RFQ # 20211210

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RFQ # 20211210

Transmittal Letter

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4.1 TRANSMITTAL LETTER

March 4, 2022

Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201
MSCAN_CHIP@medicaid.ms.gov

Reference: Mississippi Division of Medicaid Request for Qualifications
Mississippi Division of Medicaid Coordinated Care
RFQ# 20211210
RFx# 3150003991
Sealed Qualifications

Dear Sir or Madam:

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

Mississippi True d/b/a TrueCare (TrueCare) is a not-for-profit Mississippi health maintenance organization that was formed by a coalition of Mississippi's most well-established hospitals and health systems to serve as the state's one and only provider-sponsored health plan. For RFQ# 20211210, we have formed an alliance with CareSource Management Services, LLC (CareSource), a nationally recognized managed care organization with more than 30 years of Medicaid managed-care experience, a not-for-profit mission, a unique member-centric focus, and an established reputation as a leader in quality and operational excellence.

TrueCare will harness the synergy between and unique strengths of CareSource and Mississippi True. CareSource will serve as the plan's managed-care program administrator running the day-to-day operations and Mississippi True will bring local expertise and oversight. By combining Mississippi True's deep and longstanding relationship to the Mississippi provider community with CareSource's extensive experience in Medicaid health-plan operations, TrueCare offers significant advantages over the typical Medicaid plan and has the power to improve the health of Mississippians and transform the delivery of healthcare in Mississippi.

We are a coordinated care organization (CCO) **committed** to **changing** the trajectory of Mississippi's healthcare system via a fully **integrated** transparent service delivery model with the majority of its providers through real time bi-directional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence that brings a new era of provider collaboration to Mississippi. Our mission is to ensure Mississippians **can easily access** their benefits to live **healthier lives**, while **prudently** managing state resources.

All materials and enclosures being submitted in response to RFQ# 20211210 are identified at the end of this letter in Table 4.1_B.

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

TrueCare is registered to do business in Mississippi and is in good standing with the State. Its Corporate Charter Number is 1069140.

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

TrueCare confirms that it has been licensed by the Mississippi Insurance Department. A copy of its license is provided as Attachment 4.1-1. A copy of its fictitious Name Registration is included as Appendix 4.1-1.a.

4. A statement identifying the Offeror's Federal tax identification number;

TrueCare's Federal Tax Identification Number is 81-3739211.

5. A statement confirming that the Offeror has not been sanctioned by a state or federal government within the last ten (10) years;

TrueCare confirms it has not been sanctioned by a state or federal government within the last ten (10) years.

6. A statement confirming that the Offeror is not suspended or debarred under federal law and regulations or any other state's laws or regulations;

TrueCare confirms it is not suspended or debarred under federal law and regulations or any other state's laws or regulations.

7. A statement confirming that the Offeror has experience in contractual services providing the type of services described in this RFQ. All experience provided will be considered;

The TrueCare alliance confirms it has experience in contractual services and providing the type of services described in RFQ# 20211210.

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

TrueCare agrees that if it is awarded a contract under this procurement, any lost or reduced Federal matching money resulting from unacceptable performance of a task or responsibility, as defined in RFQ# 20211210, shall be accompanied by reductions in State payments to TrueCare.

9. A statement identifying any prior project where the Offeror was terminated prior to the end of the Contract period;

TrueCare has not been terminated prior to the end of a Contract period.

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

TrueCare confirms that no attempt has been made or will be made to induce any other person or firm to submit or not to submit a qualification under this procurement.

11. A statement that the Offeror has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set which is guided by the previous provisions of the Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations, a copy of which is available at 501 North West Street, Suite 701E, Jackson, Mississippi 39201 for inspection, or downloadable at http://www.DFA.ms.gov.

TrueCare confirms it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set which is guided by the previous provisions of the Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations.

12. A statement of Affirmative Action, that the Offeror does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, disability or genetic information;

TrueCare does not discriminate in its employment practices with regards to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, disability, or genetic information.

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

TrueCare agrees to the language of the Division's Business Associate Agreement (BAA) and Data Use Agreement (DUA) without expectation of negotiation.

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

TrueCare confirms receipt of the following amendments to RFQ# 20211210:

- Amendment #1 issued January 21, 2022
- Amendment #2 issued January 21, 2022
- Amendment #3 issued January 21, 2022
- Amendment #4 issued February 7, 2022
- Amendment #5 issued February 7, 2022
- Amendment #6 issued February 7, 2022
- Amendment #7 issued February 7, 2022
- Amendment #8 issued February 7, 2022
- Amendment #9 issued February 10, 2022
- Amendment #10 issued February 11, 2022
- Amendment #11 issued February 11, 2022
- Amendment #12 issued February 16, 2022

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

TrueCare confirms it has read, understands, and agrees to all provisions RFQ# 20211210 without reservation and without expectation of negotiation.

