. Investments	-	-	-
2. Real estate	-	-	-
3. Other (Items <=5% and >5% of total capital tax assets)	-	-	-
99. Subtotal	$ -	$ -	$ -
c. Deferred tax liabilities (3a99+3b99)	$ 464,313	$ 557,217	$ (92,904)
4. Net Deferred Tax Assets (2i – 3c)	$ 1,624,082	$ -	$ 1,624,082

The change in net deferred income taxes is comprised of the following (this analysis is exclusive of nonadmitted assets as the change in nonadmitted assets is reported separately from the change in deferred income taxes in the surplus section of the Annual Statement):

	12/31/2020	12/31/2019	Change
Total deferred tax assets	2,088,395	$ 1,967,667	$ 120,728
Statutory valuation allowance		(1,410,450)	1,410,450
Total deferred tax liabilities	(464,313)	(557,217)	92,904
Net deferred tax asset	$ 1,624,082	$ -	1,624,082
Tax effect of unrealized (gains)/losses			-
Change in net deferred income tax assets - increase			$ 1,624,082

The Plan is subject to taxation in the United States and the state of Mississippi. The Plan is currently under examination by the Internal Revenue Service for tax years 2015 to 2017 and may be subject to examination for calendar years 2018 and 2019. With few exceptions, the Plan is no longer subject to U.S. federal examination for tax years before 2015 and state or local tax examinations before 2017.

D. Reconciliation of Federal Income Tax Rate to Actual Effective Rate. Among the more significant book to tax adjustments were the following:

	Tax Effect	Effective Tax Rate
Provision computed at statutory rate	$ 8,788,475	21.0%
Changes in nonadmitted assets	(196,478)	-0.5%
Statutory valuation allowance	(1,410,450)	-3.4%
Non-deductible health insurance providers fee	1,356,810	3.2%
Other	(112,436)	-0.3%
Reported tax expense	$ 8,425,921	20.1%
Federal and foreign income taxes incurred	$ 10,049,960	24.1%
Federal income tax on net capital gains	43	0.0%
Change in net deferred income taxes	(1,624,082)	-3.9%
Total statutory income taxes	$ 8,425,921	20.3%

E. Operating Loss Carry Forwards and Income Taxes Available for Recoupment

1. The amounts, origination dates and expiration dates of operating loss and tax credit carry forward available for tax purposes: None.

2. The following is income tax expense for current year and proceeding years that is available for recoupment in the event of future net losses:

Year	Amount
2020	$ 10,034,626
2019	$ -

3. The Plan did not have any aggregate amount of deposits admitted under Section 6603 of the Internal Revenue Code.

F. Consolidated Federal Income Tax Return

The Plan is included in the consolidated federal income tax return with its ultimate parent, Molina. The entities included within the consolidated return are included in NAIC Statutory Statement Schedule Y - Information Concerning Activities of Insurer Members of a Holding Company Group. Federal income taxes are paid to or refunded by Molina pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses the Plan receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of Molina.

Federal income tax paid for 2020 pursuant to the tax sharing agreement was $11,050,000.

G. Federal or Foreign Federal Income Tax Loss Contingencies:

The Plan does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

H. Repatriation Transition Tax: None.

I. Alternative Minimum Tax Credit: None.

Note 5 – Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Molina has wholly owned operating subsidiaries in various states as indicated in Schedule Y, Parts 1 and 1A.

B. – C. The Plan neither paid dividends to, nor received contributions from Molina during the year ended December 31, 2020.

The Plan received contributions amounting to $27,000,000 from Molina in the year ended December 31, 2019, principally to provide funding to meet mandated net worth requirements. Molina has agreed to provide additional future funding to the Plan, if necessary, to ensure the Plan's compliance with minimum net worth requirements during the next 12 months.

The Plan has an agreement with Molina whereby Molina provides certain management services to the Plan. Expenses incurred relating to this agreement amounted to $30,582,517 and $20,550,807 for the years ended December 31, 2020 and 2019, respectively.

The Plan has an excess of loss reinsurance agreement with an affiliate, Oceangate Reinsurance, Inc. Refer to Note 1(C) "Reinsurance".

D. As of December 31, 2020 and 2019 amounts due to Molina and affiliates totaled $3,272,326 and $2,252,386, respectively. Intercompany receivables and payables are generally settled on a monthly basis.

Note 6 – Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

Consolidated/Holding Company Plans: The employees of the Plan are eligible to participate in a defined contribution 401(k) plan sponsored by Molina subject to the participation eligibility set forth in the plan. Eligible employees are allowed to contribute up to the maximum allowed by law. The Plan matches up to the first 4% of compensation contributed by the employees subject to a one-year cliff vesting requirement. The Plan has no legal obligation to provide benefits under the plan. The Plan's expense recognized in connection with the 401(k) plan was $271,017 and $188,026 for the years ended December 31, 2020 and 2019, respectively.

Note 7 – Capital and Surplus, Shareholder's Dividend Restrictions and Quasi-Reorganizations

(1) The Plan has 10,000 shares of no par value common stock authorized, 100 shares issued and outstanding. All issued and outstanding shares of common stock are held by Molina.

(2) Dividend restrictions: Without prior approval of the Department, the Plan may pay ordinary dividends up to 10 percent of total capital and surplus or any amount up to net income for the preceding calendar year.

(3) Dividends paid by the Plan to Molina: Refer to Note 5.B. above.

(4) Subject to the limitations of (2) above, no restrictions have been placed on the portion of the Plan's profits that may be paid as ordinary dividends to Molina.

(5) Changes in the balance of special surplus funds: In accordance with SSAP No. 106, *Affordable Care Act Assessments*, the Plan reclassifies an amount equal to the estimated health insurer fee due in the following calendar year from unassigned surplus to special surplus. The special surplus balance at December 31, 2019 represented the Plan's estimated health insurer fee for 2020. Due to the repeal of the health insurer fee for calendar years 2021 and beyond, the Plan did not reclassify amounts to special surplus at December 31, 2020.

(6) The portion of unassigned surplus or deficit, excluding the apportionment of estimated Section 9010 ACA subsequent fee year assessment, net income, and dividends, represented or reduced by each item below is as follows:

	2020	2019	Change
Net deferred income taxes	$ 1,624,082	$ -	$ 1,624,082
Nonadmitted assets	(4,538,726)	(3,603,115)	(935,611)
Unauthorized and certified reinsurance	(752,053)	-	(752,053)
Surplus notes	10,000,000	13,000,000	(3,000,000)
Totals	$ 6,333,303	$ 9,396,885	$ (3,063,582)

(7) The Reporting Entity Issued the Following Surplus Debentures or Similar Obligations

Date Issued	Interest Rate	Par Value (Face Amount of Notes)	Carrying Value of Note*	Principal and/or Interest Paid Current Period	Total Principal and/or Interest Paid	Unapproved Principal and/or Interest	Date of Maturity
08/01/2019	5.0%	$ 8,000,000	$ -	$ 8,566,667	$ 8,566,667	$ -	
09/30/2019	5.0%	$ 5,000,000	$ -	$ 5,312,500	$ 5,312,500	$ -	
3/31/2020	5.0%	10,000,000	10,000,000	-	-	375,000	3/31/2025
Total	XXX	$ 23,000,000	$ 10,000,000	$ 13,879,167	$ 13,879,167	$ 375,000	XXX

The surplus notes in the amount of $10,000,000, listed in the above table, were issued to Molina in exchange for cash. The surplus notes have the following repayment conditions and restrictions: Each payment of interest on and principal of the surplus notes may be made only with the prior approval of the Department. The surplus notes have the following terms: The payment of interest on and principal of the surplus notes shall be subordinated to (i) any and all claims of the Plan's policyholders, (ii) any and all of the Plan's claimant and beneficiary claims, and (iii) all other classes of the Plan's creditors (other than other surplus note holders).

On December 31, 2020, the Plan paid off the $8,000,000 surplus note issued on August 1, 2019 and the $5,000,000 surplus note issued on September 30, 2019.

Note 8 – Liabilities, Contingencies and Assessments

From time to time, the Plan may be involved in legal actions in the normal course of business, some of which involve a demand for both compensatory and punitive damages not covered by insurance. Currently, there are no pending or threatened actions which, to the knowledge and in the opinion of management and the Plan's counsel, would have a material adverse effect on the Plan's financial position, results of operations or cash flow.

The Plan routinely evaluates the collectability of all receivable amounts included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Plan's past experience, exposure related to uncollectible balances and the potential of loss for those balances not currently reserved for is not material to the Plan's financial position, results of operation or cash flow.

The Plan recognizes the financial statement benefit of a tax position after determining that the relevant tax authority would more likely than not sustain the position following an audit, including resolution of any related appeals or litigation processes, based on the technical merits of the position. The tax benefit to be recognized is measured as the largest amount of benefit that is greater than 50% likely of being realized upon ultimate settlement. Interest and penalties, if incurred, are recognized in the statutory basis statements of revenues and expenses as federal income tax expense. As of December 2020, the Plan had no tax loss contingency liability.

There are no assets that the Plan considers to be impaired at December 31, 2020 and 2019.

Note 9 – Leases

Lessee Operating Lease

(1) The Plan leases office facilities and equipment under noncancelable long-term operating leases. Some of the leases contain escalation clauses and renewal options. Rental expense relating to these leases totaled $369,260 and $416,771 for the years ended December 31, 2020 and 2019, respectively.

(2) Leases with Initial or Remaining Noncancelable Lease Terms in Excess of One Year – At December 31, 2020 the minimum aggregate rental commitments are as follows:

Year Ending December 31	Operating Leases
2021	880,828
2022	906,237
2023	609,804
Total	$ 2,396,869

Note 10 – Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

Medicaid Pass-throughs Payments

The Plan has contracted with the Division to participate in the Mississippi Hospital Access Program (MHAP). This program helps to ensure sufficient access to inpatient hospital services for the Medicaid population by including enhanced hospital reimbursement in the capitation rates. The payments and expenditures related to the MHAP program are presented in the table below:

Mississippi Hospital Access Program	Year to Date 2020	Quarter to Date as of 12/31/2020	Prior Year to Date 2019
MHAP Capitation	$ 42,977,234	$ 9,684,552	$ 29,073,724
Premium Tax Payments	1,329,193	299,522	2,182,507
MHAP Payments to Providers	44,164,986	9,177,323	29,172,468

The Plan has also contracted with the Division to participate in the Medicaid Access to Physician Services Program (MAPS). This program provides enhanced passthrough payments to physicians and other service practitioners who are employed by a qualifying hospital or assigned Mississippi Medicaid payments to a qualifying hospital. The payments and expenditures related to the MAPS program are presented in the table below:

Medicaid Access to Physician Services Program	Year to Date 2020	Quarter to Date as of 12/31/2020	Prior Year to Date 2019
MAPS Capitation	$ 3,551,737	$ 829,823	$ -
Premium Tax Payments	152,880	30,393	-
MAPS Payments to Providers	2,721,914		-

Note 11 – Fair Value Measurements

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 – Certain inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the reporting entity has the ability to access at the measurement date.

Level 2 – Certain inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability. Level 2 inputs include the following:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 – Certain inputs are unobservable inputs for the asset or liability. Unobservable inputs shall be used to measure fair value to the extent that relevant observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date.

Bonds and short-term investments are based on quoted market prices, where available.

A. Fair Value Measurements

Fair Value Measurements at Reporting Date: The Plan's assets measured and reported at fair value on a recurring basis are listed in the table below. The Plan receives monthly statements from investment brokers that provide market pricing. There were no transfers between Level 1 and Level 2 of the fair value hierarchy. Pursuant to SSAP No. 2R – Cash, Cash Equivalents, Drafts and Short-term investments, "Investments in MMMF shall be valued at fair value or NAV as a practical expedient". Beginning in 2020, the Plan has deemed MMMF to be reported as NAV in accordance with SSAP No. 2R.

2020:

Description for Each Type of Asset at Fair Value	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
Other money market mutual fund	$ -		$ -	$ 125,987,353	$ 125,987,353
Totals	$ -	$ -	$ -	$ 125,987,353	$ 125,987,353

2019:

Description for Each Type of Asset at Fair Value	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
Other money market mutual fund	$ -	$ 37,422,634	$ -	$ -	$ 37,422,634
Totals	$ -	$ 37,422,634	$ -	$ -	$ 37,422,634

There were no liabilities reported at fair value as of December 31, 2020 and 2019.

B. Fair Value Reporting under SSAP No. 100, *Fair Value Measurements*, and Other Accounting Pronouncements: In addition to bonds and short-term investments (see below), the Plan's statutory basis balance sheets typically include the following financial instruments: investment income due and accrued, federal income tax recoverable (payable), receivables, and current liabilities. The Plan believes the carrying amounts of these financial instruments approximate the fair value of these financial instruments because of the relatively short period of time between the origination of the instruments and their expected realization or payment.

C. Aggregate Fair Value Hierarchy

The aggregate fair value hierarchy of all financial instruments as of December 31, 2020 and 2019, respectively, are presented in the tables below:

2020:

	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Industrial & miscellaneous	$ 11,504,927	$ 11,060,983	$ -	$ 11,504,927	$ -	$ -	$ -
Open depositories	(1,180,799)	(1,180,799)	(1,180,799)	-	-	-	-
Other money market mutual fund	125,987,353	125,987,353	-	-	-	125,987,353	-
Political subdivisions	2,735,453	2,615,257	-	2,735,453	-	-	-
Special revenue & assessment obligations	9,713,867	9,352,867	-	9,713,867	-	-	-
States, territories, and possessions	1,087,325	1,031,056	-	1,087,325	-	-	-
U.S. Government	11,763,693	11,760,779	-	11,763,693	-	-	-
Total financial instruments	$ 161,611,819	$ 160,627,496	$ (1,180,799)	$ 36,805,265	$ -	$ 125,987,353	$ -

2019:

	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Industrial & miscellaneous	$ 1,629,794	$ 1,629,383	$ -	$ 1,629,794	$ -	$ -	$ -
Open depositories	(6,035,055)	(6,035,055)	(6,035,055)	-	-	-	-
Other money market mutual fund	37,422,634	37,422,634	-	37,422,634	-	-	-
Political subdivisions	2,634,312	2,649,496	-	2,634,312	-	-	-
Special revenue & assessment obligations	8,945,490	8,966,166	-	8,945,490	-	-	-
States, territories, and possessions	779,540	782,251	-	779,540	-	-	-
U.S. Government	25,977,813	25,977,813	-	25,977,813	-	-	-
Total financial instruments	$ 71,354,528	$ 71,392,688	$ (6,035,055)	$ 77,389,583	$ -	$ -	$ -

Note 12 – Other Items

COVID-19

As the COVID-19 pandemic continues to evolve, its ultimate impact to the Plan's business, results of operations, financial condition and cash flows is uncertain and difficult to predict. The Plan continues to monitor and assess the estimated operating and financial impact of the COVID-19 pandemic, and as the pandemic evolves, the Plan continues to process, assemble, and assess utilization information. The Plan believes that its cash flow generated from operations will be sufficient to withstand the financial impact of the pandemic, and will enable it to continue to support operations, regulatory requirements, and capital expenditures for the foreseeable future.

Stock Plans

Under an equity incentive plan adopted by Molina, the Plan's employees may be awarded restricted stock or other equity incentives. Restricted stock awards generally vest in equal annual installments over periods of up to four years from the date of grant.

Molina has an employee stock purchase plan under which the eligible employees of the Plan may purchase common shares at 85% of the lower of the fair market value of Molina's common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions.

Note 13 – Events Subsequent

Type I – Recognized Subsequent Events: None.

Type II – Nonrecognized Subsequent Events:

The Plan is subject to an annual health insurer fee under section 9010 of the Federal Affordable Care Act (ACA). This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The special surplus balance at December 31, 2019 represented the Plan's estimated health insurer fee for 2020. Due to the repeal of the health insurer fee for calendar years 2021 and beyond, the Plan did not reclassify amounts to special surplus at December 31, 2020.

A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)? No.

		2020	2019
B.	ACA fee assessment payable for the upcoming year		$ 6,600,000
C.	ACA fee assessment paid	6,461,000	-
D.	Premium written subject to ACA 9010 assessment		338,748,158
E.	Total adjusted capital before surplus adjustment		
F.	Total adjusted capital after surplus adjustment		
G.	Authorized control level		

H. Would reporting the ACA assessment as of December 31, 2020 have triggered an RBC action level? No.

The Plan has begun writing Marketplace business in the state of Mississippi in 2020.

The Plan evaluated its December 31, 2020 statutory basis financial statements for subsequent events through May 13, 2021, the date the statutory basis financial statements were available to be issued. The Plan is not aware of any subsequent events that would require recognition or disclosure in these statutory basis financial statements.

Note 14 – Retrospectively Rated Contracts and Contracts Subject to Redetermination

A. – C. The Plan began serving members through the Marketplace in January 2020. Under the risk sharing provisions of the ACA, Marketplace premiums are subject to redetermination through the risk adjustment program in which the risk scores of enrollees are used to determine the final premium amount. Beginning in 2018, the risk adjustment program also includes the Federal high cost risk pool. The high cost risk pool provides compensation for high dollar claims. In addition, Marketplace premiums are subject to retrospective rating through the risk corridor program in which the Plan and the Federal government share in loss experience above or below a specified range. The Plan estimates accrued retrospective premium adjustments for its Marketplace business through a mathematical approach with inputs that may include premiums, claims costs, administrative expenses, reinsurance recoveries, and risk adjustment transfer payments. The Plan had net premiums written of $19,395,244

for its Marketplace business for the year ended December 31, 2020, representing 4.0% of the total net premiums written in 2020.

Medicaid premiums are subject to retrospective rating and redetermination based on contractual requirements. The Plan had net premiums written relating to Medicaid of $407,066,080 and $329,064,347 for the periods ended December 31, 2020 and 2019, respectively, representing 84.6% and 97.3% of total net premiums written in 2020 and 2019, respectively.

Children's Health Insurance Program (CHIP) premiums are subject to retrospective rating and redetermination based on contractual requirements. The Plan had net premiums written relating to CHIP of $55,095,923 and $9,286,508 as of December 31, 2020 and 2019, respectively, representing 11.4% and 2.7% of total net premiums written in 2020 and 2019, respectively.

The Plan records accrued retrospective premium as an adjustment to earned premium.

D. Risk Sharing Provisions of the Affordable Care Act

(1) Did the reporting entity write accident and health insurance premium which is subject to the Affordable Care Act risk sharing provisions? Yes.

(2) Impact of Risk Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year:

a. Permanent ACA Risk Adjustment Program	Amount
Assets	
1. Premium adjustments receivable due to ACA Risk Adjustment (including high risk pool payments)	$ -
Liabilities	
2. Risk adjustment user fees payable for ACA Risk Adjustment	$ 5,861
3. Premium adjustments payable due to ACA Risk Adjustment (including high risk pool premium)	$ 1,270,758
Operations (Revenue & Expenses)	
4. Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	$ (1,270,758)
5. Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	$ (5,861)

(3) Roll forward of prior year ACA risk sharing provisions for the following asset (gross of any nonadmission) and liability balances along with the reasons for adjustments to prior year balance: The Plan did not write Marketplace business in 2019.

(4) Roll-Forward of Risk Corridors Asset and Liability Balances by Program Benefit Year: The Plan did not write Marketplace business until 2020.

(5) ACA Risk Corridors Receivable as of Reporting Date: The Plan did not write Marketplace business until 2020.

Note 15 – Change in Incurred Losses and Claim Adjustment Expenses

A. Change in Incurred Losses and Claim Adjustment Expenses

The change in prior year estimated claims reserves represents favorable and unfavorable development in claims experience as of December 31, 2020 and 2019, respectively. Original estimates are increased or decreased as additional information becomes known regarding incurred reported claims. Claims unpaid activity during 2020 and 2019 is summarized below:

	Year ended 12/31/2020	Year ended 12/31/2019
Unpaid claims liabilities, accrued medical incentives, and claims adjustment expenses, beginning of period	$ 54,158,792	$ 10,194,098
Add provision for claims, net of reinsurance:		
Current year	350,500,441	319,056,468
Prior years	(14,579,203)	5,597,747
Net incurred claims during the current year	335,921,238	324,654,215
Deduct paid claims, net of reinsurance		
Current year	314,443,134	269,016,279
Prior years	32,988,458	15,651,512
Net paid claims during the current year	347,431,592	284,667,791
Change in claims adjustment expenses	(156,615)	758,751
Change in health care receivables	1,952,173	3,219,519
Change in amounts due from reinsurers	752,053	-
Unpaid claims liabilities, accrued medical incentives, and claims adjustment expenses, end of period	$ 45,196,049	$ 54,158,792

B. Information about Significant Changes in Methodologies and Assumptions: The Plan did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid claim adjustment expenses in 2020 or 2019.

Note 16 – Health Care Receivables

Pharmaceutical Rebate Receivables

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days After Billing
December 31, 2020	$ 247,183	$ -	$ -	$ -	$ -
September 30, 2020	210,482	-	-	-	-
June 30, 2020	101,796	-	-	41,470	-
March 31, 2020	10,139	-	-	31,141	40,574
December 31, 2019	5,263	-	-	9,145	-
September 30, 2019	9,826	-	-	9,783	-
June 30, 2019	6,922	-	-	7,646	102
March 31, 2019	4,994	-	-	-	5,034
December 31, 2018	-	-	-	-	2,324

Supplementary Information

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings 1 Amount	Gross Investment Holdings 2 Percentage of Column 1 Line 13	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage of Column 5 Line 13
1.	Long-Term Bonds (Schedule D, Part 1):						
	1.01 U.S. governments	511,230	0.318	511,230	0	511,230	0.318
	1.02 All other governments		0.000			0	0.000
	1.03 U.S. states, territories and possessions, etc. guaranteed	1,031,056	0.642	1,031,056	0	1,031,056	0.642
	1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	2,615,257	1.628	2,615,257	0	2,615,257	1.628
	1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	9,352,866	5.823	9,352,867	0	9,352,867	5.823
	1.06 Industrial and miscellaneous	11,060,984	6.886	11,060,983	0	11,060,983	6.886
	1.07 Hybrid securities		0.000			0	0.000
	1.08 Parent, subsidiaries and affiliates		0.000			0	0.000
	1.09 SVO identified funds		0.000			0	0.000
	1.10 Unaffiliated Bank loans		0.000			0	0.000
	1.11 Total long-term bonds	24,571,393	15.297	24,571,393	0	24,571,393	15.297
2.	Preferred stocks (Schedule D, Part 2, Section 1):						
	2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000			0	0.000
	2.02 Parent, subsidiaries and affiliates	0	0.000			0	0.000
	2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3.	Common stocks (Schedule D, Part 2, Section 2):						
	3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)		0.000			0	0.000
	3.02 Industrial and miscellaneous Other (Unaffiliated)		0.000			0	0.000
	3.03 Parent, subsidiaries and affiliates Publicly traded		0.000			0	0.000
	3.04 Parent, subsidiaries and affiliates Other		0.000			0	0.000
	3.05 Mutual funds		0.000			0	0.000
	3.06 Unit investment trusts		0.000			0	0.000
	3.07 Closed-end funds		0.000			0	0.000
	3.08 Total common stocks	0	0.000	0	0	0	0.000
4.	Mortgage loans (Schedule B):						
	4.01 Farm mortgages	0	0.000			0	0.000
	4.02 Residential mortgages	0	0.000			0	0.000
	4.03 Commercial mortgages	0	0.000			0	0.000
	4.04 Mezzanine real estate loans	0	0.000			0	0.000
	4.05 Total valuation allowance		0.000			0	0.000
	4.06 Total mortgage loans	0	0.000	0	0	0	0.000
5.	Real estate (Schedule A):						
	5.01 Properties occupied by company		0.000	0		0	0.000
	5.02 Properties held for production of income		0.000	0		0	0.000
	5.03 Properties held for sale		0.000	0		0	0.000
	5.04 Total real estate	0	0.000	0	0	0	0.000
6.	Cash, cash equivalents and short-term investments:						
	6.01 Cash (Schedule E, Part 1)	(1,180,799)	(0.735)	(1,180,799)		(1,180,799)	(0.735)
	6.02 Cash equivalents (Schedule E, Part 2)	137,236,902	85.438	137,236,902		137,236,902	85.438
	6.03 Short-term investments (Schedule DA)	0	0.000	0		0	0.000
	6.04 Total cash, cash equivalents and short-term investments	136,056,103	84.703	136,056,103	0	136,056,103	84.703
7.	Contract loans	0	0.000	0		0	0.000
8.	Derivatives (Schedule DB)	0	0.000	0		0	0.000
9.	Other invested assets (Schedule BA)	0	0.000	0		0	0.000
10.	Receivables for securities	0	0.000	0		0	0.000
11.	Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12.	Other invested assets (Page 2, Line 11)	0	0.000	0		0	0.000
13.	Total invested assets	160,627,496	100.000	160,627,496	0	160,627,496	100.000

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2020
(To Be Filed by April 1)

Of The Molina Healthcare of Mississippi, Inc.

ADDRESS (City, State and Zip Code) Jackson , MS 39201

NAIC Group Code 1531 NAIC Company Code 16301 Federal Employer's Identification Number (FEIN) 26-4390042

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 176,555,190

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	DEUTSCHE BANK AG	MONEY MKT	$ 94,804,074	53.7 %
2.02	US BANCORP	MONEY MKT/CORP PUB	$ 21,071,999	11.9 %
2.03	BLACKROCK INC	MONEY MKT	$ 5,783,741	3.3 %
2.04	MISSISSIPPI DEVELOPMENT BANK	MUNI/MUNITAX	$ 3,405,347	1.9 %
2.05	MORGAN STANLEY	MONEY MKT/CORP PUB	$ 2,106,254	1.2 %
2.06	HSBC HOLDINGS PLC	MONEY MKT	$ 1,626,667	0.9 %
2.07	INVESCO LTD	MONEY MKT	$ 1,600,000	0.9 %
2.08	FEDERAL HOME LOAN MORTGAGE CORP	FHLMC	$ 1,328,974	0.8 %
2.09	COUNTY OF MADISON MS	MUNI/MUNITAX	$ 790,010	0.4 %
2.10	STATE OF MISSISSIPPI	MUNI TAX	$ 774,783	0.4 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 35,315,696	20.0 %	3.07	P/RP-1	$	0.0 %
3.02	NAIC-2	$ 505,246	0.3 %	3.08	P/RP-2	$	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 525,697	0.3 %
4.03	Foreign-currency-denominated investments	$	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$	0.0 %
5.02	Countries designated NAIC-2	$	0.0 %
5.03	Countries designated NAIC-3 or below	$	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1:	$	0.0 %
6.02	Country 2:	$	0.0 %
	Countries designated NAIC - 2:		
6.03	Country 1:	$	0.0 %
6.04	Country 2:	$	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$	0.0 %
6.06	Country 2:	$	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$	0.0 %
8.02	Countries designated NAIC-2	$	0.0 %
8.03	Countries designated NAIC-3 or below	$	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$	0.0 %
9.02	Country 2:	$	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$	0.0 %
9.04	Country 2:	$	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$	0.0 %
9.06	Country 2:	$	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01			$	0.0 %
10.02			$	0.0 %
10.03			$	0.0 %
10.04			$	0.0 %
10.05			$	0.0 %
10.06			$	0.0 %
10.07			$	0.0 %
10.08			$	0.0 %
10.09			$	0.0 %
10.10			$	0.0 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$	0.0 %
11.03	Canadian-currency-denominated investments	$	0.0 %
11.04	Canadian-denominated insurance liabilities	$	0.0 %
11.05	Unhedged Canadian currency exposure	$	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$	0.0 %
12.04		$	0.0 %
12.05		$	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$	0.0 %
13.03		$	0.0 %
13.04		$	0.0 %
13.05		$	0.0 %
13.06		$	0.0 %
13.07		$	0.0 %
13.08		$	0.0 %
13.09		$	0.0 %
13.10		$	0.0 %
13.11		$	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$	0.0 %
14.04		$	0.0 %
14.05		$	0.0 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06	DEUTSCHE BANK AG	$ 94,804,074	$ 94,804,074	$
14.07	US BANCORP	$ 20,572,872	$ 20,572,872	$
14.08	BLACKROCK INC	$ 5,783,741	$ 5,783,741	$
14.09	HSBC HOLDINGS PLC	$ 1,626,667	$ 1,626,667	$
14.10	INVESCO LTD	$ 1,600,000	$ 1,600,000	$
14.11	MORGAN STANLEY	$ 1,600,000	$ 1,600,000	$
14.12		$ 0	$	$
14.13		$ 0	$	$
14.14		$ 0	$	$
14.15		$ 0	$	$

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$	0.0 %
	Largest three investments in general partnership interests:		
15.03		$	0.0 %
15.04		$	0.0 %
15.05		$	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$	0.0 %
16.03		$	0.0 %
16.04		$	0.0 %
16.05		$	0.0 %
16.06		$	0.0 %
16.07		$	0.0 %
16.08		$	0.0 %
16.09		$	0.0 %
16.10		$	0.0 %
16.11		$	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$	0.0 %
16.13	Mortgage loans over 90 days past due	$	0.0 %
16.14	Mortgage loans in the process of foreclosure	$	0.0 %
16.15	Mortgage loans foreclosed	$	0.0 %
16.16	Restructured mortgage loans	$	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.02	91 to 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.03	81 to 90%	$	0.0 %	$	0.0 %	$	0.0 %
17.04	71 to 80%	$	0.0 %	$	0.0 %	$	0.0 %
17.05	below 70%	$	0.0 %	$	0.0 %	$	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$	0.0 %
18.03		$	0.0 %
18.04		$	0.0 %
18.05		$	0.0 %
18.06		$	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$	0.0 %
19.04		$	0.0 %
19.05		$	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$	0.0 %	$	$	$
20.02	Repurchase agreements	$	0.0 %	$	$	$
20.03	Reverse repurchase agreements	$	0.0 %	$	$	$
20.04	Dollar repurchase agreements	$	0.0 %	$	$	$
20.05	Dollar reverse repurchase agreements	$	0.0 %	$	$	$

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$	0.0 %	$	0.0 %
21.02	Income generation	$	0.0 %	$	0.0 %
21.03	Other	$	0.0 %	$	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$	0.0 %	$ 0	$ 0	$
23.03	Replications	$	0.0 %	$ 0	$ 0	$
23.04	Other	$	0.0 %	$ 0	$ 0	$

Statutory Basis Financial Statements and Report of Independent Certified Public Accountants

Molina Healthcare of Mississippi, Inc.

December 31, 2019 and 2018

Contents

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REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

Board of Directors and Stockholder
Molina Healthcare of Mississippi, Inc.

We have audited the accompanying statutory-basis financial statements of Molina Healthcare of Mississippi, Inc., a Mississippi corporation, which compromise the statutory-basis statements of admitted assets, liabilities, capital and surplus as of December 31, 2019 and 2018, and the related statutory-basis statements of revenue and expenses, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory-basis financial statements.

Management's responsibility for the financial statements
Management is responsible for the preparation and fair presentation of these statutory-basis financial statements in accordance with the basis of accounting practices prescribed or permitted by the Insurance Department of the State of Mississippi. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of statutory-basis financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility
Our responsibility is to express an opinion on these statutory-basis financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the statutory-basis financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory-basis financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the statutory-basis financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the statutory-basis financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory-basis financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the statutory-basis financial statements referred to above present fairly, in all material respects the financial position of Molina Healthcare of Mississippi, Inc. as of December 31, 2019 and 2018, and the results of its operations and its cash flows for the years then ended in accordance with the basis of accounting practices prescribed or permitted by the Insurance Department of the State of Mississippi described in Note 1A.

Basis of accounting
We draw attention to Note 1A of the statutory-basis financial statements, which describes the basis of accounting to meet the requirements of Insurance Department of the State of Mississippi. The statutory-basis financial statements are prepared by Molina Healthcare of Mississippi, Inc. on the basis of accounting practices prescribed or permitted by the Insurance Department of the State of Mississippi which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Supplementary information
Our audit was conducted for the purpose of forming an opinion on the statutory-basis financial statements as a whole. The summary investment schedule and the supplemental investment risks interrogatories as of December 31, 2019, are presented for purposes of additional analysis and are not a required part of the statutory basis- financial statements. Such supplementary information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. The information has been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures. These additional procedures included comparing and reconciling the information directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary information is fairly stated, in all material respects, in relation to the statutory-basis financial statements as a whole.

Restriction on use
Our report is intended solely for the information and use of Molina Healthcare of Mississippi, Inc. and the Insurance Department of the State of Mississippi and other insurance departments to whose jurisdiction the Company is subject to, and is not intended to be and should not be used by anyone other than these specified parties.

Grant Thornton LLP

Hartford, Connecticut
May 5, 2020

Molina Healthcare of Mississippi, Inc.
Statements of Admitted Assets, Liabilities, Capital and Surplus
As of December 31,

ASSETS	2019	2018
Cash and invested assets		
Cash and cash equivalents	$ 57,365,392	$ 36,167,755
Short-term investments	314,860	-
Bonds	13,712,436	507,490
Total cash and invested assets	71,392,688	36,675,245
Investment income due and accrued	140,104	10,236
Premiums due and unpaid	37,853,768	4,234,396
Amounts receivable relating to uninsured plans	98,744	-
Health care and other amounts receivable	547,514	-
TOTAL ASSETS	$ 110,032,818	$ 40,919,877
LIABILITIES, CAPITAL AND SURPLUS		
Liabilities		
Claims unpaid	$ 53,228,732	$ 10,022,789
Unpaid claims adjustment expenses	930,060	171,309
Premiums received in advance	196,896	-
General expenses due and accrued	5,958,128	1,571,611
Federal income tax payable	28,509	101,639
Amounts due to Parent and affiliates	2,252,386	29,073
Payable for securities	284,941	-
Amounts due to government agencies	3,703,520	108,084
Total liabilities	66,583,172	12,004,505
Capital and surplus		
Common stock, no par value (10,000 shares authorized and 100 shares issued and outstanding)	-	-
Special surplus funds	6,600,000	-
Paid-in surplus	60,000,000	33,000,000
Surplus notes	13,000,000	-
Unassigned surplus	(36,150,354)	(4,084,628)
Total capital and surplus	43,449,646	28,915,372
TOTAL LIABILITIES, CAPITAL AND SURPLUS	$ 110,032,818	$ 40,919,877

The accompanying notes are an integral part of these statutory basis financial statements.

Molina Healthcare of Mississippi, Inc.
Statements of Revenue and Expenses
Years ended December 31,

	2019	2018
Revenue		
Net premium income	$ 338,350,855	$ 22,819,906
Total revenue	338,350,855	22,819,906
Expenses		
Hospital and medical benefits	223,875,305	12,376,947
Other professional services	17,672,583	1,694,996
Outside referrals	8,689,436	871,054
Emergency room and out-of-area	43,388,244	2,084,451
Pharmacy	31,028,647	2,262,941
Total hospital and medical expenses	324,654,215	19,290,389
Claims adjustment expenses	7,180,765	1,039,854
General administrative expenses	35,976,297	6,209,928
Total expenses	367,811,277	26,540,171
Net underwriting loss	(29,460,422)	(3,720,265)
Other income (expense)		
Net investment income earned	1,278,143	17,290
Net realized capital gain, less capital gains tax expense of $14	51	-
Other expense	(26,100)	-
Total other income	1,252,094	17,290
Net loss before federal income taxes	(28,208,328)	(3,702,975)
Federal income taxes benefit	(5,278,144)	(684,907)
NET LOSS	$ (22,930,184)	$ (3,018,068)

The accompanying notes are an integral part of these statutory basis financial statements.

Molina Healthcare of Mississippi, Inc.
Statements of Changes in Capital and Surplus
Years ended December 31,

	2019	2018
Capital and surplus, beginning of year	$ 28,915,372	$ 5,001,013
Net loss	(22,930,184)	(3,018,068)
Change in nonadmitted assets	(2,535,542)	(1,067,573)
Change in surplus notes	13,000,000	-
Capital contributions	27,000,000	28,000,000
Capital and surplus, end of year	$ 43,449,646	$ 28,915,372

The accompanying notes are an integral part of these statutory basis financial statements.

Molina Healthcare of Mississippi, Inc.
Statements of Cash Flows
Years ended December 31,

	2019	2018
Operations		
Net premiums and revenues collected	$ 308,523,815	$ 18,693,594
Net investment income received	1,151,137	4,873
Benefit and loss-related payments	(284,667,791)	(9,267,600)
General administrative payments	(37,972,104)	(5,426,753)
Federal income taxes paid	5,205,000	786,000
Net cash (used in) provided by operations	(7,759,943)	4,790,114
Investment activities		
Proceeds from bonds sold or matured	795,007	-
Cost of bonds acquired	(13,717,809)	-
Net cash used in investment activities	(12,922,802)	-
Financing and miscellaneous activities		
Surplus notes	13,000,000	-
Capital contributions	27,000,000	28,000,000
Other cash provided (applied)	2,195,242	(1,118,608)
Net cash provided by financing and miscellaneous activities	42,195,242	26,881,392
Net increase in cash, cash equivalents and short-term investments	21,512,497	31,671,506
Cash, cash equivalents and short-term investments, beginning of year	36,167,755	4,496,249
Cash, cash equivalents and short-term investments, end of year	$ 57,680,252	$ 36,167,755

The accompanying notes are an integral part of these statutory basis financial statements.

Note 1 – Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

Molina Healthcare of Mississippi, Inc. (the Plan) was incorporated under the laws of the state of Mississippi on March 2, 2009, and received a Certificate of Authority to transact business as a health maintenance organization (HMO) effective as of January 19, 2018. The Plan is a wholly owned subsidiary of Molina Healthcare, Inc. (Molina, or the Parent), a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, the Health Insurance Marketplace (Marketplace), and other government-sponsored health care programs for low-income families and individuals.

The Plan is an HMO, licensed in the state of Mississippi, that provides comprehensive health care services to Medicaid enrollees under contracts with the the State of Mississippi, Office of the Governor, Division of Medicaid (Division). The Plan commenced operations on October 1, 2018 to serve Medicaid members. The Plan may terminate the Medicaid contract with 10-day written notice. Such contracts represent the majority of the Plan's source of premium income for the years ended December 31, 2019 and 2018.

The Plan contracts with independent physician associations, hospitals and other providers to provide medical services to its members. As an HMO, the Plan is at risk for all covered outpatient and inpatient claims incurred by its beneficiaries.

The financial statements of the Plan are presented on the basis of accounting practices prescribed or permitted by the Mississippi Insurance Department (the Department).

The Department recognizes only statutory accounting practices prescribed or permitted by the state of Mississippi for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under the Mississippi insurance law. The National Association of Insurance Commissioners' Accounting Practices and Procedures Manual (NAIC SAP) has been adopted as a component of prescribed or permitted practices by the state of Mississippi.

Such prescribed accounting practices have no effect on significant the Plan's statutory basis financial statements for the periods presented.

B. Use of Estimates in the Preparation of the Financial Statement

The preparation of financial statements in conformity with Statutory Accounting Principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. It also requires disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

C. Accounting Policy

The Plan applies the following accounting policies:

(1) Basis for Short-Term Investments: Short-term investments consist primarily of U.S. treasury notes and investments in corporate debt securities with maturity dates of greater than three months but less than one year at the time of acquisition. The basis of short-term investments is the same as for bonds as stated in Note C(2) below.

(2) Basis for Bonds and Amortization Schedule: Bonds include U.S. government and other debt securities with maturity dates of greater than one year at the time of purchase. Bonds not backed by other loans are principally stated at

amortized cost using the scientific method. Bonds with NAIC designations of one or two are stated at amortized cost. Bonds with NAIC designations of three or higher are stated at the lower of amortized cost or fair value. Amortization of bond premium or accretion of discount is computed using the scientific (constant-yield) interest method. Realized capital gains and losses are determined using the specific-identification method and were not significant for the years ended December 31, 2019 and 2018. There were no significant unrealized gains or losses on investments, and the Plan recognized no losses from other-than-temporary impairments for the years ended December 31, 2019 and 2018.

(3) Anticipated Investment Income Used in Premium Deficiency Calculation: The Plan assesses the profitability of its medical care policies to identify groups of contracts where current operating results or forecasts indicate probable future losses. The Plan anticipates investment income as a factor in the premium deficiency calculation, in accordance with Statement of Statutory Accounting Principles (SSAP) No. 54, *Individual and Group Accident and Health Contracts*. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. The Plan has not recorded any premium deficiency reserves as of December 31, 2019 or 2018.

(4) Management's Policies and Methodologies for Estimating Liabilities for Losses and Loss/Claim Adjustment Expenses for Accident & Health Contracts: Claims unpaid and unpaid claims adjustment expenses represent management's best estimate of the ultimate net cost of all reported and unreported claims incurred through December 31. Claims unpaid are based on actual historical experience and estimates of medical expenses incurred but not paid (IBNP). The Plan employs its own actuaries to estimate IBNP monthly based on a number of factors, including prior claims experience, health care service utilization data, cost trends, product mix, seasonality, prior authorization of medical services, and other factors. The Plan also considers uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership, and medical cost trends. The Plan continually reviews and updates the estimation methods and the resulting reserves. Any adjustments to reserves are reflected in current operations. Many of the Plan's medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may not come to light until a substantial period of time has passed following the contract implementation, leading to potential adjustment of some costs in the period in which they are first recorded. The Plan believes that its process for estimating IBNP is adequate, but all estimates are subject to uncertainties. Any deficiency in the Plan's estimates of IBNP would negatively affect its results of operations. Refer to Note 14, "Change in Incurred Losses and Loss Adjustment Expenses," for further information.

(5) Changes in the Capitalization Policy and Predefined Thresholds from Prior Period: The Plan has not modified its capitalization policy from the prior period.

Electronic data processing (EDP) equipment and software, which is non-admitted, is depreciated using the straight-line method over the lesser of its useful life or three years. Depreciation expense related to EDP equipment and operating system software totaled $19,125 and $9,562 for the years ended December 31, 2019 and 2018, respectively.

Furniture and equipment and leasehold improvements, which are non-admitted, are generally depreciated using the straight-line method over the estimated useful lives of the assets. Depreciation expense related to furniture and equipment and leasehold improvements totaled $145,409 and $70,547 for the years ended December 2019 and 2018, respectively.

(6) Method Used to Estimate Pharmaceutical Rebate Receivables: Amounts receivable for pharmaceutical rebates are estimated based upon historical and current utilization of prescription drugs and contract terms. Income from pharmaceutical rebates is reported as a reduction of hospital and medical expenses in the statutory basis statements of revenue and expenses. The Plan admits estimated pharmaceutical rebate receivables relating to the three months

immediately preceding the reporting date in accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans*. Refer to Note 15, "Health Care Receivables" for further information.

The Plan has also deemed the following to be significant accounting policies and/or differences between statutory practices and accounting principles generally accepted in the United States of America (GAAP):

Cash and Invested Assets

Cash and cash equivalents are defined as cash and short-term highly liquid investments that are both readily convertible into known amounts of cash and so near their maturity that they represent insignificant risk of changes in value because of changes in interest rates. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP cash overdraft balances would be classified as liabilities. Only investments with original maturities of three months or less when purchased qualify under this definition with the exception of money market mutual funds registered under the Investment Company Act of 1940 (the Act) and regulated under rule 2a-7 of the Act as described in SSAP No. 2R, *Cash, Cash Equivalents, Drafts and Short-Term Investments*. Under GAAP, the corresponding caption of cash, cash equivalents, and short-term investments include cash balances and investments that will mature in one year or less from the balance sheet date.

Investments in bonds are reported at amortized cost or fair value based on their NAIC designation. Under GAAP, investments in bonds are grouped into three separate categories for accounting and reporting purposes: available-for-sale securities, held-to-maturity securities, and trading securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. Trading securities are recorded at fair value, and holding gains and losses are recognized in net income.

Premiums Due and Unpaid

Premiums due and unpaid at December 31, 2019 and 2018, consist primarily of amounts due from the Division. Receivables are stated at net realizable value based on management's judgment of the ultimate collectibility of the accounts. Collection trends are monitored and any adjustments required are reflected in current earnings. All premiums receivable balances outstanding greater than 90 days due, with the exception of premiums due from governmental agencies, are non-admitted in accordance with NAIC SAP.

Net Deferred Tax Assets or Liabilities

The Plan follows the guidance of SSAP No. 101, *Income Taxes,* for deferred income taxes. Deferred tax assets and liabilities are recorded for temporary differences between the tax basis of assets and liabilities and their amounts reported on the financial statements, using statutory rates in effect for the year in which the differences are expected to reverse. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as a change in surplus in the period that includes the enactment date. SSAP No. 101 includes a valuation allowance criterion whereby only gross deferred tax assets that are more likely than not (defined as a likelihood of more than 50%) to be realized are potentially admissible, subject to certain limitations and admissibility tests. Under GAAP, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets not realizable.

Receivables from or Amounts Due to Parent and Affiliates

The Plan has various transactions with Molina and the Plan's affiliates. In the statutory basis statements of admitted assets, liabilities, capital and surplus, the Plan reports any unsettled amounts due from Molina and affiliates as "Receivables from Parent and affiliates." The Plan reports unsettled amounts owed to Molina and affiliates as "Amounts due to Parent and affiliates." Refer to Note 5, "Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties" for further information.

Amounts Receivable Relating to Uninsured Plans and Liability for Amounts Held Under Uninsured Plans

The amounts receivable relating to uninsured plans and liability for amounts held under uninsured plans relate to Medicaid Pass-throughs. Refer to Note 10, "Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans", for further information.

Net Premium Income and Change in Reserve for Rate Credits

The Plan recognizes premiums from members as income in the period for which health plan coverage relates. Premiums collected in advance of a coverage period are recorded as premiums received in advance. Premium revenue is fixed in advance of the periods covered and, except as described below and in Retrospectively Rated Contracts and Contracts Subject to Redetermination, is not generally subject to significant accounting estimates.

Medical Cost Floors (Medical Loss Ratio) and Corridors: For certain Medicaid premiums, amounts may be returned to the Division if certain minimum amounts are not spent on defined medical care costs, or the Plan may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Additionally, sanctions may be levied by the Division if the amounts spent on medical care costs as a percentage of premiums are not within a specified range. These sanctions include the requirements to file a corrective action plan as well as an auto assignment freeze.

Hospital and Medical Expenses

Nearly all hospital services and the majority of the Plan's primary care and physician specialist services are paid on a fee-for-service basis. Under fee-for-service arrangements, the Plan retains the financial responsibility for medical care provided and incurs costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. Medical care costs include amounts that have been paid by the Plan through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by the Plan as of the reporting date.

The Plan has also entered into agreements to pay a fixed capitated amount per member per month with certain providers. These payments are expensed in the period the providers are obligated to provide the service.

The Plan has contracts with medical provider organizations that require incentive payments if certain provisions of the contracts are met, and it records estimates for such incentive payments.

Reinsurance

The Plan has an excess risk reinsurance agreement with a non-affiliated company to limit its risk of catastrophic losses and its exposure to large claims by individuals with chronic or high cost conditions. The Plan maintains medical claims reinsurance with a deductible of $1.3 million for Medicaid. The reinsurance pays 90% of losses in excess of the deductible. The annual limit for Medicaid is $2,000,000 per member per year. Reinsurance expense is reported as a reduction of net premium income, and amounted to approximately $397,303 and $13,218 for the years ended December 31, 2019 and 2018, respectively. Reinsurance recoveries not received as of year-end are recorded as either amounts

recoverable from reinsurers or a reduction to claims unpaid in the statutory basis statements of admitted assets, liabilities, capital and surplus.

Reinsurance contracts do not relieve the Plan from its obligations to subscribers. The Plan remains liable to its subscribers for the portion reinsured to the extent that the reinsurance company does not meet the obligations assumed under the reinsurance contract.

Concentrations

The Plan has cash and invested assets deposited in financial institutions in which the balances exceed the Federal Deposit Insurance Corporation insured limit. The Plan has not experienced any losses in such accounts and management believes it is not exposed to significant credit risk. The Plan's investments and a portion of its cash are managed by professional portfolio managers operating under documented investment guidelines.

Concentration of credit risk with respect to receivables is limited because the Plan's primary payors is the Division.

Risks and Uncertainties

The Plan's sole Medicaid customer is the Division. The loss of its contract with the Division would have a material adverse effect on the Plan's financial position, results of operations and cash flows. The Plan's ability to arrange for the provision of medical services to its members is dependent upon its ability to develop and maintain adequate provider networks. The inability to develop or maintain such networks could, in certain circumstances, have a material adverse effect on the Plan's financial position, results of operations or cash flows.

The Plan's profitability depends in large part on accurately predicting and effectively managing medical care costs. Management continually reviews the Plan's premium and benefit structure as well as its underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters and malpractice litigation, are beyond the Plan's control and could adversely affect its ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on the Plan's financial condition, results of operations or cash flows.

The Plan is subject to thorough and extensive regulations by multiple state and federal agencies. Its failure to comply with various regulations and requirements could limit the Plan's revenue or increase costs. In certain circumstances, a failure to comply with regulations or the cost incurred in complying with regulations could have a material adverse effect on the Plan's financial position, results of operations or cash flows.

Cash Flow

The statutory basis statements of cash flows reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition; whereas under GAAP, the statements of cash flows reconcile the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting.

Comprehensive Income

The presentation of the statutory basis statements of admitted assets, liabilities, capital and surplus is not in conformity with GAAP with respect to the reporting of other comprehensive income.

Minimum Capital and Surplus

Title 83-41-325 of the Mississippi Insurance Code requires the Plan to maintain minimum capital and surplus equal to the greatest of (a) $1.0 million, (b) 2% of annual premium on the first $1.5 million of premium and 1% of annual premium on the premium in excess of $1.5 million, and (c) an amount equal to the sum of 3 months uncovered health care expenditures. At December 31, 2019 and 2018, the Plan was in compliance with the statutory minimum capital and surplus requirement.

The NAIC adopted Risk Based Capital (RBC) standards to measure the minimum amount of capital appropriate for a managed care organization to support its overall business operations. The state of Mississippi has passed legislation to adopt RBC. At December 31, 2019 and 2018, the Plan was in compliance with the minimum RBC requirement.

Recent Accounting Pronouncements

Recent accounting pronouncements issued by the NAIC did not have, nor does the Plan expect such pronouncements to have, a significant impact to the Plan's present or future financial statements.

D. Going Concern

The Plan is not aware of any relevant conditions or events that raise substantial doubt about its abilities to continue as a going concern.

Note 2 – Investments

The following tables summarize the Plan's investments including gross unrealized gains and losses as of the dates indicated:

	12/31/2019			
	Cost or amortized cost	Unrealized gains	Unrealized losses	Fair value
Industrial & miscellaneous	$ 1,629,383	$ 1,740	$ (1,329)	$ 1,629,794
Open depositories	(6,035,055)	-	-	(6,035,055)
Other money market mutual funds	37,422,634	-	-	37,422,634
Special revenue and special assessments	8,966,166	5,928	(26,604)	8,945,490
States, territories, and possessions	782,251	1,165	(3,876)	779,540
Political subdivisions	2,649,496	479	(15,663)	2,634,312
U.S. Government	25,977,813	-	-	25,977,813
Totals	$ 71,392,688	$ 9,312	$ (47,472)	$ 71,354,528

	12/31/2018			
	Cost or amortized cost	Unrealized gains	Unrealized losses	Fair value
Open depositories	$ (1,339,898)	$ -	$ -	$ (1,339,898)
Other money market mutual funds	37,507,653	-	-	37,507,653
U.S. Government	507,490	-	(4,620)	502,870
Totals	$ 36,675,245	$ -	$ (4,620)	$ 36,670,625

The amortized cost and fair value of the Plan's investments by contractual maturities were as follows:

	12/31/2019	
	Amortized cost	Fair value
Due in one year or less	$ 26,700,555	$ 26,701,148
Due in over one year through five years	6,581,680	6,579,558
Due after five years through ten years	6,474,156	6,437,236
Due after ten years through twenty years	248,718	249,007
Totals	$ 40,005,109	$ 39,966,949

As of December 31, 2019 and 2018, bonds included both $523,258 and $507,490, that were restricted for certain purposes as required by the Department.

Note 3 – Investment Income

The Plan had no investment income that was excluded in 2019 or 2018. All of the Plan's investments and the income derived from such investments meet the criteria for admitted receivables.

Note 4 – Income Taxes

A. Deferred Tax Assets/(Liabilities)

1. Components of Net Deferred Tax Asset/(Liability)

	2019			2018			Change		
	1	2	3	4	5	6	7	8	9
	Ordinary	Capital	(Col. 1 + 2) Total	Ordinary	Capital	(Col. 4 + 5) Total	(Col. 1 - 4) Ordinary	(Col. 2 - 5) Capital	(Col. 7 + 8) Total
a. Gross deferred tax assets	$ 1,967,667	$ -	$ 1,967,667	$ 314,944	$ -	$ 314,944	$ 1,652,723	$ -	$ 1,652,723
b. Statutory valuation allowance adjustment	1,410,450	-	1,410,450	314,944	-	314,944	1,095,506	-	1,095,506
c. Adjusted gross deferred tax assets (1a - 1b)	557,217	-	557,217	-	-	-	557,217	-	557,217
d. Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
e. Subtotal net admitted deferred tax assets (1c - 1d)	557,217	-	557,217	-	-	-	557,217	-	557,217
f. Deferred tax liabilities	557,217	-	557,217	-	-	-	557,217	-	557,217
g. Net admitted deferred tax assets / (net deferred tax liabilities) (1e - 1f)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

2. Admission Calculation Components SSAP No. 101, *Income Taxes*

	2019			2018			Change		
	1	2	3	4	5	6	7	8	9
	Ordinary	Capital	(Col. 1 + 2) Total	Ordinary	Capital	(Col. 4 + 5) Total	(Col. 1 - 4) Ordinary	(Col. 2 - 5) Capital	(Col. 7 + 8) Total
a. Federal income taxes paid in prior years recoverable through loss carrybacks	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below.)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allowed per limitation threshold	-	-	6,517,447	-	-	4,337,306	-	-	2,180,141
c. Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	557,217	-	557,217	-	-	-	557,217	-	557,217
d. Deferred tax assets admitted as the result of application of SSAP 101. Total 2(a)+2(b)+2(c)	$ 557,217	$ -	$ 557,217	$ -	$ -	$ -	$ 557,217	$ -	$ 557,217

3. Other Admissibility Criteria

	2019	2018
a. Ratio percentage used to determine recovery period and threshold limitation amount	325.7%	1894.3%
b. Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)2 above	$ 43,449,646	$ 28,915,372

4. Impact of Tax Planning Strategies

(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets, by tax character as a percentage.

	2019		2018		Change	
	1	2	3	4	5 (Col. 1 - 3)	6 (Col. 2 - 4)
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
1. Adjusted gross DTAs amount from Note 4A1(c)	$ 557,217	$ -	$ -	$ -	$ 557,217	$ -
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax planning strategies	%	%	%	%	%	%
3. Net admitted adjusted gross DTAs amount from Note 4A1(e)	$ 557,217	$ -	$ -	$ -	$ 557,217	$ -
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax planning strategies	%	%	%	%	%	%

(b) Does the Plan's tax planning strategies include the use of reinsurance? No.

B. Deferred Tax Liabilities Not Recognized: None.

C. Current and Deferred Income Taxes

1. Current Income Tax

	2019	2018	Change
a. Federal	$ (5,464,115)	$ (684,907)	$ (4,779,208)
b. Foreign	-	-	-
c. Subtotal	$ (5,464,115)	$ (684,907)	$ (4,779,208)
d. Federal income tax on net capital gains	14	-	14
e. Utilization of capital loss carry-forwards	-	-	-
f. Other	185,971	-	185,971
g. Federal and Foreign income taxes incurred	$ (5,278,130)	$ (684,907)	$ (4,593,223)

2. Deferred Tax Assets

	2019	2018	Change
a. Ordinary:			
1. Discounting of unpaid losses	$ 594,999	$ 112,582	$ 482,417
2. Unearned premium reserve	-	-	-
3. Policyholder reserves	-	-	-
4. Investments	-	-	-
5. Deferred acquisition costs	-	-	-
6. Policyholder dividends accrual	-	-	-
7. Fixed assets	266,068	113,895	152,173
8. Compensation and benefits accrual	41,358	18,639	22,719
9. Pension accrual	-	-	-
10. Receivables - nonadmitted	446,995	-	446,995
11. Net operating loss carry-forward	-	-	-
12. Tax credit carry-forward	-	-	-
13. Other (items <=5% and >5% of total ordinary tax assets)	618,247	69,828	548,419
	-	-	-
99. Subtotal	$ 1,967,667	$ 314,944	$ 1,652,723
b. Statutory valuation allowance adjustment	1,410,450	314,944	1,095,506
c. Nonadmitted	-	-	-
d. Admitted ordinary deferred tax assets (2a99-2b-2c)	$ 557,217	$ -	$ 557,217
e. Capital:			
1. Investments	-	-	-
2. Net capital loss carry-forward	-	-	-
3. Real estate	-	-	-
4. Other (items <=5% and >5% of total capital tax assets)	-	-	-
99. Subtotal	$ -	$ -	$ -
f. Statutory valuation allowance adjustment	-	-	-
g. Nonadmitted	-	-	-
h. Admitted capital deferred tax assets (2e99-2f-2g)	$ -	$ -	$ -
i. Admitted deferred tax assets (2d+2h)	$ 557,217	$ -	$ 557,217

3. Deferred Tax Liabilities

	2019	2018	Change
a. Ordinary:			
1. Investments	$ -	$ -	$ -
2. Fixed assets	-	-	-
3. Deferred and uncollected premium	-	-	-
4. Policyholder reserves	-	-	-
5. Other (items <=5% and >5% of total ordinary tax assets)	557,217	-	557,217
99. Subtotal	$ 557,217	$ -	$ 557,217
b. Capital:			
1. Investments	-	-	-
2. Real estate	-	-	-
3. Other (Items <=5% and >5% of total capital tax assets)	-	-	-
99. Subtotal	$ -	$ -	$ -
c. Deferred tax liabilities (3a99+3b99)	$ 557,217	$ -	$ 557,217
4. Net Deferred Tax Assets (2i – 3c)	$ -	$ -	$ -

The change in net deferred income taxes is comprised of the following (this analysis is exclusive of nonadmitted assets as the change in nonadmitted assets is reported separately from the change in deferred income taxes in the surplus section of the Annual Statement):

	12/31/2019	12/31/2018	Change
Total deferred tax assets	$ 1,967,667	$ 314,944	$ 1,652,723
Statutory valuation allowance	(1,410,450)	(314,944)	(1,095,506)
Total deferred tax liabilities	(557,217)	-	(557,217)
Net deferred tax asset	$ -	$ -	-
Tax effect of unrealized (gains)/losses			-
Change in net deferred income tax assets - increase			$ -

The Plan is subject to taxation in the United States and state of Mississippi. The Plan is currently under examination by the Internal Revenue Service for tax years 2015 to 2017. With few exceptions, the Plan is no longer subject to U.S. federal tax examination for tax years before 2015.

D. Reconciliation of Federal Income Tax Rate to Actual Effective Rate. Among the more significant book to tax adjustments were the following:

The provision for federal and foreign income taxes incurred is different fromthat which would be obtained byapplying the statutory federal tax rate to income before income taxes. For the year ended December 31, 2019, the significant items causing this difference are as follows:

	Tax Effect	Effective Tax Rate
Provision computed at statutory rate	$ (5,923,747)	21.0%
Changes in nonadmitted assets	(470,257)	1.7%
Statutory valuation allowance	1,095,506	-3.9%
Other	20,368	-0.1%
Reported tax benefit	$ (5,278,130)	18.7%
Federal and foreign income taxes incurred	$ (5,278,144)	18.7%
Federal income tax on net capital gains	14	0.0%
Change in net deferred income taxes	-	0.0%
Total statutory income taxes	$ (5,278,130)	18.7%

E. Operating Loss and Tax Credit Carryforwards and Protective Tax Deposits

At December 31, 2019, the Plan did not have any unused operating loss carryforwards available to offset against future taxable income.

The amount of federal income taxes incurred that will be available for recoupment in the event of future net losses is:

Year	Amount
2019	$ -
2018	$ -

The Plan did not have any protective tax deposits under Section 6603 of the Internal Revenue Code.

F. Consolidated Federal Income Tax Return

The Plan is included in the consolidated federal income tax return with its ultimate parent, Molina. The entities included within the consolidated return are included in Annual Statement Schedule Y – Information Concerning Activities of Insurer Members of a Holding Company Group. Federal income taxes are paid to or refunded by Molina pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses the Plan receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of Molina.

G. Federal or Foreign Federal Income Tax Loss Contingencies:

The Plan does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

H. Repatriation Transition Tax (RTT) - RTT owed under the TCJA: None.

I. Alternative Minimum Tax Credit: None.

Note 5 – Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Molina has wholly owned operating subsidiaries in various states as indicated in Annual Statement Schedule Y, Parts 1 and 1A.

B. – C. The Plan received contributions amounting to $27.0 million and $28.0 million from Molina in the years ended December 31, 2019 and 2018, respectively, principally to provide funding to meet mandated net worth requirements. Molina has agreed to provide additional future funding to the Plan, if necessary, to ensure the Plan's compliance with minimum net worth requirements during the next 12 months.

The Plan has an agreement with Molina whereby Molina provides certain management services to the Plan. Expenses incurred relating to this agreement amounted to $20.6 million and $1.5 million for the years ended December 31, 2019 and 2018, respectively.

D. As of December 31, 2019 and 2018, amounts due to Molina and affiliates totaled $2.3 million and $29,073, respectively. Intercompany receivables and payables are generally settled on a monthly basis.

Note 6 – Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Consolidated/Holding Company Plans: The employees of the Plan are eligible to participate in a defined contribution 401(k) plan sponsored by Molina subject to the participation eligibility set forth in the plan. Eligible employees are allowed to contribute up to the maximum allowed by law. The Plan matches up to the first 4% of compensation contributed by the employees subject to a one-year cliff vesting requirement. The Plan has no legal obligation to provide benefits under the plan. The Plan's expense recognized in connection with the 401(k) plan was $188,026 and $40,615 for the years ended December 31, 2019 and 2018, respectively.

Note 7 – Capital and Surplus, Shareholder's Dividend Restrictions and Quasi-Reorganizations

(1) The Plan has 10,000 shares of no par value common stock authorized, 100 shares issued and outstanding.

(2) Dividend Restrictions: Without prior approval of the Department, the Plan may pay ordinary dividends up to 10 percent of total capital and surplus or an amount up to net income for the preceding calendar year.

(3) Dividends paid by the Plan to Molina: Refer to Note 5.

(4) Subject to the limitations of (2) above, no restrictions have been placed on the portion of the Plan's profits that may be paid as ordinary dividends to Molina.

(5) Changes in the balance of special surplus funds: In accordance with SSAP No. 106, *Affordable Care Act Assessments*, the Plan reclassifies an amount equal to the estimated health insurer fee due in the following calendar year from unassigned surplus to special surplus. The special surplus balance at December 31, 2019 represented the Plan's estimated health insurer fee for 2020. Due to the moratorium on the health insurer fee for the 2019 calendar year, the Plan did not reclassify amounts to special surplus at December 31, 2018.

(6) The portion of unassigned surplus or deficit, excluding the apportionment of estimated Section 9010 ACA subsequent fee year assessment, net income, and dividends, represented or reduced by each item below is as follows:

	2019	2018	Change
Nonadmitted assets	$ (3,603,115)	$ (1,067,573)	$ (2,535,542)
Totals	$ (3,603,115)	$ (1,067,573)	$ (2,535,542)

(7) The Reporting Entity Issued the Following Surplus Debentures or Similar Obligations

Date Issued	Interest Rate	Par Value (Face Amount of Notes)	Carrying Value of Note*	Principal and/or Interest Paid Current Period	Total Principal and/or Interest Paid	Unapproved Principal and/or Interest	Date of Maturity
08/01/2019	5.0%	$ 8,000,000	$ 8,000,000	$ -	$ -	$ 166,667	07/31/2024
09/30/2019	5.0%	5,000,000	5,000,000	-	-	62,500	09/29/2024
Total	XXX	$ 13,000,000	$ 13,000,000	$ -	$ -	$ 229,167	XXX

The surplus notes in the amount of $13.0 million, listed in the above table, were issued to Molina in exchange for cash.

The surplus notes have the following repayment conditions and restrictions: Each payment of interest on and principal of the surplus notes may be made only with the prior approval of the Department.

The surplus note has the following subordination terms: The payment of interest on and principal of the surplus notes shall be subordinated to (i) any and all claims of the Plan's policyholders, (ii) any and all of the Plan's claimant and beneficiary claims, and (iii) all other classes of the Plan's creditor (other than other surplus note holders).

Note 8 – Liabilities, Contingencies and Assessments

From time to time, the Plan may be involved in legal actions in the normal course of business, some of which involve a demand for both compensatory and punitive damages not covered by insurance. Currently, there are no pending or threatened actions which, to the knowledge and in the opinion of management and the Plan's counsel, would have a material adverse effect on the Plan's financial position, results of operations or cash flows.

The Plan routinely evaluates the collectability of all receivable amounts included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Plan's past experience, exposure related to uncollectible balances and the potential of loss for those balances not currently reserved for is not material to the Plan's financial position, results of operations or cash flows.

The Plan recognizes the financial statement benefit of a tax position after determining that the relevant tax authority would more likely than not sustain the position following an audit, including resolution of any related appeals or litigation processes, based on the technical merits of the position. The tax benefit to be recognized is measured as the largest amount of benefit that is greater than 50% likely of being realized upon ultimate settlement. Interest and penalties, if incurred, are recognized in the statutory basis statements of revenues and expenses as federal income tax expense. The Plan has not recognized any interest or penalties for the years ended December 31, 2019 and 2018. There are no assets that the Plan considers to be impaired at December 31, 2019 and 2018.

Note 9 – Leases

Lessee Operating Lease

(1) The Plan leases office facilities and equipment under noncancelable long-term operating leases. Some of the leases contain escalation clauses and renewal options. Rental expense relating to these leases totaled $416,771 and $316,408 for the years ended December 31, 2019 and 2018, respectively.

(2) Leases with Initial or Remaining Noncancelable Lease Terms in Excess of One Year

At January 1, 2020 the minimum aggregate rental commitments are as follows:

Year Ending December 31	Operating Leases
2020	$ 855,420
2021	880,828
2022	906,236
2023	609,804
Total	$ 3,252,288

Note 10 – Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

Medicaid Pass-throughs Payments

The Plan has contracted with the Division to participate in the Mississippi Hospital Access Program (MHAP). The payments and expenditures related to MHAP are presented in the table below:

Mississippi Hospital Access Program	Year to Date 2019	Quarter to Date as of 12/31/2019	Prior Year to Date 2018
MHAP Capitation	$ 29,073,724	$ 5,469,439	$ 5,316,478
Premium Tax Payments	2,182,507	621,072	142,331
MHAP Payments to Providers	29,172,468	5,696,826	5,154,436

Note 11 – Fair Value Measurements

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 – Certain inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the reporting entity has the ability to access at the measurement date.

Level 2 – Certain inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability. Level 2 inputs include the following:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 – Certain inputs are unobservable inputs for the asset or liability. Unobservable inputs shall be used to measure fair value to the extent that relevant observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date.

Bonds and short-term investments are based on quoted market prices, where available.

A. Fair Value Measurements

Fair Value Measurements at Reporting Date: The Plan's assets measured and reported at fair value on a recurring basis are listed in the table below. The Plan receives monthly statements from investment brokers that provide market pricing. There were no transfers between Level 1 and Level 2 of the fair value hierarchy.

2019:

Description for Each Type of Asset at Fair Value	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
Other money market mutual fund	$ -	$ 37,422,634	$ -	$ -	$ 37,422,634
Totals	$ -	$ 37,422,634	$ -	$ -	$ 37,422,634

2018:

Description for Each Type of Asset at Fair Value	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
Other money market mutual fund	$ -	$ 37,507,653	$ -	$ -	$ 37,507,653
Totals	$ -	$ 37,507,653	$ -	$ -	$ 37,507,653

There were no liabilities reported at fair value as of December 31, 2019 and 2018.

B. Fair Value Reporting under SSAP No. 100, F*air Value Measurements*, and Other Accounting Pronouncements: In addition to bonds and short-term investments (see below), the Plan's statutory basis balance sheets typically include the following financial instruments: investment income due and accrued, federal income tax recoverable (payable), receivables, and current liabilities. The Plan believes the carrying amounts of these financial instruments approximate the fair value of these financial instruments because of the relatively short period of time between the origination of the instruments and their expected realization or payment.

C. Aggregate Fair Value Hierarchy

The aggregate fair value hierarchy of all financial instruments as of December 31, 2019 and 2018, respectively, are presented in the tables below:

2019:

	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Industrial & miscellaneous	$ 1,629,794	$ 1,629,383	$ -	$ 1,629,794	$ -	$ -	$ -
Open depositories	(6,035,055)	(6,035,055)	(6,035,055)	-	-	-	-
Other money market mutual fund	37,422,634	37,422,634	-	37,422,634	-	-	-
Political subdivisions	2,634,312	2,649,496	-	2,634,312	-	-	-
Special revenue & assessment obligations	8,945,490	8,966,166	-	8,945,490	-	-	-
States, territories, and possessions	779,540	782,251	-	779,540	-	-	-
U.S. Government	25,977,813	25,977,813	-	25,977,813	-	-	-
Total financial instruments	$ 71,354,528	$ 71,392,688	$ (6,035,055)	$ 77,389,583	$ -	$ -	$ -

2018:

	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Open depositories	$ (1,339,898)	$ (1,339,898)	$ (1,339,898)	$ -	$ -	$ -	$ -
Other money market mutual fund	37,507,653	37,507,653	-	37,507,653	-	-	-
U.S. Government	502,870	507,490	-	502,870	-	-	-
Total financial instruments	$ 36,670,625	$ 36,675,245	$ (1,339,898)	$ 38,010,523	$ -	$ -	$ -

Note 12 – Other Items

Stock Plans

Under an equity incentive plan adopted by Molina, the Plan's employees may be awarded Molina restricted stock or other equity incentives. Restricted stock awards generally vest in equal annual installments over periods of up to four years from the date of grant.

Molina has an employee stock purchase plan under which the eligible employees of the Plan may purchase common shares at 85% of the lower of the fair market value of Molina's common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions.

Note 13 – Events Subsequent

Type I – Recognized Subsequent Events: None.

Type II – Nonrecognized Subsequent Events:

The Plan is subject to an annual health insurer fee under section 9010 of the Federal Affordable Care Act (ACA). This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The special surplus balance at December 31, 2019 represented the Plan's estimated health insurer fee for 2020. Due to the moratorium on the health insurer fee for the 2019 calendar year, the Plan did not reclassify amounts to special surplus at December 31, 2018.

A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)? Yes.

		2019	2018
B.	ACA fee assessment payable for the upcoming year	$ 6,600,000	$ -
C.	ACA fee assessment paid	-	-
D.	Premium written subject to ACA 9010 assessment	338,748,158	-
E.	Total adjusted capital before surplus adjustment	43,449,646	
F.	Total adjusted capital after surplus adjustment	36,849,646	
G.	Authorized control level	13,341,183	

H. Would reporting the ACA assessment as of December 31, 2019 have triggered an RBC action level? No.

On March 11, 2020, the World Health Organization officially declared COVID-19, the disease caused by the novel coronavirus, a pandemic. Management is currently assessing the impact of the pandemic to the operations of Molina and its subsidiaries, and is also closely monitoring the evolution of this pandemic, including how it may affect the economy and the general population. Management has not yet determined the impact of these events to the financial condition, results of operations and cash flows of Molina and its subsidiaries.

The Plan issued a $10.0 million surplus note to Molina on March 31, 2020.

The Plan has begun writing Marketplace business in the state of Mississippi in 2020.

The Plan evaluated its December 31, 2019, statutory basis financial statements for subsequent events through May 5, 2020, the date the statutory basis financial statements were available to be issued. The Plan is not aware of any subsequent events other than the ones described above that would require recognition or disclosure in these statutory basis financial statements.

Note 14 – Change in Incurred Losses and Loss Adjustment Expenses

A. Change in Incurred Losses and Loss Adjustment Expenses

The change in prior year estimated claims reserves represents unfavorable development in claims experience as of December 31, 2019 and 2018, respectively. Original estimates are increased or decreased as additional information becomes known regarding incurred reported claims. Claims unpaid activity during 2019 and 2018 is summarized below:

	Year ended 12/31/2019	Year ended 12/31/2018
Unpaid claims liabilities, accrued medical incentives, and claims adjustment expenses, beginning of period	$ 10,194,098	$ -
Add provision for claims, net of reinsurance:		
Current year	319,056,468	19,290,389
Prior years	5,597,747	-
Net incurred claims during the current year	324,654,215	19,290,389
Deduct paid claims, net of reinsurance		
Current year	269,016,279	9,267,600
Prior years	15,651,512	-
Net paid claims during the current year	284,667,791	9,267,600
Change in claims adjustment expenses	758,751	171,309
Change in health care receivables	3,219,519	-
Unpaid claims liabilities, accrued medical incentives, and claims adjustment expenses, end of period	$ 54,158,792	$ 10,194,098

B. Information about Significant Changes in Methodologies and Assumptions: The Plan did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid claim adjustment expenses in 2019 or 2018.

Note 15 – Health Care Receivables

Pharmaceutical Rebate Receivables

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days After Billing
December 31, 2019	$ 5,263	$ -	$ -	$ -	$ -
September 30, 2019	9,826	-	-	-	-
June 30, 2019	6,922	-	-	7,646	-
March 31, 2019	4,994	-	-	-	5,034
December 31, 2018	-	-	-	-	2,324

SUPPLEMENTARY INFORMATION

SUMMARY INVESTMENT SCHEDULE

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
Investment Categories	Amount	Percentage of Column 1 Line 13	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage of Column 5 Line 13
1. Long-Term Bonds (Schedule D, Part 1):						
1.01 U.S. Governments		0.0			0	0.0
1.02 All Other Governments		0.0			0	0.0
1.03 U.S. States, Territories and Possessions, etc., Guaranteed	782,253	1.1	782,251		782,251	1.1
1.04 U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed	2,649,496	3.7	2,649,496		2,649,496	3.7
1.05 U.S. Special Revenue and Special Assessment Obligations, etc., Non-Guaranteed	8,651,304	12.1	8,651,305		8,651,305	12.1
1.06 Industrial and Miscellaneous	1,629,383	2.3	1,629,383		1,629,383	2.3
1.07 Hybrid Securities		0.0			0	0.0
1.08 Parent, Subsidiaries and Affiliates		0.0			0	0.0
1.09 SVO Identified Funds		0.0			0	0.0
1.10 Unaffiliated Bank Loans		0.0			0	0.0
1.11 Total Long-Term Bonds	13,712,436	19.2	13,712,435	0	13,712,435	19.2
2. Preferred Stocks (Schedule D, Part 2, Section 1):						
2.01 Industrial and Misc. (Unaffiliated)		0.0			0	0.0
2.02 Parent, Subsidiaries and Affiliates		0.0			0	0.0
2.03 Total Preferred Stock	0	0.0	0	0	0	0.0
3. Common Stocks (Schedule D, Part 2, Section 2):						
3.01 Industrial and Miscellaneous Publicly Traded (Unaffiliated)		0.0			0	0.0
3.02 Industrial and Miscellaneous Other (Unaffiliated)		0.0			0	0.0
3.03 Parent, Subsidiaries and Affiliates Publicly Traded		0.0			0	0.0
3.04 Parent, Subsidiaries and Affiliates Other		0.0			0	0.0
3.05 Mutual Funds		0.0			0	0.0
3.06 Unit Investment Trusts		0.0			0	0.0
3.07 Closed-End Funds		0.0			0	0.0
3.08 Total Common Stocks	0	0.0	0	0	0	0.0
4. Mortgage Loans Schedule B):						
4.01 Farm Mortgages		0.0			0	0.0
4.02 Residential Mortgages		0.0			0	0.0
4.03 Commercial Mortgages		0.0			0	0.0
4.04 Mezzanine Real Estate Loans		0.0			0	0.0
4.05 Total Mortgage Loans	0	0.0	0	0	0	0.0
5. Real Estate (Schedule A):						
5.01 Properties Occupied by Company		0.0			0	0.0
5.02 Properties Held for Production of Income		0.0			0	0.0
5.03 Properties Held for Sale		0.0			0	0.0
5.04 Total Real Estate	0	0.0	0	0	0	0.0
6. Cash, Cash Equivalents, and Short-Term Investments::						
6.01 Cash (Schedule E, Part 1)	(6,035,055)	(8.5)	(6,035,055)		(6,035,055)	(8.5)
6.02 Cash Equivalents (Schedule E, Part 2)	63,400,447	88.8	63,400,447		63,400,447	88.8
6.03 Short-Term Investments (Schedule DA)	314,860	0.4	314,860		314,860	0.4
6.04 Total Cash, Cash Equivalents, and Short-Term Investments	57,680,252	80.8	57,680,253	0	57,680,253	80.8
7. Contract Loans		0.0			0	0.0
8. Derivatives (Schedule DB)		0.0			0	0.0
9. Other Invested Assets (Schedule BA)		0.0			0	0.0
10. Receivables for Securities		0.0			0	0.0
11. Securities Lending (Schedule DL, Part 1)		0.0		XXX	XXX	XXX
12. Other Invested Assets (Page 2, Line 11)		0.0			0	0.0
13. Total Invested Assets	71,392,688	100.0	71,392,688	0	71,392,688	100.0

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For the year ended December 31, 2019

(To be filed by April 1)

Of Molina Healthcare of Mississippi, Inc.

Address (City, State, Zip Code): Jackson MS 39201

NAIC Group Code.....1531 NAIC Company Code.....16301 Employer's ID Number.....26-4390042

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $.....110,032,818

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	WELLS FARGO CASH INVESTMENT MONEY MARKET	MONEY MARKET	$.....18,388,546	.....16.7 %
2.02	STATE STREET INSTITUTIONAL US GOVERNMENT	MONEY MARKET	$.....7,203,477	.....6.5 %
2.03	HSBC US GOVERNMENT MONEY MARKET FUND	MONEY MARKET	$.....6,463,230	.....5.9 %
2.04	DWS GOVERNMENT MONEY MARKET SERIES	MONEY MARKET	$.....3,732,753	.....3.4 %
2.05	MISSISSIPPI DEVELOPMENT BANK	Municipal bond and municipal tax	$.....3,602,946	.....3.3 %
2.06	FANNIE MAE POOL	FNMA	$.....994,121	.....0.9 %
2.07	FREDDIE MAC GOLD POOL	FHLMC	$.....973,391	.....0.9 %
2.08	FREDDIE MAC POOL	FHLMC	$.....967,853	.....0.9 %
2.09	COUNTY OF MADISON MS	Municipal bond and municipal tax	$.....796,215	.....0.7 %
2.10	US BANCORP	MONEY MARKET	$.....787,695	.....0.7 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2
3.01	NAIC 1	$.....40,005,108	.....36.4 %
3.02	NAIC 2	$.....	.....0.0 %
3.03	NAIC 3	$.....	.....0.0 %
3.04	NAIC 4	$.....	.....0.0 %
3.05	NAIC 5	$.....	.....0.0 %
3.06	NAIC 6	$.....	.....0.0 %
	Preferred Stocks	**3**	**4**
3.07	P/RP-1	$.....	.....0.0 %
3.08	P/RP-2	$.....	.....0.0 %
3.09	P/RP-3	$.....	.....0.0 %
3.10	P/RP-4	$.....	.....0.0 %
3.11	P/RP-5	$.....	.....0.0 %
3.12	P/RP-6	$.....	.....0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 4.01 above is yes, responses are not required for interrogatories 5-10.

4.02	Total admitted assets held in foreign investments	$.....	.....0.0 %
4.03	Foreign-currency-denominated investments	$.....	.....0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$.....	.....0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC 1	$.....	.....0.0 %
5.02	Countries designated NAIC 2	$.....	.....0.0 %
5.03	Countries designated NAIC 3 or below	$.....	.....0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

	Countries designated NAIC 1:	1	2
6.01	Country 1:	$.....	.....0.0 %
6.02	Country 2:	$.....	.....0.0 %
	Countries designated NAIC 2:		
6.03	Country 1:	$.....	.....0.0 %
6.04	Country 2:	$.....	.....0.0 %
	Countries designated NAIC 3 or below:		
6.05	Country 1:	$.....	.....0.0 %
6.06	Country 2:	$.....	.....0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$.....	.....0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC 1	$	0.0 %
8.02	Countries designated NAIC 2	$	0.0 %
8.03	Countries designated NAIC 3 or below	$	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC 1:		
9.01	Country 1:	$	0.0 %
9.02	Country 2:	$	0.0 %
	Countries designated NAIC 2:		
9.03	Country 1:	$	0.0 %
9.04	Country 2:	$	0.0 %
	Countries designated NAIC 3 or below:		
9.05	Country 1:	$	0.0 %
9.06	Country 2:	$	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01			$	0.0 %
10.02			$	0.0 %
10.03			$	0.0 %
10.04			$	0.0 %
10.05			$	0.0 %
10.06			$	0.0 %
10.07			$	0.0 %
10.08			$	0.0 %
10.09			$	0.0 %
10.10			$	0.0 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of Interrogatory 11.

11.02	Total admitted assets held in Canadian Investments	$	0.0 %
11.03	Canadian currency-denominated investments	$	0.0 %
11.04	Canadian-denominated insurance liabilities	$	0.0 %
11.05	Unhedged Canadian currency exposure	$	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

		1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$		0.0 %
	Largest three investments with contractual sales restrictions:			
12.03		$		0.0 %
12.04		$		0.0 %
12.05		$		0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interest less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Name of Issuer	2	3
13.02		$	0.0 %
13.03		$	0.0 %
13.04		$	0.0 %
13.05		$	0.0 %
13.06		$	0.0 %
13.07		$	0.0 %
13.08		$	0.0 %
13.09		$	0.0 %
13.10		$	0.0 %
13.11		$	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

		1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$		0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:			
14.03		$		0.0 %
14.04		$		0.0 %
14.05		$		0.0 %

Ten Largest Fund Managers

	1 Fund Manager	2 Total Invested	3 Diversified	4 Non-Diversified
14.06		$	$	$
14.07		$	$	$
14.08		$	$	$
14.09		$	$	$
14.10		$	$	$
14.11.		$	$	$
14.12		$	$	$
14.13		$	$	$
14.14		$	$	$
14.15		$	$	$

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$	0.0 %
	Largest three investments in general partnership interests:		
15.03		$	0.0 %
15.04		$	0.0 %
15.05		$	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$	0.0 %
16.03		$	0.0 %
16.04		$	0.0 %
16.05		$	0.0 %
16.06		$	0.0 %
16.07		$	0.0 %
16.08		$	0.0 %
16.09		$	0.0 %
16.10		$	0.0 %
16.11		$	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$	0.0 %
16.13	Mortgage loans over 90 days past due	$	0.0 %
16.14	Mortgage loans in the process of foreclosure	$	0.0 %
16.15	Mortgage loans foreclosed	$	0.0 %
16.16	Restructured mortgage loans	$	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

Loan-to-Value	Residential		Commercial		Agricultural	
	1	2	3	4	5	6
17.01 above 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.02 91% to 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.03 81% to 90%	$	0.0 %	$	0.0 %	$	0.0 %
17.04 71% to 80%	$	0.0 %	$	0.0 %	$	0.0 %
17.05 below 70%	$	0.0 %	$	0.0 %	$	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate:

	Description	2	3
18.02		$	0.0 %
18.03		$	0.0 %
18.04		$	0.0 %
18.05		$	0.0 %
18.06		$	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans.

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans	$.....	.....0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03	.....	$.....	.....0.0 %
19.04	.....	$.....	.....0.0 %
19.05	.....	$.....	.....0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-End		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
	1	2		3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$.....	.....0.0 %	$.....	$.....	$.....
20.02	Repurchase agreements	$.....	.....0.0 %	$.....	$.....	$.....
20.03	Reverse repurchase agreements	$.....	.....0.0 %	$.....	$.....	$.....
20.04	Dollar repurchase agreements	$.....	.....0.0 %	$.....	$.....	$.....
20.05	Dollar reverse repurchase agreements	$.....	.....0.0 %	$.....	$.....	$.....

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps and floors:

		Owned		Written	
	1	2		3	4
21.01	Hedging	$.....	.....0.0 %	$.....	.....0.0 %
21.02	Income generation	$.....	.....0.0 %	$.....	.....0.0 %
21.03	Other	$.....	.....0.0 %	$.....	.....0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-End		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
	1	2		3	4	5
22.01	Hedging	$.....	.....0.0 %	$.....	$.....	$.....
22.02	Income generation	$.....	.....0.0 %	$.....	$.....	$.....
22.03	Replications	$.....	.....0.0 %	$.....	$.....	$.....
22.04	Other	$.....	.....0.0 %	$.....	$.....	$.....

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-End		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
	1	2		3	4	5
23.01	Hedging	$.....	.....0.0 %	$.....	$.....	$.....
23.02	Income generation	$.....	.....0.0 %	$.....	$.....	$.....
23.03	Replications	$.....	.....0.0 %	$.....	$.....	$.....
23.04	Other	$.....	.....0.0 %	$.....	$.....	$.....

Statutory-Basis Financial Statements and Report of Independent Certified Public Accountants

Molina Healthcare of Mississippi, Inc.

December 31, 2018 and 2017

Contents

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REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

Board of Directors and Stockholder
Molina Healthcare of Mississippi, Inc.

We have audited the accompanying statutory-basis financial statements of Molina Healthcare of Mississippi, Inc., a Mississippi corporation, which comprise the statutory-basis statements of admitted assets, liabilities, capital and surplus as of December 31, 2018 and 2017, and the related statutory-basis statements of revenues and expenses, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory-basis financial statements.

Management's responsibility for the financial statements
Management is responsible for the preparation and fair presentation of these statutory-basis financial statements in accordance with the basis of accounting practices prescribed or permitted by the Insurance Department of the State of Mississippi. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of statutory-basis financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility
Our responsibility is to express an opinion on these statutory-basis financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the statutory-basis financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory-basis financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the statutory-basis financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the statutory-basis financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory-basis financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the statutory-basis financial statements referred to above present fairly, in all material respects, the financial position of Molina Healthcare of Mississippi, Inc. as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended in accordance with the basis of accounting practices prescribed or permitted by the Insurance Department of the State of Mississippi, described in Note 1A.

Basis of accounting
We draw attention to Note 1A of the statutory-basis financial statements, which describes the basis of accounting to meet the requirements of the Insurance Department of the State of Mississippi. The statutory-basis financial statements are prepared by Molina Healthcare of Mississippi, Inc. on the basis of accounting practices prescribed or permitted by the Insurance Department of the State of Mississippi, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Supplementary information
Our audit was conducted for the purpose of forming an opinion on the statutory-basis financial statements as a whole. The summary investment schedule and the supplemental investment risks interrogatories as of December 31, 2018, are presented for purposes of additional analysis and are not a required part of the statutory-basis financial statements. Such supplementary information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. The information has been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures. These additional procedures included comparing and reconciling the information directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary information is fairly stated, in all material respects, in relation to the statutory-basis financial statements as a whole.

Restriction on use
Our report is intended solely for the information and use of Molina Healthcare of Mississippi, Inc. and the Insurance Department of the State of Mississippi, and other insurance departments to whose jurisdiction Molina Healthcare of Mississippi, Inc. is subject to, and is not intended to be and should not be used by anyone other than these specified parties.

Grant Thornton LLP

Hartford, Connecticut
May 28, 2019

Molina Healthcare of Mississippi, Inc.
Statements of Admitted Assets, Liabilities, Capital and Surplus
December 31,

ASSETS	2018	2017
Cash and invested assets		
Cash and cash equivalents	$ 36,167,755	$ 4,496,249
Bonds	507,490	504,645
Total cash and invested assets	36,675,245	5,000,894
Investment income due and accrued	10,236	665
Premiums due and unpaid	4,234,396	-
TOTAL ASSETS	$ 40,919,877	$ 5,001,559
LIABILITIES, CAPITAL AND SURPLUS		
Liabilities		
Claims unpaid	$ 10,022,789	$ -
Unpaid claims adjustment expenses	171,309	-
General expenses due and accrued	1,571,611	-
Federal income tax payable	101,639	546
Amounts due to Parent and affiliates	29,073	-
Amounts due to government agencies	108,084	-
Total liabilities	12,004,505	546
Capital and surplus		
Common stock, no par value (10,000 shares authorized and 100 shares issued and outstanding)	-	-
Paid-in surplus	33,000,000	5,000,000
Unassigned surplus	(4,084,628)	1,013
Total capital and surplus	28,915,372	5,001,013
TOTAL LIABILITIES, CAPITAL AND SURPLUS	$ 40,919,877	$ 5,001,559

The accompanying notes are an integral part of these statutory-basis financial statements.

Molina Healthcare of Mississippi, Inc.
Statements of Revenue and Expenses
Years ended December 31,

	2018	2017
Revenue		
Net premium income	$ 22,819,906	$ -
Total revenue	22,819,906	-
Expenses		
Hospital and medical benefits	12,376,947	-
Other professional services	1,694,996	-
Outside referrals	871,054	-
Emergency room and out-of-area	2,084,451	-
Pharmacy	2,262,941	-
Total hospital and medical expenses	19,290,389	-
Claims adjustment expenses	1,039,854	-
General administrative expenses	6,209,928	70
Total expenses	26,540,171	70
Net underwriting loss	(3,720,265)	(70)
Other income		
Net investment income earned	17,290	1,629
Total other income	17,290	1,629
Net (loss) income before federal income taxes	(3,702,975)	1,559
Federal income taxes (benefit) incurred	(684,907)	546
NET (LOSS) INCOME	$ (3,018,068)	$ 1,013

The accompanying notes are an integral part of these statutory-basis financial statements.

Molina Healthcare of Mississippi, Inc.
Statements of Changes in Capital and Surplus
Years ended December 31,

	2018	2017
Capital and surplus, beginning of year	$ 5,001,013	$ -
Net income	(3,018,068)	1,013
Change in non-admitted assets	(1,067,573)	-
Capital contribution	28,000,000	5,000,000
Capital and surplus, end of year	$ 28,915,372	$ 5,001,013

The accompanying notes are an integral part of these statutory-basis financial statements.

Molina Healthcare of Mississippi, Inc.
Statements of Cash Flows
Years ended December 31,

	2018	2017
Operations		
Net premiums and revenues collected	$ 18,693,594	$ -
Net investment income received	4,873	(2,015,870)
Benefit and loss-related payments	(9,267,600)	-
Commissions, expenses paid and aggregate write-ins for deductions	(5,426,753)	(70)
Federal income taxes paid	786,000	-
Net cash provided by (used in) operations	4,790,114	(2,015,940)
Investment activities		
Proceeds from bonds sold or matured	-	504,063
Cost of bonds acquired	-	1,008,126
Net cash provided by investment activities	-	1,512,189
Financing and miscellaneous activities		
Capital contributions	28,000,000	5,000,000
Other cash applied	(1,118,608)	-
Net cash provided by financing and miscellaneous activities	26,881,392	5,000,000
Net increase in cash, cash equivalents and short-term investments	31,671,506	4,496,249
Cash and cash equivalents, beginning of year	4,496,249	-
Cash and cash equivalents, end of year	$ 36,167,755	$ 4,496,249

The accompanying notes are an integral part of these statutory-basis financial statements.

Note 1 – Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

Molina Healthcare of Mississippi, Inc. (the Plan) was incorporated under the laws of the state of Mississippi on March 2, 2009, and received a Certificate of Authority to transact business as a health maintenance organization (HMO) effective as of January 19, 2018. The Plan is a wholly owned subsidiary of Molina Healthcare, Inc. (Molina), a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, the Health Insurance Marketplace (Marketplace), and other government-sponsored health care programs for low-income families and individuals.

The Plan is a HMO, licensed in the state of Mississippi, that provides comprehensive health care services to Medicaid enrollees under contracts with the State of Mississippi, Office of the Governor, Division of Medicaid (Division). The Plan commenced operations on October 1, 2018 and served approximately 26,000 Medicaid members as of December 31, 2018. The Plan or the Division may terminate the Medicaid contract with 10-day written notice. Such contracts represent the majority of the Plan's source of premium income for the years ended December 31, 2018.

The Plan contracts with independent physician associations, hospitals and other providers to provide medical services to its members. As an HMO, the Plan is at risk for all covered outpatient and inpatient claims incurred by its beneficiaries.

The financial statements of the Plan are presented on the basis of accounting practices prescribed or permitted by the Mississippi Insurance Department (the Department).

The Department recognizes only statutory accounting practices prescribed or permitted by the state of Mississippi for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under the Mississippi insurance law. The National Association of Insurance Commissioners' *Accounting Practices and Procedures Manual* (NAIC SAP or the Manual) has been adopted as a component of prescribed or permitted practices by the state of Mississippi.

Such prescribed accounting practices have no effect on the Plan's statutory basis financial statements for the periods presented.

B. Use of Estimates in the Preparation of the Financial Statement

The preparation of financial statements in conformity with Statutory Accounting Principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. It also requires disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

C. Accounting Policy

The Plan applies the following accounting policies:

(1) Basis for Bonds and Amortization Schedule

Bonds include U.S. government securities with maturity dates of greater than one year at the time of purchase. Bonds not backed by other loans are principally stated at amortized cost using the scientific method. Bonds with NAIC designations of one or two are stated at amortized cost. Bonds with NAIC designations of three or higher are stated at the lower of amortized cost or fair value. Amortization of bond premium or accretion of discount is computed using the scientific (constant-yield) interest method. Realized capital gains and losses are determined using the specific-identification method and were not significant for the year ended December 31, 2018. There were no significant unrealized gains or losses on investments, and the Plan recognized no losses from other-than-temporary impairments for the year ended December 31, 2018.

(2) Anticipated Investment Income Used in Premium Deficiency Calculation

The Plan assesses the profitability of its medical care policies to identify groups of contracts where current operating results or forecasts include probable future losses. The Plan anticipates investment income as a factor in the premium deficiency calculation, in accordance with Statement of Statutory Accounting Principles (SSAP) No. 54, *Individual and Group Accident and Health Contracts*. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. The Plan has not recorded any premium deficiency reserves as of December 31, 2018.

(3) Management's Policies and Methodologies for Estimating Liabilities for Losses and Loss/Claim Adjustment Expenses for Accident &Health Contracts

Claims unpaid and unpaid claims adjustment expenses represent management's best estimate of the ultimate net cost of all reported and unreported claims incurred through December 31. Claims unpaid are based on actual historical experience and estimates of medical expenses incurred but not paid (IBNP). The Plan employs its own actuaries to estimate IBNP monthly based on a number of factors, including prior claims experience, health care service utilization data, cost trends, product mix, seasonality, prior authorization of medical services, and other factors. The Plan also considers uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership, and medical cost trends. The Plan continually reviews and updates the estimation methods and the resulting reserves. Any adjustments to reserves are reflected in current operations. The Plan believes that its process for estimating IBNP is adequate, but all estimates are subject to uncertainties. If the Plan's actual liability for claims payments is higher than previously estimated, earnings in any particular period could be negatively affected. Refer to Note 14, "Change in Incurred Losses and Loss Adjustment Expenses," for further information.