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

TrueCare confirms our qualification submitted in response to RFQ# 20211210 is firm and binding for three hundred sixty-five (365) days from the qualification due date.

17. A statement naming any outside firms responsible for writing the qualification;

The following firms are responsible for writing TrueCare's response to RFQ# 20211210:

- [redacted]
- [redacted]
- [redacted]

18. If the use of Subcontractor(s) is proposed, a statement from each Subcontractor must be appended to the Transmittal Letter signed by an individual authorized to legally bind the Subcontractor and stating the general scope of work to be performed by the Subcontractor(s);

TrueCare proposes using the subcontractors listed in Table 4.1_A in the performance of RFQ# 20211210 scope of work. A statement from each subcontractor is appended to this Transmittal Letter, signed by an individual authorized to legally bind the subcontractor, and stating the general scope of work to be performed by the subcontractor (Appendix 4.1-2).

Table 4.1_A: Subcontractors

Subcontractor	Scope of Work to be Performed
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

19. All qualifications submitted by corporations must contain certifications by the secretary, or other appropriate corporate official other than the corporate official signing the corporate qualification, that the corporate official signing the corporate qualification has the full authority to obligate and bind the corporation to the terms, conditions, and provisions of the qualification;

Attachment 4.1-3 contains a certification attesting that the corporate official signing TrueCare's qualification has the full authority to obligate and bind the corporation to the terms, conditions, and provisions of the qualification.

20. All qualifications submitted must include a statement that the Offeror presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services under this Contract, and it shall not employ, in the performance of this Contract, any person having such interest;

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

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

TrueCare confirms that no public disclosure or news release pertaining to this procurement shall be made without prior written approval of the Division.

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

TrueCare's redacted electronic, single-document qualification referenced in 1.4.2, Release of Public Information, does not contain trade secrets or other proprietary information. In our redactions, we removed all trade secrets and proprietary information.

23. A statement that the Offeror has executed and included with the Transmittal Letter the following Certifications, located in Appendix D:

a. Certifications and Assurances Regarding Contingent Fees and Gratuities;

b. DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals (This document must be executed by the Offeror as well as any expected Subcontractors and submitted with the Offeror's qualification); and

c. DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

TrueCare confirms it has executed and included with the Transmittal Letter the following Certifications, located in Appendix D:

- Certifications and Assurances Regarding Contingent Fees and Gratuities (Appendix D 4.1-1.a)
- DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals, executed by TrueCare, as well as its expected Subcontractors (Appendix D 4.1-1b)
- DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters (Appendix D 4.1-1c)

24. Additionally, if the qualification deviates from the detailed specifications and requirements of the RFQ, the transmittal letter shall identify and explain these deviations. The Division reserves the right to reject any qualification containing such deviations or to require modifications before acceptance.

TrueCare's qualification does not deviate from the detailed specifications and requirements of RFQ# 20211210.

Thank you for the opportunity to respond.

Very truly yours,

Chuck Reece
Mississippi True d/b/a TrueCare

//attachments (See Table 4.1-1)

Table 4.1_B: List of materials and enclosures being submitted in response to RFQ# 20211210

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4.1 ATTACHMENTS AND APPENDICES

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

MISSISSIPPI TRUE
116 WOODGREEN DR.
MADISON, MS 39110

116 WOODGREEN DR.
MADISON, MS 39110

HOME OFFICE

MISSISSIPPI

PRIVILEGE TAX LICENSE

MISSISSIPPI TRUE

LICENSE NUMBER : 1600020

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

MISSISSIPPI TRUE
116 WOODGREEN DR.
MADISON, MS 39110

LICENSE NUMBER: 1600020

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

F0070
Fee: $ 25

Michael Watson
SECRETARY OF STATE

2021363489

Business ID: 1069140
Filed: 08/31/2021 10:20 AM
Michael Watson
Secretary of State

Fictitious Business Name Registration

Business Information

Business ID: 1069140
Legal Name: Mississippi True
Business Type: Non-Profit Corporation

Fictitious Business Name Information

Fictitious Business Name: TrueCare
NAICS Code: 524114 - Direct Health and Medical Insurance Carriers

Street Address(es) of Business Using Name

116 Woodgreen Crossing
Madison, MS 39110-

Signature

The Applicant, through its undersigned authorized representative, is familiar with the provisions of Mississippi Code Annotated §75-93-1 et seq. and understands that filing this form creates no exclusive rights in or to the Fictitious Business Name which is the subject of this application as of this day ***08/27/2021***.

Name:	***Address:***
Chuck Reece	2121 5th St., Suite 207
Chairman	Meridian, MS 39301

APPENDIX 4.1-2: SUBCONTRACTOR'S LEGALLY BINDING AND SCOPE OF WORK STATEMENTS

Appendix 4.1-2 includes the following:

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

February 11, 2022

RE: 4.1 Transmittal Letter, Requirement #19
Certification of Full Authority to Obligate and Bind

I, Lee McCall, as the Secretary of TrueCare, hereby certify that Chuck Reece, Chairman of Mississippi True d/b/a TrueCare, has full authority to obligate and bind TrueCare to the terms, conditions and provisions of the proposal submitted in response to the Request for Qualifications for the MississippiCAN Program (RFQ # 20211210), issued by the Division of Medicaid Coordinated Care.

Signature

Lee McCall

Printed Name

02/11/2022

Date

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 6204 (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.

TrueCare
Name of Offeror

Chuck Reece
Printed name of person attesting for Offeror

Chairman of Mississippi True d/b/a TrueCare
Title of person attesting for Offeror

Signature of person attesting for Offeror

02/03/2022
Date

APPENDIX D 4.1-1.B-1: DRUG-FREE WORKPLACE CERTIFICATES

[redacted]

[redacted]

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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.

TrueCare
Name of Offeror

Chuck Reece
Printed name of person attesting for Offeror

Chairman of Mississippi True d/b/a TrueCare
Title of person attesting for Offeror

Signature of person attesting for Offeror

02/03/2022
Date

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.

CareSource
Name of Offeror

Sanjoy Musunuri
Printed name of person attesting for Offeror

EVP of Strategy and Business Development
Title of person attesting for Offeror

Sanjoy Musunuri (Feb 19, 2022 08:01 CST)
Signature of person attesting for Offeror

02/19/2022
Date

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

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

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

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

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

Receipt of Amendment Acknowledged:

(Signature)

Chuck Reece
(Printed)

Chairman of Mississippi True d/b/a TrueCare
(Title)

TrueCare
(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: Chuck Reece

Signature: 

Chairman of Mississippi True d/b/a TrueCare

Title:

TrueCare

Company:

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)

Chuck Reece
(Printed)

Chairman of Mississippi True d/b/a TrueCare
(Title)

TrueCare
(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:

(Signature)

Chuck Reece

(Printed)

Chairman of Mississippi True d/b/a TrueCare

(Title)

TrueCare

(Company)

RFQ 20211210: Amendment 5
February 7, 2022
Cover/Acknowledgment Page

Amendment #5 to RFQ 20211210: RFQ Corrections and Clarifications

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

Receipt of Amendment 5 Acknowledged:

(Signature)

Chuck Reece

(Printed)

Chairman of Mississippi True d/b/a TrueCare

(Title)

TrueCare

(Company)

RFQ 20211210: Amendment 6
February 7, 2022
Cover/Acknowledgment Page

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

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

Receipt of Amendment 6 Acknowledged:

(Signature)

Chuck Reece

(Printed)

Chairman of Mississippi True d/b/a TrueCare

(Title)

TrueCare

(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~~1~~0 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:

(Signature)

Chuck Reece
(Printed)

Chairman of Mississippi True d/b/a TrueCare
(Title)

TrueCare
(Company)

RFQ 20211210: Amendment 8
February 7, 2022
Cover/Acknowledgement Page

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

RFQ #: 20211210 / RFx#3150003991

Date: February 7, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

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

Receipt of Amendment 8 Acknowledged:

(Signature)

Chuck Reece

(Printed)

Chairman of Mississippi True d/b/a TrueCare

(Title)

TrueCare

(Company)

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

RFQ #: 20211210 / RFx#3150003991

Date: February 10, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

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

Receipt of Amendment 9 Acknowledged:

(Signature)

Chuck Reece
(Printed)

Chairman of Mississippi True d/b/a TrueCare
(Title)

TrueCare
(Company)

RFQ 20211210: Amendment 10
February 11, 2022
Cover/Acknowledgement Page

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

RFQ #: 20211210 / RFx#3150003991

Date: February 11, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

This document contains the follow:

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

Receipt of Amendment 10 Acknowledged:

(Signature)

Chuck Reece
(Printed)

Chairman of Mississippi True d/b/a TrueCare
(Title)

TrueCare
Company)

MISSISSIPPI DIVISION OF MEDICAID

ATTENDANCE SHEET

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

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

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

MISSISSIPPI DIVISION OF MEDICAID

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

Meeting adjourned 1:30 PM.

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

(Signature)

Richard Roberson
(Printed)

Project Manager
(Title)

TrueCare
(Company)

RFQ 20211210: Amendment 11
February 11, 2022
Cover/Acknowledgement Page

Amendment #11 to RFQ 20211210: Reporting Manuals

RFQ #: 20211210 / RFx#3150003991

Date: February 11, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

- MississippiCAN Reporting Manual
- CHIP Reporting Manual

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

Receipt of Amendment 11 Acknowledged:

(Signature)

Chuck Reece
(Printed)

Chairman of Mississippi True d/b/a TrueCare
(Title)

TrueCare
(Company)

MISSISSIPPI DIVISION OF MEDICAID

Amendment #12 to RFQ 20211210: Responses Regarding Amendment 9

RFQ #: 20211210 / RFx#3150003991

Date: February 16, 2022

RFQ Name: Mississippi Division of Medicaid Coordinated Care

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

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

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

Receipt of Amendment 12 Acknowledged:

(Signature)

Chuck Reece
(Printed)

Chairman of Mississippi True d/b/a TrueCare
(Title)

TrueCare
(Company)

[END OF RESPONSE]

RFQ # 20211210

Technical Qualification

(Blind Evaluation)

TrueCare™

TRUECARE™

4.2 TECHNICAL FACTORS TABLE OF CONTENTS

4.2.1 EXECUTIVE SUMMARY

The Executive Summary shall condense and highlight the contents of the qualification in such a way as to provide a broad understanding of the entire qualification. The Executive Summary shall include a summary of the proposed approach, the staffing structure, and the task schedule, including a brief overview of:

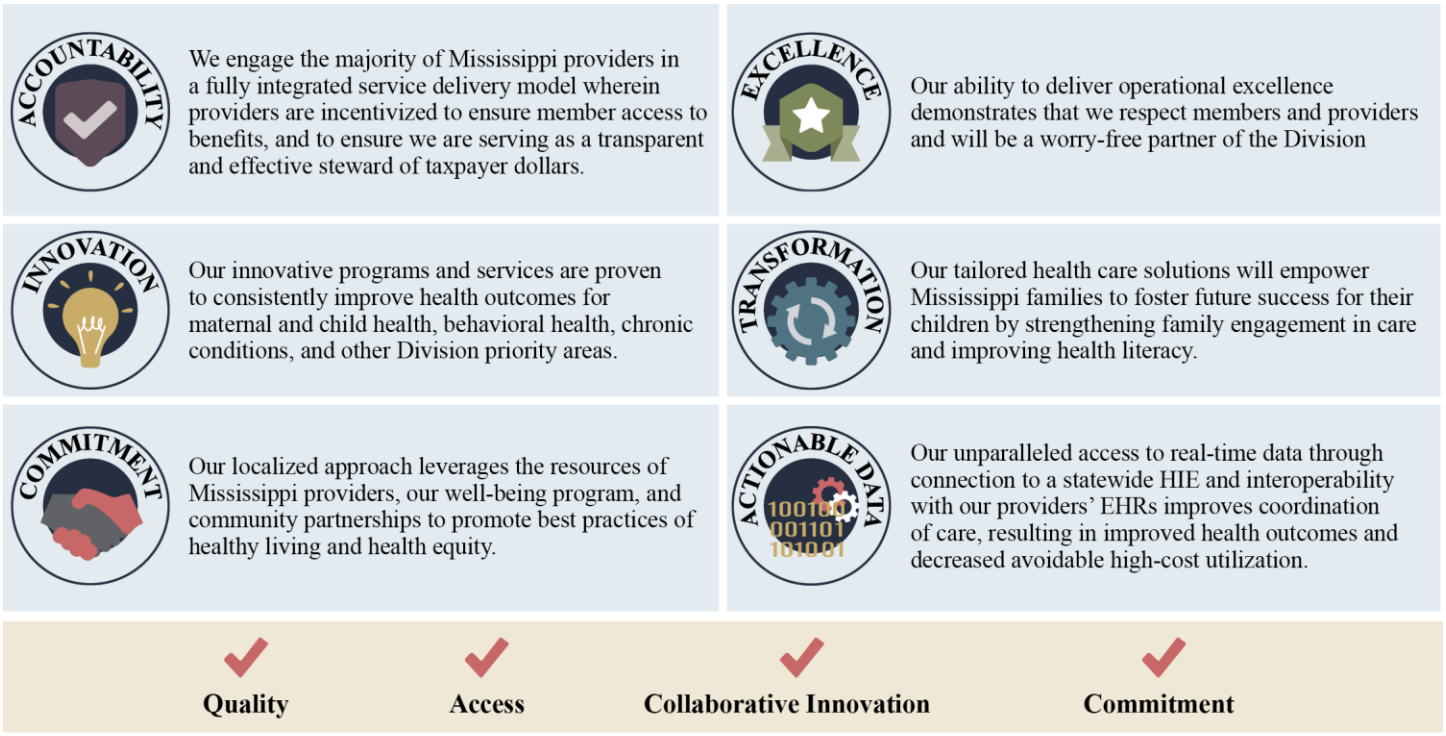
The State of Mississippi and its citizens require a health plan partner that understands its needs and priorities while demonstrating an in-depth understanding of the State's cultural preferences and differences, along with its regional variations in access to care and health outcomes. Our mission is to ensure Mississippians can easily access their benefits, our next generation member engagement and education, and community-based coordinated care to help them lead healthier lives while we prudently manage State resources. With decades of Medicaid managed care experience and deep roots in the State, we will offer unique insight, knowledge, solutions, and relationships necessary to successfully serve as a CCO that improves the health and well-being of Mississippi Coordinated Access Network (MSCAN) and Children's Health Insurance Program (CHIP) members. We are pleased to submit our response to the Division's Request for Qualifications RFQ #20211210.