(4) Changes in the Capitalization Policy and Predefined Thresholds from Prior Period

The Plan has not modified its capitalization policy from the prior period.

Electronic data processing (EDP) equipment and software, which is non-admitted, is depreciated using the straight-line method over the lesser of its useful life or three years. Depreciation expense related to EDP equipment and operating system software totaled $9,562 for the year ended December 31, 2018.

Furniture and equipment and leasehold improvements, which are non-admitted, are generally depreciated using the straight-line method over the estimated useful lives of the assets. Depreciation expense related to furniture and equipment and leasehold improvements totaled $70,547 for the year ended December 2018.

(5) Method Used to Estimate Pharmaceutical Rebate Receivables

Amounts receivable for pharmaceutical rebates are estimated based upon historical and current utilization of prescription drugs and contract terms. Income from pharmaceutical rebates is reported as a reduction of hospital and medical expenses in the statutory basis statements of revenue and expenses. The Plan admits estimated pharmaceutical rebate receivables relating to the three months immediately preceding the reporting date in accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans*.

The Plan has also deemed the following to be significant accounting policies and/or differences between statutory practices and accounting principles generally accepted in the United States of America (GAAP):

Cash and Invested Assets

Cash and cash equivalents are defined as cash and short-term highly liquid investments that are both readily convertible into known amounts of cash and so near maturity that they represent insignificant risk of changes in value because of changes in interest rates. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP cash overdraft balances would be classified as liabilities. Only investments with original maturities of three months or less when purchased qualify under this definition with the exception of money market mutual funds registered under the Investment Company Act of 1940 (the Act) and regulated under rule 2a-7 of the Act as described in SSAP 2R, Cash, Cash Equivalents, Drafts and Short-Term Investments. Under GAAP, the corresponding caption of cash, cash equivalents, and short-term investments include cash balances and investments that will mature in one year or less from the balance sheet date.

Investments in bonds are reported at amortized cost or fair value based on their NAIC designation. Under GAAP, investments in bonds are grouped into three separate categories for accounting and reporting purposes: available-for-sale securities, held-to-maturity securities, and trading securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and

unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. Trading securities are recorded at fair value, and holding gains and losses are recognized in net income.

Premiums Due and Unpaid

Premiums due and unpaid at December 31, 2018, consist primarily of amounts due from the Division. Receivables are stated at net realizable value based on management's judgment of the ultimate collectability of the accounts. Collection trends are monitored and any adjustments required are reflected in current earnings. All premiums receivable balances outstanding greater than 90 days due, with the exception of premiums due from governmental agencies, are non-admitted in accordance with NAIC SAP.

Net Deferred Tax Assets or Liabilities

The Plan follows the guidance of SSAP No. 101, *Income Taxes*, for deferred income taxes. Deferred tax assets and liabilities are recorded for temporary differences between the tax basis of assets and liabilities and their amounts reported on the financial statements, using statutory rates in effect for the year in which the differences are expected to reverse. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as a change in surplus in the period that includes the enactment date. SSAP No. 101 includes a valuation allowance criterion whereby only gross deferred tax assets that are more likely than not (defined as a likelihood of more than 50%) to be realized are potentially admissible, subject to certain limitations and admissibility tests. Under GAAP, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets not realizable.

The Plan recognizes the financial statement benefit of a tax position after determining that the relevant tax authority would more likely than not sustain the position following an audit, including resolution of any related appeals or litigation processes, based on the technical merits of the position. The tax benefit to be recognized is measured as the largest amount of benefit that is greater than 50% likely of being realized upon ultimate settlement. Interest and penalties, if incurred, are recognized in the statutory basis statements of revenues and expenses as federal income tax expense. The Plan has not recognized any interest, penalties or income tax contingencies for the year ended December 31, 2018.

Receivables from or Amounts Due to Parents, Subsidiaries and Affiliates

The Plan has various transactions with related parties. The Plan reports any unsettled amounts due as receivables from parent, subsidiaries and affiliates and unsettled amounts owed as amounts due to parent, subsidiaries and affiliates. Refer to Note 5, "Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties" for further information.

Net Premium Income and Change in Reserve for Rate Credits

The Plan recognizes premiums from members as income in the period for which health plan coverage relates. Premiums collected in advance of a coverage period are recorded as premiums received in advance. Premium revenue is fixed in advance of the periods covered is not generally subject to significant accounting estimates.

Medical cost floors (medical loss ratio) and corridors: For certain Medicaid premiums, amounts may be returned to the Division if certain minimum amounts are not spent on defined medical care costs. Additionally, sanctions may be levied by the Division if the amounts spent on medical care costs as a percentage of premiums are not within a specified range. These sanctions include liquidated damages that may be assessed against the Plan for failure to meet requirements.

Medicaid Pass-through Payments

Refer to Note 10 "Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans", for further information.

Hospital and Medical Expenses

Medical care costs include primarily fee-for-services expenses. Nearly all hospital services and the majority of the Plan's primary care and physician specialist services are paid on a fee-for-service basis. Under fee-for-service arrangements, the Plan retains the financial responsibility for medical care provided and incurs costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. Medical care costs include amounts that have been paid by the Plan through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by the Plan as of the reporting date. See below for further information.

The Plan has also entered into agreements to pay a fixed capitated amount per member per month with certain providers. These payments are expensed in the period the providers are obligated to provide the service.

The Plan has contracts with medical provider organizations that require incentive payments if certain provisions of the contracts are met, and it records estimates for such incentive payments.

Reinsurance

The Plan has an excess risk reinsurance agreement with a non-affiliated company to limit its risk of catastrophic losses and its exposure to large claims by individuals with chronic or high cost conditions. The Plan maintains medical claims reinsurance with a deductible of $1.3 million for Medicaid. The reinsurance pays 90% of losses in excess of the deductible. The annual limit for Medicaid is $2,000,000 per member per year. Reinsurance expense is reported as a reduction of net premium income, and amounted to approximately $13,218 for the year ended December 31, 2018. Reinsurance recoveries not received as of year-end are recorded as either amounts recoverable from reinsurers or a reduction to claims unpaid in the statutory basis statements of admitted assets, liabilities, capital and surplus.

Reinsurance contracts do not relieve the Plan from its obligations to subscribers. The Plan remains liable to its subscribers for the portion reinsured to the extent that the reinsurance company does not meet the obligations assumed under the reinsurance contract.

Concentrations

The Plan has cash and invested assets deposited in financial institutions in which the balances exceed the Federal Deposit Insurance Corporation insured limit. The Plan has not experienced any losses in such accounts and management believes it is not exposed to any significant credit risk. The Plan's investments and a portion of its cash are managed by professional portfolio managers operating under documented investment guidelines.

Concentration of credit risk with respect to receivables is limited because the Plan's primary payor is the Division.

Risks and Uncertainties

The Plan's sole Medicaid customer is the Division. The loss of its contract with the Division would have a material adverse effect on the Plan's financial position, results of operations and cash flows. The Plan's ability to arrange for the provision of medical services to its members is dependent upon its ability to develop and maintain adequate provider networks. The inability to develop or maintain such networks could, in certain circumstances, have a material adverse effect on the Plan's financial position, results of operations or cash flows.

The Plan's profitability depends in large part on accurately predicting and effectively managing medical care costs. Management continually reviews the Plan's premium and benefit structure as well as its underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters and malpractice litigation, are beyond the Plan's control and could adversely affect its ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on the Plan's financial condition, results of operations or cash flows.

The Plan is subject to thorough and extensive regulations by multiple state and federal agencies. Its failure to comply with various regulations and requirements could limit the Plan's revenue or increase costs. In certain circumstances, a failure to comply with regulations or the cost incurred in complying with regulations could have a material adverse effect on the Plan's financial position, results of operations or cash flows.

Cash Flow

The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition; whereas under GAAP, the statements of cash flow reconcile the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting.

Comprehensive Income

The presentation of the statutory basis statements of admitted assets, liabilities, capital and surplus is not in conformity with GAAP with respect to the reporting of other comprehensive income.

Minimum Capital and Surplus

Title 83-41-325 of the Mississippi Insurance Code requires the Plan to maintain a minimum capital and surplus equal to the greater of $1.0 million or 2% of annual premium on the first $1.5 million of premium and 1% of annual premium on the premium in excess of $1.5 million or an amount equal to the sum of 3 months uncovered health care expenditures. At December 31, 2018, the Plan was in compliance with statutory minimum net worth requirements.

Recent Accounting Pronouncements

Recent accounting pronouncements issued by the NAIC did not have, nor does the Plan expect such pronouncements to have, a significant impact to the Plan's present or future financial statements.

D. Going Concern

The Plan is not aware of any relevant conditions or events that raise substantial doubt about its abilities to continue as a going concern.

Note 2 – Investments

The following tables summarize the Plan's investments including gross unrealized gains and losses as of the dates indicated:

	12/31/2018			
	Cost or amortized cost	Unrealized gains	Unrealized losses	Fair value
Open depositories	$ (1,339,898)	$ -	$ -	$ (1,339,898)
U.S. Government	507,490	-	(4,620)	502,870
Other money market mutual fund	37,507,653	-	-	37,507,653
Totals	$ 36,675,245	$ -	$ (4,620)	$ 36,670,625

The amortized cost and fair value of the Plan's investments by contractual maturities, were as follows:

	12/31/2018	
	Amortized cost	Fair value
Due in one year or less	$ 36,675,245	$ 36,670,625
Totals	$ 36,675,245	$ 36,670,625

As of December 31, 2018, bonds included $507,490, that were restricted for certain purposes as required by the Department.

Note 3 – Investment Income

The Plan had no investment income that was excluded in 2018. All of the Plan's investments and the income derived from such investments meet the criteria for admitted receivables.

Note 4 – Income Taxes

A. Deferred Tax Assets/(Liabilities)

1. Components of Net Deferred Tax Asset/(Liability)

	2018			2017			Change		
	1 Ordinary	2 Capital	3 (Col 1+2) Total	4 Ordinary	5 Capital	6 (Col 4+5) Total	7 (Col 1-4) Ordinary	8 (Col 2-5) Capital	9 (Col 7+8) Total
a. Gross deferred tax assets	$ 314,944	$ -	$ 314,944	$ -	$ -	$ -	$ 314,944	$ -	$ 314,944
b. Statutory valuation allowance adjustment	314,944		314,944				314,944		314,944
c. Adjusted gross deferred tax assets (1a-1b)	-	-	-	-	-	-	-	-	-
d. Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
e. Subtotal net admitted deferred tax asset (1c-1d)	-	-	-	-	-	-	-	-	-
f. Deferred tax liabilities	-	-	-	-	-	-	-	-	-
g. Net admitted deferred tax assets/(net deferred tax liability) (1e-1f)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

2. Admission Calculation Components SSAP No. 101

	2018			2017			Change		
	1 Ordinary	2 Capital	3 (Col 1+2) Total	4 Ordinary	5 Capital	6 (Col 4+5) Total	7 (Col 1-4) Ordinary	8 (Col 2-5) Capital	9 (Col 7+8) Total
a. Federal income taxes paid in prior years recoverable through loss carrybacks	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allowed per limitation threshold	-	-	4,337,306	-	-	-	-	-	4,337,306
c. Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	-	-	-	-	-	-	-	-	-
d. Deferred tax assets admitted as the result of application of SSAP 101. Total (2(a)+2(b)+2(c))	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

3. Other Admissibility Criteria

	2018	2017
a. Ratio percentage used to determine recovery period and threshold limitation amount	1,894.3%	%
b. Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)2 above	$ 28,915,372	$ -

4. Impact of Tax Planning Strategies

(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets, by tax character as a percentage.

	2018		2017		Change	
	1 Ordinary	2 Capital	3 Ordinary	4 Capital	5 (Col. 1-3) Ordinary	6 (Col. 2-4) Capital
1. Adjusted gross DTAs amount from Note 4A1(c)	$ -	$ -	$ -	$ -	$ -	$ -
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax planning strategies	%	%	%	%	%	%
3. Net Admitted Adjusted Gross DTAs amount from Note 4A1(e)	$ -	$ -	$ -	$ -	$ -	$ -
4 Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax planning strategies	%	%	%	%	%	%

(b) Does the Plan's tax planning strategies include the use of reinsurance? NO

B. Deferred Tax Liabilities Not Recognized: None.

C. Current and Deferred Income Taxes

1. Current Income Tax

	1 2018	2 2017	3 (Col 1-2) Change
a. Federal	$ (684,907)	$ -	$ (684,907)
b. Foreign	$ -	$ -	$ -
c. Subtotal	$ (684,907)	$ -	$ (684,907)
d. Federal income tax on net capital gains	$ -	$ -	$ -
e. Utilization of capital loss carry-forwards	$ -	$ -	$ -
f. Other	$ -	$ -	$ -
g. Federal and Foreign income taxes incurred	$ (684,907)	$ -	$ (684,907)

2. Deferred Tax Assets

	1 2018	2 2017	3 (Col 1-2) Change
a. Ordinary:			
1. Discounting of unpaid losses	$ 112,582	$ -	$ 112,582
2. Unearned premium reserve	-	-	-
3. Policyholder reserves	-	-	-
4. Investments	-	-	-
5. Deferred acquisition costs	-	-	-
6. Policyholder dividends accrual	-	-	-
7. Fixed assets	113,895	-	113,895
8. Compensation and benefits accrual	18,639	-	18,639
9. Pension accrual	-	-	-
10. Receivables - nonadmitted	-	-	-
11. Net operating loss carry-forward	-	-	-
12. Tax credit carry-forward	-	-	-
13. Other (items <=5% and >5% of total ordinary tax assets)	69,828	-	69,828
Other (items listed individually >5%of total ordinary tax assets)			
99. Subtotal	314,944	-	314,944
b. Statutory valuation allowance adjustment	314,944	-	314,944
c. Nonadmitted	-	-	-
d. Admitted ordinary deferred tax assets (2a99-2b-2c)	-	-	-
e. Capital:			
1. Investments	$ -	$ -	$ -
2. Net capital loss carry-forward	-	-	-
3. Real estate	-	-	-
4. Other (items <=5% and >5% of total capital tax assets)	-	-	-
Other (items listed individually >5% of total capital tax assets)			
99. Subtotal	$ -	$ -	$ -
f. Statutory valuation allowance adjustment	-	-	-
g. Nonadmitted	-	-	-
h. Admitted capital deferred tax assets (2e99-2f-2g)	-	-	-
i. Admitted deferred tax assets (2d+2h)	$ -	$ -	$ -

3. Deferred Tax Liabilities

	1 2018	2 2017	3 (Col 1-2) Change
a. Ordinary:			
1. Investments	$ -	$ -	$ -
2. Fixed assets	-	-	-
3. Deferred and uncollected premium	-	-	-
4. Policyholder reserves	-	-	-

	1 2018	2 2017	3 (Col 1-2) Change
5. Other (items <=5% and >5% of total ordinary tax liabilities)	-	-	-
Other (items listed individually >5% of total ordinary tax liabilities)			
99. Subtotal	-	-	-
b. Capital:			
1. Investments	-	-	-
2. Real estate	-	-	-
3. Other (Items <=5% and >5% of total capital tax liabilities)	-	-	-
Other (items listed individually >5% of total capital tax liabilities)			
99. Subtotal	-	-	-
c. Deferred tax liabilities (3a99+3b99)	$ -	$ -	$ -
4. Net Deferred Tax Assets (2i – 3c)	$ -	$ -	$ -

The change in net deferred income taxes is comprised of the following (this analysis is exclusive of nonadmitted assets as the change in nonadmitted assets is reported separately from the change in deferred income taxes in the surplus section of the Annual Statement):

	12/31/2018	12/31/2017	Change
Total deferred tax assets	$ 314,944	$ -	$ 314,944
Statutory valuation allowance	(314,944)	-	(314,944)
Total deferred tax liabilities	-	-	-
Net deferred tax asset (liability)	$ -	$ -	-
Tax effect of unrealized (gains)/losses			-
Change in net deferred income tax assets - increase (decrease)			$ -

The Tax Cuts and Jobs Act (TCJA) was enacted on December 22, 2017. The TCJA, in part, reduced the U.S. federal corporate tax rate from 35% to 21% effective January 1, 2018. The TCJA's change in the federal rate required that the Plan remeasure deferred tax assets and liabilities based on the rates at which they are expected to reverse in the future, which is generally the new 21% federal corporate tax rate. As of December 31, 2017, the Plan had not completed its accounting for the tax effects of enactment of the Act. The Plan has not recognized a provisional amount as the Plan does not have existing deferred tax balances. Upon further analysis of certain aspects of the TCJA and refinement of calculations during the 12 months ended December 31, 2018, the Plan continues to not recognize a provisional amount as the Plan does not have existing deferred tax balances. The Plan has now completed its accounting for all of the enactment-date income tax effects of the TCJA.

The Plan is subject to taxation in the United States. With few exceptions, the Plan is no longer subject to U.S. federal tax examination for tax years before 2015.

D. Reconciliation of Federal Income Tax Rate to Actual Effective Rate:

The provision for federal and foreign taxes incurred is different from that which would be obtained by applying the statutory federal tax rate to income before taxes. The significant items causing this difference are as follows:

	Tax Effect	Effective Tax Rate (%)
Taxes on income at federal statutory tax rate	$ (777,626)	21.00%
Changes in nonadmitted assets	(224,190)	6.05%
Health insurance providers fee	314,944	-8.51%
Other	1,965	-0.05%
Totals	$ (684,907)	18.49%
Federal and foreign income tax benefit	$ (684,907)	18.49%
Total statutory income taxes	$ (684,907)	18.49%

E. Operating Loss Carryforwards and Income Taxes Available for Recoupment

At December 31, 2018, the Plan did not have any unused operating loss carryforwards available to offset against future taxable income.

The amount of federal income taxes incurred that will be available for recoupment in the event of future net losses is approximately:

Year	Amounts
2018	$ -
2017	$ 546

The Plan did not have any protective tax deposits under Section 6603 of the Internal Revenue Code.

F. Consolidated Federal Income Tax Return

The Plan is included in the consolidated federal income tax return with its ultimate parent, Molina. The entities included within the consolidated return are included in NAIC Annual Statement Schedule Y – Information Concerning Activities of Insurer Members of a Holding Company Group. Federal income taxes are paid to or refunded by Molina pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of Molina.

G. Federal or Foreign Federal Income Tax Loss Contingencies:

The Plan does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

Note 5 – Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Molina has wholly owned operating subsidiaries in various states as indicated in Annual Statement Schedule Y, Parts 1 and 1A.

B. – C. The Plan received contributions amounting to $28.0 million and $5.0 million from Molina in the years ended December 31, 2018 and 2017, respectively, principally to provide funding to meet mandated net worth requirements. Molina has agreed to provide additional future funding to the Plan, if necessary, to ensure the Plan's compliance with minimum net worth requirements during the next 12 months.

The Plan has an agreement with Molina whereby Molina provides certain management services to the Plan. Expenses incurred relating to this agreement amounted to approximately $1.5 million for the year ended December 31, 2018.

D. As of December 31, 2018, amounts due to Molina and affiliates totaled $29,073. Intercompany receivables and payables are generally settled on a monthly basis.

E. As indicated in Note 5.A. above, the Plan is a wholly owned subsidiary of Molina. The entities under common ownership of Molina are indicated in Schedule Y, Parts 1 and 1A.

Note 6 – Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

Consolidated/Holding Company Plans: The employees of the Plan are eligible to participate in a defined contribution 401(k) plan sponsored by Molina subject to the participation eligibility set forth in the plan. Eligible employees are allowed to contribute up to the maximum allowed by law. The Plan matches up to the first 4% of compensation contributed by the employees subject to a one-year cliff vesting requirement. The Plan has no legal obligation to provide benefits under the plan. The Plan's expense recognized in connection with the 401(k) plan was $40,615 for the year ended December 31, 2018.

Note 7 – Capital and Surplus, Shareholder's Dividend Restrictions and Quasi-Reorganizations

(1) The Plan has 10,000 shares of no par value common stock authorized, 100 shares issued and outstanding.

(2) Dividend Restrictions

Without prior approval of the Department, the Plan may pay ordinary dividends up to 10 percent of total capital and surplus or an amount up to net income for the preceding calendar year.

(3) Subject to the limitations of (2) above, no restrictions have been placed on the portion of the Plan's profits that may be paid as ordinary dividends to Molina.

(4) Changes in the balance of special surplus funds: In accordance with SSAP No. 106, *Affordable Care Act Assessments*, the Plan reclassifies an amount equal to the estimated health insurer fee due in the following calendar year from unassigned surplus to special surplus. Due to the moratorium on the health insurer fee for the 2019 calendar year, the Plan did not reclassify amounts to special surplus at December 31, 2018.

(5) The portion of unassigned surplus or deficit, excluding the apportionment of estimated Section 9010 ACA subsequent fee year assessment, net income, and dividends, represented or reduced by each item below is as follows:

	2018	2017	Change
Nonadmitted assets	$ (1,067,573)	$ -	$ (1,067,573)
Total	$ (1,067,573)	$ -	$ (1,067,573)

Note 8 – Liabilities, Contingencies and Assessments

Many of the Plan's medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue the Plan for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years. In addition, the Plan may be involved in legal actions in the normal course of business, some of which involve a demand for both compensatory and punitive damages not covered by insurance. Currently, there are no pending or threatened actions which, to the knowledge and in the opinion of management and the Plan's counsel, would have a material adverse effect on the Plan's financial position, results of operations or cash flow.

Note 9 – Leases

A. Lessee Operating Lease

(1) The Plan leases office facilities and equipment under noncancelable long-term operating leases. Some of the leases contain escalation clauses and renewal options. Rental expense relating to these leases totaled $316,408 for the year ended December 31, 2018.

(2) Leases with Initial or Remaining Noncancelable Lease Terms in Excess of One Year

At December 31, 2018 the minimum aggregate rental commitments are as follows:

Year Ending December 31	Operating Leases
1. 2019	$834,644
2. 2020	$875,052
3. 2021	$943,530
4. 2022	$966,237
5. 2023	$649,804
6. Total	$4,269,267

Note 10 – Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

Medicare or Similarly Structured Cost Based Reimbursement Contract

Mississippi Hospital Access Program	Year to Date 2018	Quarter to Date as of 12/31/2018	Prior Year to Date 2017
MHAP Capitation	$ 5,316,478	$ 5,316,478	$ -
Premium Tax Payments	142,331	142,331	-
MHAP Payments to Providers	$ 5,154,436	$ 5,154,436	$ -

Note 11 – Fair Value Measurements

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 – Certain inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the reporting entity has the ability to access at the measurement date.

Level 2 – Certain inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability. Level 2 inputs include the following:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 – Certain inputs are unobservable inputs for the asset or liability. Unobservable inputs shall be used to measure fair value to the extent that relevant observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date.

Bonds are based on quoted market prices, where available.

A. Fair Value Measurements

(1) Fair Value Measurements at Reporting Date

The Plan's assets measured and reported at fair value on a recurring basis are listed in the table below. The Plan receives monthly statements from investment brokers that provide market pricing. There were no transfers between Level 1 and Level 2 of the fair value hierarchy.

2018:

Description for Each Type of Asset or Liability	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
Assets at Fair Value					
Other MM Mutual Fund	$ -	$37,507,653	$ -	$ -	$ 37,507,653
Total	$ -	$37,507,653	$ -	$ -	$ 37,507,653

B. Fair Value Reporting under SSAP 100, *Fair Value Measurements and Other Accounting Pronouncement*

In addition to bonds and short-term investments (see below), the Plan's statutory basis balance sheets typically include the following financial instruments: investment income due and accrued, federal income tax recoverable (payable), receivables, and current liabilities. The Plan believes the carrying amounts of these financial instruments approximate the fair value of these financial instruments because of the relatively short period of time between the origination of the instruments and their expected realization or payment.

C. Aggregate Fair Value Hierarchy

The aggregate fair value hierarchy of all financial instruments is presented in the tables below:

2018:

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Open Depositories	$ (1,339,898)	$ (1,339,898)	$ (1,339,898)	$ -	$ -	$ -	$ -
Other MM Mutual Fund	$ 37,507,653	$ 37,507,653	$ -	$ 37,507,653	$ -	$ -	$ -
US Government	$ 502,870	$ 507,490	$ -	$ 502,870	$ -	$ -	$ -
Total Financial Instruments	$ 36,670,625	$ 36,675,245	$(1,339,898)	$ 38,010,523	$ -	$ -	$ -

Note 12 – Other Items

The Plan was awarded a contract by the Division for the Children's Health Insurance Program (CHIP). Services under the new three-year contract were initially set to begin July 1, 2019; however, the start date is now pending the outcome of a protest of the contract awards.

Stock Plans

Under an equity incentive plan adopted by Molina, the Plan's employees may be awarded Molina restricted stock or other equity incentives. Restricted stock awards generally vest in equal annual installments over periods of up to four years from the date of grant.

Molina has an employee stock purchase plan under which the eligible employees of the Plan may purchase common shares at 85% of the lower of the fair market value of Molina's common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions.

Note 13 – Events Subsequent

Type I - Recognized Subsequent Events: None.

Type II - Nonrecognized Subsequent Events:

The Plan is subject to an annual health insurer fee under section 9010 of the Federal Affordable Care Act (ACA). This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee

becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. Due to the moratorium on the health insurer fee for the 2019 calendar year, the Plan did not reclassify amounts to special surplus at December 31, 2018.

A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)? Yes [X] No [ ]

		2018	2017
B.	ACA fee assessment payable for the upcoming year	$ -	$ -
C	ACA fee assessment paid	$ -	$ -
D.	Premium written subject to ACA 9010 assessment	$ -	$ -
E.	Total adjusted capital before surplus adjustment (Five-Year Historical Line 14)	$ 28,915,372	
F.	Total adjusted capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	$ 28,915,372	
G.	Authorized control level (Five-Year Historical Line 15)	$ 1,526,470	

H. Would reporting the ACA assessment as of December 31, 2018 have triggered an RBC action level (YES/NO)? Yes [ ] No [X]

The Plan evaluated its December 31, 2018, statutory basis financial statements for subsequent events through May 28, 2019, the date the statutory basis financial statements were available to be issued. The Plan is not aware of any subsequent events that would require recognition or disclosure in these statutory basis financial statements.

Note 14 – Change in Incurred Losses and Loss Adjustment Expenses

A. Change in Incurred Losses and Loss Adjustment Expenses: Claims unpaid activity during 2018 is summarized below:

	Year ended 12/31/2018
Unpaid claims liabilities, accrued medical incentives, and claims adjustment expenses, beginning of period	$ -
Add provision for claims, net of reinsurance:	
Current year	19,290,389
Prior years	-
Net incurred claims during the current year	19,290,389
Deduct paid claims, net of reinsurance	
Current year	9,267,600
Prior years	-
Net paid claims during the current year	9,267,600
Change in claims adjustment expenses	171,309
Change in health care receivables	-
Change in amounts due from reinsurers	-
Unpaid claims liabilities, accrued medical incentives (if applicable), and claims adjustment expenses, end of period	$ 10,194,098

B. Information about Significant Changes in Methodologies and Assumptions

The Plan did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid claim adjustment expenses in 2018.

SUPPLEMENTARY INFORMATION

SUMMARY INVESTMENT SCHEDULE

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
Investment Categories	Amount	Percentage	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage
1. Bonds:						
1.1 U.S. treasury securities	507,490	1.4	507,490		507,490	1.4
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies		0.0			0	0.0
1.22 Issued by U.S. government sponsored agencies		0.0			0	0.0
1.3 Non-U.S. government (including Canada, excluding mortgage-backed securities)		0.0			0	0.0
1.4 Securities issued by states, territories and possessions and political subdivisions in the U.S.:						
1.41 States, territories and possessions general obligations		0.0			0	0.0
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations		0.0			0	0.0
1.43 Revenue and assessment obligations		0.0			0	0.0
1.44 Industrial development and similar obligations		0.0			0	0.0
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA		0.0			0	0.0
1.512 Issued or guaranteed by FNMA and FHLMC		0.0			0	0.0
1.513 All other		0.0			0	0.0
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA		0.0			0	0.0
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-based securities issued or guaranteed by agencies shown in Line 1.521		0.0			0	0.0
1.523 All other		0.0			0	0.0
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)		0.0			0	0.0
2.2 Unaffiliated non-U.S. securities (including Canada)		0.0			0	0.0
2.3 Affiliated securities		0.0			0	0.0
3. Equity interests:						
3.1 Investments in mutual funds		0.0			0	0.0
3.2 Preferred stocks:						
3.21 Affiliated		0.0			0	0.0
3.22 Unaffiliated		0.0			0	0.0
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated		0.0			0	0.0
3.32 Unaffiliated		0.0			0	0.0
3.4 Other equity securities:						
3.41 Affiliated		0.0			0	0.0
3.42 Unaffiliated		0.0			0	0.0
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated		0.0			0	0.0
3.52 Unaffiliated		0.0			0	0.0
4. Mortgage loans:						
4.1 Construction and land development		0.0			0	0.0
4.2 Agricultural		0.0			0	0.0
4.3 Single family residential properties		0.0			0	0.0
4.4 Multifamily residential properties		0.0			0	0.0
4.5 Commercial loans		0.0			0	0.0
4.6 Mezzanine real estate loans		0.0			0	0.0
5. Real estate investments:						
5.1 Property occupied by company		0.0			0	0.0
5.2 Property held for production of income (including $.....0 of property acquired in satisfaction of debt)		0.0			0	0.0
5.3 Property held for sale (including $.....0 property acquired in satisfaction of debt)		0.0			0	0.0
6. Contract loans		0.0			0	0.0
7. Derivatives		0.0			0	0.0
8. Receivables for securities		0.0			0	0.0
9. Securities lending (Line 10, Asset Page reinvested collateral)		0.0		XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	36,167,755	98.6	36,167,755		36,167,755	98.6
11. Other invested assets		0.0			0	0.0
12. Total invested assets	36,675,244	100.0	36,675,244	0	36,675,244	100.0

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For the year ended December 31, 2018
(To be filed by April 1)
Of Molina Healthcare of Mississippi, Inc.
Address (City, State, Zip Code): Jackson MS 39201
NAIC Group Code.....1531 NAIC Company Code.....16301 Employer's ID Number.....26-4390042

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.
Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $.....40,919,877

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01			$	0.0 %
2.02			$	0.0 %
2.03			$	0.0 %
2.04			$	0.0 %
2.05			$	0.0 %
2.06			$	0.0 %
2.07			$	0.0 %
2.08			$	0.0 %
2.09			$	0.0 %
2.10			$	0.0 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2
3.01	NAIC 1	$.....507,490	1.2 %
3.02	NAIC 2	$	0.0 %
3.03	NAIC 3	$	0.0 %
3.04	NAIC 4	$	0.0 %
3.05	NAIC 5	$	0.0 %
3.06	NAIC 6	$	0.0 %
	Preferred Stocks	**3**	**4**
3.07	P/RP-1	$	0.0 %
3.08	P/RP-2	$	0.0 %
3.09	P/RP-3	$	0.0 %
3.10	P/RP-4	$	0.0 %
3.11	P/RP-5	$	0.0 %
3.12	P/RP-6	$	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 4.01 above is yes, responses are not required for interrogatories 5-10.

4.02	Total admitted assets held in foreign investments	$	0.0 %
4.03	Foreign-currency-denominated investments	$	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC 1	$	0.0 %
5.02	Countries designated NAIC 2	$	0.0 %
5.03	Countries designated NAIC 3 or below	$	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

	Countries designated NAIC 1:	1	2
6.01	Country 1: YES	$	0.0 %
6.02	Country 2:	$	0.0 %
	Countries designated NAIC 2:		
6.03	Country 1:	$	0.0 %
6.04	Country 2:	$	0.0 %
	Countries designated NAIC 3 or below:		
6.05	Country 1:	$	0.0 %
6.06	Country 2:	$	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC 1	$	0.0 %
8.02	Countries designated NAIC 2	$	0.0 %
8.03	Countries designated NAIC 3 or below	$	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC 1:		
9.01	Country 1:	$	0.0 %
9.02	Country 2:	$	0.0 %
	Countries designated NAIC 2:		
9.03	Country 1:	$	0.0 %
9.04	Country 2:	$	0.0 %
	Countries designated NAIC 3 or below:		
9.05	Country 1:	$	0.0 %
9.06	Country 2:	$	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01			$	0.0 %
10.02			$	0.0 %
10.03			$	0.0 %
10.04			$	0.0 %
10.05			$	0.0 %
10.06			$	0.0 %
10.07			$	0.0 %
10.08			$	0.0 %
10.09			$	0.0 %
10.10			$	0.0 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of Interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian Investments	$	0.0 %
11.03	Canadian currency-denominated investments	$	0.0 %
11.04	Canadian-denominated insurance liabilities	$	0.0 %
11.05	Unhedged Canadian currency exposure	$	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

		1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$		0.0 %
	Largest three investments with contractual sales restrictions:			
12.03		$		0.0 %
12.04		$		0.0 %
12.05		$		0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interest less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Name of Issuer	2	3
13.02		$	0.0 %
13.03		$	0.0 %
13.04		$	0.0 %
13.05		$	0.0 %
13.06		$	0.0 %
13.07		$	0.0 %
13.08		$	0.0 %
13.09		$	0.0 %
13.10		$	0.0 %
13.11		$	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

		1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$		0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:			
14.03		$		0.0 %
14.04		$		0.0 %
14.05		$		0.0 %

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$	0.0 %
	Largest three investments in general partnership interests:		
15.03		$	0.0 %
15.04		$	0.0 %
15.05		$	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$	0.0 %
16.03		$	0.0 %
16.04		$	0.0 %
16.05		$	0.0 %
16.06		$	0.0 %
16.07		$	0.0 %
16.08		$	0.0 %
16.09		$	0.0 %
16.10		$	0.0 %
16.11		$	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$	0.0 %
16.13	Mortgage loans over 90 days past due	$	0.0 %
16.14	Mortgage loans in the process of foreclosure	$	0.0 %
16.15	Mortgage loans foreclosed	$	0.0 %
16.16	Restructured mortgage loans	$	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.02	91% to 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.03	81% to 90%	$	0.0 %	$	0.0 %	$	0.0 %
17.04	71% to 80%	$	0.0 %	$	0.0 %	$	0.0 %
17.05	below 70%	$	0.0 %	$	0.0 %	$	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate:

	Description	2	3
18.02		$	0.0 %
18.03		$	0.0 %
18.04		$	0.0 %
18.05		$	0.0 %
18.06		$	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans.

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans	$	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$	0.0 %
19.04		$	0.0 %
19.05		$	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-End		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$	0.0 %	$	$	$
20.02	Repurchase agreements	$	0.0 %	$	$	$
20.03	Reverse repurchase agreements	$	0.0 %	$	$	$
20.04	Dollar repurchase agreements	$	0.0 %	$	$	$
20.05	Dollar reverse repurchase agreements	$	0.0 %	$	$	$

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps and floors:

	Owned		Written	
	1	2	3	4
21.01 Hedging	$	0.0 %	$	0.0 %
21.02 Income generation	$	0.0 %	$	0.0 %
21.03 Other	$	0.0 %	$	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

	At Year-End		At End of Each Quarter		
			1st Qtr	2nd Qtr	3rd Qtr
	1	2	3	4	5
22.01 Hedging	$	0.0 %	$	$	$
22.02 Income generation	$	0.0 %	$	$	$
22.03 Replications	$	0.0 %	$	$	$
22.04 Other	$	0.0 %	$	$	$

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

	At Year-End		At End of Each Quarter		
			1st Qtr	2nd Qtr	3rd Qtr
	1	2	3	4	5
23.01 Hedging	$	0.0 %	$	$	$
23.02 Income generation	$	0.0 %	$	$	$
23.03 Replications	$	0.0 %	$	$	$
23.04 Other	$	0.0 %	$	$	$

4.3.2.6 AUDITED FINANCIAL STATEMENTS AND PRO FORMA FINANCIAL TEMPLATE

Appendix 2

Documentation of Available Lines of Credit

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2021

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)

(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	MOH	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☒ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐ Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2021, the last business day of our most recently completed second fiscal quarter, was approximately $14.7 billion (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2021).

As of February 11, 2022, approximately 58,400,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2022 Annual Meeting of Stockholders to be held on May 4, 2022, are incorporated by reference into Part III of this Form 10-K, to the extent described therein.

MOLINA HEALTHCARE, INC. 2021 FORM 10-K

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The following tables provide information about our consolidated incurred and paid claims development as of December 31, 2021, as well as cumulative claims frequency and the total of incurred but not paid claims liabilities. The pattern of incurred and paid claims development is consistent across each of our segments. The cumulative claim frequency is measured by claim event, and includes claims covered under capitated arrangements.

Incurred Claims and Allocated Claims Adjustment Expenses					
Benefit Year	2019	2020	2021	Total IBNP	Cumulative number of reported claims
	(Unaudited)	(Unaudited)	(In millions)		
2019	$ 14,176	$ 14,083	$ 14,040	$ 12	105
2020		16,233	16,056	52	140
2021			23,943	2,416	181
			$ 54,039	$ 2,480	

Cumulative Paid Claims and Allocated Claims Adjustment Expenses			
Benefit Year	2019	2020	2021
	(Unaudited)	(Unaudited) (In millions)	
2019	$ 12,554	$ 14,056	$ 14,028
2020		13,871	16,004
2021			21,148
			$ 51,180

The following table represents a reconciliation of claims development to the aggregate carrying amount of the liability for medical claims and benefits payable.

	2021
	(In millions)
Incurred claims and allocated claims adjustment expenses	$ 54,039
Less: cumulative paid claims and allocated claims adjustment expenses	(51,180)
All outstanding liabilities before 2019	6
Acquired balances	224
Non-risk and other provider payables	274
Medical claims and benefits payable	$ 3,363

11. Debt

Contractual maturities of debt, as of December 31, 2021, are illustrated in the following table. All amounts represent the principal amounts of the debt instruments outstanding.

	Total	2022	2023	2024	2025	2026	Thereafter
				(In millions)			
4.375% Notes due 2028	$ 800	$ —	$ —	$ —	$ —	$ —	$ 800
3.875% Notes due 2030	650	—	—	—	—	—	650
3.875% Notes due 2032	750	—	—	—	—	—	750
Total	$ 2,200	$ —	$ —	$ —	$ —	$ —	$ 2,200

All our debt is held at the parent which is reported in the Other segment. The following table summarizes our outstanding debt obligations, all of which are non-current as of the dates reported below:

	December 31,	
	2021	2020
	(In millions)	
Non-current portion of long-term debt:		
5.375% Notes due 2022	$ —	$ 700
4.375% Notes due 2028	800	800
3.875% Notes due 2030	650	650
3.875% Notes due 2032	750	—
Less: debt issuance costs	(27)	(23)
Total	$ 2,173	$ 2,127

Credit Agreement

We are party to a credit agreement (the "Credit Agreement") which includes a revolving credit facility ("Credit Facility") of $1.0 billion, among other provisions. The Credit Agreement has a term of five years, and all amounts outstanding will be due and payable on June 8, 2025. Borrowings under the Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus in each case, the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Agreement, we are required to pay a quarterly commitment fee.

The Credit Agreement contains customary non-financial and financial covenants. As of December 31, 2021, we were in compliance with all financial and non-financial covenants under the Credit Agreement and other long-term debt. As of December 31, 2021, no amounts were outstanding under the Credit Facility.

Senior Notes

Our senior notes are described below. Each of these notes are senior unsecured obligations of Molina and rank equally in right of payment with all existing and future senior debt, and senior to all existing and future subordinated debt of Molina. In addition, each of the notes contain customary non-financial covenants and change of control provisions.

The indentures governing the senior notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture.

5.375% Notes due 2022. In December 2021, we completed the early redemption of the entire $700 million aggregate principal amount of senior notes (the "5.375% Notes") that would have been due November 15, 2022. In accordance with the indenture governing such notes, the 5.375% Notes were settled at 100% of par, plus an early redemption premium which amounted to $23 million, plus accrued and unpaid interest. In conjunction with the redemption we wrote off $2 million in unamortized deferred issuance costs directly related to the 5.375% Notes.

4.375% Notes due 2028. We have $800 million aggregate principal amount of senior notes (the "4.375% Notes") outstanding as of December 31, 2021, which are due June 15, 2028, unless earlier redeemed. Interest, at a rate of 4.375% per annum, is payable semiannually in arrears on June 15 and December 15.

3.875% Notes due 2030. We have $650 million aggregate principal amount of senior notes (the "3.875% Notes due 2030") outstanding as of December 31, 2021, which are due November 15, 2030, unless earlier redeemed. Interest, at a rate of 3.875% per annum, is payable semiannually in arrears on May 15 and November 15.

3.875% Notes due 2032. On November 16, 2021, we completed the private offering of $750 million aggregate principal amount of senior notes (the "3.875% Notes due 2032") due May 15, 2032, unless earlier redeemed. The 3.875% Notes due 2032 contain optional early redemption provisions, with redemption prices in excess of par. Interest, at a rate of 3.875% per annum, is payable semiannually in arrears on May 15 and November 15 of each year, commencing on May 15, 2022. A large majority of the net proceeds from the 3.875% Notes due 2032 offering was used to repay $700 million principal amount outstanding under the 5.375% Notes, and the balance is intended to be used for general corporate purposes. Deferred issuance costs amounted to $10 million.

In 2021, we recognized an aggregate loss on debt repayment of $25 million including costs incurred in the early redemption of the 5.375% Notes described above. In 2020, we recognized an aggregate loss on debt repayment of $15 million including costs incurred in repayment of the term loan facility, the early redemption of the entire

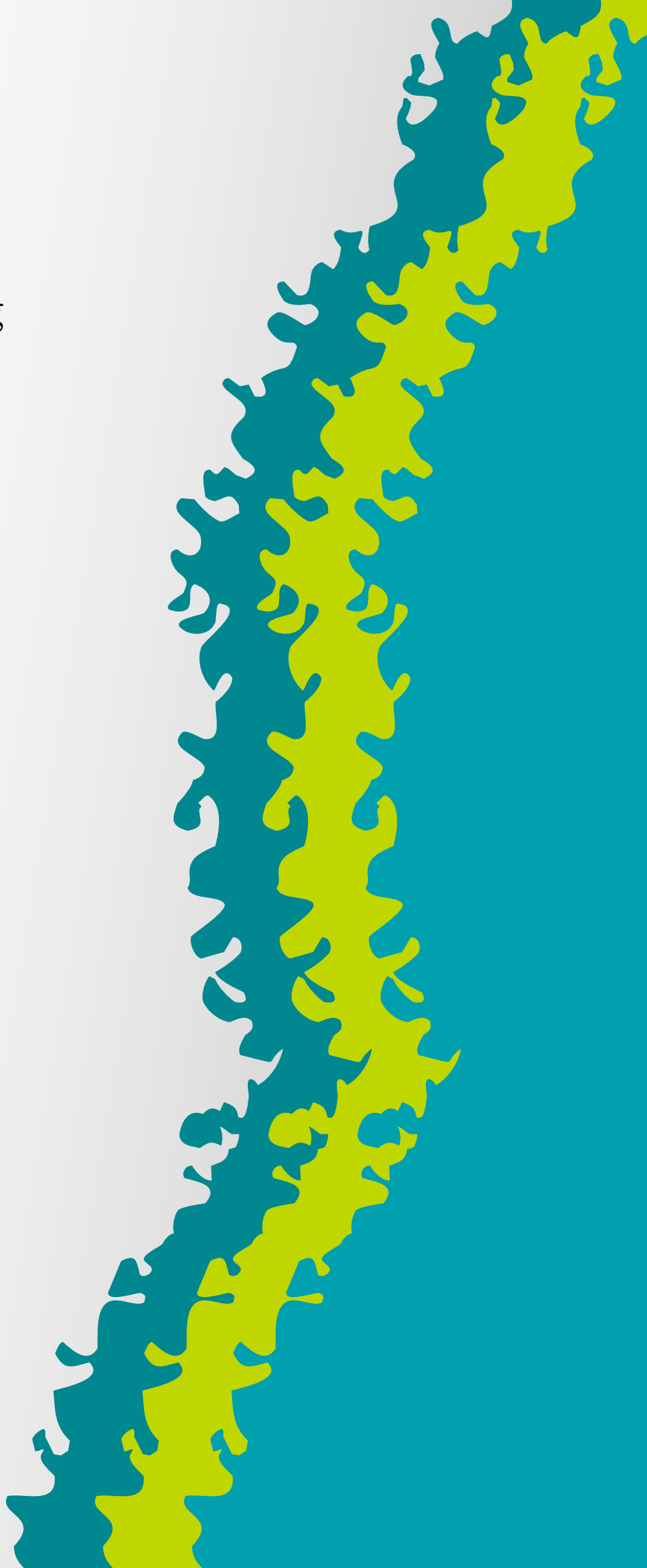
4.3.2.6 AUDITED FINANCIAL STATEMENTS AND PRO FORMA FINANCIAL TEMPLATE

Appendix G
Financial Pro Forma

Appendix G: Financial Pro Forma is attached as an Excel File.

4.3.3

Organization and Staffing



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4.3.3 ORGANIZATION AND STAFFING

To build the Division's CCO Program on the strongest foundation possible, Molina will leverage our current staff and robust infrastructure already in place for MississippiCAN and CHIP. We have applied our high-touch staffing model—already tested and proven successful in Mississippi—to determine that we will need approximately 174 Molina employees located across the State to support the CCO Program. Our proposed staff includes all RFQ-required positions and 23 FTE positions **above and beyond the Contract requirements.** All staff are FTEs and fully dedicated to this Contract. Our local staff will be supported by the resources and services of four proposed Subcontractors: Molina Healthcare, Inc. (Molina Healthcare); MARCH® Vision Care Group, Inc. (MARCH); Medical Transportation Management, Inc. (MTM); and SKYGEN®, USA (SKYGEN).

We approach our staffing plans with the same precision and attention to detail used to ensure Members receive the care and support that works best for them.

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Our organization and staffing approach use a dedicated Implementation Phase team of subject matter experts (SMEs) familiar with Medicaid and CHIP who will complete implementation tasks while ensuring minimal disruption to Members. As we recruit, hire, and train locally based and appropriately licensed candidates to meet staffing needs, we select only those individuals who meet or exceed our stringent internal experience/qualification requirements and the Division's high standards for performance excellence.

Throughout the Contract, we will continually monitor membership enrollment levels, program changes, and fluctuations in functional areas, such as the call centers and care management, to determine if additional staff are required to meet the needs of Members, Providers, or the Division. We will obtain the Division's approval for all staffing changes.