We are **committed to changing the trajectory of Mississippi's healthcare system**. We will bring a new era of provider collaboration to Mississippi via **a transparent service delivery model which fully integrates with most Mississippi providers and offers real-time bidirectional data exchange**.

Summary of Our Proposed Approach. Our approach, which is summarized in this section and demonstrated throughout our proposal, encompasses population health and health equity; quality management; provider network services and supports; information technology; and programs to support the Division's quality-based initiatives. Throughout our proposal, we use icons to highlight the differentiators we will use to achieve Division goals (Figure 4.2.1_A).

Figure 4.2.1_A: Achieving Division Goals Through our Differentiating Model, Programs, & Capabilities[1]

Our model, operational capabilities, and innovative programs and services support the achievement of Division priorities and improve the quality of life for MSCAN and CHIP members.



[1] Graphic identifier number included at the bottom of graphic is used for internal tracking purposes.

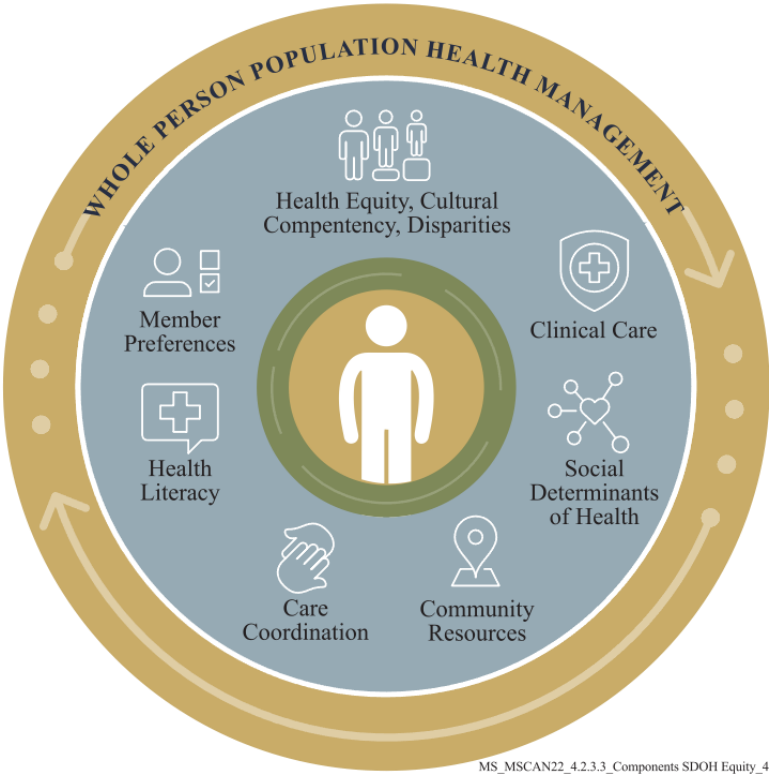
The remainder of this section summarizes our proposed work plan (task schedule), staffing structure, key personnel, and our understanding of the Mississippi environment and MSCAN/CHIP requirements.

Population Health and Health Equity

With decades of experience developing and implementing strategies to improve member experience and outcomes, while reducing health care costs, we understand that population health and health equity are achieved through a transparent, fully integrated, whole person service delivery approach that fully engages with and supports members across the care continuum. This requires active, ongoing collaboration between members, providers, care partners, community-based organizations (CBOs), and other key stakeholders. We view every member in a holistic manner, continuously working to mitigate health care barriers and empower members to serve as the primary voice in their individual care and outcomes.

Figure 4.2.1_B: Approach to Whole Person Population Health Management

Members' SDOH, clinical, behavioral, and health literacy needs are addressed through a data-driven, culturally aligned approach to population health management, with respect for members' preferences and values.



Our whole person approach to population health and health equity, depicted in Figure 4.2.1_B, is foundational to maintaining and improving member physical and psychosocial well-being and addressing their social determinants of health (SDOH), physical and behavioral health needs, and health disparities through targeted, cost-effective solutions. Our **integrated service delivery** approach to covered services and benefits, value-added benefits, and other non-Medicaid services, supports members across the care continuum. Effective communication and information-sharing between members, providers, CBOs, the Division, State agencies, and other stakeholders empowers members to achieve optimal health and improved quality of life.

In addition to enrollment file analysis, we use a multi-modal, data-driven strategy to identify specific high-risk populations (e.g., high-risk pregnant members, members with behavioral health diagnosis, severe mental illness, and substance use disorder [SUD]; children in foster care; etc.) who are likely to benefit from our population health initiatives and enrollment in our integrated care management (ICM) program. Through our integrated clinical platform, we develop a **360-degree view of every member**, which is used by our care managers, providers, and community partners to provide services to members based on their strengths, cultural considerations, and preferences.

To serve the diverse needs of Mississippi members, our innovative member-centered ICM system will be staffed by Mississippi-based ICM teams and specialist care managers to address specific needs of complex populations. We will use geospatial intelligence and heat mapping to place regional ICM teams based on member population density and areas of high need. Because our staff will live in the same communities as our members, they understand local healthcare and social landscapes and are equipped to link members to culturally and linguistically appropriate services. The teams will coordinate with existing local resources to facilitate collaboration directly in the community, sometimes co-locating in care settings to increase member access to critical care management services. Our teams will take the lead or co-manage care (dictated by member choice) and work in partnership with hospitals, primary

care providers, pharmacies, community mental health centers (CMHCs), CBOs, and faith-based organizations. Table 4.2.1_A summarizes several additional member-centered care management strategies and programs.

Table 4.2.1_A: Programs and Local Partners Supporting Member-Centered Care

Program	Description
Rapid Response Program	A dedicated unit of care managers, care coordinators, life coaches, and peer supports serving as an integrated rapid response team, dispatched in real-time to identify members at risk of a crisis.
Institute for Relational Health	Our Institute for Relational Health will provide an upstream framework necessary to support members with specialized health needs, incorporating innovative research and evidence-based practices from national and local thought leaders based on the connection between personal relationships and health. The Institute focuses on promoting person- and family-centered planning and breaking down silos to support a fully integrated approach that addresses all member medical and non-medical needs.
Person-Centered Planning	We will partner with the University of Southern Mississippi's Person-Centered Planning Facilitation Initiative (PCP-FI), deploying their training model to create and infuse strong person-centered planning for all Medicaid participants across the network. Person-centered care represents an established set of service delivery principles that place members at the forefront of their care and treatment goals. This lends itself to a large-format conference/workshop, as well as ongoing training inherent in our overall approach internally and with providers.
Maternal and Child Health	Our innovative and results-driven maternal and child health model of care will support individuals and their families through the continuum of their reproductive lives. It is composed of several interrelated, cross-functional programs, including our maternal health/high-risk obstetrics program, neo-natal intensive care unit (NICU) program, women's and children's health outcomes program, pregnancy engagement initiative, and our maternal-focused housing subsidy program.
Foster Care	Our continuum of foster care services will focus on supportive services for children in foster care and for families to prevent the need for foster care. We will collaborate with and support parents, families, and caregivers in navigating the health and foster care systems, identifying and accessing social supports, and managing medication administration, provider appointments, high stress, and personal health issues.
Behavioral Health	We will implement a data-driven SUD health home model that brings together enhanced care coordination and peer support to improve member outcomes. We will offer employment support through coaches, intensive care management, a teen-centric support application with coaching, serious emotional disturbance and serious mental illness care coordination programs, a comprehensive opioid management program, and family support/family peer program partnerships.
Well-being Program to Address SDOH	Our well-being program addresses the socioeconomic barriers to health that Medicaid members often experience, such as access to nutrition, affordable housing, transportation, education, and sustained employment. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool is used to align members' needs with the programs that best serve them. Life coaches work with members one-on-one to identify, navigate, and support members across SDOH domains. This program includes our employment support program, our housing navigation program, and our food program.

To ensure optimal member engagement, we will employ an empowerment model with member-centered and culturally sensitive engagement strategies to involve members in wellness activities and health education, and to help them access a variety of self-management tools. [redacted]

Leveraging technology, we will deliver digital solutions that help to simplify member engagement. Table 4.2.1_B summarizes several key strategies and programs designed to increase member engagement.

Table 4.2.1_B: Key Strategies to Increase Member Engagement

Program	Description
Social Media Communities	We engage members early to determine their individual communication preferences and to ensure a personalized member experience. Based on member preferences, we will engage through social media (e.g., Facebook, Twitter, Instagram) as access points to proactively connect with members in a manner convenient to them. Harnessing social communities, we provide two-way communication when, where, and however members choose to engage. This includes a streamlined path to telehealth services and access to immediate online assistance. Since 2019, we have seen a 3,200% increase in members seeking care on social media. We are available 24 hours per day, seven days per week, to direct members through social media including how to find care, access ID cards, and address other high priority needs. By meeting members where they are, we deliver faster, more effective care and streamline member access to services, such as telehealth, our nurse advice line, care management services, and other enhanced benefits.
Voice Application	By using Amazon Alexa devices, we will help members, particularly those with limited mobility, engage with us. Members can interact with the device in a secure, HIPAA-compliant channel and connect with customer service, call their case manager, ask