We comply with the requirements in RFQ § 4.3.3, Organization and Staffing; Appendix A, Draft Contract § 1.13, Administration Management, Facilities, and Resources; and all other applicable sections of the RFQ and Draft Contract. In this response, we present the following information:

- **Organization charts.** Organization charts for the Implementation, Operations, and Turnover phases
- **Job descriptions.** Detailed job descriptions for the 9 executive positions listed in Draft Contract § 1.13.1.1; the 11 administrative positions listed in Draft Contract § 1.13.1.2; and the 4 staff positions that meet Draft Contract § 1.13.2 requirements not already met by designated executive and administrative staff
- **Administrative requirements.** Verification of administrative requirements regarding our office location and administrative records/data
- **Staffing.** Staffing numbers/ratios and job qualifications/training/education for Member services call center, Provider services call center, and Provider Relations employees; Quality Management (QM) staff descriptions and qualifications; Care Manager and care management staff education, experience, and training (including cultural competency training) and Member assignment by Member risk level and needs; NCQA accreditation process and successes; descriptions of staff responsible for FWA, subrogation/TPL, and encounter reconciliation policies and processes; and our approach to responding to requests from the Division
- **Subcontractors.** Approach to Subcontractor hiring/oversight and identification of proposed Subcontractors using the RFQ-required forms in Appendix H
- **Economic impact.** Completed RFQ Appendix H Economic Impact forms for Mississippi-based staff positions listed in Draft Contract § 1.13.1; a list of other Mississippi-based staff positions and salaries; and an explanation of other investments we plan to make in the State

4.3.3.1 ORGANIZATION

Molina's organization charts for the CCO Program reflect our expertise in developing organizational structures and staffing for government healthcare programs. These structures are based on the proven national model Molina Healthcare created for all affiliated health plans using input gathered from key health plan and corporate leaders to ensure that we build in the support needed within each functional area. We have customized this model for Mississippi to reflect all RFQ requirements as well as the unique needs of Members and Providers. Our successful delivery of services for these two programs demonstrates that we know how to organize and staff programs to fully support Members and Providers throughout the State.

1. Organization and Staffing During Each Phase as Described in the RFQ

Our CCO Program organization charts show our comprehensive organization and staffing during the Implementation, Operations, and Turnover phases. We will use our local team supplemented by an Implementation team for the Implementation Phase. This combined team is tasked with getting the operation and systems in place and ready for successful implementation of the new Contract.

Our organization charts are presented on the following pages in **Exhibit 1** Implementation Phase Organizational Chart; **Exhibit 2** Operations Phase Organizational Chart; and **Exhibit 3** Turnover Phase Organizational Chart. Each chart includes:

- Position titles and the number of staff in each position
- Identification of staff who are based in Mississippi and those who are not based in Mississippi
- Identification of proposed staff above and beyond RFQ requirements
- Identification of functions and services to be provided by corporate resources
- Acknowledgment that staffing is based on an estimated 125,000 Members and that care management staff numbers depend on assigned populations, engagement factors, and attribution

2. Full-time, Part-time, and Temporary Status of All Employees

All positions for this Contract are FTEs. Consistent with our practices at our affiliate health plans throughout the nation, all positions are filled by permanent employees. If conditions in Mississippi require us to adjust our staffing plan, we will obtain advance written approval from the Division for those adjustments.

3. Indication Staff will be Dedicated or Shared Staff

As noted on each chart and in compliance with Draft Contract § 1.13, all staff are wholly dedicated to this Contract unless otherwise noted. The same staff—except for our Project Management Office team during Implementation—perform their roles through each Contract phase to ensure health plan continuity and smooth transitions.

4.3.3.2 JOB DESCRIPTIONS 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.

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
Description of Position: The Chief Executive Officer (CEO) is a full-time designated role with decision-making authority to administer the day-to-day business activities conducted pursuant to this Contract. This individual serves as the Contract Officer for Molina. This position is authorized and empowered to make operational and financial decisions, including rate negotiations for Mississippi business, claims payment, and Provider relations/contracting. The Chief Executive Officer can make decisions about coordinated care activities and represent Molina at meetings required by the Division. This role provides the overall direction and administration of Molina's operational departments, programs, and services by implementing programs in alignment with our strategic and operating plan; overseeing the day-to-day leadership and management of the Mississippi market or product operations that mirrors the company's mission, vision, and core values; and ensuring the efficient and compliant operations of the market or product of the health plan.
Description of Responsibilities of Position: • Formulates and implements business plans and strategies to provide profitable operations, meet short-term objectives, and ensure long-term growth, success, and competitive position • Directs the growth of the State plan, including overseeing business development activities • Identifies, analyzes, and recommends strategic alliances and/or acquisitions to provide better products and services to Members • Develops and implements adequate measures to meet the fiscal needs of the company, conserve its assets, and maintain an effective system of budgetary control • Reviews forecasts and proposed capital expenditures, recommends programs and policies by analyzing the changing needs of the membership and industry, identifies and analyzes trends, and evaluates options • Amends existing policies to improve operations and creates new policies as needed • Presents reports and recommendations on the operations and finances of the State plan and proposes changes to major policies • Ensures the overall level of quality for delivery of medical services meets or exceeds appropriate standards • Provides personal leadership that encourages employee productivity and responsiveness to the needs of current and prospective Members, Providers, and other community and regulatory stakeholders • Ensures programs are established to comply with all relevant Federal, State, and local regulations • Fosters and builds a collaborative working environment with internal and external colleagues and constituents • Makes rapid-cycle, timely, and responsive decisions regarding health plan operations while ensuring high-quality care delivery to Members • Represents Molina with State regulators, legislators, advocates, and other constituents

- Fosters and builds a collaborative working environment with internal and external colleagues and constituents
- Attends all required meetings with the Division

Minimum Experience Required:

- 15 or more years of progressive experience in the managed healthcare industry, including 10 or more years of management experience
- Working knowledge of Medicaid and Medicare products

Skills Required:

- Soft skills including, but not limited to, critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Bachelor's in Business, Health Administration, or related field

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi
- Local travel of up to 40% may be required
- Working environment is generally favorable and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred experience**: Transition and/or acquisition experience; direct experience with Medicaid and Medicare managed care plans
- **Preferred education**: Master's in Business, Health Administration, or related field

Key Position: Job Description
Title of Position: Chief Operating Officer
Description of Position: The Chief Operating Officer (COO) is a dedicated, full-time position that oversees day-to-day business activities pursuant to this Contract and is authorized to make decisions about program issues. This individual oversees the development and administration of the health plan's operational departments, programs, and services in alignment with Molina Healthcare's overall mission, core values, and strategic plan and in compliance with all relevant Federal, State, and local regulatory requirements. **The COO position meets the RFQ Draft Contract § 1.13.2 requirement for a designated person to be responsible for data processing and the provision of accurate and timely reports and Member encounter data to the Division. It also meets the requirement for a designee who can respond to issues involving systems and reporting and grievances and appeals.**
Description of Responsibilities of Position: • Directs and coordinates Mississippi health plan operations under the leadership of the CEO • Ensures our metrics consistently meet and/or exceed all compliance requirements, key performance targets, and associated service-level agreements • Plans, organizes, staffs, and coordinates program operations • Works with staff and senior management to develop and implement improvements and oversight for nonclinical operations • Serves as the senior plan leader and liaison for Molina service operations, including claims, configuration information management, enrollment, call center operations, IT, Provider configuration management, program integrity, risk adjustment, Provider resolution team, Provider grievances and appeals, Member grievances and appeals, and other departments as required • Proactively develops, tracks, and reports to health plan leadership all service operations performance relative to compliance requirements, key performance targets, and/or associated service-level agreements • Escalates performance issues to the CEO and health plan leadership with mitigation action plans • Identifies and adopts best practices from across the enterprise for health plan and Molina service operations, develops strategies and tactics in partnership with Molina service operations to mitigate any issues or performance levels not meeting established service levels, and provides corporate oversight, including the efficacy of vendor management • Serves as the liaison with enrollment and call center operation leaders to ensure full and consistent compliance with CCO Program, State, Contract, and regulatory requirements • Works collaboratively with corporate business owners to mitigate risk related to enrollment processes and call center performance • Directs analytical activities to identify trends and potential opportunities with those corporate operations functions that may affect the functionality of health plan operations • Directly manages benefit configuration, claim payment policies, and maintenance or modifications to support accurate and timely claims payment

- Manages the Provider configuration/information activities to ensure compliance with regulatory requirements and accurate claims and encounter submissions
- Partners to support encounter submissions to regulators
- Leads efforts through local data/business analysts to audit Provider contract loads and claims payments to ensure compliance with Provider contract requirements
- Manages the project management and process improvement teams and resources
- Performs contracts and relationship management for State and Federal partners and key State-elected officials
- Represents Molina at Division meetings and other State meetings, attends all required meetings with the Division, and develops strategies to advocate for best practices that demonstrably improve contract terms or facilitate business objectives
- Makes rapid-cycle, timely, and responsive decisions while ensuring high-quality care delivery to Members; responds to issues involving information systems and reporting, appeals, quality improvement, Member services, service management, pharmacy management, medical management, care coordination, and issues related to Member health, safety, and welfare
- Assists the CEO with various advocacy efforts in support of plan business operations; provides leadership on emerging healthcare issues, new business implementation, and strategic planning for the health plan
- Leads and supervises regulatory submissions and filings
- Works with key Statewide advocacy groups and Provider trade associations and develops strategic partnerships
- Represents the health plan within key industry groups, such as State programs and Legislative and Regulatory Affairs Committees; prepares and coordinates deliverables for the health plan with these groups
- In coordination with Legal Affairs, assesses and provides analyses for proposed changes to CHIP, Medicaid, Medicare, Exchange, and other government-sponsored healthcare program contracts, governing regulations, and new legislation and policy requirements
- Oversees and monitors the implementation of new CHIP, Medicaid, and Medicare contractual and policy requirements, new legislation and regulations, and all State requirements
- Educates health plan staff on complying with new healthcare program requirements
- Institutes reporting standards to meet new program requirements
- Performs routine market assessments to identify bid opportunities
- Coordinates health plan’s request for proposal responses to bid opportunities in collaboration with the Molina proposal team
- Coordinates with the Compliance Officer’s initiatives to improve adherence to plan policies and procedures, and represents the Government Contracts department on the Compliance Committee
- Coordinates the establishment of and maintains memoranda of understanding for the health plan’s carved-out and linked services in State and county healthcare programs, as applicable, ensuring the health plan meets the requirements and obligations set forth in memoranda of understanding; serves as a key plan liaison with carved-out and linked services Providers to enhance the plan’s partnership with these entities

- Manages subordinate staff, acts as ombudsperson and coordinator with other Molina offices, and manages staff relationship with the State
- With Regulatory Affairs department, partners with contracted lobbyist to develop legislative plan and implement various tactics, including legislative and health plan visits
- Works with the Molina VP, Regulatory Affairs to provide timely and informative updates on regulatory issues of concern and periodic reports to support regulatory communications initiatives
- Partners with Federal relations team to provide updates on State issues with Federal impact, such as ACA implementation and CMS issues
- Operational duties as assigned by the CEO

Minimum Experience Required:

- 7 or more years of experience in healthcare administration, health plan operations, managed care, or Provider services
- Experience managing or supervising employees
- Demonstrated adaptability and flexibility to a rapidly moving business environment

Skills Required:

- Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Bachelor's in Business, Health Services Administration, or related field

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi
- Local travel of up to 40% may be required
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred experience**: Direct experience with Medicaid and Medicare managed care plans
- **Preferred education**: Master’s in Business, Health Administration, or related field

Key Position: Job Description
Title of Position: Chief Financial Officer
Description of Position: The Chief Financial Officer (CFO) is a dedicated, full-time position responsible for financial-related functions including overseeing the budget and accounting systems to deliver accurate, timely financial reports and overall financial and business leadership to develop and execute strategies that drive growth and profitability across the entire Molina organization.
Description of Responsibilities of Position: • Coordinates efforts with similar lines of business to ensure consistent processes for managing premium revenue including LTSS revenue management and appropriate risk adjustment • Reviews and analyzes premium rates for appropriateness • Develops analysis and arguments to support rate negotiations with the State • Collaborates with the VP, Policy and Planning and VP, Government Contracts to ensure a consistent message to policy makers on rate development as applicable; reviews and analyzes financial terms of Provider agreements and rate development to provide recommended changes • Provides regional support for Provider report card/performance monitoring activities regarding quality, pay for performance, and clinical performance measurements • Develops a standardized approach to manage medical expenses • Collaborates with our Medical Director and COO to improve medical management efficiency and identify/implement profit improvement initiatives across the region • Standardizes productivity measures for routine processing activities to improve administrative efficiencies • Collaborates with the Medical Director, National Medical Director, CEO, and COO to establish standard metrics included in staffing models and identify opportunities for improvement • Monitors actual budget/forecast performance by identifying and implementing appropriate responses to variances • Works with our corporate medical informatics to support reporting, financial performance, common metrics, and formatting to increase quality in all healthcare data analytical activities • Standardizes activities to ensure all encounters are successfully submitted and errors are resolved • Ensures the encounter process fully supports rate development and collection of case rate payments, and maximizes risk scores while complying with State guidelines • Reviews and analyzes medical cost performance, including Provider contract and medical management efficiency; identifies and implements opportunities for improved profitability; monitors and compares across regions, populations, Provider panels, and external and internal benchmarks

- Reviews and analyzes monthly claims reserves for accuracy; assists corporate actuarial department in setting monthly claims reserves
- Reviews and analyzes administrative costs, identifying and implementing opportunities for improved profitability
- Develops and prepares management reports
- Manages health plan functional departments, including reporting and analysis, project management, facilities services, and enrollment
- Manages relationship with State Department of Insurance and other regulators for all financial matters
- Reconciles premium receipts to eligibility in claims system
- Responds to all utilization management data needs that facilitate care coordination
- Ensures full data support with data needs for quality improvement activities HEDIS and CAHPS; provides local plan support for Provider report card/performance monitoring activities regarding quality, pay for performance, and medical costs
- Represents the finance function by participating on committees, task forces, work groups, and multidisciplinary teams as necessary
- Acts as a liaison to both internal and external customers on behalf of Molina and data management areas
- Leads a regional finance organization providing financial analysis to make sound business decisions, including profit improvement initiatives for medical management metrics, Member growth/retention initiatives, targeted line-of-business extension or expansion, and rate advocacy efforts
- Facilitates best practices on projects including standardization for reporting, systems application, and staffing models; hires and provides training to the finance organization to new finance leaders

Minimum Experience Required:

- 15 or more years progressive healthcare finance or analytical experience
- 5 or more years of managed care/Medicaid experience
- 10 or more years of previous supervisory/management experience
- 3 or more years of Structured Query Language, programming skills, relational database, and financial analysis skills

Skills Required:

- Soft skills including, but not limited to, critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?
[x] Yes [ ] No

If yes, list below:
Bachelor's in Finance, Accounting, or related field; advanced training or experience in healthcare analytics

Are any professional licenses or certifications required for this position?
[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?
[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi
- Local travel of up to 40% may be required
- Working environment is generally favorable and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function.
- **Preferred experience**: 15 years of accounting
- **Preferred education**: Master's in Business, Finance, Accounting, or postgraduate training in Finance

Key Position: Job Description
Title of Position: Medical Director
Description of Position: The Medical Director is a full-time Mississippi-licensed physician who is responsible for all Molina clinical decisions and oversees the proper provision of covered services to Members. This role serves as a liaison between Molina and Providers; is available to staff for consultation on referrals, denials, grievances, and appeals; reviews potential quality of care problems; participates in the development and implementation of corrective action plans; and serves on quality workgroups as required by the Division. **The Medical Director position meets the RFQ Draft Contract § 1.13.2 requirement for a designee who can respond to issues involving mental health and medical management.**
Description of Responsibilities of Position: • Facilitates conformance to Medicare, Medicaid, NCQA, and other regulatory requirements • Reviews quality-referred issues and focused reviews and recommends corrective actions • Conducts retrospective reviews of claims and appeals and resolves grievances related to medical quality of care • Attends or chairs committees, as required, such as credentialing, pharmacy, and therapeutics • Evaluates authorization requests in timely support of nurse reviewers; reviews cases requiring concurrent review and manages the denial process • Monitors appropriate care and services through continuum among hospitals, skilled nursing facilities, and home care to ensure quality, cost-efficiency, and continuity of care • Ensures medical decisions are rendered by qualified medical personnel, not influenced by fiscal or administrative management considerations, and that the care provided meets the standards for acceptable medical care • Ensures medical protocols and rules of conduct for plan medical personnel are followed • Develops and implements plan medical policies • Provides implementation support for quality improvement activities • Stabilizes, improves, and educates the PCP and specialty Provider networks • Monitors practitioner practice patterns and recommends corrective actions if needed • Works with Contracting department in contract negotiation • Fosters clinical practice guideline implementation and evidence-based medical practice • Uses IT and data analysts to produce tools to report, monitor, and improve utilization management (UM) • Actively participates in regulatory, professional, and community activities • Oversees the health plan's clinical functions; actively involved in all major health programs developed by Molina • Responsible for treatment policies, protocols, quality improvement activities, population health management activities, and UM decisions, devoting sufficient time to ensure timely medical decisions • Ultimately responsible for all of Molina's clinical decisions; oversees and is responsible for the proper provision of covered services to Members

- Available to Molina staff for consultation on referrals, denials, complaints, grievances, and appeals; reviews potential quality of care problems and participates in the development and implementation of corrective action plans
- Works collaboratively with our Population Health Director and Care Management Director to develop and implement clinical policies and provide clinical oversight
- Directs the medical affairs team to work with the healthcare services team to develop and implement effective and efficient standards, protocols, decision support systems, reports, and benchmarks that meet annual cost and quality targets
- Supports credentialing processes and manages credentialing policies; oversees the Molina Credentialing Committee as chair
- Serves as the clinical face of Molina to the community
- Responsible for meeting annual healthcare cost and quality targets for the plan and achieving/retaining NCQA rating
- Provides oversight, support, and direction for health plan's quality programs in the areas of healthcare services, delegation oversight, credentialing, and NCQA (HEDIS and CAHPS)
- Provides oversight, support, and direction to the Quality Management (QM) Director and drives the HEDIS and NCQA processes to achieve and maintain an excellent rating
- Provides oversight, support, and direction to the Pharmacy Director to develop cost-effective clinical protocols
- Supports Provider network management activities that improve unit cost, access, and quality; assists with contracting and solidifying relationships with key Providers
- Supports and supervises the behavioral health lead and drives integration of behavioral and physical health components in all aspects of service to Members
- Influences changes that benefit Molina and Members by participating in community committees and task forces with the State, Providers, and community organizations
- Develops advocates among the State's clinical community that can be called upon to speak on behalf of issues that are important to Molina before legislators, regulators, and other key influencers
- Chairs the executive QM Committee and participates in all quality committees, such as the Clinical Quality Improvement Committee, the Satisfaction Committee, and other internal task forces and work groups required by NCQA
- Ensures compliance with contractual, accreditation, and regulatory requirements for all medical affairs teams

Minimum Experience Required:

Either an actively practicing physician in Mississippi or has been an actively practicing physician in Mississippi in the past 5 years and is located in Mississippi with 7 or more years of relevant experience, including:

- 5 or more years clinical practice
- 2 or more years previous experience as a Medical Director
- 3 or more years in utilization and quality program management
- 2 or more years of managed care experience
- Current clinical knowledge
- Experience demonstrating strong management and communication skills, consensus building and collaborative ability, and financial acumen

- Knowledge of applicable State, Federal, and third-party regulations

Skills Required:

- Soft skills, including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Doctorate in Medicine, board-certified or eligible in a primary care specialty

Are any professional licenses or certifications required for this position?

[x] Yes [ ] No

If yes, list below:

Currently licensed in Mississippi by the Mississippi State Board of Medical Licensure as an MD or Doctor of Osteopathic Medicine with no restrictions or other licensure limitations and free of Medicaid or Medicare sanctions

Are there any continuing education requirements for this position?

[ ] Yes [X] No

If yes, list below:

Any additional information relevant to this position:

- Local travel of up to 40% may be required
- Working environment is generally favorable and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred experience**: Peer review; medical policy/procedure development; Provider contracting; NCQA, HEDIS, Medicaid, and Medicare; pharmacy benefit management; group or independent physician association practice; capitation; managed care regulations and managed healthcare systems; quality improvement; medical UM; risk management, risk adjustment, disease management; and evidence-based guidelines
- **Preferred additional education**: Master's in Business, Public Health, or Healthcare Administration
- **Preferred licenses or certifications**: Board Certification (Primary Care preferred)

Key Position: Job Description
Title of Position: Perinatal Health Director
Description of Position: The Perinatal Health Director is a Mississippi-licensed physician who reports to our Medical Director and oversees the development and implementation of perinatal health policy through covered services to Members. The Perinatal Health Director will either 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 years and be located in Mississippi. The Perinatal Health Director serves as a liaison between Molina and Providers; is available to our staff for consultation on referrals, denials, grievances, and appeals; reviews potential quality-of-care problems; and participates in the development and implementation of corrective action plans. The Perinatal Health Director will serve on quality workgroups as required by the Division.
Description of Responsibilities of Position: • Facilitates compliance with Medicare, Medicaid, NCQA, and other regulatory requirements regarding perinatal medicine • Reviews quality issues and focused reviews and recommends corrective actions regarding perinatal medicine • Conducts retrospective reviews of claims and appeals and resolves grievances regarding perinatal medical quality of care • Attends and participates in clinical rounds for perinatal care, general medical, and behavioral health • Evaluates authorization requests in timely support of nurse reviewers; reviews cases requiring concurrent review • Monitors appropriate care and services through continuum among hospitals, skilled nursing facilities, and home care to ensure quality, cost-efficiency, and continuity of care • Ensures that medical decisions are rendered by qualified medical personnel, are not influenced by fiscal or administrative management considerations, and that the care provided meets the standards for acceptable perinatal medical care • Ensures that medical protocols and rules of conduct for health plan medical personnel are followed • Develops and implements health plan perinatal care medical policies • Stabilizes, improves, and educates primary care and specialty Providers about perinatal care • Monitors perinatal practitioner practice patterns and recommends corrective action, if needed • Fosters clinical practice guideline implementation and evidence-based medical practice • Uses IT and data analysts to produce tools to report, monitor, and improve UM • Develops treatment policies, protocols, quality improvement activities, population health management activities, and UM decisions regarding perinatal medicine, devoting sufficient time to ensure timely medical decisions

- Is available to Molina staff for consultation on referrals, denials, complaints, grievances, and appeals; reviews potential quality-of-care problems and participates in the development and implementation of corrective action plans
- Works collaboratively with our Population Health Director and Care Management Director to develop and implement clinical policies and provide perinatal medicine clinical oversight
- Influences changes that benefit Molina and Members by participating in community committees and task forces with the State, Providers, and community organizations
- Develops advocates among the State's clinical community that can be called upon to speak on behalf of issues that are important to Molina before legislators, regulators, and other key influencers regarding perinatal medicine

Minimum Experience Required:

Either an actively practicing physician in Mississippi or an actively practicing physician in Mississippi in the past 5 years and located in Mississippi with 7 or more years of relevant experience, including:

- 5 or more years of clinical practice
- Experience demonstrating strong management and communication skills by building consensus, collaboration, and financial acumen
- Knowledge of applicable State, Federal, and third-party regulations

Skills Required:

- Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Doctorate in Medicine, Board Certified or eligible in Obstetrics and Gynecology

Are any professional licenses or certifications required for this position?

[x] Yes [ ] No

If yes, list below:

Currently licensed in Mississippi by the Mississippi State Board of Medical Licensure as an MD or DO with no restrictions or other licensure limitations and free of Medicaid or Medicare sanctions

Are there any continuing education requirements for this position?

[x] Yes [ ] No

If yes, list below:

Maintain Board certification by meeting continuing medical education requirements

Any additional information relevant to this position:

- Local travel of up to 40% may be required
- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred experience**: Peer review, medical policy/procedure development, Provider contracting experience, experience with NCQA, HEDIS, Medicaid, Medicare, and pharmacy benefit management, group or independent physician association practice, capitation, managed care regulations, managed healthcare systems, quality improvement, medical UM, risk management, risk adjustment, disease management, and evidence-based guidelines
- **Preferred education**: Master's in Business Administration, Public Health, or Healthcare Administration
- **Preferred licenses or certifications**: Board Certification (Primary Care preferred) in Obstetrics and Gynecology

Key Position: Job Description
Title of Position: Behavioral Health Director
Description of Position: The Behavioral Health Director oversees the development and implementation of behavioral health policy through covered services to Members; serves as a liaison between Molina and Providers; is available to our staff for consultation on referrals, denials, grievances, and appeals; reviews potential quality of care problems; participates in the development and implementation of corrective action plans; and serves on quality work groups as required by the Division. This individual provides psychiatric leadership for UM and care management programs for mental health and chemical dependency services and supervises the implementation of integrated behavioral health care management programs. This individual works closely with the VP, Behavioral Health and National Medical Directors to develop and implement enterprise-wide standardized UM policies and procedures that will improve quality outcomes and decrease costs. This position is a Mississippi-licensed physician who reports to the Medical Director.
Description of Responsibilities of Position: • Coordinates efforts to provide Molina's behavioral health services • Provides psychiatric leadership for UM and care management programs for mental health and chemical dependency services • Indirectly supervises health plan Psychiatric Medical Directors in implementing integrated behavioral health care management programs • Works closely with the VP, Behavioral Health and National Medical Directors to develop standardized UM policies and procedures to be implemented enterprise-wide to improve quality outcomes and decrease costs • Develops scorecard benchmarks for behavioral health clinical staff productivity • Standardizes UM practices and quality and financial goals across all lines of business • Responds to behavioral health-related RFQ sections and reviews behavioral health portions of State contracts • Works with trainers to develop and provide enterprise-wide teaching on psychiatric diagnoses and treatment • Writes, refines, and approves behavioral health policies and procedures for UM and care management • Provides second-level behavioral health clinical reviews, behavioral health peer reviews, and appeals • Facilitates behavioral health committees for quality compliance • Implements clinical practice guidelines and medical necessity review criteria • Tracks all clinical programs for behavioral health quality compliance with NCQA and CMS • Participates in the recruitment, placement, and orientation of new psychiatric MDs • Ensures all behavioral health programs and policies are in line with industry standards and best practices

- Assists with new program implementation and supports the health plan in-source behavioral health services
- Assists with reviewing and evaluating behavioral health vendors

Minimum Experience Required:

- 5 years active practice as a physician in Mississippi with a specialty in behavioral health or an actively practicing physician in the past five years
- 2 years of experience as a Medical Director
- 3 years of experience in utilization/quality program management
- 5 years of clinical practice
- 5 years of HMO/managed care experience
- Current clinical knowledge
- Experience demonstrating strong management and communication skills, consensus building, collaborative ability, and financial acumen
- Knowledge of applicable State, Federal, and third-party regulations

Skills Required:

- Soft skills, including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Doctorate in Medicine (MD or DO) with Board Certification in Psychiatry

Are any professional licenses or certifications required for this position?

[x] Yes [ ] No

If yes, list below:

Current and unrestricted State Medical License in Mississippi with no restrictions or other licensure limitations and free of Medicaid or Medicare sanctions

Are there any continuing education requirements for this position?

[x] Yes [] No

If yes, list below:

Continuing education required to maintain an active State Medical License

Any additional information relevant to this position:

- Must be located in Mississippi
- Working environment is generally favorable and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods

- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred experience:** Peer review, medical policy/procedure development, Provider contracting experience; experience with NCQA, HEDIS, Medicaid, Medicare and pharmacy benefit administration, Group/Independent Practice Association practice, capitation, HMO regulations, managed healthcare systems, quality improvement, medical UM, risk management, risk adjustment, disease management, and evidence-based guidelines

Key Position: Job Description
Title of Position: Chief Information Officer
Description of Position: The Chief Information Officer oversees IT and systems to support Molina operations, including submission of accurate and timely Member encounter data; leverages technology for the benefit of the business; manages strategic relationships with business partners by representing and promoting information management capabilities; and provides direct oversight of all health plan IT activities. This role provides process expertise and manages relationships with Molina health plan leadership, business subject matter experts, project managers, local IT staff, and the State.
Description of Responsibilities of Position: • Oversees IT and systems to support operations, including submission of accurate and timely encounter data • Builds, manages, and maintains effective business relationships with key stakeholders in the business domain across health plans, corporate healthcare functions, and State officials • Documents, manages, and maintains State service level agreements for compliance deliverables for IT • Interacts with State officials and contracted Providers for data access, submissions planning, gaps, and improvements • Provides technical and process knowledge within IT across silos and business partners to support consulting, problem resolution/facilitation, and effective intake and solutioning • Defines requirements for the Analytics team, including full testing methodology, detailed plans for conducting unit testing, and detailed plans with checklists describing how to utilize the tools and products • Identifies and documents changes to IT services and supporting processes and/or opportunities for service delivery improvement • Facilitates groups for problem solving and service improvement, including definition/documentation and business workflow analysis • Develops effective processes, forums, and tracking mechanisms for continuous improvement through business feedback, proactive handling of business complaints, and facilitation of resolution • Conducts semi-yearly service reviews of IT project status/metrics and major milestones • Conducts bi-weekly operations and issues meeting • Works with Software Development Management team to develop and enhance the IT Infrastructure Library Business Relationship Management Model • Develops and maintains a Service Delivery Plan for individual health plans or corporate functions to include business strategies/needs with corresponding IT strategies/plans, IT projects, IT performance measurements, and customer satisfaction improvement plans • Communicates and facilitates issue resolution with third-party vendors • Presents to Software Development Management team the semi-annual IT report to include IT accomplishments, performance metrics, project intake, and release plan or roadmap status

- Uses standard communication protocols and forums to consistently provide updates and promotion of IT services and projects, which includes support and maintenance of marketing plan to promote within IT organization, IT wins/major projects, and improvements in IT value perception both with IT employees and with our business community
- Effectively manages business escalations within the IT organization by ensuring appropriate accountability, sense of urgency, communication, and follow-through to closure
- Demonstrates knowledge of the CCO Contract compliance requirements that affect IT services or processes
- Facilitates estimation of staffing requirements, including resource skills, and supports assigned project manager to assemble a team and/or resolve start-up issues
- Facilitates and leads processes and activities to complete deliverables on behalf of the State, including RFP responses, audit response/coordination, and evaluation of new Contract requirements
- Consolidates IT responses, and leads the walkthrough of IT responses with IT management
- Participates in government meetings and coordinates additional IT subject matter experts' participation as necessary

Minimum Experience Required:

- 7 or more years of business function or relations management experience and/or 5 or more years IT or system delivery or related experience
- 3 or more years of strategic planning experience
- Project management background

Skills Required:

- Soft skills including, but not limited to, critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Master's in Business, Healthcare, Computer Science, Information Systems, or related equivalent experience

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Local travel of up to 40% may be required
- Working environment is generally favorable and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred experience**: Three or more years of management or three or more years of managed care
- **Preferred licenses or certifications**: Six Sigma Black Belt, Project Management Professional, or IT Infrastructure Library Certification

Key Position: Job Description
Title of Position: Compliance Officer
Description of Position: The Compliance Officer is a full-time professional designated to act as a primary point of contact for the Division, reporting to the CEO and Board of Directors. This individual is responsible for oversight and management of all compliance activities, serves as a resource on compliance issues, and provides leadership and expertise to help facilitate compliance with applicable statutes, contractual requirements, policies, and procedures. The Compliance Officer trains and educates about compliance requirements and prepares written reports for the Board and Compliance Committee no less than quarterly to inform on the status of activities pertaining to overall health plan compliance. **The Compliance Officer position meets the RFQ Draft Contract § 1.13.2 requirement for a designee who can respond to issues involving management of any other services rendered under this Contract.**
Description of Responsibilities of Position: • Oversees and directs implementation and day-to-day operations of the Medicaid and Medicare compliance programs, compliance plan, code of conduct, and FWA Plan across the business while ensuring compliance with governmental and contractual requirements • Provides oversight and assistance with ongoing facilitation and monitoring of the delegation oversight functions and responsibilities • Develops, manages, and updates facility compliance response plans • Oversees and directs compliance, and the FWA incident response management process including investigation, mitigation, reporting, remediation, and training • Maintains current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to the Contract and oversees Molina's compliance with the laws and requirements of the Division • Serves as the primary contact for and facilitates communications between Molina leadership and the Division related to Contract compliance issues • Monitors compliance and oversees Molina's implementation of, and evaluates any actions required to correct a deficiency or address noncompliance with, Contract requirements as identified by the Division • Establishes audit controls and measurements to ensure correct processes are established; develops and performs internal audits/risk assessments and monitoring for Molina departments; provides post-audit findings and recommendations to ensure State and Federal compliance • Coordinates development of written policies and procedures regarding compliance with local, State, and Federal guidelines • Establishes active relationships with third parties who have specific experience conducting fraud investigations • Responds to inquiries and reports concerning compliance or noncompliance • Assists management with enforcement and discipline in appropriate instances of noncompliance

- Reports upon discovery incidents and issues of noncompliance related to HIPAA to the Privacy Official within 24 hours
- Submits all Protected Health Information requests to privacy officials for approval/processing
- Works with all business segments to increase awareness of the importance of the compliance and anti-fraud plans
- As a representative of key management, enforces in day-to-day responsibilities the compliance plan, code of conduct, and anti-fraud plan

Minimum Experience Required:

- 7 or more years of compliance program management or other related healthcare or legal experience
- Previous management experience including responsibilities for hiring, training, assigning work, and managing staff performance

Skills Required:

- Soft skills including, but not limited to, critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Master's or equivalent combination of education and experience

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi
- Local travel of up to 40% may be required
- Working environment is generally favorable and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function

Preferred experience: 10 or more years of experience, including:

- 5 or more years with healthcare regulatory agencies in development or implementation of compliance and fraud programs
- 5 or more years of experience overseeing implementation of contract requirements
- 5 or more years of previous compliance program and contract experience with Medicaid/Medicare programs, including conduct of internal and State audits
- Experience providing representation to the Board of Directors and senior management on health plan issues relating to compliance and fraud program management

Preferred education: Master's in Computer Science, Information Systems, or healthcare related field

Key Position: Job Description
Title of Position: Implementation Project Manager
Description of Position: The Project Manager oversees Contract implementation during the Implementation Phase and possesses knowledge of Medicaid programs, particularly Medicaid managed care programs, and relevant experience navigating similar complex projects. The Project Manager focuses on process improvement, organizational change management, project management, and other processes relevant to the business, including estimating, scheduling, costing, planning, and issue/risk management.
Description of Responsibilities of Position: • Provides effective management of intermediate- to large-scale projects using prescribed approaches, including knowledge of methods and techniques used in project management initiatives • Develops detailed project plans, communication plans, schedules, role definitions, risk management strategies, and assumptions • Understands standard applications and project-specific software and can learn new software with little to no instruction within a short time frame and instruct others on its functionality • Identifies problems and anticipates potential problems with the ability to present alternatives to manage and overcome obstacles • Manages all aspects of assigned projects throughout the development lifecycle, including project scope, schedule, resources, quality, costs, and change • Develops and maintains detailed project plan including milestones, tasks, and targeted/actual dates of completion • Revises project plans as appropriate to meet changing needs and requirements • Prepares and submits project status reports to management • Schedules and conducts project meetings, including logistics, agendas, and meeting minutes • Conducts regularly scheduled project status update meetings • Develops process workflows related to assigned projects and supports internal process improvement initiatives • Interfaces, when appropriate, with all areas affected by the project, including internal subject matter experts, external corporate departments, and health plans • Collaborates well with all levels of personnel within the company; provides exemplary customer service
Minimum Experience Required: • 2 or more years of relevant work experience in business, engineering, or a related field acceptable in lieu of degree

Skills Required:

- Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Bachelor's degree and at least one project management course required

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi during the Implementation Phase
- Local travel of up to 40% may be required
- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education**: Additional formal training in project management
- **Preferred licenses or certifications**: Project Management Professional or Six Sigma Green Belt Certification

Key Position: Job Description
Title of Position: Provider Services Manager
Description of Position: The Provider Services Manager is a dedicated, full-time professional who is responsible for Provider Services functions including providing customer support, resolving issues, and addressing Provider needs fairly and effectively while demonstrating Molina values through their actions. This role provides product and service information and identifies opportunities to improve Provider experiences.
Description of Responsibilities of Position: • Manages Provider Services operations • Ensures compliance with State, Federal, Contract, and regulatory requirements • Identifies new opportunities for process development • Develops and implements interventions to address deficiencies and negative trends • Provides exemplary customer service to Providers, coworkers, vendors, government agencies, business partners, and the general public • Coordinates all call center communications with Providers; enables Providers to receive prompt resolution of their issues, problems, and inquiries • Performs strategic planning for call center operations and interdepartmental processes • Develops and drives a culture that is passionate about quality and delivering exemplary customer experience • Provides leadership oversight of call center operations and support functions • Establishes, reviews, and modifies standard performance metrics and benchmarks • Develops infrastructure related to staffing and process gaps to drive optimal call center operations • Ensures operational excellence through process improvements and promotes change management processes • Ensures and monitors compliance with implementation of standardized processes and best practices • Serves as a subject matter expert in support of customer experience strategy projects • Collaborates, reviews, and proposes recommendations to enhance training curriculum • Drives a culture that is passionate about coaching; pursues continuous enhancements of the coaching experience • Tracks and trends data, identifying areas for improvement in support of improved customer experience and administrative efficiency • Works with coworkers, management, and other departments to help coordinate problem-solving in an effective and timely manner • Provides technical expertise to coworkers and handles elevated calls • Assists agents with questions and escalated calls; recognizes trends and patterns in call types and engages leadership with suggested solutions • Achieves individual performance goals related to call center objectives

- Demonstrates personal responsibility and accountability by meeting attendance and schedule adherence expectations

Minimum Experience Required:

- 5 years of supervisory experience
- 3 years of hands-on experience in Medicaid, Medicare, or CHIP
- Extensive knowledge of managed healthcare

Skills Required:

- Ability to coordinate activities of and interact with multiple constituencies
- Excellent interpersonal and verbal and written communication skills
- Excellent leadership and managerial skills
- Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Bachelor's Degree or equivalent combination of education and experience

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi
- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Graduate degree or equivalent combination of education and experience

Key Position: Job Description
Title of Position: Network/Contracting Manager
Description of Position: The Network/Contracting Manager is a dedicated, full-time professional who is responsible for network development, including accurate and timely maintenance of critical Provider information on all claims and Provider databases and oversight of required coordination with the Division's contracted credentialing verification organization. **The Network/Contracting Manager position meets the RFQ Draft Contract § 1.13.2 requirement for designated staff responsible for ensuring that all network Providers and out-of-network Providers to whom Members may be referred are properly licensed in accordance with Federal and State laws and regulations.**
Description of Responsibilities of Position: • Develops health plan-specific Provider contracting strategies, identifying specialties and geographic locations on which to concentrate resources for purposes of establishing a sufficient network of participating Providers to serve the healthcare needs of Members • Prepares the Provider contracts collaboratively with established company guidelines with physicians, hospitals, LTSS, and other healthcare Providers • Coordinates workforce development initiatives conducted by Molina and collaboratively with the Division and other contracted MCOs • Coordinates all communications and contractual relationships between Molina and our Subcontractors and Providers • Ensures Providers are appropriately educated about Medicaid program participation • Ensures and maintains a sufficient Provider network, developing and implementing Provider and contract strategies, and identifying specialties and geographic locations on which to focus resources • Develops a market-specific Provider reimbursement strategy consistent with reimbursement tolerance parameters across multiple specialties/geographies • Assists in achieving annual savings through recontracting initiatives; implements cost control initiatives to positively influence the medical care ratio • Uses standardized contract templates and pay-for-performance strategies • Uses established reimbursement tolerance parameters (across multiple specialties/ geographies) and oversees the development of new reimbursement models • Oversees the maintenance of all Provider and payer Contract templates and works with legal and corporate network management to modify Contract templates to ensure compliance with contractual and/or regulatory requirements • Ensures compliance with applicable Provider panel and network capacity, adequacy requirements, and guidelines • Produces and monitors weekly/monthly reports to track and monitor compliance with network adequacy requirements • Develops and implements strategies to minimize the company's financial exposure • Monitors and adjusts strategy implementation as needed to achieve desired goals and minimize the company's financial exposure

- Synchronizes data among multiple claims systems and application of business rules as they apply to each database
- Validates data to be housed on Provider databases and ensures adherence to business and system requirements of customers as it pertains to contracting, network management, and credentialing
- Maintains all Provider contract information and Provider Contract templates and ensures all contracts negotiated are configured in the claims system
- Ensures Contract templates comply with all contractual and/or regulatory requirements
- Provides plan-specific fee schedule management
- Oversees Provider services, including all Provider services representatives, and coordinates activities with Provider associations and Joint Operations Committee management
- Provides accountability for the health plan's delegation oversight function
- Oversees the Provider network administration area, including Provider information management and business analyses of Contracts and benefits to support accurate configuration for claims payment
- Oversees all Provider/Member problem prevention, research, and resolution, as well as the Provider/Member grievances and appeals processes
- Formulates and implements business plans, tactics, and strategies to provide for efficient, effective, and compliant operations to meet short-term objectives/obligations and ensure long-term growth and success
- Develops and implements adequate measures to meet operational needs, efficiently use resources, and maintain an effective system of operational processes and outcome measurement
- Creates new policies and amends existing policies to improve operations
- Ensures the overall level of quality for operational and contractual obligations meet or exceed appropriate standards

Minimum Experience Required:

- 5 years of healthcare administration, managed care, and/or Provider services, or related field

Skills Required:

- Soft skills, including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Bachelor's degree in business, health services administration, or related field, or equivalent experience

Are any professional licenses or certifications required for this position?
[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?
[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi
- Working environment is generally favorable and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Master's degree in health or business-related field

Key Position: Job Description
Title of Position: Member Services Manager
Description of Position: The Member Services Manager is a dedicated, full-time professional who is responsible for Member Services functions including providing customer support, resolving issues, and addressing Member needs fairly and effectively while demonstrating Molina values through their actions. This role provides product and service information and identifies opportunities to improve Member experiences.
Description of Responsibilities of Position: • Manages Member Services operations • Ensures compliance with State, Federal, Contract, and regulatory requirements • Identifies new opportunities for process development • Develops and implements interventions to address deficiencies and negative trends • Provides exemplary customer service to Members, coworkers, vendors, Providers, government agencies, business partners, and the general public • Coordinates all communications with Members; enables Members to receive prompt resolution of their issues, problems, and inquiries • Performs strategic planning for call center operations and interdepartmental processes • Develops and drives a culture that is passionate about quality and delivering exemplary customer experience • Provides leadership oversight of call center operations and support functions • Establishes, reviews, and modifies standard performance metrics and benchmarks • Develops infrastructure related to staffing and process gaps to drive optimal call center operations • Ensures operational excellence through process improvements and promotes change management processes • Ensures and monitors compliance with implementation of standardized processes and best practices • Serves as a subject matter expert in support of customer experience strategy projects • Collaborates, reviews, and proposes recommendations to enhance training curriculum • Drives a culture that is passionate about coaching; pursues continuous enhancements of the coaching experience • Tracks and trends data, identifying areas for improvement in support of improved customer experience and administrative efficiency • Works with coworkers, management, and other departments to help coordinate problem-solving in an effective and timely manner • Provides technical expertise to coworkers and handles elevated calls • Assists agents with questions and escalated calls; recognizes trends and patterns in call types and engages leadership with suggested solutions • Achieves individual performance goals related to call center objectives

- Demonstrates personal responsibility and accountability by meeting attendance and schedule adherence expectations

Minimum Experience Required:

- 5 years of supervisory experience
- 3 years of hands-on experience in Medicaid, Medicare, or CHIP
- Extensive knowledge of managed healthcare

Skills Required:

- Ability to coordinate activities of and interact with multiple constituencies
- Excellent interpersonal and verbal and written communication skills
- Excellent leadership and managerial skills
- Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Bachelor's Degree or equivalent combination of education and experience

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi
- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Graduate degree or equivalent combination of education and experience

Key Position: Job Description
Title of Position: Quality Management Director
Description of Position: The Quality Management Director is a dedicated, full-time healthcare practitioner located in Mississippi to implement and oversee QM and quality improvement activities. This role serves as a leader of health plan quality strategy and activities, including leadership and primary Molina interface with State agencies, leadership of local quality committees, and oversight of intervention activities intended to improve quality measures and outcomes. The Quality Management Director collaborates with Molina quality leaders to conduct data collection, reporting, and monitoring for key quality performance measurement activities and implements NCQA accreditation surveys and Federal quality compliance activities. **The Quality Management Director meets the RFQ Draft Contract § 1.13.2 requirement for a designee who can respond to issues involving quality assessment, EPSDT services management, and well-baby and well-child care assessments and immunization services.**
Description of Responsibilities of Position: • Serves as the primary contact to State agencies for all quality matters • Leads the local quality committees • Prepares required documentation for State PIPs • Designs, implements, monitors, and analyzes the effectiveness of a comprehensive quality intervention strategy and facilitates stakeholder input and strategic direction from the Joint Operations Committee • Collaborates with the national, regional, and State analytics and strategic teams to develop, present, and evaluate intervention strategies • Collaborates with quality-for-accreditation activities and supports those activities with local resources and leadership • Plans and implements evidence-based quality intervention strategies and initiatives that meet State and Federal intervention rules and are aligned with effective practices as identified in the healthcare quality improvement literature and within Molina strategic plans • Serves as operations and implementation lead for quality improvement activities using a defined roadmap, timeline, and key performance indicators • Communicates with the CEO, Molina senior leadership team, Medical Director, and national intervention collaborative analytics and strategic teams about key deliverables, timelines, barriers, and escalated issues that need immediate attention • Communicates with network leadership to establish quality benchmarks and requirements for value-based contracts. • Oversees efforts to develop broad-based quality data analytics to support ongoing, real-time, local value-based contract requirements • Relies on and collaborates with Molina HEDIS operations to do majority of HEDIS abstractions; oversees local resources to facilitate local abstraction for required value-based contracting customized reports to meet value-based network contract obligations not supported by the national Molina team

- Presents summaries, key takeaways, and action steps about quality strategy; demonstrates ability to lead and influence cross-functional teams that oversee implementation of quality interventions
- Possesses a strong knowledge in quality to implement effective interventions that drive change; functions as key lead for interventions, including qualitative analysis, reporting and development of program materials, templates, or policies
- Maintains strong knowledge of and ability to inspire and work directly with external Providers to advance Molina's value-based quality initiatives; maintains advanced ability to collaborate and educate network Providers to develop effective practice-based quality improvements; serves as a member of the State's Provider engagement team for large, contracted, value-based Provider systems
- Attends State and regional quality improvement and/or board of directors' meetings and represents Molina
- Represents Molina in external forums, presenting Molina's quality results, and serves as the external quality expert and emissary in statewide conferences
- Leads critical incident and potential quality of care investigation and reporting

Minimum Experience Required:

- 3 years of quality compliance and HEDIS operations, customer service or Provider service in a managed care setting with supervisory experience, project management and team building experience, and experience developing performance measures that support business objectives
- Knowledge of quality discipline, including metrics and performance standards in a managed healthcare setting

Skills Required:

- Soft skills, including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Master's degree or equivalent combination of education and experience

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Working environment is generally favorable and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function

Preferred experience:

- 7 years of experience in managed healthcare administration
- 7 years of experience in quality leadership role with a managed care payer with experience in all lines of business

Key Position: Job Description
Title of Position: Care Management Director
Description of Position: The Care Management Director is a dedicated, full-time professional responsible for care management services. This individual oversees and manages all care management programs and functions. The Care Management Director works with Members, Providers, and multidisciplinary team members to assess, facilitate, plan, and coordinate integrated delivery of care across the continuum for Members with high-need potential. The Care Management Director works to ensure each Member's progress toward desired outcomes with quality care that is medically appropriate and cost-effective based on the severity of illness and the site of service.
Description of Responsibilities of Position: • Works collaboratively with the Medical Director to develop and implement processes to effectively manage clinical policies that meet healthcare cost and quality targets • Works with the Healthcare Services management team to achieve successful implementation of Molina clinical strategy and direction • Mentors, guides, and develops the skills of management team members in a consistent and effective manner • Develops and implements effective and efficient standards, protocols, processes, decision-support systems, reporting, and benchmarks that facilitate ongoing improvements of clinical operations functions and promote quality, cost-effective healthcare for Members • Manages implementation of analytical studies that clearly quantify the benefits of Healthcare Services departmental programs to ensure resources are appropriately allocated to programs, operational controls are in place, and efficiencies are maximized • Continually refines operational processes and champions review of team processes, workflows, and activities • Ensures compliance with contractual, accreditation, and regulatory requirements for all Healthcare Services teams • Participates personally on or assigns appropriate staff to Molina quality committees and external community committees on which Healthcare Services departments require representation • Develops the Healthcare Services department budget and meets budget targets, including administrative and healthcare costs • Ensures effective interdepartmental collaboration and interaction between Healthcare Services staff and other departments • Ensures monthly auditing of Healthcare Services staff is conducted and appropriate actions and/or coaching are performed • Oversees clinical training activities and outcomes • Monitors Healthcare Services-related delegation oversight • Directs and oversees care management/disease management/transitions of care; utilization management (prior authorizations) and management of inpatient certification review staff for initial, concurrent, and retrospective reviews; LTSS; and Nurse Advice Line

- Develops, implements, and monitors standardized protocols for clinical and non-clinical team activities to facilitate integrated proactive care review and management
- Develops, performs, and promotes interdepartmental integration and collaboration to enhance clinical services
- Facilitates and participates in committees, task forces, workgroups and multidisciplinary teams as needed to promote a standardized approach to care management programs
- Engages in clinical training activities and outcomes

Minimum Experience Required:

- 7 years of managed healthcare experience with line management responsibility including clinical operations
- Experience working within applicable State, Federal, and third-party regulations

Skills Required:

- Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Bachelor's degree in healthcare-related field (equivalent combination of education, experience, and/or nursing license will be considered in lieu of Bachelor's degree)

Are any professional licenses or certifications required for this position?

[x] Yes [ ] No

If yes, list below:

If licensed, license must be active, unrestricted, and in good standing

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi
- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Master's degree in business, healthcare, social work, or related field

- **Preferred experience:** 10 or more years managed care, operational, and process improvement experience; demonstrated experience meeting NCQA, HEDIS, and Medicare STARS standards
- **Preferred license, certification, association:** Active, unrestricted State RN license in good standing; Utilization Management Certification, Certified Professional in Health Care Quality, or other healthcare or management certification

Key Position: Job Description
Title of Position: Population Health Director
Description of Position: The Population Health Director is a dedicated, full-time professional who is responsible for population health initiatives that include working with Members, Providers, and multidisciplinary team members to assess, facilitate, plan, and coordinate integrated delivery of care across the continuum. This individual works to ensure Member progress toward desired outcomes with quality care that is medically appropriate and cost-effective, with a focus on disease management and preventive care.
Description of Responsibilities of Position: • Responsible for planning, consultation, strategic design, implementation, and evaluation of population health initiatives • Continually updates health initiatives to ensure they meet State and Federal regulatory guidelines • Participates with senior managers, managers, supervisors, and team leaders across the organization to facilitate operational management of the service, including integrated service delivery, planning, quality assurance, risk management, and occupational health and safety • Provides leadership, motivation, and direction to ensure the organization supports population health best practices • Ensures programs and projects are evidence-based and tailored to local communities • Works in partnership with the State to implement and direct a preventive community model • Recruits, trains, and supports professional development of staff in collaboration with the Care Management department • Represents Molina at relevant network meetings and other workgroups • Works in collaboration with senior managers, managers, Board of Directors, staff, Providers, and the community to improve CCO Program population health outcomes • Forecasts and reviews trends and developments, both internally and externally, that affect current and future service for continued improvement of programs • Oversees all reporting and accountability requirements for programs in collaboration with Care Management department • Develops strategies for Molina staff and the local community to have input into the development of evidence-based health promotion planning and delivery tailored to local requirements • Works collaboratively with managers and team leaders to promote the pursuit of quality improvement and innovation • Works in collaboration with population health analytics, IT, and quality to ensure alignment of care management • Leads strategic effort in translating organizational goals into executable projects • Demonstrates a willingness to collaborate with others and maintains a positive attitude • Analyzes reports and develops strategies to improve outcomes and close gaps

- Develops and implements effective and efficient standards, protocols, processes, decision-support systems, reporting, and benchmarks that support ongoing improvement of population health operations functions and promote quality, cost-effective healthcare for Members
- Facilitates integration of care coordination, long-term care, and behavioral health
- Continually refines operational processes and champions review of team processes, workflows, and activities
- Ensures compliance with contractual, accreditation, and regulatory requirements for population health initiatives
- Oversees population health training activities and outcomes

Minimum Experience Required:

- 7 years of managed healthcare experience with line management responsibility including clinical operations
- Experience working within applicable State, Federal, and third-party regulations

Skills Required:

- Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Bachelor's in healthcare-related field (equivalent combination of education, experience, and/or nursing license will be considered in lieu of Bachelor's degree)

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Must be located in Mississippi
- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods

- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Master's in business, healthcare, social work, or related field
- **Preferred experience:** 10 or more years managed care experience, operational and process improvement experience, demonstrated experience meeting quality accreditation standards (NCQA/HEDIS/STARS)
- **Preferred license, certification, association:** Active, unrestricted State RN license in good standing; Utilization Management Certification, Certified Professional in Health Care Quality, or other healthcare or management certification

Key Position: Job Description
Title of Position: Utilization Management Coordinator
Description of Position: The Utilization Management Coordinator is a designated healthcare practitioner who is responsible for utilization management functions including supervision and coordination of daily utilization management operations, concurrent review, retrospective reviews, and discharge planning in accordance with systems, processes, policies, and procedures.
Description of Responsibilities of Position: • Oversees hiring, orientation, and training of staff to ensure maximum efficiency and productivity and the work of subcontractors performing services relevant to utilization management • Responsible for developing and implementing projects, policies, and procedures as assigned to ensure the utilization management program meets NCQA standards and all contractual requirements • Oversees staff performance appraisals, ongoing monitoring of data entry, and application of medical necessity review criteria and guidelines • Collaborates with and keeps the Medical Director apprised of operational issues, staffing, resources, system, and program needs • Use clinical assessment skills and knowledge of patient care to assist staff with decisions regarding appropriateness or medical necessity of services, and determines which cases should be referred to the Medical Director for evaluation • Coordinates and reports utilization management statistics, including health plan utilization, staff productivity data, cost-effective utilization of services, and triage activities • Identifies and reports under- and overutilization management issues, delays in service or treatment, and quality-of-service issues per policies and procedures • Acts as liaison to internal and external customers on behalf of the Utilization Management department to ensure open communication, effective interface, and prompt resolution of identified issues • Coordinates staff schedules to ensure adequate coverage during business hours
Minimum Experience Required: • 7 years of managed care experience with utilization management responsibility, including clinical operations • Experience working within applicable State, Federal, and third-party regulations • Operational and process improvement experience
Skills Required: • Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic • Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?
[x] Yes [ ] No

If yes, list below:
Bachelor's in healthcare-related field (equivalent combination of education, experience, and/or nursing license will be considered in lieu of Bachelor's degree)

Are any professional licenses or certifications required for this position?
[ ] Yes [x] No

If yes, list below:
If licensed, license must be active, unrestricted, and in good standing

Are there any continuing education requirements for this position?
[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Master's in business, healthcare, social work, or related field
- **Preferred experience:** 10 or more years managed care experience, operational and process improvement experience, demonstrated experience meeting quality accreditation standards (NCQA/HEDIS/STARS)
- **Preferred license, certification, association:** Active, unrestricted State RN license in good standing; UM Certification, Certified Professional in Health Care Quality, or other healthcare or management certification

Key Position: Job Description
Title of Position: Grievance and Appeals Coordinator
Description of Position: The Grievance and Appeals Coordinator is a dedicated position responsible for leading, organizing, and directing the processing and resolution of grievances and appeals. This position reviews and resolves Member complaints and communicates resolution to Members or authorized representatives in compliance with Contract requirements and applicable State and Federal regulations.
Description of Responsibilities of Position: • Manages staff responsible for the submission and resolution of Member inquiries, grievances, and appeals and ensures resolutions are compliant • Proactively assesses and audits business processes to determine which are most effective and efficient at resolving Member problems • Serves as primary interface with corporate claims and configuration counterparts and ensures standard processes are implemented • Oversees preparation of narratives, graphs, and flowcharts to be used for committee presentations, audits, and internal/external reports; oversees necessary correspondence in accordance with regulatory requirements • Maintains call tracking system of correspondence and outcomes for Member grievances and appeals; oversees monitoring of each Member submission/resolution to ensure compliance with internal and regulatory timelines • Assists Members throughout the complaint, grievance, and Division fair hearing processes • Plans, directs, and coordinates staff functions, including development and training of staff • Oversees research and documentation for each Provider/Member inquiry, dispute, and appeal and ensures compliant resolution • Coordinates workflows among departments and interfaces with internal and external resources • Manages Provider and Member disputes and appeals database • Oversees monitoring of each Provider/Member dispute and appeal to ensure all internal and regulatory timelines are met • Maintains well-organized, accurate, and complete files for all Provider/Member disputes and appeals • Interfaces with Providers and performs duties pertaining to participating network satisfaction (e.g., credentialing, education, and communication) • Oversees claims policies and procedures specific to benefits, contracts, and State requirements

Minimum Experience Required:

- 4 years of experience in healthcare claims review and/or Member dispute resolution
- Experience reviewing all types of medical claims (e.g., HCFA 1500, Outpatient/Inpatient UB92, Universal Claims, Stop Loss, Surgery, Anesthesia, high-dollar complicated claims, Coordination of Benefits, and DRG/RCC pricing)

Skills Required:

- Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Associate degree or 4 years of Medicaid or Medicare grievance and appeals experience

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Bachelor's degree
- **Preferred experience:** 6 years of experience in healthcare claims review and/or Member dispute resolution; supervisory or management experience

Key Position: Job Description
Title of Position: Claims Administrator
Description of Position: The Claims Administrator is a dedicated professional who oversees claims administration and is responsible for administering claims payments, maintaining claim records, and providing counsel to claimants regarding coverage amount and benefit interpretation; monitoring and controlling backlog and workflow of claims; and ensuring that claims are settled in a timely manner and in accordance with cost-control standards.
Description of Responsibilities of Position: • Manages and develops a team focused on meeting or exceeding established performance targets based on Federal, State, and CCO Program requirements • Proactively plans for daily priorities and responds to new priorities within the organization • Compiles and submits daily, weekly, and monthly departmental reports to management • Acts as a technical expert in handling complaints and other escalated issues from internal and external customers • Supports claims performance improvement via participation in special claims initiatives • Participates in and supports the development of strategies to meet business needs • Oversees staff to provide for the timely and accurate processing of claims, encounter forms, and other information necessary for meeting agreement requirements and ensuring the efficient management of the health plan • Implements processes to standardize the overall end-to-end processing of claims, as well as the configuration of various modules of the Molina Administrative Platform (MAP) • Engages staff and coordinates projects around various systems enhancements, conversions, and upgrades • Identifies projects/initiatives that reduce administrative costs for Molina and Providers; identifies opportunities to ensure accurate claims editing to assist in the management of organizational healthcare costs • Works with relevant vendors to identify and initiate appropriate recovery opportunities • Convenes workgroups and develops implementation plans with identified tasks, timelines, and assigned parties • Leads testing to validate system changes and material configuration changes to ensure expected outcomes prior to implementation of those changes in the production environment • Participates on the corporate operational leadership team, along with IT staff, to analyze root cause information on variations in claims payment and propose ways to improve performance results, identify potential risks, and lead the needed systems or configuration changes within the claims process to support the organizational needs of the CCO Program • Ensures all State, Federal, and Molina regulations, policies, and procedures are implemented and followed on a consistent basis

Minimum Experience Required:

- 5 years of claims payment and administration experience

Skills Required:

- Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

Bachelor's or equivalent combination of education and experience

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Graduate degree or equivalent combination of education and experience
- **Preferred experience:** 7 years of claims payment and administration experience
- **Preferred licenses or certifications:** Certification in training and development for manager overseeing training unit; internal audit certification for manager overseeing regulatory quality audit unit

Key Position: Job Description
Title of Position: Data and Analytics Manager
Description of Position: The Data and Analytics Manager is a dedicated professional who is responsible for data and analytics management to ensure timely creation of executive and health plan management reports.
Description of Responsibilities of Position: • Ensures data integrity • Interacts with various departments, including IT, Finance, Claims, call center, and Utilization Management • Manages team of data analysts • Acts as liaison to all other internal and external customers on behalf of Molina and enrollment data management areas • Provides day-to-day technical management and mentoring as required under the Contract
Minimum Experience Required: • 8 years of related experience • 2 years of supervisory and/or management experience in managed care or a Medicaid-related field • 3 years in SQL, programming, relational database, and financial analysis
Skills Required: • Soft skills including critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic • Hard skills, if any, as noted above in **Description of Responsibilities of Position**
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** Bachelor's degree or equivalent combination of education and experience
Are any professional licenses or certifications required for this position? **[ ] Yes [x] No** **If yes, list below:**
Are there any continuing education requirements for this position? **[ ] Yes [x] No** **If yes, list below:**

Any additional information relevant to this position:

- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Graduate degree or equivalent combination of education and experience

Key Position: Job Description
Title of Position: Clinical Pharmacist
Description of Position: The Clinical Pharmacist is a dedicated professional responsible for coordination of all pharmacy services and reporting to ensure Members have access to medically necessary prescription drugs and that drugs are used in a cost-effective, safe manner. This position is responsible for creating, operating, and monitoring pharmacy clinical programs in accordance with Federal and State laws.
Description of Responsibilities of Position: • Provides a clinical pharmacy outreach service to educate Members and their healthcare team to optimize medication-related healthcare outcomes, ensure Member safety, recommend cost-effective medication strategies, and coordinate care efficiently and effectively • Provides medication therapy management, including examination of Member medical records; performs a comprehensive medication review and communicates that information to Members and Providers • Reviews Members' medication profiles and applies evidence-based medicine and national guidelines when recommending ways for Providers to optimize Members' medication regimens • Analyzes and reviews medication lists for potential Member safety problems, including drug interactions and suboptimal medication regimens • Promotes clinically appropriate prescribing practices based on evidence-based medicine and national guidelines through various modalities (e.g., Provider profiling, Member drug profile reviews, medication protocols/criteria, and case-by-case interventions) • Researches, develops, and implements drug utilization and disease management strategies and intervention techniques to deliver high-quality, cost-effective healthcare • Assists in coordination of care for pharmacy-related issues among Members, Providers, and the Member's interdisciplinary care team • Follows up with Members and Providers to check on progress toward meeting drug treatment goals • Serves as a drug information resource to Pharmacy staff, Medical Affairs staff, and Providers • Reviews and analyzes pharmacy reports to track general trends in drug utilization and identify potential targeted UM activities • May prepare drug monographs and utilization reports for the Pharmacy and Therapeutics Committee • Develops and updates policies and procedures and implements changes to comply with State and Federal regulations • Reviews Member, Provider, pharmacy, and drug utilization reports; identifies trends affecting the pharmacy budget; requests, reviews, and summarizes ad hoc reports as required; provides regular summaries of activities to the Medical Director

- Designs, implements, and manages the pharmacy clinical programs
- Participates in quality improvement and health education programs related to pharmacy, including healthcare management and any Contract-required programs

Minimum Experience Required:

- American Society of Health-System Pharmacists-accredited residency or two or more years of relevant pharmacy experience
- Current knowledge and expertise in clinical pharmacology and disease management

Skills Required:

- Soft skills include critical thinking and problem-solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic
- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?

[x] Yes [ ] No

If yes, list below:

- Doctor of Pharmacy (Bachelor's degree in Pharmacy and 10 years of relevant experience, including clinical work, will be considered in lieu of Doctor of Pharmacy degree)
- Continuing education required to maintain an active pharmacist license

Are any professional licenses or certifications required for this position?

[x] Yes [ ] No

If yes, list below:

Active and unrestricted State Pharmacy License for workplace and plan location

Are there any continuing education requirements for this position?

[x] Yes [ ] No

If yes, list below:

Continuing education as required to maintain an active State Pharmacy License

Key Position: Job Description
Title of Position: Care Manager
Description of Position: The Care Manager works with Members, Providers, and the interdisciplinary care team (ICT) to assess, facilitate, plan, and coordinate an integrated delivery of care across the continuum, including behavioral health and long-term care for Members with high-need potential. This individual ensures medically appropriate and cost-effective care based on the severity of illness and the site of service that supports Member progress toward desired outcomes. **The Care Manager position meets the RFQ Draft Contract § 1.13.2 requirement for sufficient medical management staffing to perform all necessary medical assessments and to meet all Members' care management needs at all times.**
Description of Responsibilities of Position: • Completes clinical assessments of Members per regulated timelines and determines who may qualify for care management based on clinical judgment, changes in Member's health or psychosocial wellness, and triggers from the assessment • Develops and implements a care plan in collaboration with the Member, caregiver, physician, and/or other appropriate healthcare professionals and Member's support network to address the Member's needs and goals • Conducts telephonic, face-to-face, and home visits as required • Performs ongoing monitoring of the care plan to evaluate effectiveness, document interventions and goal achievement, and suggest changes • Maintains ongoing Member caseloads for regular outreach and management • Promotes integration of services for Members, including behavioral and long-term services and support to enhance the continuity of care for Molina members • May implement specific Molina wellness programs such as asthma and depression disease management • Facilitates ICT meetings and informal ICT collaboration • Uses motivational interviewing and Molina clinical guideposts to educate, support, and motivate change during Member contacts • Assesses for barriers to care, provides care coordination and assistance, and addresses Member concerns • Collaborates with RN Care Managers and supervisors as needed or required • Provides consultation, resources, and recommendations to peers as needed (applicable to Care Managers in behavioral health and social science fields)
Minimum Experience Required: 1 year in care management, disease management, managed care, or medical or behavioral health settings
Skills Required: • Soft skills, including critical thinking and problem solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic

- Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?
[x] Yes [ ] No

If yes, list below:
Completion of an accredited Licensed Vocational Nurse or Licensed Practical Nurse program or Bachelor's or Master's degree (preferably in a social science, psychology, gerontology, public health, or social work or related field)

Are any professional licenses or certifications required for this position?
[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?
[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Local travel of up to 40% may be required
- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment where there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred experience:** 3 years in care management, disease management, managed care, or medical or behavioral health settings
- P**referred licenses or certifications:** Licensed Clinical Social Worker, Advanced Practice Social Worker, Certified Case Manager, Certified in Health Education and Promotion, Licensed Professional Counselor, Respiratory Therapist, or Licensed Marriage and Family Therapist

Key Position: Job Description
Title of Position: Materials and Communications Manager
Description of Position: The Materials and Communication Manager collaborates with health plan leadership to develop communications and marketing materials to meet strategic goals. This role is responsible for brand and message management, along with writing, editing, and reviewing the content of marketing and communication materials. **The Materials and Communications Manager position meets the RFQ Draft Contract § 1.13.2 requirement for designated staff responsible for Member communications.**
Description of Responsibilities of Position: • Leads the health plan communications program, which includes handbooks and manuals, presentations, bulletins, newsletters, and websites • Manages the production and fulfillment processes with all internal departments and external vendors • Develops Provider education and training materials collaboratively with Provider Services department and the management team • Oversees and coordinates the submission and approval processes required by State and Federal guidelines for materials per State requirements and Molina policies • Tracks and trends all Member and Provider education, training, and meetings for internal review and regulatory review • Identifies any systemic issues for tracking, trending, and process improvement • Responsible for facilitating and coordinating communications materials, updates, and edits while ensuring compliance and effectiveness • Ensures all State and Federal regulatory and accreditation requirements are met for the health plan's materials and communications • Responsible for maintaining policies and procedures related to materials and communications • Supports in the development, distribution, and processing of all materials for all products and initiatives
Minimum Experience Required: • 5 years of relevant or related experience
Skills Required: • Soft skills, including critical thinking and problem solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic • Hard skills, if any, as noted above in **Description of Responsibilities of Position**
Are there any educational requirements for this position? **[x] Yes [ ] No**

If yes, list below:

Bachelor's degree or equivalent combination of education and experience

Are any professional licenses or certifications required for this position?

[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?

[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Working environment is generally favorable, and lighting and temperature are adequate.
- Work is generally performed in an office environment where there is only minimal exposure to unpleasant and/or hazardous working conditions.
- Must have the ability to sit for long periods.
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function.
- **Preferred experience:** 7 years of relevant or related experience
- **Preferred education:** Bachelor's degree in journalism, English, communications, or related field

Key Position: Job Description
Title of Position: Marketing and Public Relations Director
Description of Position: The Marketing and Public Relations Director is responsible for continuous quality improvements regarding Member engagement and retention by representing Member issues in areas of impact and engagement, including appeals and grievances, Member problem research and resolution, and the development and maintenance of Member materials. **The Marketing and Public Relations Director position meets the RFQ Draft Contract § 1.13.2 requirement for designated staff responsible for marketing and public relations.**
Description of Responsibilities of Position: • Ensures access and availability for Members to voice concerns, request information, and obtain assistance with benefit interpretation; represents Member issues on our senior leadership team • Reviews call metrics and root cause analyses of Member complaints and ensures communication and collaboration to address process and training opportunities • Monitors open projects and provides support to escalate as needed • Addresses process and training opportunities to ensure compliance with health plan requirements • Develops, coordinates, and leads a continuous quality improvement program for Member-related activities • Ensures that employees and management understand/participate in identifying and implementing opportunities for improvement to support Member retention • Develops and maintains all Member materials in coordination with the Materials and Communications Director; coordinates communications with Members; ensures Member materials meet contract and regulatory requirements • Maintains knowledge of Contract obligations with the State, Members, and other parties; works with other departments to ensure compliance with contractual obligations
Minimum Experience Required: • 7 years of relevant or related experience • 5 years in the health plan/insurance industry • 3 years in a managed care environment, preferably in Medicaid • 1 year in a management role
Skills Required: • Soft skills, including critical thinking and problem solving, teamwork and collaboration, leadership, oral and written communication skills, professionalism, and strong work ethic • Hard skills, if any, as noted above in **Description of Responsibilities of Position**

Are there any educational requirements for this position?
[x] Yes [ ] No

If yes, list below:
Bachelor's degree in business or health care administration or equivalent experience

Are any professional licenses or certifications required for this position?
[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?
[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment where there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function

Preferred experience: 10 years of related healthcare experience

Preferred education: Bachelor's degree in business or healthcare administration

Key Position: Job Description
Title of Position: Executive Assistant
Description of Position: The Executive Assistant provides administrative-level support to management and/or unit team members, prioritizes requests to meet business objectives, and supports the day-to-day administrative operations of a department and/or site. **The Executive Assistant position meets the RFQ Draft Contract § 1.13.2 requirement for sufficient support staff to conduct daily business in an orderly manner.**
Description of Responsibilities of Position: • Composes and types routine memos and correspondence at an executive level • Copies, faxes, and routes information as requested • Establishes and maintains official documents and records in appropriate files • Responds to a broad range of inquiries • Keeps management's calendar up to date • Makes necessary arrangements to ensure details for meetings are completed • Conducts outside research for projects, as necessary • Prepares recurring and special reports and presentations by gathering data, interpreting data, and assembling reports for executive review and distribution • Proofreads and edits materials • Provides confidential administrative and clerical support to executives • Receives, opens, sorts, reads, and prioritizes executives' mail • Schedules appointments, meetings, conferences, luncheons, hotel reservations, and travel • Serves as a receptionist for executives, receiving and screening visitors and telephone calls • Serves as recording secretary for committees; schedules meetings, distributes materials, and records and transcribes meeting minutes
Minimum Experience Required: • 5 years of office/clerical experience • 3 years of experience with Microsoft Office Suite
Skills Required: • Soft skills, including critical thinking and problem-solving, teamwork and collaboration, oral and written communication skills, professionalism, and strong work ethic • Hard skills, if any, as noted above in **Description of Responsibilities of Position**
Are there any educational requirements for this position? **[x] Yes [ ] No** **If yes, list below:** High School diploma or equivalent GED

Are any professional licenses or certifications required for this position?
[ ] Yes [x] No

If yes, list below:

Are there any continuing education requirements for this position?
[ ] Yes [x] No

If yes, list below:

Any additional information relevant to this position:

- Working environment is generally favorable, and lighting and temperature are adequate
- Work is generally performed in an office environment where there is only minimal exposure to unpleasant and/or hazardous working conditions
- Must have the ability to sit for long periods
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential function
- **Preferred education:** Business-related courses
- **Preferred experience**: Three years in an administrative role

4.3.3.3 ADMINISTRATIVE REQUIREMENTS

In this section, Molina verifies the Mississippi-based location of our administrative office and describes the maintenance and retrieval process for administrative records and data. We have completed the attestation in RFQ Appendix H § 4.3.3.3 Administrative Requirements, which is included at the end of this response.

1. Location of Molina's Administrative Office

Molina has established an administrative office at 188 E. Capitol Street, Ste. 700, Jackson, MS 39201, which is 0.5 miles from the Division's High Street location. As a current health plan administrator for MississippiCAN and CHIP, we have supported these programs from our Capitol Street location since April 2018.

For the new Contract, we will make space, technologies, and supplies available to the Division at their request. We understand that the Division will give us 24-hour advance notice if they require the use of our Jackson-based administrative office.

2. Administrative Records and Data Maintenance and Retrieval

We generate and maintain administrative records and data in formats such as electronic media, print, and tape. In the paragraphs below, we describe the types of records we maintain, how and where we maintain/store the records, and our process and time frame for retrieving records requested by the Division or other State or external review representatives.

Permanent and Nonpermanent Records

Records and data that must be maintained indefinitely to comply with regulatory requirements or business needs are designated as permanent records. These records have ongoing significance for the business and are retained in a secure and confidential manner as appropriate. Permanent documents include:

- Executed final transaction documents
- Annual directors' reports
- Annual financial reports
- Budgets
- Policy
- Personnel and payroll records
- Audit reports
- Building specifications
- Regulatory filings

Nonpermanent records include all other records not listed above. Nonpermanent records are retained for a minimum of 10 years or until all issues relating to those records are resolved, whichever is the later date.

Records Retention Policy

Our comprehensive records management and records retention policies are designed to ensure compliance with Federal and State laws, regulations, and CCO Program requirements and to eliminate accidental destruction of records and promote efficiency within our operations. We periodically destroy records and/or data that are duplicates or designated as nonpermanent, such as those that are no longer useful and/or not required to be maintained indefinitely. Our employees retain records if there is any doubt as to whether they should be retained or not.

In the event of an imminent or pending government investigation, administrative proceeding, or litigation that may involve records generated or maintained by us, Molina Healthcare's Office of Legal Affairs is immediately notified. That office informs Molina employees if any of the record retention policies should be suspended due to a pending government investigation, administrative proceeding, or litigation. In those circumstances, no records relevant to any proceeding may be destroyed, regardless of the age of the records, until further notice from the Office of Legal Affairs.

Secure Data Storage

We store records and data both physically and electronically. We ensure secure storage by maintaining reasonable and appropriate levels of safeguards as follows:

- **Physical safeguards** include maintaining strict physical access controls within our facilities. Visitor registration is required to enter all Molina facilities, and data rooms are secured by separate facility access controls. All paper records are locked up when left in an unattended room.
- **Electronic safeguards** include workstation access control systems, as well as industry-standard data backup and storage procedures. Backup of electronic information is required to support emergency procedures in the event of a catastrophe or other unforeseen event. All storage of electronic data, including backups, is performed in a manner that protects data integrity. All procedures related to the electronic storage and backup of data are documented in detail.

In compliance with the Draft Contract, we will maintain all records at one central office in Jackson, Mississippi, as approved by the Division.

Record Retrieval Process

We retrieve and transfer all requested records and/or data to the requestor as soon as practicable, but no longer than the contractually or statutorily required time frame. Per the Draft Contract, all records, including training and Subcontractor records, shall be maintained and available for review by authorized Federal and State agencies during the Contract term and for a period of 10 years or until all issues are finally resolved, whichever is later. The records must be readily retrievable within three business days for review at the request of the Division and its authorized representatives at no cost to the Division or its authorized representatives.

If electronic transmission of records to an outside entity is required, we encrypt the records to ensure security of confidential information transmitted over a public network. Our encryption controls include Transport Layer Security version 1.2 (over the Internet) and Pretty Good Privacy for media or other transfer methods. We also use Secure File Transfer Protocols to transmit data over a Secure Shell data stream.

In the case of an on-site review, the records and or/data are produced immediately. Records and/or data that are requested to be transmitted in a physical format are copied and reproduced in such a way that the original records are exactly replicated. We mail and/or ship copied records as requested.

[END OF RESPONSE]

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.

Molina Healthcare of Mississippi, Inc,

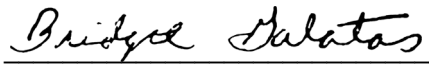
Name of Offeror

Bridget L. Galatas

Printed name of person attesting for Offeror

Chief Executive Officer

Title of person attesting for Offeror



Signature of person attesting for Offeror

March 3, 2022

Date

4.3.3.4 STAFFING

A.1. Member Services

For this Contract, we will have 28 Member services call center employees and 5 Nurse Advice Line staff. Our Nurse Advice Line is a 24/7/365, toll-free, multilingual hotline providing culturally competent, comprehensive, and personalized clinical and nonclinical services and after-hours support for Member issues and inquiries.

The following **Table 1** demonstrates our staffing ratios per enrolled Member, including the number of Member services call center employees and Nurse Advice Line employees. **Table 1** also identifies the staffing ratio of Member Services Supervisors to Member services call center employees.

Table 1. Member Services Call Center Employees and Staffing Ratios. We provide the appropriate numbers of experienced staff to meet or exceed call center performance standards and ensure high-quality services to Members.

Position and Number of Staff	Staffing Ratio
Member Services Manager (1)	1 per 27 Member Services Supervisors
Member Services Supervisor (2)	1 per 13 Member services call center employees
Member services call center employee (25)	1 per 5,000 Members
Nurse Advice Line triage nurse (5)	1 per 5,500 Members*
* The ratio represents the total Nurse Advice Line staff to estimated Members. The staffing ratio for Nurse Advice Line triage nurses to Members is incremental to our Nurse Advice Line staffing pool, which supports all of our health plans across the enterprise. Staffing, which is based on 24-hour operations, is adjusted for actual call volume versus membership.	

Job qualifications for Member services call center employees are as follows:

- **Member Services Manager.** Bachelor's degree in healthcare- or business-related field or equivalent experience; 5 years of experience involving customer service and Medicaid/Medicare programs; 5 years of managed healthcare experience; 2 years of supervisory experience; master's degree in healthcare- or business-related field and 7 years of experience preferred
- **Member Services Supervisor.** Associate degree or equivalent combination of education and experience; 3 years of experience in a call center environment; 1 year of supervisory experience; bachelor's degree and 5 years of experience preferred
- **Member services call center employee.** High school diploma and/or 1 year of experience; associate degree and 3 years of experience preferred
- **Nurse Advice Line triage nurse.** Active RN license in Mississippi; 3 years of telephone triage experience; background in acute care, such as ER or intensive care unit, preferred

Training and Education

All new Molina staff must complete orientation training on our company's mission, values, goals, structure, and services. In **Table 2**, we present a summary of the training and education required specifically for Member services call center staff.

Table 2. Member Services Call Center Training Topics. Our training modules cover a comprehensive range of topics to ensure that staff are fully prepared to respond to calls from Members.

Training Category	Training Topics
Compliance	• FWA • HIPAA Criteria • HIPAA Law • HIPAA Privacy Incidents • Minor Consent • PHI • Quality Assurance Call Monitoring • Compliance Hotline and How to Report Instances of Noncompliance
Systems, Applications, Websites	• Call Code • Call Documentation • Call Routing • CCO Program Website • Molina Public Website and Member Portal

Training Category	Training Topics
	• PBA • Phones • Customer Relationship Management/System Training
Customer Service	• Heart of Communication: Building Rapport Through Empathy • Phone Presence: Call Handling, Irate Calls, Crisis Calls • Probing for Understanding: The Art of Questioning • Service: The Molina Way • Special Needs Sensitivity Training: Visual, Auditory, and Kinesthetic Simulation
Product Training	• Grievances and Appeals • Authorizations and Referrals • Benefits/Value-adds and Incentives • Crisis Calls • Critical Events and Incidents • Demographic Changes • Eligibility Verification • Materials Requests • Medicaid Care Management • Medicaid Introduction • Medicaid PCP Changes • Pharmacy • Substance Use Disorders (SUDs) • Training Resources Library
Role-play	• Accessing Resources • Call Handling • Call Scenario Simulation • Demonstration of Skills • Documentation • Peer Review • Problem-solving
Nesting/Live Call Listening	• Transition to Floor Nesting Area with Supervisor and SME Support

Newly hired call center employees are placed on an accelerated quality monitoring program where our Quality Assurance team and Member Services Supervisors monitor 10 calls during the new employee's first month of work. Our online quality tools allow us to identify specific areas of opportunity—such as product knowledge and building rapport with the Member—and, if we identify a concern, the employee receives additional training and one-on-one coaching as needed. Employees are categorized by grade (A, B, C, D, or F) based on the Internal Service Quality score achieved during the previous month, and those with lower grades are monitored closely and retrained to ensure we meet our Internal Service Quality goals. Ongoing training occurs for all employees in response to changes in products/processes, Contract requirements, or evolving situations, such as the COVID-19 pandemic.

We provide COVID-19 training to call center staff so they can provide immediate, accurate answers to Member questions about where and how to access applicable information and services.

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A.2. Provider Services

For the new Contract, we will have 10 Provider services call center employees. Our staffing numbers for the Provider services call center correlate to the membership attributed to the CCO Program and will be adjusted as needed to reflect membership changes and comply with performance standards.

Table 3 presents our Provider services call center employee ratios, including the number of staff per Member and supervisor-to-staff ratios.

Table 3. Provider Services Call Center Staff and Staffing Ratios. We provide sufficient numbers of experienced staff to meet or exceed call center performance standards and ensure high-quality services to Providers.

Position and Number of Staff	Staffing Ratio
Provider Services Manager (1)	1 per 20 Provider call center employees
Provider services call center employees (9)	1 per 15,000 Members

Job qualifications for Provider services call center employees are as follows:

- **Provider Services Manager.** Bachelor's degree in healthcare- or business-related field or equivalent experience; 5 years of experience involving customer service and Medicaid/Medicare programs; 5 years of managed healthcare experience; 2 years of supervisory experience; master's degree in healthcare- or business-related field and 7 years of experience preferred
- **Provider services call center employee.** High school diploma and/or 1 year of experience; associate degree and 3 years of experience preferred

For the new Contract, we will also have 31 on the Provider Representative team. This team focuses on Provider education, including orientation and on-site visits; relationship management; issue resolution; and ensuring Provider accountability and compliance with network performance standards. Our Provider Representatives across Mississippi will be assigned to one of five specialty areas: BH, primary care/FQHCs, specialty care, hospitals, and claims payment.

Table 4 presents our Provider Relations staff ratios, including the number of staff per Provider and supervisor-to-staff ratios.

Table 4. Provider Relations Staff and Staffing Ratios. One Provider Relations Manager will oversee five teams of Provider Representative Leads and Provider Representatives.

Position and Number of Staff	Staffing Ratio
Provider Relations Manager (1)	1 per 5 Provider Representative Leads
Provider Representative Lead (5)	1 per 5 Provider services employees
Provider Representative (25)	1 per 1,300 Providers

The job qualifications for Provider Relations staff are as follows:

- **Provider Relations Manager/Supervisor.** Bachelor's degree in healthcare- or business-related field or equivalent experience; three years of supervisory experience in managed healthcare; four years of claims and/or benefits interpretation and Provider networking; substantive knowledge of healthcare policy and direction; master's degree in healthcare- or business-related field and seven years of experience preferred
- **Provider Representative Lead.** Bachelor's degree or equivalent Provider contract, network development and management, or project management experience in a managed care setting; three years of customer service, Provider service, or claims experience in a managed care setting; three years of experience in managed healthcare administration and/or Provider services; five years of experience in Provider contract negotiations, ideally in negotiating varied types of Provider contracts; working familiarity with managed care Provider compensation methodologies, primarily across Medicaid and Medicare lines of business; master's degree preferred
- **Provider Representative.** Bachelor's degree or equivalent Provider contract, network development and management, or project management experience in a managed care setting; two years of customer service, Provider service, or claims experience in a managed care setting; working familiarity with various managed care Provider compensation methodologies, primarily across Medicaid and Medicare lines of business; five years of experience in managed healthcare administration and/or Provider services and Provider contract negotiations preferred

Training and Education

All new Molina staff must complete orientation training on our company's mission, values, goals, structure, and services. **Table 5** presents a summary of the training and education required specifically for Provider services call center employees.

Table 5. Provider Services Call Center Training Topics. Employees receive comprehensive training using the most appropriate training modality.

Training Modality	Training Topics
Online Modules	• Compliance • FWA • HIPAA in the Hi-tech Era • HIPAA Security • HIPAA Privacy • Provider Services the Molina Way
WebEx and Face-to-Face	• Call Tracking • System: Overview, Claims, and Provider Modules • Provider Portal • Website (corporate and health plan site)
Documentation and Face-to-Face	• CCO Program Benefits and Programs • Communications • FAQs • Forms • Provider Manual
Shadowing On-site at Molina or Affiliated Health Plan	• Member and Provider Call Center • Overview of CCO Program Contract, Policies, and Procedures • Member/Provider Inquiry Research and Resolution • UM • Care Management

Provider Relations staff receive the same training as Provider services staff. In addition, they participate in field shadowing (e.g., visits to Provider offices) with Provider Representative Leads and/or more experienced Provider Representatives to ensure they have the appropriate skills to interact directly with Providers and their office staff.

A.3. Quality Management

Under the leadership of our QM Director, our locally based QM staff conduct all quality-related functions for the CCO Program. **The QM Director reports to our CEO who is ultimately responsible for the health plan's quality programs.** The local team is supported by national QM leadership who provide expertise acquired through best quality practices implemented in our health plans throughout the enterprise.

Descriptions of our QM program staff and their qualifications are presented in **Table 6**.

Table 6. QM Program Staff and Qualifications. QM staff conduct quality-focused activities across the spectrum of Contract-required services.

Position Title	Summary of Responsibilities	Qualifications
QM Director	• Serves as a leader of health plan quality strategy and activities, including primary Molina interface with State agencies, leadership of local quality committees, and oversight of intervention activities intended to improve quality measures and outcomes • Collaborates with Molina quality leaders to conduct data collection, reporting, and monitoring for key quality performance measurement activities • Implements NCQA accreditation surveys and Federal quality compliance activities • Meets the Draft Contract § 1.13.2 requirement for a designee who can respond to issues involving quality assessment, EPSDT services management, and well-baby and well-child care assessments and immunization services	• Three years of quality compliance and HEDIS operations, customer service or Provider service in a managed care setting with supervisory experience, project management and team-building experience • Experience developing performance measures that support business objectives • Knowledge of quality discipline, including metrics and performance standards, in a managed healthcare setting • Master's degree or equivalent combination of education and experience
Health Equity and SDOH Manager	• Develops targeted health promotion and education activities to improve Member outcomes • Works in partnership with internal and external leadership to ensure health promotion and education outreach programs and interventions align with population health and quality strategies	• Five years of experience identifying and addressing health disparities • Experience leading through influence across large organizations • Exceptional communication skills, including writing and public speaking

Position Title	Summary of Responsibilities	Qualifications
	• Uses risk stratification and segmentation of membership to focus strategies on target population streams and sub-streams • Verifies that initiatives, partnerships, and engagement strategies reflect Member preferences, risk levels, and needs; address disparities; and are culturally appropriate • Serves as a leading expert and prominent voice in supporting and advancing the needs of diverse and socially vulnerable individuals	• Credentials in specialty or subspecialty or advanced clinical degree, such as RN, Licensed Master Social Worker, Licensed Clinical Social Worker, or equivalent
CHIP Program Manager	• Oversees, plans, and implements new and existing healthcare quality improvement initiatives and education programs for CHIP Members • Ensures maintenance of programs for Members in accordance with prescribed quality standards • Conducts data collection, reporting, and monitoring for key performance measurement activities • Provides direction and implementation of NCQA accreditation surveys and Federal/State quality compliance activities	• Five years of experience in managed care, including at least two years in health plan quality improvement or equivalent/related experience • Technical experience in reporting and/or programming • Proficiency with Microsoft Excel and Visio (or equivalent) and demonstrated ability to learn new information systems and software programs • HEDIS reporting/collection and CAHPS experience preferred • Supervisory, project management, and team-building experience preferred • Bachelor's degree or equivalent work experience
EPSDT Coordinator	• Provides outreach related to improving EPSDT compliance with State, Contract, and regulatory guidelines • Conducts initial outreach over the phone to accurately and thoroughly complete assessments within established timeframes • Verifies eligibility, enrollment history, demographic data, PCP, and current health status of Members • Makes recommendations and/or referrals based on assessment/screening findings • Assists in education of Members regarding health conditions, available benefits and Providers, plan services, and available EPSDT services • Works with PCPs and Members to ensure EPSDT well-child visits are conducted on eligible Members under age 21 to identify health and developmental problems	• Two years of healthcare experience • Three years of experience in care management, disease management, managed care, or medical or behavioral settings • Valid driver's license with good driving record • High school diploma or GED • Associate degree preferred
Senior Quality Specialist	• Oversees, plans, and implements new and existing healthcare quality improvement initiatives and education programs • Ensures maintenance of programs for Members in accordance with prescribed quality standards • Conducts data collection, reporting, and monitoring for key performance measurement activities • Provides direction and implementation of NCQA accreditation surveys and Federal/State quality compliance activities	• Three years of experience in healthcare • Two years of experience in health plan quality improvement, managed care, or equivalent • Demonstrated business writing experience • Operational knowledge and experience with Microsoft Excel and Visio (or equivalent) • One year of experience in Medicaid or Medicare preferred • Bachelor's degree or equivalent combination of education and work experience, with preferred education in clinical quality, public health, or healthcare
Mobile Health Team	• Certified Medical Assistant • Maximizes patient care and satisfaction by interacting with staff, patients, and Providers • Prepares patients for healthcare visits by directing and/or accompanying them to the exam room • Verifies patient information by interviewing patients, reviewing and/or recording medical history, taking vital signs, and confirming purpose of visit or treatment • Performs patient-oriented procedures under the clinical supervision of a practitioner • Demonstrates knowledge of office functions in accordance with the Certified Medical Assistant role	• Clinical, procedural, and documentation skills consistent with Certified Medical Assistant role • Active, unrestricted Certified Medical Assistant license/certification • Active, unrestricted certificate in CPR • High school diploma or GED • One year of Certified Medical Assistant experience in family practice/pediatrics preferred • Bilingual skills and managed care experience preferred
CHW Driver	• Performs a variety of routine and complex transportation work related to driving a 39' Class A Winnebago • Assesses Member eligibility for mobile services and explains how to access those services • Evaluates and resolves problems related to Members' ability to access services	• High school diploma or GED • One year of relevant experience or equivalent combination of education and experience that demonstrates the ability to do the job • Valid Mississippi driver's license • Associate degree in healthcare field or medical assistant certification preferred

Position Title	Summary of Responsibilities	Qualifications
	• Establishes and maintains relationships with community and social resources, employees, and supervisors	• Two years of experience in healthcare preferred
Provider Quality and Practice Transformation Team Manager	• Oversees, plans, and implements new and existing healthcare quality improvement initiatives and education programs • Ensures maintenance of programs for Members in accordance with prescribed quality standards • Conducts data collection, reporting, and monitoring for key performance measurement activities • Provides direction and implementation of NCQA accreditation surveys and Federal/State quality compliance activities	• Three years of experience in healthcare • Two years of experience in health plan quality improvement, managed care, or equivalent • Demonstrated solid business writing experience • Operational knowledge and experience with Microsoft Excel and Visio (or equivalent) • One year of experience in Medicaid or Medicare preferred • Bachelor's degree or equivalent combination of education and work experience, with preferred education in clinical quality, public health, or healthcare
Executive Assistant	• Provides administrative-level support to management and/or unit team members • Prioritizes requests to meet business objectives • Supports the day-to-day administrative operations of the QM department • Meets the Draft Contract § 1.13.2 requirement for sufficient support staff to conduct daily business in an orderly manner	• Five years of office/clerical experience • Three years of experience with Microsoft Office Suite • High school diploma or GED

A.4. Care Management

Care Managers play a pivotal role in the success of our care management approach, acting as primary service coordinators, advocates, and points of contact for Members. From person-centered planning and cultural competency to specializations in specific populations, our Care Managers are a critical part of our delivery of care model for the CCO Program. Care management teams bring Providers, community partners, and Members and their families together to develop a care plan that encompasses each Member's physical, behavioral, and social needs. Individual and team functions include:

- Coordinating physical health and BH services to focus on specific conditions ranging from developmental disabilities and SUD to diabetes, asthma, and obesity
- Working in partnership with Members and their families to ensure access to services and assistance programs
- Monitoring and regulating the acquisition and use of Members' medications
- Monitoring Member satisfaction and success in reaching their care plan goals
- Empowering Members with the tools and education they need to manage their health issues
- Working with Providers to coordinate and monitor supports and services
- Working closely with our Medical Director and Medical Affairs staff on cases that warrant specific clinical input

For additional information on Care Manager functions and responsibilities, please see our Care Manager position description in RFQ § 4.3.3.2, Qualifications.

Education, Training and Experience Required for Care Managers

Care Managers participate in Molina Healthcare's Clinical Operations Training Program to acquire the knowledge, skills, and behaviors to assist them in executing job responsibilities in alignment with organizational goals. Our training life cycle begins with new employee orientation, which includes standardized, enterprise-wide training on policies, procedures, and processes; contractual requirements; and CMS and NCQA standards. Training modalities reflect the various learning styles of participants, including a blend of instructor-led training, online courses, instructional videos, self-study, and coaching. Our online learning management system manages training content and student activities such as course completion, test scores, student feedback, and compliance reporting. The online system ensures on-demand access to learning resources to supplement instructor-led training and strengthen knowledge.

The Care Manager-specific training curriculum is based on established policies, workflows, and job aids. Hands-on practical application exercises and competency-based assessments align with behavioral learning objectives to ensure that staff are ready to work upon completion of their training. Learning continues and skills are reinforced as staff transition from the classroom into their new roles, where they are mentored by SMEs who

support learning transfer. Continuous learning and professional development provide ongoing educational opportunities to enhance knowledge of clinical programs, initiatives, and product solutions.

Table 7 details the required and preferred levels of education, training, and experience required for Care Managers.

Table 7. Care Manager Education and Experience Requirements. Our Care Managers are required to hold an active, unrestricted license in their area of expertise and have three years of care management experience.

Category	Description
Education and Experience	**Required Education:** Undergraduate and/or graduate degree in social work or a related field or licensed as a Licensed Practical Nurse or master's-level BH professional **Preferred Education:** Master's degree in a social science, psychology, gerontology, public health, social work, or related field **Required Experience:** Three years in care management **Preferred Experience:** One year in disease management, managed care, or physical health or BH settings; knowledge of applicable State, Federal, and third-party regulations and standards; pediatric and family care management
License/Credentials	**Required:** One or more of the following active, unrestricted licenses in Mississippi: RN, Licensed Vocational Nurse, or Licensed Practical Nurse; Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Professional Counselor, or Licensed Marriage and Family Therapist **Preferred:** Certification in case management

Culturally Competent Care Managers

We conduct annual cultural competency training for all employees and report the number of employees who have completed training on a quarterly basis to the Division. Staff are trained in cultural competency through a web-based, self-paced program focused on identifying and responding to cultural aspects when working with Members. Care Managers make every effort to honor a Member's cultural preferences. Required policies include communicating in a Member's preferred language, both spoken and written, and providing guidance for Care Managers to access oral interpretation or sign language interpreter services. Care plan and health education materials reflect the Member's preferred language, and culturally meaningful milestones and activities are incorporated into care planning goals. Provider and community resources align with a Member's preferences, including faith-based preferences. We ensure that family members and others identified by the Member and the Member's family are included and actively engaged as part of the Member's care team.