Program	Description
	questions about their coverage and get a reminder about prescription refills. By placing this technology in the homes of some of the most at-risk members, we will mitigate health disparities related to a lack of technology and mobility and positively impact self-management.
Increasing Access to High-Speed Internet	Many times, low-income neighborhoods and rural areas are overlooked for broadband expansion due to financial constraints. This further widens the technology gap in low-income communities and rural areas. In such instances, it takes a concerted, collaborative effort to close the digital divide. That is why we will invest in a Digital Equity Initiative that helps bring high-speed broadband service to areas often overlooked. By partnering with local providers, housing authorities, and local government agencies to address lack of access, we will help equip housing complexes in low-income neighborhoods with high-speed access and network routers to ensure every apartment, communal area, and green space is afforded reliable internet service. We will also help identify and secure additional grant dollars to provide Chrome books to families, which is a lifeline for students trying to complete assignments online and parents looking for employment and needing to apply for jobs online. This service will be provided free of charge to residents.
Advanced Text Messaging Capabilities	We use data analytics to design advanced text message campaigns that reach members with the right message to motivate them to act on their health and wellness. For example, in another market, we partner with a provider health system in a very rural area, we used texts to target members requiring follow-up breast screening exams. Members received a text message with a link that allowed them to be immediately connected with an accessible, in-network provider. The provider reported a 70% increase in call volume to schedule screenings immediately following completion of the text campaign.

Quality Management

We promote the integration of our quality and performance improvement activities across all systems, processes, and programs, with the goal of improving the quality of life and health outcomes of every member we are privileged to serve. With innovation at the forefront of our quality management program, we employ state-of-the-art technology, predictive data analytics, and information necessary to ensure accurate and efficacious measurement. This affords the Division a **superior model for accountable, data-driven outcomes, and quality care**, using the power of data to develop and to implement initiatives to drive improved outcomes.

We have successfully obtained NCQA accreditation for all programs we administer, and we comply with the requirement for accreditation in Appendix A, Section 8.2. Our **score of 100% on the NCQA quality standards and population health management standard** in another market underscores our adeptness in developing and implementing processes and procedures that support positive health outcomes, enhance the member experience, and ensure appropriate utilization of services and cost-effective care.

Quality Improvement in Other Markets

Prenatal Care – Percentage of women with a prenatal care visit in the first trimester within 42 days of enrollment**:**

- Market 1 – 88% increase, 2017-2020
- Market 2 – 49% increase, 2018-2020

Postpartum Care – Percentage of women with a postpartum care visit within recommended timeframes:

- Market 1 – 27% Increase, 2017-2020
- Market 2 – 63% Increase, 2018-2020

Childhood Immunizations (Combo 10) – Percentage of children with all recommended vaccines by age 10

- Market 1 – 61% Increase, 2018-2020
- Market 2 – 32% Increase, 2018-2020

We offer proven methods, experience, and innovative solutions to manage unnecessary, or avoidable, emergency department (ED) utilization, avoidable hospitalization, and readmissions. Our high-value, data-driven processes and tools identify, track, and evaluate provider practice patterns' impact on specific health outcomes metrics for members in their care. Our advanced quality analytics include a modern data platform that stores all incoming data to authenticate accurate data aggregation. This is achieved by performing integration and regression testing, assessing volume, and validating data quality. Our vendor partnership enables an end-to-end QM, business intelligence, and analytics platform. To help manage quality, we can access more than 700 key performance indicators – **the largest measure library in the industry.**

Provider Network Services and Supports

We will offer a fully integrated service delivery model and propose to bring the first **real-time bidirectional data exchange capabilities to MSCAN and CHIP programs through our health information exchange (HIE) connection** to hospitals, CMHCs, patient centered medical homes (PCMHs), federally qualified health center (FQHCs), rural health centers (RHCs), and private practice providers. We will also champion an innovative collaboration to encourage all CCOs to replicate our level of connectivity to better serve Mississippians.

Through our Provider Innovation Collaborative (PIC) and provider services staff, we will offer a high-level of customer service for providers, coupled with a hub of resources, training, and technical assistance, which enables them to operate as fully accountable, quality-driven, innovative care partners who can adopt and scale evidence-based practices and participate in value-based payment (VBP) programs.

Our PIC provider engagement model achieves four objectives related to provider performance, growth, innovation, and community development:

1. **Doing it Right the First Time to Minimize Issues**: for the few issues that may arise, real-time technical assistance and issue resolution to reduce administrative friction for providers and the Division
2. **Enablement and Education:** coordinated approach to provider education and training offering in-person, virtual, and hybrid options for weekly open office hours, our educational series with nationally recognized experts, and invitation to Institute for Relational Health Innovation Series events, with continuing education units and continuing medical education available
3. **Innovation**: investment in **practice transformation activities related to improving the quality of member care** through VBP programs and provider incentives
4. **Community**: collaboration with CBOs to arrange on-premises health clinics and practice transformation investment for providers for portable equipment needed to accurately assess member health in the CBO setting (e.g., portable EKG, ECG, ultrasound technologies)

Our experienced Provider Services Organization (PSO) will ensure successful management of our Mississippi provider network. We will employ a team-based approach to resolving issues in real-time or near real-time to ease the administrative burden and to improve provider satisfaction. Our PSO will provide day-to-day support to providers with an **emphasis on integrated service delivery, communication, and collaboration**.