We are an industry leader in promoting cultural competency, with 79% of our Medicaid health plans enterprise-wide having earned NCQA's Multicultural Health Care Distinction.

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How a Member's Initial Risk Level and Needs May Factor into Care Manager Assignment

All new Members are screened within the first 30 days of enrollment and assigned to one of three risk stratification levels: low, medium, or high. Per Contract requirements, Members identified as medium or high risk will be assigned to a Care Manager. Based on assigned risk levels, we then prioritize the right healthcare interventions for each Member.

As part of the assignment process, our care management team takes a Member's initial risk level, including SDOH, into account. We then match the Member to a specific Care Manager's skill set. For example, some Care Managers specialize in BH or social science fields while others who are RNs may be more appropriately matched to Members with medical needs such as chronic illness. We also have Care Managers who specialize in helping Members successfully navigate transitions in care. In all cases, the Member's physical health and emotional well-being are our top priorities.

Proposed Ratio of Care Managers to Members

Molina understands that medium- and high-risk Members are to be assigned a Care Manager in compliance with Draft Contract § 7.5 and that the required 40:1 ratio indicates that no Care Manager may have a caseload of more than 40 Members. We also understand that ensuring the appropriate number of FTE Care Managers to maintain the 40:1 ratio requires membership data and assumptions about the percentage of Members expected to be categorized as medium- and high-risk. We will closely monitor membership and utilization data throughout the Contract term to ensure that we meet the required ratio of Care Managers to Members. We have

established processes for recruiting, hiring, and training Care Managers and, if needed, we can also access the staff resources of our parent company to respond quickly to fluctuations in staffing requirements.

Training and Education Provided to Care Managers

All new Molina staff must complete orientation training on our company's mission, values, goals, structure, and services. **Table 8** presents a list of the training and education topics that Molina provides to Care Managers.

Table 8. Care Management Training and Education Topics

Care Management	Specifics related to CMS, NCQA, and State regulatory requirements following the care management process for screening, assessing, stratifying risks, planning, and implementation of a person-centered care plan as, well as follow-up and evaluation: • Assessments • Comprehensive assessments • Condition-specific assessments • Closing the loop of identified conditions/concerns based on Member assessment and motivational interviewing skills • Person-centered care plan development – Elements of an individualized care plan – Member-prioritized goals – Identification of individualized barriers to adherence and treatment goals – Person-centered care plan interventions designed to assist Members in overcoming identified barriers to adherence or treatment goals – Measurable outcomes – Member consent • Care Management team – Member care plan updates based on outcomes of multidisciplinary care plan team meetings – Advanced care planning – SDOH – Motivational interviewing – Pre-call reviews – Transitions of care • Letters: Member and Provider communication and collaboration regarding the care plan • Practice scenarios with live feedback based on audit findings used to identify any additional training needs • IT systems – Clinical CareAdvance® – Claims operations – Member 360
	For BH Care Managers and Supervisors/Managers: • Online courses, including: Required: – Confidentiality with Substance Abuse and 42 CFR Part 2 – Crisis Calls for Clinical Staff – Elements of Depression – Helping Members with Challenging BH Diagnoses and Behaviors – Verbal De-escalation Skills – Understanding BH: Defining Diagnoses and Treatment Options – Basic Overview of ASAM Principles – SMI/Serious Emotional Disturbance Care Model: Care Manager Training, Parts 1 and 2 – SUD Navigator Training – SUD 101 – Drug Testing 101 – Addiction 101 – National Institute on Drug Abuse assessment – Geriatrics and SUD Optional courses: – Dementia – Perinatal Depression – Elements of Depression – Delirium and Dementia – Perinatal Depression – Self-care at Work, Parts 1 and 2 – Crisis Calls for Support Staff • Required taped or self-paced training (not exhaustive): – Red Flag List – BH Benefits 101 – Assessment and Intervention Tools for Care Management – Addiction 101 – Social Determinants of Health

- Crisis Management Prevention, Assessment, and Intervention
- Peer Support Services
- Trauma-informed Care
- Medical Comorbidities to SUDs
- Medication-assisted Treatment
- Pain and Addiction
- Pediatric SUDs
- Psychiatric Co-occurring Disorders and SUDs
- SUDs and Perinatal Addiction

• Review of UM Quick Reference Guides
• Completion of UM case scenarios
• Meeting with BH Supervisor and Manager for post-self-training question-and-answer session to ensure completion/understanding
• Completion of post-test

For non-BH Care Managers and Supervisors/Managers:

• Required online courses including:
  - BH 101—An Overview
  - Understanding BH: Defining the Diagnosis and Treatment Options
  - Confidentiality with Substance Abuse and 42 CFR Part 2
  - Crisis Calls for Clinical Staff
  - Elements of Depression
  - Helping Members with Challenging BH Diagnoses and Behaviors
  - Verbal De-escalation Skills
  - Assessment and Intervention Tools for Care Management
  - Opioid Use Disorder Model of Care and SUD Care Management Overview
• Optional online courses, including:
  - Perinatal Depression
  - Crisis Calls for Support Staff
  - NIDA Assessment Training
  - Medication-assisted Treatment
  - Pain and Addiction
  - Delirium and Dementia
  - Self-care at Work, Parts 1 and 2
• Required taped or self-paced training (not exhaustive):
  - Assessment and Intervention Tools for Care Management
  - Addiction 101
  - BH Benefits
  - Social Determinants of Health
  - Crisis Management Prevention, Assessment, and Intervention
  - Trauma-informed Care
  - Medical Comorbidities to SUDs

A.5. NCQA Accreditation

Molina affiliates have almost 30 years of experience improving health outcomes among Medicaid and CHIP populations. Demonstrating Molina Healthcare's commitment to quality, all of our Medicaid health plans have either achieved or are working to achieve NCQA Health Plan Accreditation.

In this section of our response, we describe our process and time frames for achieving accreditation. We also identify the States in which Molina is accredited and assert that we have had no unsuccessful NCQA accreditation attempts.

Molina's NCQA Accreditation Process

Molina's process to work toward NCQA Health Plan Accreditation status reflects our company's national NCQA expertise, the established processes refined across all Molina affiliates, and the well-documented health plan accreditation process provided by the NCQA. Our national quality team oversees all aspects of the NCQA accreditation process to ensure consistency while collaborating with each individual health plan to address unique programs and activities.

Our NCQA accreditation preparation activities include:

- Conducting a gap analysis
- Preparing required accreditation documentation
- Conducting data analysis to complete required reports

- Reviewing, approving, and implementing policies and procedures and program documents
- Identifying required documents and submitting them to NCQA

After initial document submission, our team prepares for the on-site review by NCQA surveyors and subsequent file review on key elements. Once the documentation and file reviews are completed and approved, NCQA accreditation is achieved.

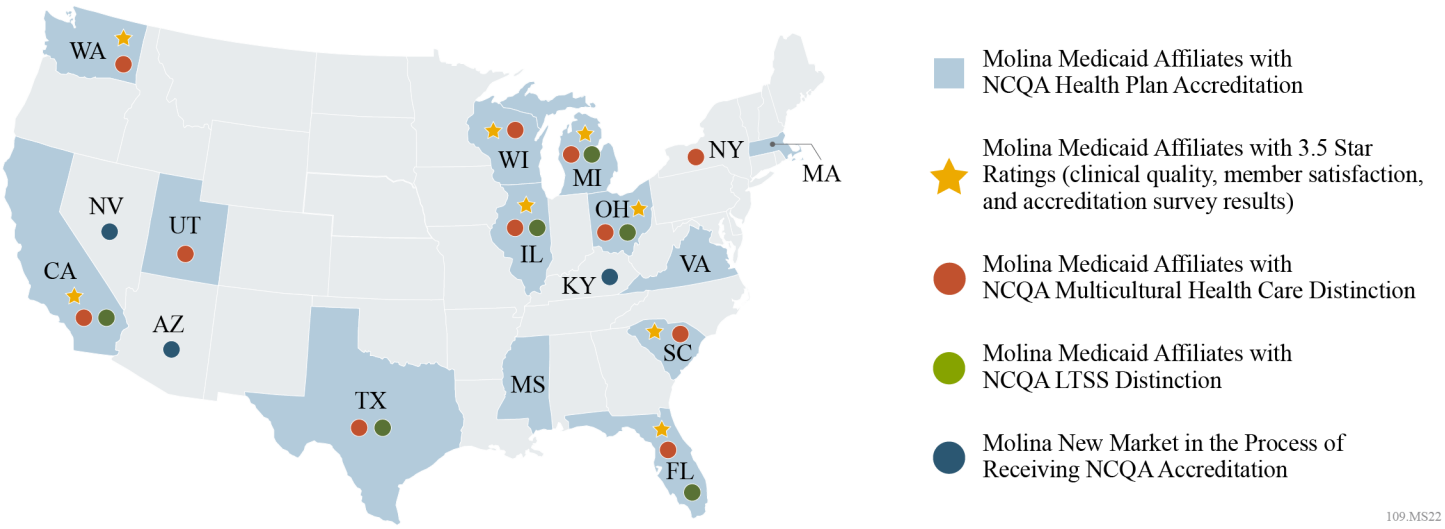
Successful Accreditation in Other Managed Care Programs

As determined by NCQA's Medicaid Health Plan Ratings 2021–2022, our Medicaid affiliate health plans have achieved NCQA accreditation and ratings/distinctions as follows:

- Thirteen health plans have achieved NCQA Health Plan Accreditation.
- Six health plans have achieved NCQA's Long Term Services and Supports (LTSS) Distinction.
- Eleven health plans have achieved NCQA's Multicultural Health Care Distinction for their focus on improving culturally and linguistically appropriate services and reducing healthcare disparities.
- Two accredited health plans (Florida and Washington) have achieved 4-star ratings.
- Eight health plans (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, and Wisconsin) have achieved 3.5-star ratings.

Exhibit 4 illustrates the depth and breadth of Molina's accreditation status nationwide.

Exhibit 4. NCQA Accreditation Status Nationwide. Molina Medicaid affiliates are consistently successful in pursuing and achieving NCQA accreditation and distinctions.



Successful Accreditation in Mississippi

Molina Healthcare of Mississippi achieved interim Health Plan Accreditation for an 18-month period, which was based on policy and procedure review. We will be going through our renewal survey in February 2022 to achieve Health Plan Accreditation for three years.

Time Frames to Achieve NCQA Accreditation

Molina always meets the State-required time frames needed to achieve NCQA Health Plan Accreditation. Based on the date requested for accreditation, we manage the NCQA preparatory time frame internally to meet that external deadline. As discussed previously, the preparation needed to achieve NCQA includes gap identification, document and policy and procedure preparation, and completion of needed reports and program documents. Once these preparation activities are completed, our plan will work with NCQA to submit the NCQA Health Plan Accreditation timeline specific to Mississippi. We also plan to obtain Health Equity accreditation for Mississippi in mid-2022, so this distinction will be achieved prior to the award renewal announcement.

Unsuccessful Accreditation Attempts

Molina has had no unsuccessful accreditation attempts.

A.6. Fraud, Waste, and Abuse

Our Program Integrity staff work as part of a broad corporate structure, leveraging proven processes and new technologies to prevent and detect FWA. In 2016, we joined the Healthcare Fraud Prevention Partnership, furthering our efforts to safeguard the efficiency and proper use of government funds.

Our Mississippi-based **Compliance Officer**, who will report directly to the CEO and the Board of Directors, will serve as the primary point of contact for all FWA efforts with the State and will be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the Contract. Chaired by our Compliance Officer, our Mississippi Regulatory Compliance Committee will oversee our compliance program, Contract requirements, and FWA activities. Our AVP, Compliance, in collaboration with the Manager, Fraud and Abuse, will have day-to-day responsibility for ensuring adherence to the FWA Compliance Plan and all applicable State and Federal FWA mandates. This individual also oversees the work of the SIU on any Mississippi-focused FWA investigations.

To maximize program integrity and our commitment to preventing, detecting, and investigating suspected FWA in Mississippi, **we will employ two Mississippi-based SIU Investigators**. The allocation of two investigators exceeds the RFQ requirement for one individual in this position. These individuals focus on data reviews, such as utilization, and conduct audits from source documents. They perform extensive investigations involving medical necessity to validate appropriateness of services billed by Providers. In addition, they aid in staff education on best practices and the latest trends for FWA detection. As appropriate, they also receive ongoing training from the National Healthcare Anti-Fraud Association, of which we are a member.

To ensure access to adequate resources and systems to carry out program integrity requirements, the local investigators will be supported by our national SIU team (see **Table 9**).

Table 9. SIU Resources. Our Mississippi-based FWA activities will be supplemented by specialized national support.

SIU Intake team	Handles initial triage of our FWA compliance hotline
SIU Manager	Manages referral intake and investigation functions
SIU RN Investigators	Conduct FWA investigations related to clinical medical records
SIU Investigators	Conduct FWA investigations based on leads generated from data analysis, law enforcement, and regulatory referrals; and assist with on-site audits and other FWA detection activities under the direction of the SIU Manager
SIU Supervisor	Oversees SIU certified coding analysts; conducts audits involving Provider FWA related to coding and billing issues
SIU Clinician Manager	Oversees the SIU RN Investigators
SIU Data/Certified Coding Analysts	Manage special data analytics and certified coding projects assessing potential FWA

Our proposed Mississippi-based investigators and centralized SIU team have effective Medicaid claims investigations experience, including an understanding of coding and medical records review protocols. Team members also hold professional accreditations and certifications, including Certified Fraud Examiners, Certified Procedural Coders, Accredited Health Care Fraud Investigators, Certified Professional Coders, and nursing, underscoring our commitment to combatting FWA. Complementing the experience of our team, SIU leadership brings extensive fraud detection strategy and planning expertise. This includes application of leadership experience in law enforcement and participation in the healthcare fraud task force within the FBI, as well as regulatory leadership in a State insurance fraud division.

SIU Staff. The SIU includes highly qualified employees focused on FWA prevention, detection, education, investigation, and reporting. They conduct investigations and mine claims data to identify, prevent, and report suspected FWA committed by network Providers, including nonparticipating Providers, Members, caregivers, employees, or other third parties.

A.7. Responsiveness to the Division

Our Compliance Officer is the point of contact for all Division requests regarding regulatory and ad hoc reports, complaints, and other requests as required in Draft Contract § 1.10, Responsiveness to the Division. Under the

Compliance Officer's direction and with the support of competent staff and a robust regulatory reporting tracking system, we are confident of our capability to be fully responsive to all Division requests and requirements.

Regulatory Reports

Designated staff oversee the coordination of recurring reports due to the Division. Our regulatory reporting tracking system captures the following information:

- Report name
- Line of business
- Business owner
- Status of report
- Internal due date
- Due date month
- Date the report was submitted to the Division
- Report frequency
- Final leadership approval/sign-off
- Reporting instructions
- Reporting template
- Report naming conventions

The system generates automated regulatory reporting reminders to the business owners approximately 10 days before the internal due dates. The Regulatory Reporting Coordinator conducts a quality check of all reports prior to submission to ensure compliance with reporting requirements. Metrics such as internal key performance indicators, are established for all Contract-required reports. We track timeliness trends in report submissions and adjust immediately to reporting obstacles and constraints—including, as appropriate, communicating early with the Division about potential submission delays. When the Division grants an extension, we ensure the report is ultimately submitted within the agreed-upon time frame.

In 2021, we delivered 1,173 regulatory reports to the Division on time. **No reports were late**.

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Ad Hoc Requests

To process a request from the Division, the appropriate Molina business owner and approver are notified via email upon receipt of the request. The initial acknowledgment to the Division includes the required date of resolution, with the acknowledgment submitted in the same manner as the request is received (in writing or electronically). If the request is received orally, our Compliance Officer acknowledges receipt orally and immediately follows up with a written or electronic acknowledgment of the request.

We then schedule calendar reminders to indicate internal and external due dates. A final response is submitted to our Government Contracts department, which reviews the response and either requests revisions or submits it to the Division. Upon completion of the request and on or before the required date of completion, our Compliance Officer submits a detailed completion summary—including all necessary information, action, and resolution taken—that conforms to the Division's standards, if any, for form, format, and content. We understand that Division requests will not be considered timely if we fail to submit the completion summary on or before the required completion date and that submission of the summary itself does not constitute completion of the request.

In 2021, we received 283 ad hoc requests from the Division and **delivered every one on time**.

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Our regulatory reporting tracking system will be the primary tool we use to ensure we are properly tracking, documenting, and promptly responding to the Division's request. Our system will have automated reminders that are sent to the business owners based on the internal due date, well ahead of the due date to the Division, to allow ample time to quality check the response. Once all the information is received from the business owner, the request coordinator will review the information to ensure the request is appropriately and adequality fulfilled and the information is within the perimeters of the request. Once this is confirmed, the information is submitted to the State before or on the request Division of Medicaid's due date. If an extension is needed, the request coordinator will proactively communicate with the Division of Medicaid about the restraints of

supplying the request information within the Divisions of Medicaid request time frame and request an extension.

We will have internal key performance indicators related to regulatory communications and regulatory complaints that are received from State regulators. We have quarterly goals of 100% around providing timely responses to all Member and Provider complaints and promptly implementing executive orders from the Governor's office, and regulations produced by the Medicaid agency, such as memos, regulatory guidance released by the Medicaid agency, and any regulations that enable recently passed legislation produced by the Medicaid agency.

Our ad hoc request tracker will be capable of providing reporting around timely submission of requests and the number of types of requests. These reports will allow us to highlight trends for ad hoc requests and to develop necessary counter measures for those trends. We trend any Member or Provider complaints received by the Division and report them to our Member and Provider work group for mitigation.

With oversight from our CEO, the Compliance Officer ensures we meet Division requirements for timely responses, including:

- Acknowledging receipt of the Division’s written, electronic, or oral request for assistance no later than one business day from receipt of request from the Division
- Acknowledging receipt of an urgent request from the Division immediately and without unreasonable delay, and giving the urgent request priority
- Competing the request (urgent or nonurgent) to the Division’s satisfaction within five business days unless the Division specifies another time frame

A.8. Subrogation and Third-party Liability

Our health plan AVP, Compliance, maintains oversight responsibility for this function and its impact on Mississippi, and our Claims department is responsible for subrogation and TPL activities as part of normal processing duties. We make every reasonable effort to determine the legal liability of third parties to pay for services rendered to Members and to avoid cost and/or recover any such liability from the third party. The primary individuals responsible for managing subrogation and TPL activities include:

- **CFO.** Supported by national resources and technologies, our Mississippi-based AVP, Compliance, oversees subrogation and TPL activities. This position requires a BA or BS in finance, accounting, or a related field and advanced training or experience in healthcare analytics. It also requires 10 years of progressive healthcare finance or analytical experience, 5 years of managed care experience, preferably working with the Medicaid product, and 3 years of previous supervisory/management experience.
- **Compliance Officer.** This individual develops and implements policies, procedures, and practices designed to ensure compliance with Contract requirements, including the accuracy and timeliness of reported information and supplemental third-party data and files provided to the Division. The Compliance Officer, who is certified in healthcare compliance, is the single point of contact for the Division.
- **Claims Administrator.** This individual oversees a staff of three FTEs (claims examiners and adjustors) to provide for the timely and accurate processing of claims and encounters and to review/investigate claims for possible recovery. This position requires a BA, with a master’s degree preferred, or appropriate relevant healthcare experience (four years for relevant BA background or seven years for relevant master’s background). The Claims Administrator is supported by a team of claims examiners and adjustors.

The Payment Integrity team partners with our Data Analytics team to produce an accurate overpayment identification report that incorporates State-specific recovery time frames, excludes non-covered services, and ensures the appropriate Medicaid allowed amount was fulfilled.

We deploy resources and controls to ensure we provide medically necessary covered services to Members and that Medicaid is the payer of last resort. **This includes our internal TPL investigative team that supplements the work performed by our TPL vendors,** differentiating us from our competitors that solely rely on Subcontractors.

TPL team members and our recovery vendor receive training on COB/TPL when hired and at least annually thereafter, or more frequently if we enact major process changes. The training is either instructor-led or web-based, and staff can access current policies at any time.

A.9. Encounter Reconciliation Policies and Process Staff

Our Encounter team will submit complete, accurate, and timely encounter data to the Division that meets both Federal and Division requirements. Our local Encounter staff are supported by staff in multiple departments, including Provider Relations, Operations, Claims, and Compliance. Staff ensure that encounter performance, processes, timelines, and all Division objectives are consistently met. They are supported by a centralized encounter team composed of eight FTEs at our parent company, which has extensive experience receiving, processing, and reporting encounter data. The centralized team, which includes the Director, Encounters; Manager, Encounter Program; Business Analysts, Encounters; and a Project Coordinator, IT Encounters, is responsible to the VP, Encounters. The VP, Encounters, manages interdepartmental teams and oversees operational functions supporting encounter responsibilities. The preferred candidate has a college degree and 7–10 years in a senior management role/experience in claims and/or encounter operations.

Our Mississippi-based team is led by our COO, who reports to our CEO. Additionally, the Compliance Officer submits the annual Member encounter data completeness plan to the Division and provides guidance on contractual compliance and service-level agreements. The CEO has ultimate oversight authority over the encounter submissions and operations function and provides guidance and support as needed.

A.10. Dedicated and Shared Staff

As indicated in our response to RFQ § 4.3.3.1, all proposed staff are FTEs who will be wholly dedicated to the new Contract. No staff will be part-time or shared with other health plans or projects. In addition to required staff, we propose an additional 23 staff who are not required by the contract and will be based in Mississippi:

- Addiction Medicine Medical Director (1)
- CHIP Program Director (1)
- CHIP Program Manager (1)
- CHWs (6)
- Foster Care Management team (4)
- Health Equity and SDOH Manager (1)
- [redacted]
- Mobile Health team (3)
- Provider Quality and Practice Transformation team (3)
- Pulmonologist Medical Director (1)
- SIU Investigator (1)

Based on staffing ratio requirements and as needed, we will add care management staff to ensure successful delivery of services. If additional Network and Provider Relations staff are needed to support Provider-related issues, we will respond promptly. Call center employees will be added based on membership and staffing ratios to support Members and Providers. We will address the need for additional staffing by continually monitoring membership enrollment levels, programmatic changes, and fluctuations in other areas to fully meet Member and Provider needs and the Division’s requirements.

[END OF RESPONSE]

4.3.3.5 SUBCONTRACTORS

Molina submits completed Subcontractor forms for our four proposed Subcontractors: Molina Healthcare; MARCH; MTM; and SKYGEN. We also submit completed Prior Experience with Subcontractor forms for services provided to us in the past three years by each Subcontractor (see Attachment 4.3.3.5, Subcontractor Forms).

In acknowledgment of RFQ Amendment #7 dated February 7, 2022, below is an overview of Molina's overall philosophy for Subcontractor hiring and management.

Subcontractor Hiring and Management

Our Subcontractor oversight program will be customized for the CCO Program to ensure ongoing oversight of Subcontractor services, receipt and reconciliation of all required data, appropriate utilization of healthcare services, delivery of administrative and healthcare services that meet RFQ-required standards, adherence to required grievance policies and procedures, and a timely and effective process for addressing Subcontractor deficiencies or contractual variances. While we subcontract certain services as permitted under applicable regulatory requirements, we do not delegate management of any potential risk related to the provision of those services. We take full responsibility for Subcontractor performance; therefore, we select Subcontractors only after diligent vetting and confirmation of their proven records of high-quality service for the benefit of CCO Program Members. We hold ourselves and our Subcontractors accountable for Member outcomes, overall performance, and every dollar spent. All our Subcontractors are located in the US.

We take full responsibility for Subcontractor performance and will never delegate management of any potential risk related to delivery of services to Members.

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Pre-delegation Audits

When we identify a need for Subcontractor services, we place a high priority on potential Subcontractors with Medicaid and CHIP experience. We then prequalify each Subcontractor using a comprehensive pre-delegation audit process to evaluate their ability to meet or exceed contractual agreements; program requirements; applicable CMS, Federal, and State requirements; applicable NCQA standards; and our company's compliance program standards.

Our due diligence process is exhaustive, including:

- Interviews with Subcontractor staff
- Review of the Subcontractor's website, policies, procedures, documented workflows, committee minutes, and other files, as applicable
- Assessment of financial qualifications and strength
- An information security assessment to ensure that their infrastructure can effectively protect Members' protected health information

We evaluate every step of the pre-delegation audit through the "eyes and experience" of the Member. When we interview Subcontractor staff, for example, we assess their level of courtesy and helpfulness from the perspective of a Member who calls the Subcontractor for information or to schedule an appointment. We navigate the Subcontractor's website to see if it will be user-friendly for the Member. We may even call the Subcontractor's call center line to listen to the voice prompts and find out how many transfers are required to speak with a representative.

We spend as much time as needed to ensure we have the right Subcontractor for the job. A highly complex audit might take more than 500 hours to complete.

196A.MS22

The scope and duration of each audit is driven by the complexity and number of functions to be subcontracted. A highly complex audit—for example, of a Subcontractor who will provide Member-facing services such as vision or dental benefits management—might easily take more than 500 hours.

After the pre-delegation audit is complete and we have decided to engage the Subcontractor, we carefully draft, negotiate, and execute all applicable BAA, nondisclosure, independent Contractor, and other necessary agreements to document the Subcontractor's services and/or delegated functions for each contract. The written

agreement that governs our monitoring and oversight, which we refer to as a delegation agreement, will meet all requirements in Draft Contract § 13, including:

- Delegated activities or obligations and related reporting responsibilities
- File exchange and encounter data submission requirements
- Operational service-level and key performance standards
- Member rights regarding grievances and appeals, State fair hearings, continuation of benefits during pending appeals, and (for CHIP Members) independent external review rights
- Provisions protecting Members against balance billing
- Provision regarding gratuities
- Revocation and termination/sanctions language if a Subcontractor's performance is not satisfactory
- Corrective action plan (CAP) process and expectations
- Language that confirms the right of the Division and Federal regulators with jurisdiction to inspect, audit, and evaluate Subcontractor books, records, contracts, computers, or other electronic systems for up to 10 years after the end of the Contract period or the date of completion of any audit

In addition, each delegation agreement will include any language the Division has identified within the Contract that governs Subcontractor oversight.

Summary of Oversight Activities

Subcontractor oversight requires established policies and processes, accountability, and an unwavering commitment to review performance, audit subcontracted functions, and stay in close communication with Subcontractors, the Division, and other stakeholders. In addition, we must work diligently to help Subcontractors meet our high standards of performance excellence and, if needed, correct poor or nonperformance with CAPs and other contract enforcement options.

We access every available source of information—from call center statistics and satisfaction surveys to complaints and grievances—to help assess Subcontractor performance and support optimal delivery of subcontracted services.

196B.MS22

Our Subcontractor oversight activities are summarized below.

Reports. We review daily, monthly, and quarterly reports outlining performance of delegated responsibilities, such as file exchanges and call center statistics. We access every available source of information to help assess performance. When we do our monthly review of complaint/grievance reports, for example, we assess the data against indicators of Member and Provider satisfaction. The outcome may be not only a CAP to improve Subcontractor performance, but also modifications to policies and procedures to help improve overall delivery of services.

We conduct all reviews to ensure delivery, accuracy, and completeness of Subcontractor services. We use report data to confirm compliance with the State's metrics and KPIs. We also analyze data to identify any emerging risks that, once identified, can be swiftly addressed, remediated, and/or mitigated.

Audits. We conduct audits for each function delegated to each Subcontractor every year, more frequently when requested by the Division or as required by State or Federal agencies. Annual audits follow a format similar to pre-delegation audits. We also conduct ad hoc audits if we identify noncompliance or a trend in Member complaints received by call center employees. Our State delegation oversight committee reviews annual and ad hoc audit results and decides on the appropriate course of action, which may range from a CAP to termination, if necessary.

Meetings. Regularly scheduled internal meetings are opportunities to assess Subcontractor performance against key performance indicators. We also conduct monthly and quarterly meetings, in many cases jointly with Subcontractor staff and appropriate program stakeholders, to discuss Subcontractor performance and opportunities for improvement.

CAPs and Other Contract Enforcement Options. Our policies and procedures include guidelines for enforcement of nonperformance and corrective actions used to improve performance, typically in the form of a CAP. Our subcontracts provide for financial penalties for Subcontractor noncompliance. Subcontractors may be

sanctioned, required to pay penalties, or have their delegated functions revoked if performance is inadequate. In the event of a Subcontractor's significant underperformance, the subcontract may be terminated.

Addressing Subcontractor Deficiencies or Contractual Variances

Our Subcontractor delegation agreements and internal policies and procedures include guidelines for enforcement of underperformance, nonperformance, and corrective actions designed to improve Subcontractor performances. We conduct ongoing oversight of delegated functions as stated in each delegation agreement to ensure each Subcontractor meets their responsibilities. As stated earlier in this response, the agreement specifies activities and reporting responsibilities delegated to the Subcontractor, along with remedies for under-/nonperformance.

Follow-up to under-/nonperformance may include CAPs, sanctions, penalties, revocation of delegated functions, and/or contract termination. We work collaboratively with our Subcontractors to support their delivery of all services as required. In that way, we treat them as partners. However, we also build performance guarantees into the contract so nonperformance/poor performance will be taken seriously, with the understanding that it can result in significant financial penalties. We conduct oversight internally for virtually all operations, as well as through outside audit firms if/as independent and specialized expertise may be warranted.

When a deficiency or contractual variance is identified and a CAP is required, our State delegation oversight team works with the Subcontractor to resolve any issues. We do not close CAP items until the Subcontractor can demonstrate that the issues have been resolved—for example, through updated/approved policies or workflows or a passing score on a file re-audit. Updated and completed CAPs summarizing remediation efforts are taken to the State delegation oversight committee for formal closure.

[END OF RESPONSE]

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: Molina Healthcare, Inc.				
TIN/SSN (as applicable): 134-20-4626		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 200 Oceangate				
Address Line 2: Ste. 100				
City: Long Beach	**State:** CA	**Zip Code:** 90802		**County:** Los Angeles
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Description of Services to be Rendered by Subcontractor for this Contract: Molina Healthcare is an experienced managed care company providing quality healthcare to those who depend on government assistance. Molina Healthcare works with CHIP, Medicaid, Medicare, and other government programs. Molina Healthcare provides the following services to Molina: • Human resources and training • Legal • Facilities • IT • Marketing/Public Relations • Corporate finance • Claims • Member/Provider call center overflow • Administrative Clinical program support • Healthcare Services Support • Network Management Support • Quality • Subcontractor Oversight				

How will the Offeror monitor and manage this Subcontractor?

Molina conducts a pre-delegation audit of the Subcontractor to ascertain and test its ability to meet the expectations and the regulations of the State and Molina. The assessment is completed annually prior to delegation-effective dates and post-effective dates. For the delegated functions, the audit includes, at a minimum, review of the Subcontractor's policies and procedures, program descriptions, workflows, standard operating procedures, and committee minutes. The policies and procedures must meet minimum acceptable standards and applicable State requirements. File reviews are conducted when possible, or, in cases when the delegated function includes use of Members' protected health information, they may be conducted 60 days after, so a responsible sample can be identified and audited.

The Subcontractor is subject to continual performance review, monitoring, and formal reviews in accordance with the periodic schedules established by the State. Performance review is ongoing and dynamic. This includes, at a minimum, review of monthly/quarterly performance reports for the functions delegated to the Subcontractor and evaluating for compliance and performance; key performance indicator monitoring; complaints/grievances; oversight meetings of the Joint Operations Committee, which can occur monthly or quarterly; corrective action plan assignment and management; and, when regulatory changes occur, reviews to ensure the Subcontractor makes the change both on time and effectively.

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: Molina Healthcare of Mississippi				
Client Location				
Address Line 1: 188 E. Capitol St.				
Address Line 2: Ste. 700				
City: Jackson	**State:** MS	**Zip Code:** 39201		**County:** Hinds
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Daniel Bradshaw				
Title: Manager, Network/Provider Contracting				
Phone Number: (601) 281-5446	**Email Address:** Daniel.Bradshaw@molinahealthcare.com			
Work Details				
Number of covered lives: 92,000				
Time period of contract: Effective October 2018, to remain in effect thereafter for a period of 1 year. Upon the expiration of the initial term, the agreement automatically renews for successive periods of 1 year. The agreement is in the process of being amended and restated to include required terms and conditions of the MississippiCAN contract.				
Total number of staff hours expended during time period of contract: 865,280				
Personnel requirements: Personnel must pass drug screenings and background checks and are screened regularly against Federal and State sanction lists. Personnel must have the minimum experience required in their specialized areas; appropriate levels of education, degrees, and/or accreditations outlined for their respective positions; and basic skills and business knowledge in using various software programs, functional tools, and communications, as applicable to each organizational role.				

Geographic and population coverage requirements:

Geographic area: Mississippi. All counties

Population coverage: Medicaid (TANF, ABD), CHIP

Publicly funded contract cost: $2,698,286,243

Description of work performed under this contract

Molina Healthcare is an experienced managed care company providing quality healthcare to those who depend on government assistance. Molina Healthcare works with CHIP, Medicaid, Medicare, and other government programs. Molina Healthcare provides the following services to Molina:

- Human resources and training
- Legal
- IT
- Marketing/Public Relations
- Corporate finance
- Claims
- Member/Provider call center overflow
- Clinical telephony
- Administrative clinical program support
- Network management support
- Healthcare services support
- Quality
- Subcontractor Oversight

Subcontractor				
Name of Subcontractor: March Vision Care Group, Incorporated				
TIN/SSN (as applicable): 95-4874334		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 6601 Center Dr. W.				
Address Line 2: Ste. 200				
City: Los Angeles	**State:** CA	**Zip Code:** 90045	**County:** Los Angeles	
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**

Description of Services to be Rendered by Subcontractor for this Contract:

March Vision Care will administer the routine vision benefits, including routine eye exams and eyewear, and will:

- Maintain and manage a Provider network made up of optometrists, retail Providers, and opticians, with services to include Provider education, network development, Provider credentialing and recredentialing, first-level Provider appeals, and resolution of Provider issues
- Administer customer service functions for both Members and Providers
- Process claims for post-service payments
- Provide benefit and eligibility administration

How will the Offeror monitor and manage this Subcontractor?

Molina conducts a pre-delegation audit of the Subcontractor to ascertain and test its ability to meet the expectations and the regulations of the State and Molina. The assessment is completed annually prior to delegation-effective dates and post-effective dates. For the delegated functions, the audit includes, at a minimum, review of the Subcontractor's policies and procedures, program descriptions, workflows, standard operating procedures, and committee minutes. The policies and procedures must meet minimum acceptable standards and applicable State requirements. File reviews are conducted when possible, or, in cases when the delegated function includes use of Members' protected health information, they may be conducted 60 days after so a responsible sample can be identified and audited.

The Subcontractor is subject to continual performance review, monitoring, and formal reviews in accordance with the periodic schedules established by the State. Performance review is ongoing and dynamic. This includes, at a minimum, review of monthly/quarterly performance

reports for the functions delegated to the Subcontractor and evaluating for compliance and performance; key performance indicator monitoring; complaints/grievances; oversight meetings of the Joint Operations Committee, which can occur monthly or quarterly; corrective action plan assignment and management; and, when regulatory changes occur, reviews to ensure the Subcontractor makes the change both on time and with effectiveness.
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: Molina Healthcare of California				
Client Location				
Address Line 1: 200 Oceangate				
Address Line 2: Ste. 100				
City: Long Beach	**State:** CA	**Zip Code:** 90802		**County:** Los Angeles
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: John Arce-Ignacio				
Title: National Contracting Director				
Phone Number: (888) 562-5442 ext. 126777		**Email Address:** John.Arce-Ignacio@molinahealthcare.com		
Work Details				
Number of covered lives: 485,000				
Time period of contract: January 1, 2005, to present (thereafter, it will automatically renew for successive one-year terms unless and until terminated by either party in accordance with the provisions of the agreement or in accordance with applicable State and Federal provisions				
Total number of staff hours expended during time period of contract: 54,185				
Personnel requirements: March Vision Care personnel must pass drug screenings and background checks and are screened regularly against Federal and State sanction lists. Personnel must have the minimum experience required in their specialized areas; appropriate levels of education, degrees, and/or accreditations outlined for their respective positions; and basic skills and business knowledge in using various software programs, functional tools, and communications, as applicable to each organizational role.				
Geographic and population coverage requirements: **Geographic area:** • California Medi-Cal (Two-Plan): Imperial County, Los Angeles County, Riverside/San Bernardino counties				

- California Medi-Cal Geographic Managed Care Plan: Sacramento County and San Diego

Population coverage:

- Sacramento and San Diego Counties: Medi-Cal recipients, including ABD, TANF, Expansion, and ABD Dual
- Imperial and Los Angeles Counties: Medi-Cal recipients, including ABD, TANF, Expansion, and ABD Dual
- Riverside/San Bernardino Counties: Medi-Cal recipients, including ABD, TANF, Expansion, and ABD Dual

Publicly funded contract cost: $42,964,082,751

Description of work performed under this contract

March Vision Care administers the routine vision benefits for Medi-Cal, Medicare, and MMP programs. These benefits include routine eye exam and eyewear for all Molina Healthcare of California Medi-Cal, Medicare and MMP members. March Vision is delegated for certain functions as follows:

- Maintaining and managing a Provider network made up of optometrists, retail Providers, and opticians, with delegated functions including Provider education, network development, ensuring Providers are credentialed and recredentialed appropriately, managing first-level Provider appeals, and resolving any Provider issues
- Customer service functions for both Members and Providers
- Claims processing for post-service payments
- Benefit and eligibility administration

Prior Experiences with Subcontractor				
Client's Name: Molina Healthcare of Kentucky dba Passport Health Plan by Molina Healthcare				
Client Location				
Address Line 1: 5100 Commerce Crossings Dr.				
Address Line 2:				
City: Louisville	**State:** KY	**Zip Code:** 40229	**County:** Jefferson	
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: John Arce-Ignacio				
Title: National Contracting Director				
Phone Number: (888) 562-5442 ext. 126777	**Email Address:** John.Arce-Ignacio@molinahealthcare.com			
Work Details				
Number of covered lives: 297,000				
Time period of contract: January 1, 2021, to present (thereafter, it will automatically renew for successive one-year terms unless and until terminated by either party in accordance with the provisions of the agreement or in accordance with applicable State and Federal provisions)				
Total number of staff hours expended during time period of contract: 13,066				
Personnel requirements: March Vision Care personnel must pass drug screenings and background checks and are screened regularly against Federal and State sanction lists. Personnel must have the minimum experience required in their specialized areas; appropriate levels of education, degrees, and/or accreditations outlined for their respective positions; and basic skills and business knowledge in using various software programs, functional tools, and communications, as applicable to each organizational role.				
Geographic and population coverage requirements: **Geographic area:** Kentucky (all counties) **Population coverage:** Medicaid (TANF, ABD)				

Publicly funded contract cost: $7,694,822,270
Description of work performed under this contract
March Vision Care administers the routine vision benefits for Medi-Cal, Medicare, and MMP programs. These benefits include routine eye exam and eyewear for all Molina Healthcare of Kentucky Medicaid members. March Vision is delegated for certain functions as follows: • Maintaining and managing a Provider network made up of optometrists, retail Providers, and opticians, with delegated functions including Provider education, network development, ensuring Providers are credentialed and recredentialed appropriately, managing first-level Provider appeals, and resolving any Provider issues • Customer service functions for both Members and Providers • Claims processing for post-service payments • Benefit and eligibility administration

Prior Experiences with Subcontractor				
Client's Name: Molina Healthcare of Mississippi, Inc.				
Client Location				
Address Line 1: 188 E. Capitol St.				
Address Line 2: Ste. 700				
City: Jackson	**State:** MS	**Zip Code:** 39201		**County:** Hinds
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: John Arce-Ignacio				
Title: National Contracting Director				
Phone Number: (888) 562-5442 ext. 126777		**Email Address:** John.Arce-Ignacio@molinahealthcare.com		
Work Details				
Number of covered lives: 92,000				
Time period of contract: July 1, 2018, to present (thereafter, it will automatically renew for successive one-year terms unless and until terminated by either party in accordance with the provisions of the agreement or in accordance with applicable State and Federal provisions)				
Total number of staff hours expended during time period of contract: 13,066				
Personnel requirements: March Vision Care personnel must pass drug screenings and background checks and are screened regularly against Federal and State sanction lists. Personnel must have the minimum experience required in their specialized areas; appropriate levels of education, degrees, and/or accreditations outlined for their respective positions; and basic skills and business knowledge in using various software programs, functional tools, and communications, as applicable to each organizational role.				
Geographic and population coverage requirements:				
Geographic area: Mississippi. All counties				
Population coverage: MississippiCAN Medicaid (TANF, ABD); Mississippi CHIP				

Publicly funded contract cost: $2,698,286,243
Description of work performed under this contract
March Vision Care administers the routine vision benefits for Medi-Cal, Medicare, and MMP programs. These benefits include routine eye exam and eyewear for all Molina Healthcare of Mississippi Medicaid and CHIP Members. March Vision is delegated for certain functions as follows: • Maintaining and managing a Provider network made up of optometrists, retail Providers, and opticians, with delegated functions including Provider education, network development, ensuring Providers are credentialed and recredentialed appropriately, managing first-level Provider appeals, and resolving any Provider issues • Customer service functions for both Members and Providers • Claims processing for post-service payments • Benefit and eligibility administration

Prior Experiences with Subcontractor				
Client's Name: Molina Healthcare of Ohio, Inc.				
Client Location				
Address Line 1: 3000 Corporate Exchange Dr.				
Address Line 2:				
City: Columbus	**State:** OH	**Zip Code:** 43231		**County:** Franklin
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: John Arce-Ignacio				
Title: National Contracting Director				
Phone Number: (888) 562-5442 ext. 126777		**Email Address:** John.Arce-Ignacio@molinahealthcare.com		
Work Details				
Number of covered lives: 307,000				
Time period of contract: August 9, 2005, to present (thereafter, it will automatically renew for successive one-year terms unless and until terminated by either party in accordance with the provisions of the agreement or in accordance with applicable State and Federal provisions)				
Total number of staff hours expended during time period of contract: 52,116				
Personnel requirements: March Vision Care personnel must pass drug screenings and background checks and are screened regularly against Federal and State sanction lists. Personnel must have the minimum experience required in their specialized areas; appropriate levels of education, degrees, and/or accreditations outlined for their respective positions; and basic skills and business knowledge in using various software programs, functional tools, and communications, as applicable to each organizational role.				

Geographic and population coverage requirements:

Geographic area:

- Southwest: Butler, Hamilton, Warren, Claremont, Clinton
- West Central: Montgomery, Greene, Clark
- Southwest: Union, Madison, Delaware, Franklin, Pickaway

Population coverage:

- Covered Families and Children, ABD children ABD adults, CSHCN, AEP, SCHIP,
- Healthy Families, TANF, Transitional

Publicly funded contract cost: $15,618,453,626

Description of work performed under this contract

MARCH Vision Care administers the routine vision benefits for Medi-Cal, Medicare, and MMP programs. These benefits include routine eye exam and eyewear for all Molina Healthcare of Ohio Medicaid members. March Vision is delegated for certain functions as follows:

- Maintaining and managing a Provider network made up of optometrists, retail Providers, and opticians, with delegated functions including Provider education, network development, ensuring Providers are credentialed and recredentialed appropriately, managing first-level Provider appeals, and resolving any Provider issues
- Customer service functions for both Members and Providers
- Claims processing for post-service payments
- Benefit and eligibility administration

Prior Experiences with Subcontractor				
Client's Name: Molina Healthcare of South Carolina, Inc.				
Client Location				
Address Line 1: 4105 Faber Pl. Dr.				
Address Line 2: Ste. 120				
City: North Charleston	**State:** SC	**Zip Code:** 29405		**County:** Charleston
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: John Arce-Ignacio				
Title: National Contracting Director				
Phone Number: (888) 562-5442 ext. 126777		**Email Address:** John.Arce-Ignacio@molinahealthcare.com		
Work Details				
Number of covered lives: 163,000				
Time period of contract: September 1, 2013, to present (thereafter, it will automatically renew for successive five-year terms unless and until terminated by either party in accordance with the provisions of the agreement or in accordance with applicable State and Federal provisions)				
Total number of staff hours expended during time period of contract: 48,434				
Personnel requirements: March Vision Care personnel must pass drug screenings and background checks and are screened regularly against Federal and State sanction lists. Personnel must have the minimum experience required in their specialized areas; appropriate levels of education, degrees, and/or accreditations outlined for their respective positions; and basic skills and business knowledge in using various software programs, functional tools, and communications, as applicable to each organizational role.				
Geographic and population coverage requirements: **Geographic area:** Statewide (46 counties) **Population coverage:** ABD, TANF				

Publicly funded contract cost: $3,142,823,869
Description of work performed under this contract
MARCH Vision Care administers the routine vision benefits for Medi-Cal, Medicare, and MMP programs. These benefits include routine eye exam and eyewear for all Molina Healthcare of South Carolina Medicaid members. March Vision is delegated for certain functions as follows: • Maintaining and managing a Provider network made up of optometrists, retail Providers, and opticians, with delegated functions including Provider education, network development, ensuring Providers are credentialed and recredentialed appropriately, managing first-level Provider appeals, and resolving any Provider issues • Customer service functions for both Members and Providers • Claims processing for post-service payments • Benefit and eligibility administration

Subcontractor				
Name of Subcontractor: Medical Transportation Management, Inc. (MTM)				
TIN/SSN (as applicable): 43-1719762		**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**		
Address Line 1: 635 Maryville Centre Dr.				
Address Line 2: Ste. 300				
City: St. Louis	**State:** MO	**Zip Code:** 63141		**County:** St. Louis County
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**

Description of Services to be Rendered by Subcontractor for this Contract:

Non-emergency medical transportation, non-medical transportation, and non-emergency ambulance and stretcher services:

- Services available 24/7/365
- If network transportation Providers are incapable of providing or unwilling to provide adequate and sufficient transportation services, MTM coordinates and compensates other network transportation Providers to provide services as necessary
- Services provided using sedan and taxi service (excluding rental cars), wheelchair van transport, stretcher transport, and volunteer driver and gasoline reimbursement programs (subject to applicable laws and program requirements)
- Vehicles used to provide transportation services comply with applicable State and Federal safety standards

How will the Offeror monitor and manage this Subcontractor?

Molina conducts a pre-delegation audit of the Subcontractor to ascertain and test its ability to meet the expectations and the regulations of the State and Molina. The assessment is completed annually prior to delegation-effective dates and post-effective dates. For the delegated functions, the audit includes, at a minimum, review of the Subcontractor's policies and procedures, program descriptions, workflows, standard operating procedures, and committee minutes. The policies and procedures must meet minimum acceptable standards and applicable State requirements. File reviews are conducted when possible, or, in cases when the delegated function includes use of Members' protected health information, they may be conducted 60 days after so a responsible sample can be identified and audited.

The Subcontractor is subject to continual performance review, monitoring, and formal reviews in accordance with the periodic schedules established by the State. Performance review is ongoing and dynamic. This includes, at a minimum, review of monthly/quarterly performance reports for the functions delegated to the Subcontractor and evaluating for compliance and performance; key performance indicator monitoring; complaints/grievances; oversight meetings

of the Joint Operations Committee, which can occur monthly or quarterly; corrective action plan assignment and management; and, when regulatory changes occur, reviews to ensure the Subcontractor makes the change both on time and effectively.
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: Molina Healthcare of Illinois				
Client Location				
Address Line 1: 1520 Kensington Dr.				
Address Line 2: Ste. 212				
City: Oak Brooke	**State:** IL	**Zip Code:** 60534		**County:** DuPage
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Tom Rodakowski				
Title: VP, Network Management and Operations and Health Plan Operations				
Phone Number: (630) 203-3972 Ext. 163972	**Email Address:** Tom.Rodakowski@molinahealthcare.com			
Work Details				
Number of covered lives: 300,000				
Time period of contract: October 1, 2020, and ongoing (contract will continue in effect until terminated by either party in accordance with the provisions of the agreement)				
Total number of staff hours expended during time period of contract: 111,242				
Personnel requirements: Personnel must pass drug screenings and background checks and are screened regularly against Federal and State sanction lists. Personnel must have the minimum experience required in their specialized areas; appropriate levels of education, degrees, and/or accreditations outlined for their respective positions; and basic skills and business knowledge in using various software programs, functional tools, and communications, as applicable to each organizational role. Personnel are screened and hired for their ability to contribute to the organization's culture and overall success by embodying the organization's core values to respect individuals, act with integrity, align with clients, deliver value, and collaborate to innovate.				

Geographic and population coverage requirements:

Geographic area: Illinois (all counties)

Population coverage:

- Medicaid: Families and children eligible for Medicaid under TANF and S-CHIP and adults eligible for Medicaid under ACA expansion, excluding individuals eligible for Medicare
- Medicare-Medicaid Program (Medicare Medicaid Alignment Initiative), Health Insurance Marketplace (Molina Marketplace): ABD with Medicare, LTSS

Publicly funded contract cost: $14,966,585,543

Description of work performed under this contract

Non-emergency medical transportation, non-medical transportation, and non-emergency ambulance and stretcher services:

- Services available 24/7/365
- If network transportation Providers are incapable of providing or unwilling to provide adequate and sufficient transportation services, MTM coordinates and compensates other network transportation Providers to provide services as necessary
- Services provided using sedan and taxi service (excluding rental cars), wheelchair van transport, stretcher transport, and volunteer driver and gasoline reimbursement programs (subject to applicable laws and program requirements)
- Vehicles used to provide transportation services comply with applicable State and Federal safety standards

Prior Experiences with Subcontractor				
Client's Name: Molina Healthcare of Mississippi				
Client Location				
Address Line 1: 188 E. Capitol St.				
Address Line 2: Ste. 700				
City: Jackson	**State:** MS	**Zip Code:** 39201	**County:** Hinds	
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Daniel Bradshaw				
Title: Director, Provider Contracting				
Phone Number: (601) 281-5446	**Email Address:** Daniel.Bradshaw@molinahealthcare.com			
Work Details				
Number of covered lives: 92,000				
Time period of contract: September 1, 2020–August 31, 2021 (thereafter, it will automatically renew for successive one-year terms unless and until terminated by either party in accordance with the provisions of the agreement or in accordance with applicable State and Federal provisions.)				
Total number of staff hours expended during time period of contract: 9,626				
Personnel requirements: Personnel must pass drug screenings and background checks and are screened regularly against Federal and State sanction lists. Personnel must have the minimum experience required in their specialized areas; appropriate levels of education, degrees, and/or accreditations outlined for their respective positions; and basic skills and business knowledge in using various software programs, functional tools, and communications, as applicable to each organizational role. Personnel are screened and hired for their ability to contribute to the organization's culture and overall success by embodying the organization's core values to respect individuals, act with integrity, align with clients, deliver value, and collaborate to innovate.				

Geographic and population coverage requirements:

Geographic area: Mississippi. All counties

Population coverage: MississippiCAN Medicaid (TANF, ABD)

Publicly funded contract cost: $2,698,286,243

Description of work performed under this contract

Non-emergency medical transportation, non-medical transportation, and non-emergency ambulance and stretcher services:

- Services available 24/7/365
- If network transportation Providers are incapable of providing or unwilling to provide adequate and sufficient transportation services, MTM coordinates and compensates other network transportation Providers to provide services as necessary
- Services provided using sedan and taxi service (excluding rental cars), wheelchair van transport, stretcher transport, and volunteer driver and gasoline reimbursement programs (subject to applicable laws and program requirements)
- Vehicles used to provide transportation services comply with applicable State and Federal safety standards

Subcontractor				
Name of Subcontractor: SKYGEN, USA				
TIN/SSN (as applicable): 81-0762694	**The entity is a:** **[X] Subcontractor** **[ ] Wholly-Owned Subsidiary** **[ ] Affiliate under the same common ownership**			
Address Line 1: W140 N8981 Lilly Rd.				
Address Line 2:				
City: Menomonee Falls	**State:** WI	**Zip Code:** 53051		**County:** Waukesha
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**

Description of Services to be Rendered by Subcontractor for this Contract:

SKYGEN's dental benefits administration services include:

- Member and Provider call center services
- Utilization management
- End-to-end claim processing from intake to payment for continuous automation
- Instant online claim estimator
- Instant online explanations of benefits to support immediate payments from Members
- Provider profiling reports and analytics to identify inefficient Provider practices
- Integrated benefit portals for Providers and Members to securely perform self-service administration

How will the Offeror monitor and manage this Subcontractor?

Molina conducts a pre-delegation audit of the Subcontractor to ascertain and test its ability to meet the expectations and the regulations of the State and Molina. The assessment is completed annually prior to delegation-effective dates and post-effective dates. For the delegated functions, the audit includes, at a minimum, review of the Subcontractor's policies and procedures, program descriptions, workflows, standard operating procedures, and committee minutes. The policies and procedures must meet minimum acceptable standards and applicable State requirements. File reviews are conducted when possible, or, in cases when the delegated function includes use of Members' protected health information, they may be conducted 60 days after so a responsible sample can be identified and audited.

The Subcontractor is subject to continual performance review, monitoring, and formal reviews in accordance with the periodic schedules established by the State. Performance review is ongoing and dynamic. This includes, at a minimum, review of monthly/quarterly performance reports for the functions delegated to the Subcontractor and evaluating for compliance and performance; key performance indicator monitoring; complaints/grievances; oversight meetings

of the Joint Operations Committee, which can occur monthly or quarterly; corrective action plan assignment and management; and, when regulatory changes occur, reviews to ensure the Subcontractor makes the change both on time and effectively.
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: Molina Healthcare of Michigan				
Client Location				
Address Line 1: 880 W. Long Lake Rd.				
Address Line 2: Ste. 600				
City: Troy	**State:** MI	**Zip Code:** 48098		**County:** Oakland
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Marty Bailey				
Title: Associate Vice President, Market Leader				
Phone Number: (972) 280-7314	**Email Address:** Marty.Bailey@molinahealthcare.com			
Work Details				
Number of covered lives: 338,000				
Time period of contract: May 1, 2021, to present (evergreen)				
Total number of staff hours expended during time period of contract: 3,908				

Personnel requirements:

- Background checks required for all personnel assigned to Molina
  - Background checks must comply with Fair Credit Reporting Act and all other applicable laws
  - Prohibited from assignment to Molina if background check indicates the following convictions:
    - Any felony conviction
    - Any conviction resulting in time spent in jail
    - More than one misdemeanor of any kind (excluding traffic violations)
    - Any sex offense
    - Any offense involving a weapon
    - Any offense involving violence
    - Any crime against a previous employer
    - Any crime involving fraud, theft, deception, or similar
- May not assign any employee or other individual to Molina who is an unauthorized alien under the Immigration and Reform and Control Act of 1986 or its implementing regulations
- Prospective staff and employees at all levels must be screened against Office of Inspector General and System for Award Management exclusion lists prior to hire/effective dates and annually; employees must also be monitored against all new information within 30 days of updated information being released from the source
- Officers, Directors, or employees (including any personnel) may not be or have ever been listed by a Federal or State agency as debarred, excluded, or otherwise ineligible for participation in any Federal or State program
- Hearing panel members involved in an appeal of an adverse credentialing or recredentialing decision must be peers of the affected Provider
- Staffing plans must meet the needs of Members and participating Providers and include proper training of customer service representatives based on the lines of business included in delegation
- Dental consultants must be board-certified and credentialed
  - Medical necessity approval decisions must be made only by a licensed healthcare Provider
  - Medical necessity denial decisions must be made only by a licensed physician or dentist
- Compensation for employees shall not include any financial incentive for denying medically necessary care
- Compensation for physicians shall comply with Medicaid managed care requirements set forth in 42 CFR 438.210 (e)

Geographic and population coverage requirements:

Geographic area: Michigan (all counties)

Population coverage: Medicaid Expansion, MMP

Publicly funded contract cost: $8,355,524,013

Description of work performed under this contract

SKYGEN's dental benefits administration services include:

- Member and Provider call center services
- Utilization management
- End-to-end claim processing from intake to payment for continuous automation
- Instant online claim estimator
- Instant online explanations of benefits to support immediate payments from Members
- Provider profiling reports and analytics to identify inefficient Provider practices
- Integrated benefit portals for Providers and Members to securely perform self-service administration

Prior Experiences with Subcontractor				
Client's Name: Molina Healthcare of Mississippi				
Client Location				
Address Line 1: 188 E. Capitol St.				
Address Line 2: Ste. 700				
City: Jackson	**State:** MS	**Zip Code:** 39201		**County:** Hinds
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Daniel Bradshaw				
Title: Manager, Network/Provider Contracting				
Phone Number: (601) 281-5446		**Email Address:** Daniel.Bradshaw@molinahealthcare.com		
Work Details				
Number of covered lives: 92,000				
Time period of contract: October 1, 2021, to present (evergreen)				
Total number of staff hours expended during time period of contract: 2,139				

Personnel requirements:

- Background checks required for all personnel assigned to Molina
  - Background checks must comply with Fair Credit Reporting Act and all other applicable laws
  - Prohibited from assignment to Molina if background check indicates the following convictions:
    - Any felony conviction
    - Any conviction resulting in time spent in jail
    - More than one misdemeanor of any kind (excluding traffic violations)
    - Any sex offense
    - Any offense involving a weapon
    - Any offense involving violence
    - Any crime against a previous employer
    - Any crime involving fraud, theft, deception, or similar
- May not assign any employee or other individual to Molina who is an unauthorized alien under the Immigration and Reform and Control Act of 1986 or its implementing regulations
- Prospective staff and employees at all levels must be screened against Office of Inspector General and System for Award Management exclusion lists prior to hire/effective dates and annually; employees must also be monitored against all new information within 30 days of updated information being released from the source
- Officers, Directors, or employees (including any personnel) may not be or have ever been listed by a Federal or State agency as debarred, excluded, or otherwise ineligible for participation in any Federal or State program
- Hearing panel members involved in an appeal of an adverse credentialing or recredentialing decision must be peers of the affected Provider
- Staffing plans must meet the needs of Members and participating Providers and include proper training of customer service representatives based on the lines of business included in delegation
- Dental consultants must be board-certified and credentialed
  - Medical necessity approval decisions must be made only by a licensed healthcare Provider
  - Medical necessity denial decisions must be made only by a licensed physician or dentist
- Compensation for employees shall not include any financial incentive for denying medically necessary care
- Compensation for physicians shall comply with Medicaid managed care requirements set forth in 42 CFR 438.210 (e)

Geographic and population coverage requirements:

Geographic area: Mississippi. All counties

Population coverage: Medicaid (TANF, ABD) and CHIP
Publicly funded contract cost: $2,698,286,243
Description of work performed under this contract
SKYGEN's dental benefits administration services include: • Member and Provider call center services • Utilization management • End-to-end claim processing from intake to payment for continuous automation • Instant online claim estimator • Instant online explanations of benefits to support immediate payments from Members • Provider profiling reports and analytics to identify inefficient Provider practices • Integrated benefit portals for Providers and Members to securely perform self-service administration

Prior Experiences with Subcontractor				
Client's Name: Molina Healthcare of Ohio				
Client Location				
Address Line 1: 3000 Corporate Exchange Dr.				
Address Line 2:				
City: Columbus	**State:** OH	**Zip Code:** 43231	**County:** Franklin	
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Marty Bailey				
Title: Associate Vice President, Market Leader				
Phone Number: (972) 280-7314	**Email Address:** Marty.Bailey@molinahealthcare.com			
Work Details				
Number of covered lives: 307,000				
Time period of contract: May 1, 2021, to present (evergreen)				
Total number of staff hours expended during time period of contract: 3,402				

Personnel requirements:

- Background checks required for all personnel assigned to Molina
  - Background checks must comply with Fair Credit Reporting Act and all other applicable laws
  - Prohibited from assignment to Molina if background check indicates the following convictions:
    - Any felony conviction
    - Any conviction resulting in time spent in jail
    - More than one misdemeanor of any kind (excluding traffic violations)
    - Any sex offense
    - Any offense involving a weapon

- Any offense involving violence
- Any crime against a previous employer
- Any crime involving fraud, theft, deception, or similar

- May not assign any employee or other individual to Molina who is an unauthorized alien under the Immigration and Reform and Control Act of 1986 or its implementing regulations
- Prospective staff and employees at all levels must be screened against Office of Inspector General and System for Award Management exclusion lists prior to hire/effective dates and annually; employees must also be monitored against all new information within 30 days of updated information being released from the source
- Officers, Directors, or employees (including any personnel) may not be or have ever been listed by a Federal or State agency as debarred, excluded, or otherwise ineligible for participation in any Federal or State program
- Hearing panel members involved in an appeal of an adverse credentialing or recredentialing decision must be peers of the affected Provider
- Staffing plans must meet the needs of Members and participating Providers and include proper training of customer service representatives based on the lines of business included in delegation
- Dental consultants must be board-certified and credentialed
  - Medical necessity approval decisions must be made only by a licensed healthcare Provider
  - Medical necessity denial decisions must be made only by a licensed physician or dentist
- Compensation for employees shall not include any financial incentive for denying medically necessary care
- Compensation for physicians shall comply with Medicaid managed care requirements set forth in 42 CFR 438.210 (e)

Geographic and population coverage requirements:

Geographic area:	Ohio (all counties)
Population coverage:	TANF, Medicaid Expansion, Adoption and Foster, ABD Non-Dual, ABD Children, MMP Opt-out, MMP Opt-in

Publicly funded contract cost: $15,618,453,262

Description of work performed under this contract
SKYGEN's dental benefits administration services include: • Member and Provider call center services • Utilization management • End-to-end claim processing from intake to payment for continuous automation • Instant online claim estimator • Instant online explanations of benefits to support immediate payments from Members • Provider profiling reports and analytics to identify inefficient Provider practices • Integrated benefit portals for Providers and Members to securely perform self-service administration

Prior Experiences with Subcontractor				
Client's Name: Molina Healthcare of Wisconsin				
Client Location				
Address Line 1: 11002 W. Park Place				
Address Line 2:				
City: Milwaukee	**State:** WI	**Zip Code:** 53224	**County:** Milwaukee	
Mailing Address (P.O. Box): Same as above	**City:**	**State:**	**Zip Code:**	**County:**
Direct Contact for Client				
Name: Marty Bailey				
Title: Associate Vice President, Market Leader				
Phone Number: (972) 280-7314	**Email Address:** Marty.Bailey@molinahealthcare.com			
Work Details				
Number of covered lives: 70,000				
Time period of contract: May 1, 2021 to present (evergreen)				
Total number of staff hours expended during time period of contract: 2,335				

Personnel requirements:

- Background checks required for all personnel assigned to Molina
  - Background checks must comply with Fair Credit Reporting Act and all other applicable laws
  - Prohibited from assignment to Molina if background check indicates the following convictions:
    - Any felony conviction
    - Any conviction resulting in time spent in jail
    - More than one misdemeanor of any kind (excluding traffic violations)
    - Any sex offense
    - Any offense involving a weapon

- Any offense involving violence
- Any crime against a previous employer
- Any crime involving fraud, theft, deception, or similar

- May not assign any employee or other individual to Molina who is an unauthorized alien under the Immigration and Reform and Control Act of 1986 or its implementing regulations
- Prospective staff and employees at all levels must be screened against Office of Inspector General and System for Award Management exclusion lists prior to hire/effective dates and annually; employees must also be monitored against all new information within 30 days of updated information being released from the source
- Officers, Directors, or employees (including any personnel) may not be or have ever been listed by a Federal or State agency as debarred, excluded, or otherwise ineligible for participation in any Federal or State program
- Hearing panel members involved in an appeal of an adverse credentialing or recredentialing decision must be peers of the affected Provider
- Staffing plans must meet the needs of Members and participating Providers and include proper training of customer service representatives based on the lines of business included in delegation
- Dental consultants must be board-certified and credentialed
  - Medical necessity approval decisions must be made only by a licensed healthcare Provider
  - Medical necessity denial decisions must be made only by a licensed physician or dentist
- Compensation for employees shall not include any financial incentive for denying medically necessary care
- Compensation for physicians shall comply with Medicaid managed care requirements set forth in 42 CFR 438.210 (e)

Geographic and population coverage requirements:

Geographic area:	Wisconsin (six counties: Milwaukee, Kenosha, Racine, Waukesha, Washington, Ozaukee)
Population coverage:	ABD Non-Dual, Childless Adult, TANF

Publicly funded contract cost: $2,591,793,904

Description of work performed under this contract
SKYGEN's dental benefits administration services include: • Member and Provider call center services • Utilization management • End-to-end claim processing from intake to payment for continuous automation • Instant online claim estimator • Instant online explanations of benefits to support immediate payments from Members • Provider profiling reports and analytics to identify inefficient Provider practices • Integrated benefit portals for Providers and Members to securely perform self-service administration

4.3.3.6 ECONOMIC IMPACT

In this response, Molina presents the following:

- Completed Appendix H Economic Impact forms for the 19 key personnel positions identified in Draft Contract § 1.13.1 that will be based in Mississippi
- A list of other Mississippi-based positions and their expected wages (as required in RFQ Amendment 3, issued January 21, 2022)
- A description of other investments that we plan to make in Mississippi

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	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Chief Operating Officer	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Chief Financial Officer	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Medical Director	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Perinatal Health Director	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Behavioral Health Director	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Compliance Officer	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Implementation Project Manager	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Provider Services Manager	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Network/Contracting Manager	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Member Services Manager	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Quality Management Director	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Care Management Director	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Population Health Director	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Utilization Management Coordinator	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Grievance and Appeals Coordinator	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Claims Administrator	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**
Title of Position: Data and Analytics Manager	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

Title of Position: Clinical Pharmacist	
If Position is not a Key Position, provide description: N/A	
Number of Staff Expected to Fill this Position/Staffing Need: 1	**Expected Wage of Position (Hourly rate or salary):** [redacted]
Employee(s) filling this position would be: **[ ] Hourly [X] Salaried**	**Employee(s) filling this position would be:** **[X] Full-Time [ ] Part-Time**

List of Mississippi-based Positions and Expected Wages for Those Positions

Organizational Chart Position Title	Position Titles for Team Members	Salary Range
Addiction Medicine Medical Director		[redacted]
Associate Provider Contracts Specialist		[redacted]
AVP, Compliance		[redacted]
Behavioral Health Nurse Practitioner		[redacted]
Behavioral Health Team	Behavioral Health Manager	[redacted]
	Clinical Review Clinician	[redacted]
	Care Manager	[redacted]
	Transition of Care Coach	[redacted]
	Peer Support Specialist	[redacted]
Business Analyst		[redacted]
Care Management Team	Healthcare Services Manager, Care Management	[redacted]
	Healthcare Services Manager, Behavioral Health	[redacted]
	Clinical Auditor	[redacted]
	Clinical Lead	[redacted]
	Nonclinical lead	[redacted]
	Care Manager, RN	[redacted]
	Care Manager, Behavioral Health	[redacted]
	Transitions of Care Coach, Behavioral Health	[redacted]
	Community Health Worker	[redacted]
	Peer Support Specialist	[redacted]
CHIP Program Director		[redacted]
CHIP Program Manager		[redacted]
Communications Specialist		[redacted]
Community Engagement Team	Community Engagement Specialist	[redacted]
Community Health Workers		[redacted]
EPSDT Team	EPSDT Coordinator	[redacted]
Executive Assistant		[redacted]
Finance Director		[redacted]
Finance Plan & Analysis Director		[redacted]
Foster Care Management Team	Care Manager	[redacted]
	Foster Care Liaison	[redacted]
Government Contracts Specialist		[redacted]
Grievances and Appeals Team	Grievances and Appeals Auditor	[redacted]
	Grievances and Appeals Senior Specialist	[redacted]
	Grievances and Appeals Lead Analyst	[redacted]
	Grievances and Appeals Analyst	[redacted]
	Grievances and Appeals Specialist	[redacted]
	Grievances and Appeals Lead (Licensed Vocational Nurse/Licensed Practical Nurse)	[redacted]
	Grievances and Appeals Associate Specialist	[redacted]
Health Equity and SDOH Manager		[redacted]

Organizational Chart Position Title	Position Titles for Team Members	Salary Range
Healthcare Analytics Senior Analyst		[redacted]
[redacted]		[redacted]
Marketing and Public Relations Director		[redacted]
Materials and Communications Manager		[redacted]
Member Services Call Center Employee		[redacted]
Member Services Call Center Supervisor		[redacted]
Mobile Health Team	Medical Assistant	[redacted]
	Driver	[redacted]
Network Administration Manager		[redacted]
Network Administration Specialist		[redacted]
Pediatric Associate Medical Director		[redacted]
Program Manager		[redacted]
Provider Quality and Practice Transformation Team	Senior Quality Specialist	[redacted]
Provider Relations Manager		[redacted]
Provider Representative		[redacted]
Provider Representative Lead		[redacted]
Provider Services Call Center Employee		[redacted]
Pulmonologist Medical Director		[redacted]
Receptionist		[redacted]
Senior Government Contracts Specialist		[redacted]
Senior Provider Contracts Specialist		[redacted]
Senior Quality Specialist		[redacted]
SIU Investigator		[redacted]
Subcontractor Oversight Specialist		[redacted]
Utilization Management Team	Utilization Management Manager	[redacted]
	Clinical Review Clinician	[redacted]
	Care Review Processor	[redacted]
	Clinical Auditor	[redacted]
	Associate Program Manager	[redacted]
	Correspondence Processor	[redacted]

Description of Other Investments We Plan to Make in Mississippi

We estimate that our health plan and the MolinaCares Accord will contribute significantly to the economic impact to the State of Mississippi. This is based on the following factors:

- Directly employing at least 200 Mississippians
- Paying State taxes
- Renting and maintaining local office space
- Paying local companies for employee costs and other operating expenses
- [redacted]
- Applying the Regional Input-Output Modeling System from the Bureau of Economic Analysis that calculates downstream economic impacts and the multiplier effects of investments such as employee costs that generate additional community spend

The MolinaCares Accord extends our mission by channeling investment into solving for gaps in healthcare, particularly for disadvantaged populations. Their priority areas are addressing racial disparities in the access to

and delivery of care; SDOH; opioid use disorder and SUD; rural access to healthcare; healthcare for the elderly, impaired, and frail; and other healthcare issues affected by socioeconomic disparities.

[END OF RESPONSE]

4.3.4

Management and Control

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4.3.4 MANAGEMENT AND CONTROL

Molina's comprehensive approach to management and control of the CCO Program reflects our extensive experience with program implementations and operations and our proven commitment to continuous quality improvement. For this Contract, we will apply the best practices and working relationships established and maintained as a current health plan for MississippiCAN and CHIP. In addition, we will draw upon the resources of our parent company and the expertise of our 17 affiliated Medicaid health plans that serve more than 3.8 million Medicaid Members.

In compliance with RFQ requirements, our response describes our approach to day-to-day program management, problem management, backup personnel, and emergency preparedness. In cases when our approach varies from one phase to another, we provide an explanation of the variances between the phases.

4.3.4.1 DAY-TO-DAY MANAGEMENT

Molina's approach to day-to-day Contract management is fully aligned with Project Management Institute standards, industry best practices, and the nationwide experience of our parent company and 17 affiliated Medicaid health plans. As a current health plan for MississippiCAN and CHIP, our existing policies and processes offer a strong foundation for customizing day-to-day management of the CCO Program. In this response, we first present a summary of how we meet each of the 8 management requirements in RFQ § 4.3.4.1, Items 1–8. We then provide detailed descriptions of each function and/or responsibility.

Our day-to-day management approach aligns with industry best practices and Molina Healthcare's nationwide Medicaid experience.

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1. **Program management approach.** We evaluate each program against established criteria to apply the appropriate set of industry-standard methodologies. This may include system development life cycles such as Waterfall, Agile, or hybrid methodologies. We take a holistic view of the program to include people, processes, and technology. Our scaled approach addresses the complexities of a multidisciplinary effort and uses best practices to meet the needs of the Division, Providers, and CCO Program Members.

2. **Program control approach.** Our program control approach facilitates decision-making, feedback generation, quality assurance, and scope, schedule, and budget management. Cross-functional governance committees oversee the program. The Implementation and Operations Phases use the same core program control approach but are customized to meet the specific goals of each phase. Company senior executive leadership ensures the program has appropriate funding/resources and monitors program deliverables and risks, intervening if needed to keep the program on track.

3. **Manpower and time-estimating methods.** Our experience with Medicaid and CHIP implementations provides us with the empirical data to derive baseline staffing models, level of execution effort, and timeline estimations. From this baseline, we apply Mississippi-specific requirements and our plan leadership's local knowledge to refine staffing and support requirements.

4. **Sign-off procedures for completion of deliverables and major activities.** Our rigorous deliverables approval process involves a breadth of key stakeholders at multiple levels. Business requirements are approved by a business owner, IT lead, and standing committees composed of cross-functional local and corporate leads. Local health plan staff, in collaboration with the Division, have final authority over the quality of product delivered for this program. For public, Member-, and Provider-facing products such as information packets and websites, we leverage our vast experience to produce quality materials and always look for opportunities to refine them to enhance the overall Member and Provider experience.

5. **Management of performance standards, milestones, and/or deliverables.** We modify our standard methods and tools to address the Contract's requirements. Key performance indicators allow us to track progress toward performance standards and goals, while weekly detailed status reports allow us to confirm we are measuring and adhering to our commitments. At the beginning of each implementation, we establish a roadmap with defined milestones and deliverable dates that are tracked to completion through the program's life cycle. We leverage project management tools to identify and track key deliverables and milestone dates through all phases of the program.

6. **Internal quality control monitoring.** During implementation, dedicated Quality Assurance and business teams monitor quality outcomes. All aspects of the program are subject to our standard quality control processes, such as schedule, deliverables, financials, cross-functional dependency management, and risk and issues management. Operationally, our Technical Quality Assurance team and business Quality Management (QM) team are responsible for continuous quality monitoring and control. All teams use established measurement and analysis tools to identify opportunities and drive improvements throughout our organization. Once the Quality Assurance teams validate, the solution goes through system integration testing and user acceptance testing processes prior to being deployed into production.

7. **Program status reporting, including examples of types of reports.** Status reporting for each business process area conveys overall progress against timelines, budget, scope, barriers, mitigation strategies for identified barriers, and key achievements. Program leadership aggregates individual status reports into an overall status view for executive oversight on a weekly basis. During the Implementation Phase, we hold regular executive-level steering committee meetings to review project status and ensure it is on track and resourced appropriately. Examples of status reports include financial/budget; timeliness report; burn-down chart/progress toward scope delivery report; risk, actions, issues, and decisions (RAID) log; workstream status report; and a leadership governance report that summarizes key workstream updates and identifies key project risks.

8. **Approach to the Division's interaction with Contract Management staff.** We will develop a communication plan specific to the needs of the CCO Program. The plan details the methods of communication, such as reporting and documentation, status meetings, executive visits, and system demonstrations. We maintain a communications matrix that defines the type of communication, purpose, frequency, and stakeholders. We have established a communication protocol led by our Compliance Officer, who serves as the primary liaison to the Division. A comprehensive, dynamic communication plan—including reporting, status meetings, and walkthroughs—is open and transparent with the Division and other stakeholders.

1. Program Management Approach

Our project and program management approach align with industry standards and maintains flexibility and scalability to meet the individualized needs of each CCO Program component. Project management is essentially technical in nature (particularly in IT projects) and focuses on the achievement of a task, whereas program management is a more complex concept focused on the achievement of a business objective. We incorporate program management aspects—including a focus on realizing benefits, resource planning, risk management across sub-projects and business process areas, integrated end-to-end testing with iterative test cycles across systems, and a prioritization of resources—across all sub-phases to successfully manage the Implementation Phase.

The core of our methodology is based on a variety of program and project management standards and frameworks such as the Project Management Institute® Project Management Body of Knowledge (PMBOK®). In addition, Molina uses various system development life cycles such as Waterfall and Agile. The program and project management framework provide guidance and best practices for planning, measuring, and overseeing complex projects and programs over their entire life cycle. Our extensive program management experience allows us to successfully manage multiple sub-projects in a coordinated way to obtain benefits across systems,

business processes, and organizational teams. Each phase of the program has its own demands and life cycle, and our approach to program management flexes appropriately. This ensures consistent program management over the life of the Contract, regardless of the phase.

Implementation Phase

Although our Mississippi health plan is fully implemented and operational, our Mississippi Implementation Program Office—in consultation with and supported by our Corporate Implementation Office—will own all aspects of any required updates. Our Chief Executive Officer (CEO) and Compliance Officer will oversee the implementation. The Implementation Office lead will provide deep expertise in health plan implementations, enterprise tools, and governance. The joint leadership will set overall strategy and approve all specific work-thread strategies. The office will set schedules, budget, and quality targets. As part of the leadership team, our Compliance Officer will be our information conduit to and from the Division.

Our Implementation Office lead manages the Implementation Phase with direct input from the health plan CEO and Compliance Officer. The Implementation Office leader oversees project and program management to ensure we have the infrastructure, operational processes, and business systems needed to fulfill our mission of providing quality health services to CCO Program Members. They collaborate with all relevant stakeholders, including cross-functional teams (e.g., local and corporate leadership), to plan, manage, and deliver the project.

Working closely with the Implementation Office lead and other functional leaders in Mississippi, staff in the project management office will remain engaged until the new Contract has achieved full operational readiness and functionality. These leaders share best practices within their respective areas of expertise and champion specific Member and Provider needs unique to the region.

During the Implementation Phase, we execute six interdependent sub-phases, including initiation and planning, requirements, design and development, testing and readiness review, implementation/training, and post-implementation support, to effectively manage Division-required activities and deliverables. We describe our pre-implementation activities and these sub-phases below.

Pre-implementation activities. We have been continuously engaged with stakeholders, entities, and organizations throughout Mississippi to help us understand the State's and CCO Program's evolving needs. Our pre-implementation activities began well before the Division released its RFQ in December 2021 and included re-engaging stakeholders to determine how to expand our current offerings to meet the new Contract's needs and the Division's expectations. We have invested significant time and resources in expanding partnerships with entities such as the Mississippi Department of Health and Mars Food US. In addition, we have met with dozens of leading physician organizations, health systems, behavioral health (BH) organizations, State agencies, legislators, disability rights organizations, family service organizations, supportive employment organizations, housing organizations, numerous other community service organizations, and Medicaid and CHIP leadership—all to help strengthen our community-focused services. For example, we met with the Mississippi Department of Health to collaborate on our Pacify initiative (24/7/365 unlimited, on-demand video calls with lactation consultants and registered nurses); initiated telehealth discussions with the University of Mississippi Medical Center; and analyzed the Mississippi Medicaid population to determine the best locations for our Molina on the Move Mobile Help Center and Pop-Up Help Centers.

Initiation and planning. The main initiation and planning activity in this sub-phase is project management administration, which includes the creation of CCO Program collaboration tools such as SharePoint and Microsoft Teams, the development and finalization of key project management artifacts, and the kickoff of project implementation activities.

Requirements. We map the Division's specific requirements and develop CCO Program requirements documentation during this sub-phase. We engage the Business Requirements Review Committee, which is a multidepartmental peer review committee that evaluates business requirement documents and benefit interpretation guidelines that govern configuration of our Molina Administrative Platform (MAP). We then customize a solution that includes configuration design, MAP implementation, external interface coordination, human resources initiation, care management development, and call center planning. In addition, we identify needed Subcontractor services, conduct comprehensive pre-delegation audits of prospective Subcontractors, obtain written approval of selected Subcontractors from the Division, and execute delegation agreements with

Subcontractors that include their scopes of work and other information in compliance with Contract requirements.

Design and development. This sub-phase focuses on the design and the development of documentation (e.g., policies and procedures, standard operating procedures, and training materials) across functional areas, including human resources, enrollment, accounting, care management, utilization review, pharmacy, Member materials, claims, Provider materials, quality, finance, call centers, appeals and grievances, and compliance. We place increased emphasis on Provider and Member training, offering Provider orientation and educational materials while continuing to meet with Provider groups. We deploy a variety of methods to educate Providers about Molina policies to ensure Members have the resources they need to make informed decisions. We design and develop the technology for the program, including system configuration, IT development (e.g., enrollment, Provider data processing, claims, website, and care systems), and continuity of care data management—all in preparation for completing the IT development for testing and readiness review.

Testing and readiness review. We complete a preliminary operational desk review, mock readiness reviews, system demonstrations, and all testing necessary for a successful go-live of all functional areas and services performed by staff and Subcontractors. We develop test plans according to subsystems and functional areas and complete full systems integration testing, which includes testing all hardware, software, and telecommunications required to support the Contract and producing data extracts and electronic data transfers and transmissions. We conduct full user acceptance testing prior to the program's start date to validate business processes and procedures, data interfaces, and reporting functions. This sub-phase ensures staff and systems function according to plan. This thorough testing and readiness assessment leads to successful participation in a Division on-site readiness review.

Implementation and training. This sub-phase encompasses operational department readiness, external interface coordination, IT technical deployment, and program implementation. We release outputs to production from prior sub-phases, and we begin processing production data, including Member eligibility, Provider enrollment, Provider contracting, authorizations, claims, and encounters. We also mail Member materials (e.g., ID cards) to Members. To facilitate continuity of care for Members transitioning to Molina, we coordinate with their former CCOs and service Providers and incorporate clinical Member data into our care management process. This facilitates a smooth transition for Members by ensuring they receive appropriate care on Day 1 of participation.

Post-implementation support. During this sub-phase, we identify issues that affect operations and quickly resolve them while performing formal close-out processes. Following implementation, the management team stays engaged by regularly monitoring the program to address objectives and maintain quality performance.

Our dedicated staff are key to our overall management approach, driving collaborative partnerships and outstanding communication at all levels. To ensure optimal support of the CCO Program, we propose a team with extensive State/industry experience and proven project management expertise. The team is led by our Chief Operating Office, supported by our Implementation Office, and overseen by our CEO.

Operations Phase

During this phase, we deliver an effective CCO Program that meets all contractual requirements; build solid, engaged relationships with Providers; and provide continuous high-quality service to Members. We deploy a proven suite of identified tools and techniques such as Six Sigma and Lean methodologies, along with ongoing stakeholder meetings, extensive reporting, and performance monitoring and evaluation to gather critical information such as Provider and Member feedback, new regulations and mandates, and financial, clinical, and operational data.

Essential to this phase are the reports we have already developed, and new/enhanced reports as needed for the new Contract and reporting manual. We anticipate more than 200 reports will be used during implementation to manage and monitor operations, including but not limited to validation of enrollment, claims turnaround, and encounter submissions. We then employ the data to update documentation and plans and evaluate opportunities for process improvements and risk assessment.

Turnover Phase

When a Contract with one of our State partners is nearing completion, renewal is always our goal. However, we understand that this may not always be possible. As a result, it is critical to the health of Members that we manage the Turnover Phase with the same priority and attention as the Implementation Phase. Our Turnover process is very similar to our Implementation process and will be managed by the Project Manager and supported and guided by the Implementation Office. As with every other phase of the CCO Program, we employ best practices and PMBOK-aligned strategies, along with the highest degree of professionalism. Although the focus is ensuring Member continuity of care, activities during Turnover include Division notifications; transfer of patient and medical records, as needed; claims run-out; encounters reporting; and a transfer of all data and records in accordance with the Division's requests and requirements.

2. Program Control Approach

Program management processes consist of overlapping activities that occur at varying levels of intensity throughout each phase of the program. Driven by rigorous performance standards and guided by a set of comprehensive tools, we ensure the program is successfully controlled throughout the entire life cycle. Our program control approach supports flexibility and scalability based on the needs of the Division and Members. Our main tools are a series of documents housed in our collaboration sites. Our documents are living, intended to evolve over time.

Our **Executive Steering Committee** provides strategic direction for overall project management. It is our ultimate decision-making body for the program, in charge of overseeing progress and facilitating collaboration among program stakeholders. This committee, which ensures the project follows its critical path to completion, signs off on all executive-level decisions.

Our **Business Requirements Review Team** meets regularly to review and approve business-required documents, ensuring quality and compliance throughout all program phases. This team relies heavily on foundational control tools to provide the inventory and scope of deliverables based on approved work in the Contract. Its membership includes subject matter experts from all operational areas, program leadership, and local health plan staff, thereby ensuring all business requirements are reviewed and approved by the appropriate experts. This combined experience results in a comprehensive set of Mississippi-specific business requirements. We leverage a template for each requirement that maps back to our core systems to consistently address the major categories of work and provide quality control across all areas of scope. Key program deliverables help us control and communicate project status and manage progress, providing stakeholders with the opportunity to monitor operational performance and adjust direction, where needed. Examples of documents and tools that monitor and communicate project status include:

- **Scope configuration playbook.** The business scope document typically covers more than 130 references that manage the IT implementation across more than a dozen core applications. The log provides an inventory of scope deliverables based on approved work in the Contract. It tracks assignments for documents related to business, benefit business, and report requirements, along with status and due dates from inception to post-implementation.
- **Agile user stories.** This document specifically focuses on capturing business needs by memorializing system requirements that need IT development or configuration and providing traceability.
- **Change control log.** This log tracks changes to scope, schedule, and budget.
- **Decision document.** This document summarizes options and analyzes the pros and cons of each option for ease of comparison. It is used to facilitate and memorialize the decision-making process.
- **Decision form.** This key tool is used for monitoring and control of open decisions.
- **Go-live readiness calendar.** A readiness checklist is specifically designed for use in the two months prior to go-live to monitor and control internal and external milestone and deliverable dates, including providing information on each task's owner and status. This checklist is converted into a calendar presentation for visual monitoring.
- **Impact log.** This log tracks and manages risks, issues, critical actions, and opportunities.

- **Oracle Primavera.** The system is our enterprise program management repository that houses all historical project actuals by resource type and process area, which we adjust to forecast the hours and timelines needed in each phase.
- **Project charter.** This document is the formal authorization of the CCO Program at Molina. It defines project goals, scope, participants, milestones, risks, budget, timelines, and program management approach.
- **Reporting matrix.** After the reports are designed and developed, this matrix tracks the subsequent delivery of all reports to completion.
- **Collaboration site.** An online internal repository tool for program management documentation, the site ensures collaboration, version control, and traceability. Examples include SharePoint and Microsoft Teams.
- **Staffing plans.** These plans outline roles, responsibilities, and reporting relationships of program staff.
- **Status reports.** Status reporting is our mechanism to summarize project progress and health.
- **Turnover checklist.** The checklist is designed for use in the 30 days leading up to a program closure or the Turnover Phase. It monitors and controls milestones and deliverables similar to the go-live readiness checklist.
- **Work plan.** An efficient work plan and schedule provides a road map for a rigorous program management approach and systematic communication among all stakeholders. It identifies time frames and key checkpoints, along with the project scope, resources, tasks, deliverables, critical paths, and dependencies. It contains the dates for performing scheduled activities and planned timelines for achieving scheduled or required milestones. By identifying these features, it demonstrates the interrelationships among all tasks.

Program Control Approach—Variances Through the Phases

Our program control tools are developed during implementation and supported by our PMBOK-aligned methodology, which promotes ongoing communication among stakeholders. Control monitoring is particularly critical during the requirements, testing, and readiness review sub-phases. **Table 1** highlights the main control tools used throughout the three phases.

Table 1. Program Control Approach Throughout All CCO Program Phases. Our strategic array of proven control tools are used to monitor every phase of the Contract and ensure successful outcomes.

Desired Phase Outcome	Main Tools Used to Ensure Outcome	
Implementation		
Seamless implementation with no disruption in services to stakeholders, delivering a compliant turnkey program and deliverables to meet all readiness review requirements	• Scope Configuration Playbook • Agile User Stories • Change control log • Decision document • Decision form • Go-live readiness checklist • Impact log	• Oracle Primavera • Project charter • Collaboration tool • Implementation staffing plan • Status reports • Implementation work plan
Operations		
Effective program deliverables that meet all contractual requirements; solid, engaged relationships with Providers; and continuous, high-quality service to Members	• Scope Configuration Playbook • Agile User Stories • Change control log • Decision document • Decision form • Impact log • Oracle Primavera	• Project charter • Reporting matrix (200+ reports) • Collaboration tool • Operations staffing plan • Operations work plan • Six Sigma and Lean methodologies
Turnover		
Timely, complete transition of operations to designated entities with the goal of securing continuity of care for Members	• Scope Configuration Playbook • Agile User Stories • Change control log • Decision document • Decision form • Impact log • Oracle Primavera	• Project charter • Collaboration tool • Turnover staffing plan • Status reports • Turnover checklist • Turnover work plan

3. Manpower and Time-estimating Methods (Resource Management)

We approach resource management with the same precision and attention to detail used to ensure Members receive the care and support that works best for them. To create a strong foundation for the CCO Program, our staffing and time planning activities will include determining any additional resources necessary to support the project organizational structure and a staffing plan that outlines roles, responsibilities, and reporting relationships. We estimate our staffing and timeline based on historical data and projects/programs in similar markets, membership, lines of business, and the complexity of any new requirements. Oracle Primavera houses all historical project actuals by resource type and process area, which we adjust to forecast the specific staffing hours and timeline needed during each phase. We continue to monitor, track, and supplement resources as needed over the life of the Contract.

Subcontractor resource allocation and monitoring. Subcontractor selection and management are important elements of program management. We are responsible for Subcontractor performance and have selected Subcontractors with proven records of high-quality service. We conduct pre-delegation audits to determine whether Subcontractors have the resources and processes in place to meet Contract requirements and standards. By scheduling pre-delegation audits, we can determine if a Subcontractor is fit to provide services; in the event that the Subcontractor is deemed unfit, we implement an alternative plan (e.g., selection of a different Subcontractor) to meet our contractual obligations.

In addition to the pre-delegation audits, we conduct annual delegation audits of Subcontractors to ensure compliance with the performance of delegated functions. During the annual audit, we interview staff and review the Subcontractor's policies, procedures, and applicable files. We maintain a monitoring plan for each Subcontractor, which includes performance requirements for all delegated functions; required reporting and interfaces; a review of the financial operation and amounts paid for covered services, if applicable; and a review of Contract compliance, logged complaints, and functional performance measurements.

Staffing Management—Variances Through the Phases

Resource allocation and deployment begins with human resource planning and continues with acquiring, developing, deploying, and managing the project team. We determine the resources necessary to support the project organizational structure and create a staffing plan that outlines the roles, responsibilities, and reporting relationships. Although staffing allocation begins during the initiation, planning, design, and development phases, we monitor, track, and supplement staffing resources over the life of the Contract as needed. Oracle Primavera and our program control tools determine allocation during implementation and then help us monitor, track, and supplement resources as needed throughout operations.

A staffing plan per phase. We deliver the final staffing plan shortly after Contract execution and collaboration and confirmation with the Division. We recognize the variances of necessary resources during each phase to develop a staffing plan that outlines the appropriate roles, responsibilities, and reporting relationships. During implementation, we focus on recruiting and hiring the right Mississippi-based staff for successful operations. New staff members at all levels participate in a comprehensive training program, which includes required corporate-wide training and program-specific training in each functional area. Although the Implementation team remains in a supportive role after the go-live date, the Operations team will be fully functional by Day 1 of go-live, carrying out all operational activities required under the Contract and maintaining responsibility for monitoring and supplementing staff. As needed, the local Operations team is supported by regional or corporate experts.

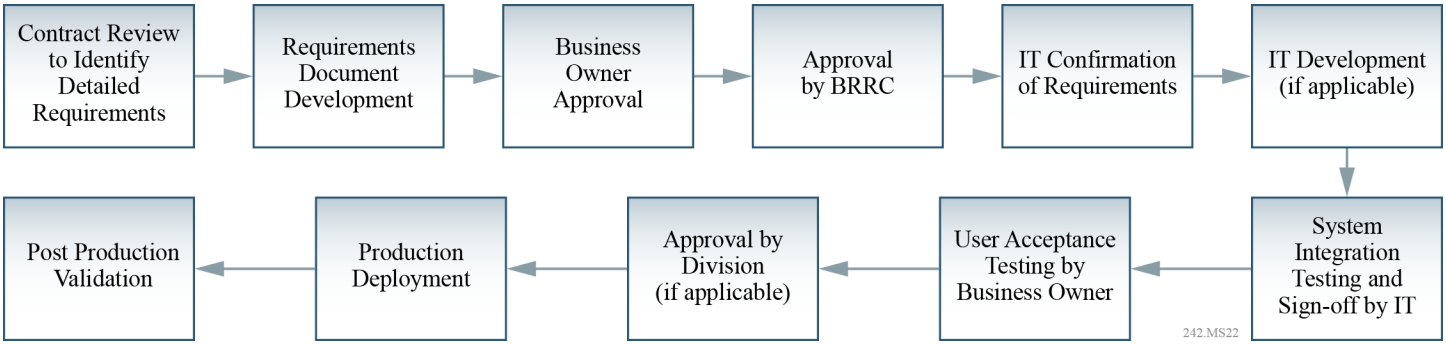
4. Sign-off Procedures (Deliverables Management)

Our proven deliverables management process includes quality checks and final confirmation of completed deliverables, both internally and externally; ensures deliverables and major activities are delivered on time and with the highest quality; and aligns with the Division's expectations. Deliverables management is an essential component of each phase of the CCO Program Contract.

Our overall deliverables process (see **Exhibit 1)** consists of internal and external checkpoints leading up to final approval of a deliverable by the Division. Our Business Requirements Review Committee monitors all deliverables associated with the implementation of a new Contract and, during implementation, is responsible

for final sign-off on all deliverables prior to their submission to the Division. The multidisciplinary nature of the committee ensures deliverables and activities are given a final quality review by the appropriate subject matter experts.

Exhibit 1. Deliverable Management Process. Every deliverable undergoes a rigorous development, review, and validation process before being submitted to the Division.



Our Compliance Officer and staff manage deliverables and activities required under this Contract. The Compliance Officer becomes the single point of contact, ensuring all requests for deliverables or change activities from the Division are closely monitored to completion. This supports our goal of providing the Division with on-time, quality deliverables and reporting.

We use our collaboration tool to house a historical record of all deliverables and activities submitted to the Division for final approval. For example, the multiple versions of the entire review and revision process between the Division and Molina when developing the Member Information Packet can be preserved for future use, if necessary. We log documentation for each approval in our collaboration tool. Keeping exact documentation of the date of approval and the Division staff member who provided the approval minimizes confusion if there are staffing changes at either Molina or the Division.

User acceptance testing takes place after technical IT design and development occurs and technical systems integration testing is complete. This is a rigorous process for instituting business approval and acceptance of all core applications. We develop test scripts to identify the most complex cases and test the applications from an end-to-end and intra-system perspective. The code gets pushed to production for deployment following process owner sign-off.

Deliverables Management—Variances Through the Phases

Deliverables management and sign-off procedures for completion of all deliverables and major activities remain steady through the Implementation and Operations Phases. Our Business Requirements Review Committee holds the primary responsibility within Molina for providing a final sign-off prior to submission. We will work with the Division to obtain their review and sign-off, understanding the Division's level of final sign-off will depend on the specific deliverable.

5. Management of Performance Standards, Milestones, and Deliverables

The CCO Program Contract, along with all Federal and State laws governing the provision of services, is our main source for performance standards, milestones, and deliverables. We work with the Division to clarify contractual requirements to drive the development of our reporting and performance measurement tools. The tools include any Division-defined metrics and provide real-time and retrospective measurement of program goals, population-specific and Member-focused improvements, and validation of outcomes. To deliver consistent, high-quality deliverable and services in a timely manner, we use the tools, processes, and ongoing application of best practices summarized below.

Business Scope Playbook. The Business Scope Playbook, housed within the CCO Program collaboration tool, maintains version control and collaboration and monitors overall performance of Contract requirements. We use the Playbook throughout all phases to track each item, the assigned owner, and priority level based on the work plan timeline. Each item drives a report requirements document that develops an automated IT solution to collect data in Division-required formats and frequencies. We regularly use this tool to monitor and control the project's development and progress for on-time delivery.

Routine and required reporting. Each Contract-required report adheres to the reporting template provided by the Division. When there is no template available, we will collaborate with the Division to ensure we provide all requested data elements in an acceptable format. We use reports as a measure of operational performance, and a reporting matrix tracks the subsequent delivery of the report to completion during operations.

Ad hoc reporting. When a concern arises regarding the performance of a specific operational area, we develop and run ad hoc reports based on the issue. Our Compliance Officer and staff receive, coordinate, and fulfill ad hoc requests.

Compliance team. Throughout the life of the Contract, we monitor and track performance in adherence with regulatory and Contract compliance. Our Compliance program includes formal, disciplined, and rigorous policies and protocols and key performance indicators to address regulatory and contractual compliance. This program, administered and operated by our Compliance team, incorporates ongoing risk management to ensure adherence to all applicable requirements. For example, our Compliance team conducts internal audits to evaluate the performance of operational functions and, with accountable business owners, takes corrective action as necessary to ensure ongoing compliance. Audits can be routine—such as a review of claims processing time frames—or ad hoc when we suspect a problem area.

Operational Review and Oversight Committee. This cross-functional committee makes development decisions regarding configuration changes based on evaluation of operational, business, and/or financial impacts. The committee summarizes the key components and reports to the Benefits and Provider Contract Configuration Review Committee. It facilitates full internal implementation, including internal and external communications, and the prioritization of referred issues. Attendees include CCO Program resources staff and corporate resources staff.

The committee meetings are a forum to:
- Review, discuss, and approve proposed configuration changes
- Review and update claims and configuration change logs
- Approve activities such as testing approaches and proposed change communications
- Develop review/tracking mechanisms to support these functions through regulatory updates, Provider contracts, requirements documents, benefit plan changes, and corporate initiatives
- Develop an effective auditing and reporting approach to review implementation status
- Monitor for completion and accuracy post-implementation

Once the committee approves a configuration change, it reviews implementation status of the change. Status components include confirmation of the change's completion and accuracy post-implementation and audits/reports of the change's effectiveness.

One example of an Operational Review and Oversight Committee meeting is our weekly configuration and claims meeting. The committee members are responsible for developing configuration needs for changes in benefits, Provider contracts, and regulatory communication benefit and fee schedules.

Performance Management — Variances Through the Phases

Our performance management methodology includes continuous monitoring, reporting, and oversight committees, employing data to make informed decisions. We use these committees and data throughout all phases of the Contract. The types of reports—and the staff responsible—shift during each phase. For example, during Operations, we anticipate the development and use of more than 200 reports to monitor and measure operational performance.

6. Internal Quality Control Monitoring (Quality Management)

QM is intended to ensure the deliverables, activities, and services we provide to the Division and Members adhere to a defined set of quality criteria. These criteria are mainly derived from the CCO Program Contract but can be taken from other sources such as NCQA.

During the Implementation Phase, quality control is implemented in each of the interdependent sub-phases to meet the highest levels of quality expected by the Division and Molina. The RFQ and Contract—and all associated reports, companion guides, and manuals—are reviewed in detail to identify pertinent program

management requirements. These are then distilled down to the process area level and explored in discovery sessions by more than 30 process owners and leads, assisted by project management and business and clinical analyst staff. The result of this work becomes the business requirements document and report requirements document that comprise our Scope Confirmation Playbook. The Playbook is reviewed and approved by the Business Requirements Review Committee to verify that Contract requirements are mapped completely and accurately. This scope of work completes the system development life cycle for design and development, testing and readiness review, and implementation and training. Quality control includes extensive technical testing and user acceptance testing.

Our readiness review provides a checkpoint for quality control measures and metrics during the Implementation Phase. We work with the Division to prepare our systems and processes for a walkthrough, which may include a desk review and on-site readiness review. When we identify corrections or necessary adjustments, we can make modifications and incorporate these changes in our systems and processes before finalizing them and obtaining Division approval. These steps ensure the highest levels of quality for delivery to Members and Providers.

During the transition to Operations, we use various ongoing measurement and analysis tools to monitor the quality of deliverables and operational functions. Throughout Operations, we continually evaluate the effectiveness of our processes and look for areas of improvement. Through ongoing monitoring, we can institute rapid-cycle process improvements to make appropriate recommendations to senior leadership, which then develops a course of action and applicable interventions.

In addition to managing the quality of deliverables, we must monitor the quality of the care and customer service provided to Members during operations. Our QM goals comply and fully align with the Division's mission and vision for the CCO Program. They are also consistent with CMS' quality and Triple Aim strategies. We continually evaluate our quality program and strategies, analyzing relevant performance measures and preparing accurate and compliant reports. We perform a comprehensive annual QM program evaluation to measure the overall effectiveness of the program and its strategies.

Led by our Medical Director and QM Director, our QM Committee is the foundation of our overall quality strategy when it comes to service delivery. This committee collects data and feedback to monitor and maintain the overall quality of the CCO Program, implementing process improvements as necessary. We use multiple ongoing measurement and analysis tools to prioritize topics, implement evidence-based guidelines, design interventions, and evaluate the effectiveness of our QM activities. The QM Committee instills rapid-cycle process improvements based on Member outcomes and makes recommendations to senior leadership to develop a course of action and applicable interventions. We receive and incorporate ongoing feedback from a variety of sources such as community advocates, Member advisory committees, and Providers.

7. Program Status Reporting

Our status reporting process begins with the Contract requirements. We use multiple formalized reports to track project and program progress against the work plan for each phase. In addition to this overall program status reporting, we have specialized reports that examine each specific business area or function. Examples of our status reporting tools are discussed below.

Status report. Our standard program status report is used to monitor and control project progress and escalate potential issues to stakeholders. We track the status of scope, budget, and schedule constraints using "stoplights" to quickly communicate project health. We report by each business process area with detail to convey overall progress, key accomplishments, upcoming activities, risks, actions, issues, and decisions. Links to the impact log allow easy drill-down capability to track individual issues, risks, and decisions. In addition, process-specific status reports detail the status of functional areas such as enrollment, accounting, corporate operations, and Member and Provider services. Finally, specific IT status reports detail the status of the overall IT applications, systems, and infrastructure development.

Accurate and timely claims dashboard. We monitor and manage claims inventory, key performance indicators, and regulatory and quality standards (e.g., claims statistics and claim history) through our reports and dashboards. We can develop parameters for Division reports using specific date ranges, lines of business, types of claims, and other filters. We can produce required and ad hoc reports.

Provider Network Status. We leverage GeoAccess and Quest Analytics report mapping solutions to monitor Provider network accessibility, identify network gaps, and confirm continued compliance with time and distance standards. Additional tools include Member complaint data related to network access and Member-to-Provider ratios. Provider contracting staff and the QM Committee review these reports on a regular basis. If they identify network gaps for any specialty or in any region, they alert Provider Relations staff to take immediate corrective action and initiate targeted Provider recruitment activities.

8. Interaction with Contract Management Staff

Employees receive training to engage with Members, Providers, community-based organizations (CBOs), the Division, and other stakeholders using clear, effective oral and written communication. This includes using concise and accurate documentation for recording events and sharing information with other healthcare professionals. Our tools and processes maintain well-documented, traceable, and intentional control throughout the entire program.

To provide effective communication, we use well-defined processes and procedures for reporting and documentation, status meetings, executive visits, and walkthroughs. We apply our comprehensive project management approach and offer direct communication with project stakeholders. We value our stakeholder groups and keep them informed and engaged. We apply the following industry standards for communications management of the CCO Program:

- Identify project stakeholders
- Document the communication needs of each identified stakeholder group
- Distribute information in a consistent, high-quality format (e.g., through status meetings or emails)
- Manage expectations related to the project
- Keep communication open and frequent between the Compliance Officer and the Division
- Report project performance, progress, and potential changes (e.g., performance reports) to stakeholders

Our Compliance Officer understands the importance of collaboration and will be a single point of contact with the Division. We offer the Division a solid communications methodology, introduced during the Implementation Phase and continuing through Operations and Turnover. Our communications management process enables us to share information across the entire project or program. We distribute a communications matrix that defines the types of project communications, purpose for the communication, frequency, and stakeholders affected.

4.3.4.2 PROBLEM MANAGEMENT

Molina's approach to problem management is built into our day-to-day management process. As discussed throughout this response, we have a well-established risk management program that fully supports identification of anticipated problem areas, a response to loss of personnel, and problem identification and resolution.

1. Assessment of Program Risks and Approach to Managing Them

A risk is defined by PMBOK as an uncertain event or condition that, if it occurs, affects a project or program. Our established management processes include risk identification, assessment, response planning, and monitoring and control—all beginning during project development and continuing through all Contract phases. We employ a formal risk management process aligned with PMBOK, proactively identifying and managing potential issues or factors and the probability and potential consequences of ignoring risks.

We employ many risk identification methods, including but not limited to data analysis and feedback, events, lessons learned from past comparable projects, and each client's program structure and populations. We gather input from our highly experienced, cross-functional Implementation team, which allows us to identify risks to proactively avoid or mitigate them. Our monitoring and reporting tools identify risks, as described below.

RAID log. This log is used to monitor and control project risks and issues, along with critical actions and decisions. New items are logged, assigned to an accountable owner, and given a priority level based on risk probability and consequence. Items with a high-risk score are included in status reports and escalated, as needed, to ensure remediation. Housed in our collaboration tool, the log facilitates communication such as email

notifications. The tool is used regularly during Implementation team meetings to drive the project to completion. It provides a clear record of project activities.

A risk management log is a key component of our overall risk management and resolution methodology. The log tracks any possible risk or issue and is updated continuously as part of our impact log, which traces back to the business document log. We review and update the log daily to identify risks early, communicate clearly, and respond quickly. We include key issues and risks in the weekly status report to ensure visibility and timely completion of critical items. The log is used to evaluate risks and confirm our proactive mitigation plans throughout the three phases.

As risks are identified, we conduct a risk assessment to evaluate the likelihood that it will occur and how it might impact operations. Our management team also works with the functional area in which the risk exists to develop a risk mitigation plan. The plan identifies the path to reduce the adverse effects of a risk. Examples of our risk mitigation strategies related to business continuity and emergency preparedness are discussed below.

When we identify a risk, we immediately develop a risk mitigation plan.
197C.MS22

Business continuity. We identify essential business functions and the systems needed to support these functions when developing specific Business Continuity Management (BCM) plans. During an emergency or other incident (e.g., inclement weather or a power outage), downtime procedures enable continued operations as well as time for recovery. Our investments to recover systems and data in emergencies include advanced telecommunication, data protection, system monitoring, and backup and recovery systems to minimize the effects of software and hardware failures.

We have invested in redundant information and telecommunication systems so we can switch to an alternate system if an emergency affects a primary system. For example, distributing our servers across data centers in New Mexico and Texas enables us to balance workloads and ensure system availability across our health plans. Advanced technology ensures automated backup and off-site storage.

Risk assessment and business impact analysis are the foundation of our emergency preparedness efforts.
197H.MS22

Emergency preparedness. We draw upon our experience and resources to mitigate any impact on operations and provide high levels of service and continuity of care, even when a disaster or emergency may affect Members, their caregivers, our employees, or our facilities. Risk assessment and business impact analysis form the foundation of our emergency preparedness efforts. These activities inform our approach and the BCM Plan, which guides our overall business continuity and disaster recovery efforts.

In addition to the BCM Plan, our local team has the support and resources of our entire corporation, including a department solely dedicated to ensuring our processes and procedures for business continuity and disaster planning are as comprehensive and robust as possible. Our Molina Healthcare business continuity team trains our Mississippi-based team in their respective roles and responsibilities.

Risk Management—Variances Through the Phases

In striving for effective risk management, we continually identify risk, evaluate its likelihood and impact, and develop risk mitigation strategies. As risk monitoring and identification is constant and critical, this process begins early in the Implementation Phase and continues through the Operations Phase. As the program moves through its phases, our staff use their expertise to bring value to the risk identification process.

2. Anticipated Problem Areas and the Approach to Management of These Areas

A problem is an already existing factor that, if not appropriately managed, will affect a project or program. After spending a great deal of time in Mississippi meeting with various stakeholders and administering MississippiCAN and CHIP, we have identified some anticipated problem areas, including our planned practice transformation rollout, new regulatory reporting requirements, and loss of key and other personnel.

Practice transformation rollout. As part of this procurement and our ongoing commitment to Mississippi, we plan to implement a sophisticated practice transformation initiative across the State. With this type of program, we expect obstacles to include the lack of Provider readiness to take the next step in value-based advancement,

legislative rules around Provider compensation rates and structures, market constraints around access and quality, and general alignment of market goals.

To mitigate these anticipated problem areas, we will leverage our Provider education program and expanded field-based Provider services team. We have structured our program to include stepped value-based reimbursement to ease the burden on Providers. In addition, our QM team will monitor access and quality at the Provider level, with a particular focus on Providers who have agreed to participate. Finally, we offer a robust set of tools for technology support to assist Providers in monitoring their journey to practice transformation.

New regulatory reporting requirements. As stated in RFQ Amendment 4 issued on February 7, 2022, the Division supplied Offerors with downloadable links for the new reporting manuals that detail requirements for MississippiCAN and CHIP reporting. We have a long history of successfully responding to new reporting requirements in Mississippi, including these responses in 2021:

- All Division ad hoc requests, totaling 283 requests, were tracked, completed, and delivered on time to the Division.
- A total of 1,173 regulatory reports were delivered to the Division on time. Thirty-seven reports included instances where Molina requested an extension and delivered the report to the Division within the agreed-upon time frame. No reports were late.

We will assess all new reporting requirements for risk and will work closely with the Division to meet their expectations for the new reports.

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Upon reviewing the new manuals, we have not identified any new reports that will need to be developed or need modifications. However, we believe that an ongoing risk remains should the volume of ad hoc report requests continue at the volume of 2021's requests. Even with our demonstrated success in developing and delivering reports to the Division, there are inherent risks when adding and changing reports of this magnitude. Specifically, risks include unclear and changing report and field-level definitions and aligning internal departments on these new expectations. Mitigation of these risks will require Molina to have open lines of communication with the Division and all other relevant internal stakeholders for discussion of any definitions that seem unclear. Once reports are developed, we will engage our quality improvement techniques, such as continued education on necessary data for plan improvements.

Loss of key personnel and loss of other personnel. We work diligently to find the right person for each position to ensure a successful program life cycle. For the Implementation Phase, we have selected our executive and administrative staff based on their work in our health plans or at corporate headquarters. These individuals, having acquired knowledge of State operations, then serve as our first line of backup support. As such, in the event of a loss of key personnel or other personnel assigned to the program, we have succession planning in place to ensure equally qualified backup personnel are immediately available to fill roles upon Division approval. We also have a standardized knowledge transfer process and a repository of program artifacts to ensure knowledge retention.

Further, we continually identify management and staff who will be the next generation of leaders for our organization. With 14,000 employees across our enterprise, we have the resources and flexibility to respond quickly to any potential crises or changing conditions within our Mississippi operations. Additionally, our corporate culture and commitment to a careful hiring process are the keys to workforce longevity. In 2021, our enterprise's voluntary turnover rate was 18%, compared with the industry average of 25%, according to the US Bureau of Labor Statistics. For our MississippiCAN and CHIP staff, the turnover rate last year was only 4.3%.

Problem Areas—Variances Through the Phases

The overall management of problem areas remains constant throughout all phases, with continuous and unceasing monitoring that identifies and resolves problems reflecting each phase and environment of the CCO Program.

3. Approach to Problem Identification and Resolution

The goal of our problem management approach is to identify potential problems, prevent incidents from happening, eliminate recurring incidents that result from a problem area, and minimize the impact of incidents that cannot be prevented. Our problem identification and resolution activities are

designed to diagnose the root cause of incidents and determine the resolution to the problem that caused the incident. When resolutions are identified, we document and implement them by using appropriate program control tools as discussed previously in this response.

A problem is often found where there is a difference between the actual situation and the desired situation. In that scenario, Contract requirements and metrics are the foundation for our problem identification approach. We develop numerous monitoring mechanisms that allow quick detection of problems, as described below.

24/7/365 system monitoring. We monitor our systems 24/7/365 using multiple system availability and performance tools. Our Network Operations Center and network operation engineers are alerted when resources reach critical thresholds or experience problems. The alerts are detailed messages that give critical information to direct network administrators regarding the root cause of a problem, thus reducing resolution time. We provide the Division with information regarding system events, status updates, and resolutions on a regular basis via email and telephone.

Monitoring claims processing. Our Claims Management team identifies and assesses deficiencies with individual claims or across our claims processing and payment system and develops a corrective action plan to research, resolve, and report resolutions to team leadership. Additionally, a cross-functional Provider Payment Initiative team identifies root causes and mitigates under- and overpayments. This team includes staff who offer end-to-end work experience and focus on identifying and implementing more efficient claims processes. They work closely with other functional teams—such as the centralized Provider Telephonic and Web Portal teams—to understand common payment inquiries and concerns expressed by the Provider network. This is particularly important for Providers working for the first time with an CCO who may be unfamiliar with managed care contracting and bill submission.

Call center monitoring. We continuously monitor various metrics in our call center, such as the number of active and waiting calls, call abandonment rate, average handle time, and post-call customer satisfaction. As such, we can identify problems (e.g., the need for overflow call support) in a timely manner.

Stakeholder, Member, and Provider input. Another resource for problem identification is our open communication with program stakeholders, CBOs, Members, and Providers. Feedback through tools such as Member and Provider satisfaction surveys and our consumer advisory committees help us identify problem areas in operational functions and care delivery. Once a problem is identified, Implementation and Operations staff find solutions and develop interventions to prevent future incidents from occurring. We use a tracking mechanism called Decision Form to track our problem assessment.

Decision Form. This form is used for monitoring and control of open decisions by the project team throughout the program life cycle. It documents alternative scenarios and recommended decisions that affect implementation of a solution. The form enables stakeholders to make informed decisions with thoughtful input regarding contractual requirements, pros and cons of proposed alternatives, and associated cost and timeline impact. It facilitates clear communication across the affected areas.

Problem Areas—Variances Through the Phases

Management of problem areas is an important component during all phases of the Contract. The time period immediately following implementation—when all our systems, reports, and functions are in production and fully operational with Members for the first time—has the most potential for problems to occur, and we monitor this period very closely. During implementation, the management of problem areas is largely performed by the Implementation team. During operations, this accountability shifts to the Operations team.

4.3.4.3 BACKUP PERSONNEL PLAN

At Molina, we approach our backup personnel plan with the same precision and attention to detail we use to ensure Members receive the best care and support. Experienced, qualified staff are critical to successful delivery of CCO Program services, and we take seriously our responsibility to adapt to situations that might require additional personnel in a manner that does not negatively affect Members, Providers, and the Division. In this response, we describe our backup personnel plan and resources, including our focus on longevity of staff to allow for effective Division support.

Plans and Resources if Additional Staff are Required

Many of Molina Mississippi's executive and administrative staff have been with our health plan since its inception in 2017. With their hands-on knowledge of MississippiCAN, CHIP, and the Division's requirements, they will serve as our first line of backup support for the CCO Program. If new staff are needed, our hiring managers will access the resources of local recruiters to identify and hire qualified candidates.

The size and breadth of our parent company, Molina Healthcare, gives us on-demand access to additional staff as required to perform Contract functions. With more than 14,000 employees, Molina Healthcare has the staff resources and flexibility to respond quickly to any potential crisis—for example, mobilizing staff in response to a hurricane—and changing conditions within our Mississippi operations. In addition to internal monitoring of staffing adequacy, we benefit from our parent company's ongoing oversight to detect any program-specific issues that need further attention or increased staffing.

Our established presence and extensive staff in Mississippi, along with access to parent company staff, allow us to respond quickly if backup personnel are needed.

197D.MS22

Ensuring Longevity of Staff

Molina Healthcare is committed to becoming the employer of choice for the managed care industry. From comprehensive hiring and training processes to a focus on employee engagement and professional development, Molina Healthcare offers a corporate culture in which individuals can thrive. The company conducts an enterprise-wide Employee Experience Survey annually, and the results directly influence workplace modernization initiatives and policies and practices. When the 2021 survey identified career development, communication, and work-life balance as high priorities, the response was to set action items for 2022 to focus on those areas. It is that level of responsiveness that contributed to an enterprise-wide staff turnover rate of 18% in 2021, which was significantly lower than the industry average of 25%. For our MississippiCAN and CHIP staff, the turnover rate last year was only 4.3%.

Molina's 12-month rolling turnover rate for staff was only **4.3%** in 2021, far less than the industry average of 25%.

197F.MS22

We offer competitive compensation and a package of health benefits—such as flexible work schedules and tuition reimbursement—that are among the best in the industry. We are proud of our volunteer time-off program, which allows employees to use company time to participate in events that bring them closer to their communities. We pay attention to the "cultural fit," seeking employees with the appropriate skills to work in the healthcare industry and the passion to improve outcomes for underserved populations. **The result of these efforts is a committed, highly professional workforce that provides the highest level of service to Mississippians.**

Yearly Talent Review and Succession Planning

Another key to workforce longevity is identifying and supporting employees to maximize their work performance and potential. We use an industry-standard talent management and succession planning tool called 9-box, which includes a performance/potential assessment of every employee (usually at the Director level or higher) and helps management determine the employee's risk of leaving the organization and what the impact would be.

During our yearly Talent Review Meeting, management staff identify Molina's critical talent—meaning those employees with skills and competencies essential to our business and for which there is a limited supply of talent or a high level of competition. We focus on the employees and roles that are crucial to the achievement of organizational outcomes. To ensure consistent application of the 9-box tool, management staff may participate in a calibration meeting to clarify the assessment steps and ratings.

Succession planning involves an integrated, systematic approach for identifying, developing, and retaining skilled employees in line with current and projected business objectives. To ensure uninterrupted and high-quality delivery of healthcare services for the CCO Program, we require at least one successor for each critical position.

Succession planning for the CCO Program identifies at least one skilled successor for each critical position.

197G.MS22

We also create development plans that set employee objectives for a defined period and allow us to track, measure, and monitor their progress. These plans help our talent develop the skills and competencies required

for either their current role or a future role. During each annual Talent Review Meeting, participants are asked to identify one development goal for each of their successors.

Performance Management

Performance management is an ongoing cycle that ensures alignment, accountability, and the documentation of performance outcomes. This cycle is aimed at helping employees achieve goals aligned with the organization's desired outcomes. It consists of three activities: goal setting, mid-year check-in, and end-of-year performance review.

Goal setting starts with identifying goals, monitoring progress of those goals, and measuring goal success at the end-of-year performance review. Setting performance goals allows employees to plan and organize their work, define success, focus their efforts on their most important priorities, and align with larger organizational outcomes.

The **mid-year check-in** gives leadership and employees an opportunity to formally touch base and discuss progress made on goals and performance. Employees get feedback on their performance, along with suggestions for how to improve performance during the second half of the year. Leaders get insight into the employee's challenges and hurdles and offer solutions and resources to overcome those barriers.

The **end-of-year performance review** process is a formal opportunity for managers and employees to review and evaluate performance. As we continue to work toward a performance-based culture and reward high performers, we prioritize dialogue between managers and employees. Managers make a commitment to coach employees and provide ongoing feedback—and, at the end-of-year review, the employees are rewarded for their performance before repeating the cycle.

Ensuring Effective Division Support

As a current health plan for MississippiCAN and CHIP, our existing employees provide a strong foundation for staffing the CCO Program. All local staff will transition to the new Contract, which will minimize any disruptions and ensure successful delivery of services to Members. We will build on the working relationships we have already established with the Division to effectively support them in the new Contract.

4.3.4.4 EMERGENCY PREPAREDNESS PLAN

In preparation for Hurricane Ida in August 2021, our Emergency Management team mobilized quickly to contact Members who might be affected by the storm. We distributed water and supplies and information about how to access services if needed.

197A.MS22

There is no hard-and-fast definition of what constitutes an emergency such as a natural disaster, pandemic, or act of public enemy. It may develop quickly with little or no warning, or it may loom for weeks until it becomes a threat. While Molina cannot predict an emergency, we can react to one with a clear, thoughtful plan. We did exactly that in August 2021 when Hurricane Ida was predicted to bring devastating winds, flooding, and storm surges to the Mississippi Gulf Coast. Prior to the storm, our Emergency Management team hosted emergency preparedness events; supplied many residents with flashlights, water, and totes for important document storage; and conducted telephone outreach to direct Members to available resources if needed. Although the hurricane's path spared most of the Gulf Coast, our emergency preparedness efforts greatly enhanced the likelihood of successful recovery with minimal impact to Members and Providers if the predicted level of devastation had occurred in that area.

Molina is prepared to provide immediate support to Members, Providers, Division staff, and our employees to address emergency-related challenges. Our experienced BCM team oversees and administers our BCM program, and we maintain up-to-date emergency response policies and processes in our Business Continuity Plan. In this section of our response, we focus on the following services and staffing continuity components of our overall BCM program:

- Continuity of services and care for Members
- Continuity of services to Providers
- Continuity of pharmacy services
- Continuity of services during the COVID-19 pandemic
- Communication with staff and suppliers
- Continuity of staffing

For a comprehensive BCM program description, please see our response to RFQ § 4.2.2.6.D, Continuity of Operations.

Continuity of Services and Care for Members

Using our Business Continuity Plan as a baseline, we support Members before, during, and after an emergency event such as a disaster. Emergency preparedness information is available on the Member portal, our website, and through our My Molina app. We have outbound text message capabilities to text Members during an emergency and, as needed, we add messaging to the Member Services call center line to give them pertinent information such as the nearest clinics and pharmacies open-for-business.

As illustrated in our response to Hurricane Ida last August, we immediately mobilize our Emergency Management team when weather alerts such as tornados or hurricanes indicate that Members may be affected. Our primary concern is Member safety and the resources to meet care needs such as access to housing, food, medication, power sources for durable medical equipment (DME), and local emergency contacts. For Members receiving care management services, our Care Management staff work proactively with them to develop action plans to ensure continuous access to needed care and services. For example, we document whether the Member intends to evacuate or remain in their residence, and we develop a plan for oxygen-dependent Members if there is a power outage. We also ensure availability of caregivers who can take responsibility for essential personal care services normally provided to Members by our Subcontractors.

All staff whose skills and resources are needed—from the Emergency Management and Care Management teams to Utilization Management (UM) staff and the Medical Director—work with our Compliance team to ensure regulatory approvals and timely delivery of services. Our priorities include, but are not limited to:

- Contacting affected Members by phone or text to determine if there are any changes in status or residence due to the disaster
- Calling or texting Members in care management who are on chronic medications or DME/oxygen and identifying/responding to any immediate interventions needed
- Coordinating additional care and services for Members displaced by the disaster—such as working with our Provider and UM teams to temporarily authorize services with non-contracted Providers
- Expediting service coordination, as determined by urgency of needs, when Members contact our Care Management team or call center
- Contacting Members via text who had a prescription filled within the previous 30 days to give them information on how and where to get replacement medications
- Continuing to provide support services through our Nurse Advice Line

Helping Members During the December 2021 Tornados in Kentucky

Within 24 hours of the tornado touchdowns, our affiliate health plan in Kentucky responded by:

- Contacting every Member in the two hardest-hit counties, including those inpatient and in active care management
- Texting every Member in those counties who filled a prescription in the last 30 days to say that emergency refills were automatically approved for medications lost during the tornados (and giving locations where the Members could get their prescriptions refilled)
- Initiating the same outreach efforts to Members in nine additional counties devastated by the tornados
- Announcing a commitment of $200,000 to the Team Western Kentucky Tornado Relief Fund through the MolinaCares Accord

108.MS22

Continuity of Services to Providers

During an emergency, we do not require prior authorization for medical services. Providers are contractually required to provide and coordinate all covered services to Members—and hospitals and non-network Providers are expected to deliver necessary services and advise us thereafter.

We provide education and training to Providers to enhance awareness and develop an understanding of emergency protocols and expectations. Our disaster recovery protocols are available in our Provider manual and on our Provider portal. Education occurs through multiple modalities, including webinars and in-person training conducted by local staff. We conduct symposiums to educate, train, coordinate, and plan for any disaster that could affect Mississippi, and we invite Providers to attend those events.

If a disaster occurs, we use email, text messaging, the Provider portal, the Provider call center, the My Molina app, and the Provider website to give Providers information on protocols to ensure continuity of services. We ensure Providers can communicate with their designed Provider Services Representatives, who are available to

not only offer routine support but also to help resolve disaster-related concerns such as claims processing if computer systems are unavailable due to a power outage.

Continuity of Pharmacy Services

To ensure Members have access to medications in disaster-affected service areas when a declaration of emergency is issued, our pharmacy team will collaborate with the Division and the CCO Program's PBA to initiate standard operating protocols. Our support includes:

- Enabling pharmacies to bypass early refill, prior authorization, and non-formulary edits without calling us or the PBA (72-hour emergency override)
- Allowing the PBA pharmacy and Member call centers, on behalf of Molina, to authorize medications that edit beyond the scenarios mentioned above
- Ensuring that specialty and mail order programs ship to alternative addresses as needed

We understand that the PBA will notify the pharmacy network of the above protocols via email/fax blast, website post, and in the Provider manual. Under the Division's guidance and instruction, we will leverage our experience and resources to assist in providing uninterrupted pharmacy services to Members.

Continuity of Services During a Disaster

Our BCM team and local Molina resources monitor weather-related conditions using a tool that provides alerts from the National Weather Service. The tool identifies affected counties and includes a map showing the path and severity of the hazardous weather, which aids our preparation and communication efforts.

Our redundant backup IT systems allow us to maintain essential functions and continued program operations during and immediately following a disaster.

197B.MS22

During a disaster, all critical services are deployed into a primary/disaster recovery site with remote disaster recovery access. This means that Members and Providers can expect communications systems such as telephones, faxing, and email to continue working. These systems are designed to be fully redundant in multiple locations and to route Members, Providers, and other users to the closest available system. The Member and Provider portals, as well as the transactional systems that manage claims, utilization, and care services, will be unavailable until recovered. Once disaster recovery protocols have been initiated, restoration of systems can be expected within 24 hours. Data will be current to just moments prior to the onset of the disaster.

We distribute technology systems and services across a hybrid cloud with four operating locations:

- **Primary/disaster recovery:** South Central US
- **Secondary/disaster recovery:** North Central US
- **Systems:** Molina-owned-and-operated data center
- **Disaster recovery:** Molina-owned-and-operated data center

Additionally, data center and Network Operations Center staff monitor systems, including applications, databases, networks, and routers/switches. We also have a suite of proactive enterprise monitoring tools that monitor systems, applications, and infrastructure performance to provide early detection of episodes that affect operations. We have established an incident management process via an IT Service Management program, which allows for timely resolution of business-critical incidents. We notify affected stakeholders of incidents that affect business users, communicate regular updates until issue resolution, and provide a dashboard where real-time information can be viewed.

Continuity of Services During the Pandemic

COVID-19 Core Task Force

Our Crisis Manager chairs this task force, which comprises cross-functional enterprise disciplines providing subject matter expertise to facilitate the company-wide response. This group monitors, develops, and coordinates responses to the evolving situation.

197J.MS22

Our Business Continuity Plan supports the resumption of critical business functions and information systems in the event of situations such as the COVID-19 pandemic. We have trained response teams who execute necessary steps and recovery strategies, and our enterprise Emergency Management team conducts training tailored to specific emergencies likely to occur in locations where we provide services. That team will develop training for our CCO Program team, ensuring they have the tools, processes, and resources to provide the right response when it is most important.

We have established a task force to monitor the evolving pandemic situation and develop/coordinate appropriate responses. Many employees can work remotely, mitigating a situation where their workplace becomes unavailable. Employees in critical operational functions are cross trained at other locations to allow the transfer of workload should one location be adversely affected by the pandemic.

On March 18, 2020, Molina Healthcare announced that it had temporarily transitioned thousands of employees to remote status to prevent potential exposure to COVID-19. By March 24, most employees were transitioned to remote status. Across the enterprise and for our Mississippi health plan, we have taken additional steps to continue service delivery and provide access to physical health and BH care for Members without leaving their homes, which includes:

- Providing virtual urgent care for Members through our partnership with Teladoc® (a telehealth option that connects Members with Providers via the Internet)
- Monitoring and updating all other telehealth services based on Division program updates
- Educating Members about free prescription home delivery from their health plans' pharmacies
- Launching an online Coronavirus Chatbot tool to help Members identify COVID-19 symptoms and immediately connect with support resources
- Covering screening tests for COVID-19, including office visits, urgent care, and emergency room (ER) visits

In addition, Providers have been given personal protective equipment, credentialing has been expedited, and payment processes have been adjusted to reimburse Providers the same amount for telehealth visits as for in-person visits.

Communication with Staff and Stakeholders

In the event normal systems are unavailable due to a business interruption, our Business Continuity Plan indicates the order and time frames in which essential parties are notified. We have an emergency notification system that can be used to broadcast critical information to key personnel and affected employees and stakeholders. The Incident Notification System sends emails, texts, and phone calls (personal and work) to our staff and is tested biannually. We maintain a status line that employees can call for information regarding the status of an incident that affects their office or location. In the case of a business interruption, specific operational departments contact suppliers to relay information regarding service interruptions. We also update our automatic call distribution (ACD) message, Member and Provider portals, and health plan websites with appropriate information and instructions.

For the CCO Program, we will notify the Division regarding relevant and major incidents in compliance with Contract guidelines.

Continuity of Staffing

Within our Business Continuity Plan, we identify essential business functions and employees needed to address continuity of critical operations and support functions in the event of an unanticipated interruption to normal business operations. As part of our business continuity load balancing and risk reduction strategy, for example, call center staff in other states will be trained and ready to take Member calls if Mississippi operations are not functioning due to a disaster. Our ACD system will route callers to our overflow call center operations to provide seamless continuity of services for Members, Providers, and the Division.

We ensure continuity of staffing through a strategic combination of cross-training, transferring workloads across multiple locations, and working remotely. **Table x** identifies essential operational functions and our approach to contingency planning to ensure staff performing those functions are supported during an emergency or disaster.

Table 2. Essential Operational Functions and Staffing Contingency Plans. Essential operational functions and systems are designed with contingency plans in place to restore business operations expeditiously.

Essential Operational Function	High-level Overview of Contingency Plan
Call Center	Cross-training of staff for active call sharing strategy across different sites
Care Management	Many staff work in the field and have remote capabilities; staff can work on-site if field work is impeded; office-based work is handled by those able to work remotely
Claims Processing	Shared services are geographically dispersed; cross-training among sites; redundancy is built into electronic processing of claims

Essential Operational Function	High-level Overview of Contingency Plan
Member and Provider Grievances and Appeals	Transfer workload to a non-impacted site
Pharmacy	Cross-training of staff; transfer workload across multiple locations
Provider Services	Staff have ability to work remotely or on-site; cross-training of staff
Quality Improvement	Staff have ability to work remotely or on-site; cross-training of staff
UM	Cross-training of staff; transfer workload across multiple locations

[END OF RESPONSE]

Coordinated Care Procurement - 4.3.2.6 Pro Forma Financial 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 template will automatically calculate the MLR credibility adjustment required based upon the table in the template provided by 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: **Molina Healthcare of Mississippi**

Pro Forma Statutory Balance Sheet

(In Thousands)

	2024	2025	2026
Admitted Assets			
1. Bonds	$ 72,114	$ 72,926	$ 73,772
2. Stock	$ -	$ -	$ -
3. Real Estate/Mortgage Investments	$ -	$ -	$ -
4. Affiliated Investments	$ -	$ -	$ -
5. Affiliated Receivables	$ -	$ -	$ -
6. Cash/Cash Equivalents	$ 71,549	$ 72,353	$ 73,193
7. Aggregate write in for assets	$ -	$ -	$ -
8. All Other Assets	$ 29,104	$ 29,256	$ 29,410
9. Total Assets(1+2+3+4+5+6+7+8)	**$ 172,767**	**$ 174,535**	**$ 176,375**
Liabilities			
10. Losses (Unpaid Claims for Accident and Health Policies)	$ 68,479	$ 69,156	$ 69,840
11. Unpaid claims adjustment expenses	$ 616	$ 622	$ 629
12. Reserve for Accident and Health Policies	$ 20,653	$ 20,653	$ 20,653
13. Ceded Reinsurance Payable	$ -	$ -	$ -
14. Payable to Parents, Subsidiaries & Affiliates	$ -	$ -	$ -
15. MLR rebates	$ -	$ -	$ -
16. Premiums received in advanced	$ 2,555	$ 2,555	$ 2,555
17. All other Liabilites	$ 16,495	$ 16,548	$ 16,601
18. Total Liabilities (10+11+12+13+14+15+16+17)	**$ 108,798**	**$ 109,534**	**$ 110,278**
Capital and Surplus			
19. Capital Stock	$ -	$ -	$ -
20. Gross Paid In and Contributed Surplus	$ 60,000	$ 60,000	$ 60,000
21. Surplus Notes	$ -	$ -	$ -
22. Unassigned Surplus	$ 3,969	$ 5,001	$ 6,097
23. Other Items(elaborate)	$ -	$ -	$ -
24. Total Capital and Surplus(19+20+21+22+23)	**$ 63,969**	**$ 65,001**	**$ 66,097**
25. Authorized Control Level Risk-Based Capital	$ 18,319	$ 18,500	$ 18,682
26. Calculated Risk-Based Capital (24/25)	**349%**	**351%**	**354%**

Company Name: **Molina Healthcare of Mississippi**

Pro Forma Statutory Profit & Loss Statement

(In Thousands, except Member Months, in Whole numbers)

	2024	2025	2026
1. Member months	1,595,853	1,579,967	1,564,240
Revenue:			
2. Net Premium Income	555,133	560,600	566,120
3. Fee for Service			
4. Risk Revenue			
5. Change in unearned premium reserves			
6. Aggregate write in for other health related revenue			
7. Aggregate write in for other non-health related revenue			
8. Total (L2+L3+L4+L5+L6+L7)	**$ 555,133**	**$ 560,600**	**$ 566,120**
Hospital and Medical Expense:			
9. Hospital/Medical Benenfits	494,069	498,934	503,846
10. Other professional Services			
11. Prescription Drugs	-	-	-
12. Aggregate write ins for other hospital/medical			
13. Subtotal (L9+L10+L11+L12)	**$ 494,069**	**$ 498,934**	**$ 503,846**
Less:			
14. Reinsurance recoveries	1,021	1,011	1,001
15. Total hospital and Medical (L13 -L14)	**$ 493,047**	**$ 497,922**	**$ 502,845**
16. Non health claims			
17. Claims adjustment expenses			
18. General admin expenses	51,461	51,968	52,479
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**$ 544,508**	**$ 549,890**	**$ 555,325**
21. Net underwriting gain or loss (L8 -L20)	**$ 10,625**	**$ 10,710**	**$ 10,795**
22. Net investment income earned			
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes	2,656	2,677	2,699
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**$ 7,969**	**$ 8,032**	**$ 8,096**
28. Prior YE Surplus	63,000	63,969	65,001
29. Net Income	**$ 7,969**	**$ 8,032**	**$ 8,096**
30. Capital Increases	-	-	-
31. Other Increases (Decreases)	-	-	-
32. Dividends to Stockholders	7,000	7,000	7,000
33. YE Surplus (L28+L29+L30+L31-L32)	**$ 63,969**	**$ 65,001**	**$ 66,097**

***Itemize in Assumptions**

Company Name: **Molina Healthcare of Mississippi**

Pro Forma Statutory Cash Flow Statement

(In Thousands)

	2024	2025	2026
Cash From Operations			
1. Premiums Collected Net of Reinsurance	$ 557,583	$ 560,448	$ 565,966
2. Benefits Paid	$ 497,850	$ 497,245	$ 502,161
3. Underwriting Expenses Paid	$ 55,734	$ 51,909	$ 52,420
4. Total Cash From Underwriting (L1-L2-L3)	**$ 3,999**	**$ 11,294**	**$ 11,385**
5. Net Investment Income	$ -	$ -	$ -
6. Other Income	$ -	$ -	$ -
7. Dividends to Policyholders	$ 7,000	$ 7,000	$ 7,000
8. Federal and Foreign Income Taxes (Paid) Recovered	$ (2,656)	$ (2,678)	$ (2,699)
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**$ (5,657)**	**$ 1,616**	**$ 1,686**

Cash From Investments			
10. Net Cash from Investments	$ 2,840	$ (812)	$ (846)

Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	$ -	$ -	$ -
12. Surplus Notes	$ -	$ -	$ -
13. Borrowed Funds	$ -	$ -	$ -
14. Dividends	$ -	$ -	$ -
15. Other Cash Provided (Applied)	$ -	$ -	$ -
16. Net Cash from Financing and Misc Sources	$ -	$ -	$ -
(L11+L12+L13-L14+L15)	**$ -**	**$ -**	**$ -**

17. Net Change in Cash, Cash Equivalents and Short -Term	**$ (2,817)**	**$ 804**	**$ 840**

Company Name: **Molina Healthcare of Mississippi**
Preliminary MLR Statement
(In Thousands)

Medical Loss Ratio (MLR) Rebate Calcuation (MSCAN)				
State Fiscal Year-to-Date Through:		2024	2025	2026
	Capitation Revenue and Tax Assessments			
1	**Total YTD Capitation Revenue**	$ 731,888	$ 735,934	$ 740,052
	Tax Components of Reported Revenue			
2				
3	Less: Allocation for premium taxes	$ 21,957	$ 22,078	$ 22,202
4	Less: Other taxes and other revenue-based assessments	$ 5,000	$ 5,500	$ 6,000
5	**NET Current YTD Adjusted Premium Revenue**	**$ 704,931**	**$ 708,356**	**$ 711,851**
	MLR Medical and Administrative Expenses			
6a	Net Medical Expenses from Income Statement	$ 482,966	$ 487,722	$ 492,524
6b	Passthrough Expenses (i.e. MHAP & MAPS)	$ 154,798	$ 153,257	$ 151,731
6c				
6	**Total Net Medical Expenses**	**$ 637,764**	**$ 640,978**	**$ 644,255**
	MLR Expense Adjustments as defined in Exhibit C			
7	Incurred claims adjustment additions	$ -	$ -	$ -
8	Incurred claims adjustment deductions	$ -	$ -	$ -
9	Incurred claims adjustment exclusions	$ -	$ -	$ -
10	**Adjusted Net Medical Expenses**	**$ 637,764**	**$ 640,978**	**$ 644,255**
	Health Care Quality Improvement (HCQI) and Health Care Information Technology (HIT) Meaningful Use Expenses			
11	HCQI and HIT Administrative Expenses from Income Statement	$ 11,103	$ 11,212	$ 11,322
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	$ -	$ -	$ -
13	**Adjusted HCQI/HIT Expenses**	**$ 11,103**	**$ 11,212**	**$ 11,322**
14	**Other Non-Claims Costs (FOR REPORTING PURPOSES ONLY. NOT INCLUDED IN NUMERATOR.)**	$ 40,358	$ 40,756	$ 41,157
15	**Program Integrity Costs (FOR REPORTING PURPOSES ONLY. NOT INCLUDED IN NUMERATOR.)**	$ -	$ -	$ -
16	**Total Adjusted Current YTD MLR Medical Expenditures**	**$ 648,866**	**$ 652,190**	**$ 655,578**
17	**Reporting MLR Percentage**	**92.0%**	**92.1%**	**92.1%**
18	**MLR percentage requirement for rebate calculation**	**87.5%**	**87.5%**	**87.5%**
19	**Percentage below 87.5% Requirement**	**0.0%**	**0.0%**	**0.0%**
20	**Dollar Amount of Rebate Requirement**	**$ -**	**$ -**	**$ -**
	Credibility Adjustment Applied			
21	MLR Member Months	1,595,853	1,579,967	1,564,240
22	**MLR Member Months (Annualized)**	1,595,853	1,579,967	1,564,240
23	**Credibility Adjustment**	**0.0%**	**0.0%**	**0.0%**
24	**Adjusted Reporting MLR Percentage**	**92.0%**	**92.1%**	**92.1%**
25	**MLR Percentage Requirement for Rebate Calculation**	**87.5%**	**87.5%**	**87.5%**
26	**Percentage below 87.5% Requirement**	**0.0%**	**0.0%**	**0.0%**
27	**Dollar Amount of Rebate Required**	**$ -**	**$ -**	**$ -**

Company Name: **Molina Healthcare of Mississippi**

Denials

Claims Denial Report

The Mississippi Division of Medicaid provides a template to report on denials requiring to be completed by each contracted managed care organization. The template includes a detail of information including In Network, Out of Network, Prior Authorizations, Claims Completions errors, etc. A detailed explanation is required if the percentages exceed a certain amount.

Assumption: Based on your expectation or history of denials review, what do you project your denials rate would be for services covered under this contract?

			2024	2025	2026
% Total Claims Entirely Accepted			82%	83%	83%
% Total Claims Entirely Denied			9%	8%	8%
% Total Claims Partially Accepted and Denied			8%	7%	7%
Please provide any additional information to support your projection and expectation of denied claims.					

Molina Healthcare of Mississippi
Statement of Assumptions

List below all of the relevant assumptions used to create the proforma statements.
We have assumed that the years in the column headings should be the same on all tabs (they were different on the Balance Sheet and Denials tabs).
P&L - Re membership, we calculated impact if one of the other of the two non-Molina CCOs were to be replaced with a new entrant CCO, and incorporating assumptions about membership retention, new member choice, auto-assignment to get new entrant to 20%, etc. And then we used the average of the membership resulting from those two scenarios. We assumed the overall number of beneficiaries in TANF, ABD and CHIP will decline at 1% per year after the current redetermination effort normalizes.
P&L - PMPM premiums, excluding premium tax and pass-throughs, in CY 2024 are $347.86 and grow at 2% pa to in line with expected medical cost trend; $347.86 pmpm premium is based on SFY 2022 MSCAN and CHIP rates adjusted for the
P&L - Assumes direct MLR, i.e. medical costs as percentage of premiums ex premium taxes and pass throughs of 89%, which is 70 bps below what we assume is assumed in rates
P&L - Assumes reinsurance recoveries of $0.64 pmpm
P&L - G&A, including QA, local controllable admin and corporate charges of 9.27% of revenue in all years
B/S - Premiums receivable estimated using days premium outstanding of approximately 10 days.
B/S - Unpaid claims estimated using days in claims payable of approximately 50 days.
Authorized control level risk-based capital is estimated using 3.3% of revenue for each year.
MLR - Premium taxes are 3%
MLR - Passthroughs are assumed to be $97 pmpm ($100 pmpm incl prem tax) and remain at that level all three years
MLR - HCQI/HCIT 2% of premiums, excluding premium tax and pass-throughs