Beyond provider-facing staff, we have an internal Provider Resolution Unit (PRU) dedicated to resolving complex provider issues or concerns about managed care (e.g., claims, credentialing, grievances and appeals, etc.) that require additional internal escalation. The PRU is comprised of manager and director level staff who provide concierge-like services and serve as an additional level of support for our provider representatives if they encounter delays receiving timely or complete resolution through routine issue resolution processes. In addition to performing this level of internal support, the PRU will work closely with the Compliance Officer, who serves as a point of contact for the Division, to address any concerns the Division receives from providers and to obtain status and resolution.

Information Technology and Operations

To support the Division's ongoing efforts to enhance the use of health care data to improve quality, transparency, and outcomes, our HITRUST-certified Medicaid Management Information System (MMIS) ensures the effective administration of the MSCAN and CHIP programs. To deliver operational excellence, we will leverage leading-edge applications, including our claims processing, quality management, care management, and utilization management platforms, all of which comply with all federal privacy and security requirements. **Since 2018, we have invested more than $500 million in our information technology to ensure a secure, stable, and scalable enterprise MMIS platform and infrastructure.**

We are committed to supporting the Division's vision to develop inter-operability and data-sharing among the Mississippi health care community, with **unparalleled access to real-time data through Federally Qualified Health Centers, school-based health centers, and hospitals** through HIEs coupled with population health technology, data reporting, and analytics partners.

Supporting the Division's Quality-Based Initiatives

Our innovative proposed programs will focus on improving health outcomes, equity, access to care, member engagement, and collaboration with CBOs and the Division. Table 4.2.1_C summarizes our key innovations.

Consistently High Performance Across All Medicaid Markets

- 98% auto-adjudication
- 100% of clean and non-clean claims processed within 30 calendar days of receipt
- 99% of behavioral health claims paid in less than five days
- 99.5% claims payment accuracy
- Greater than 99% encounter timeliness within 14 days
- 100% claims encounter accuracy
- Greater than 99% first-pass accuracy rate

Table 4.2.1_C: Programs to Support the Division's Quality-Based Initiatives

Program	Description
Value-based Purchasing	To drive optimal health outcomes, quality of care, and efficiency, we follow the Health Care Payment Learning and Action Network alternative payment model (APM) framework, with specific value-based purchasing strategies based on provider preferences and willingness to participate. We will leverage our understanding of Mississippi providers and their needs to meet them where they are in terms of readiness to participate in risk-based and capitated payments, supporting them along the APM continuum. We also support providers through connections to a statewide HIE to empower better continuity of care.
Patient-Centered Medical Homes	We will support providers with adoption of the NCQA patient-centered medical home (PCMH) recognition program through direct, on-site education and guidance; breaking down financial barriers to attaining and maintaining recognition; establishing a Mississippi provider learning collaborative; and providing existing and prospective PCMHs with timely, practice-specific, actionable data.
Social Determinants of Health	The development and implementation of our SDOH strategy focuses on SDOH-specific programs based on evidence-based practices and measurable results, formalized partnerships to provide social services and technology solutions, and integration of SDOH within our model of care. This is accomplished through building and fostering strong partnerships with network providers and CBOs, coupled with increased use of data to drive our planning, partnerships, pilots, and decisions necessary to address members' SDOH needs and to improve health equity.
Value-Added Benefits	We incorporate the State's desired value-added benefits (VABs), including a wide array of additional easy-to-use VABs to promote self-management, cost savings, and utilization of services in the appropriate setting. Each of our VABs aligns with one or more of the Division's program goals, and with the following categories: perinatal care, expanded primary care, dental, vision, transportation; addressing SDOH member needs; managing chronic disease; improving mental health; and supports for children, childcare, and caregivers.
Performance Improvement Projects	We design and implement performance improvement projects (PIPs) that follow the Institute for Healthcare Improvement's (IHI) Quality Improvement (QI) Model for Improvement. Our PIPs improve weight management among Mississippi's youth and reduce infant mortality among Black members living in the Mississippi Delta Region, increase child and adolescent well-care visits, and improve follow-up care with mental health providers for children and adolescents.
Health Literacy	Our health literacy campaigns are developed, implemented, and evaluated through a data-driven health equity lens to ensure we identify and address barriers to care and SDOH for specific communities and/or populations.
Telehealth	Our comprehensive telehealth strategy will employ policies, procedures, and processes necessary to extend access to primary care, through the implementation of a nurse practitioner telehealth program, collaboration with a nationally recognized telehealth provider, and through the provision of access to telehealth platforms by network primary care and specialty care providers.
Use of Technology	Our centralized modern data platform (MDP) will serve as a sole source of truth for our organization and the Division. The MDP uses sophisticated artificial intelligence/machine learning (AI/ML) and predictive analytics capabilities to provide insight and transparency to the Division on data-gathering and analysis and program efficacy.
Mississippi Partnerships	[redacted]

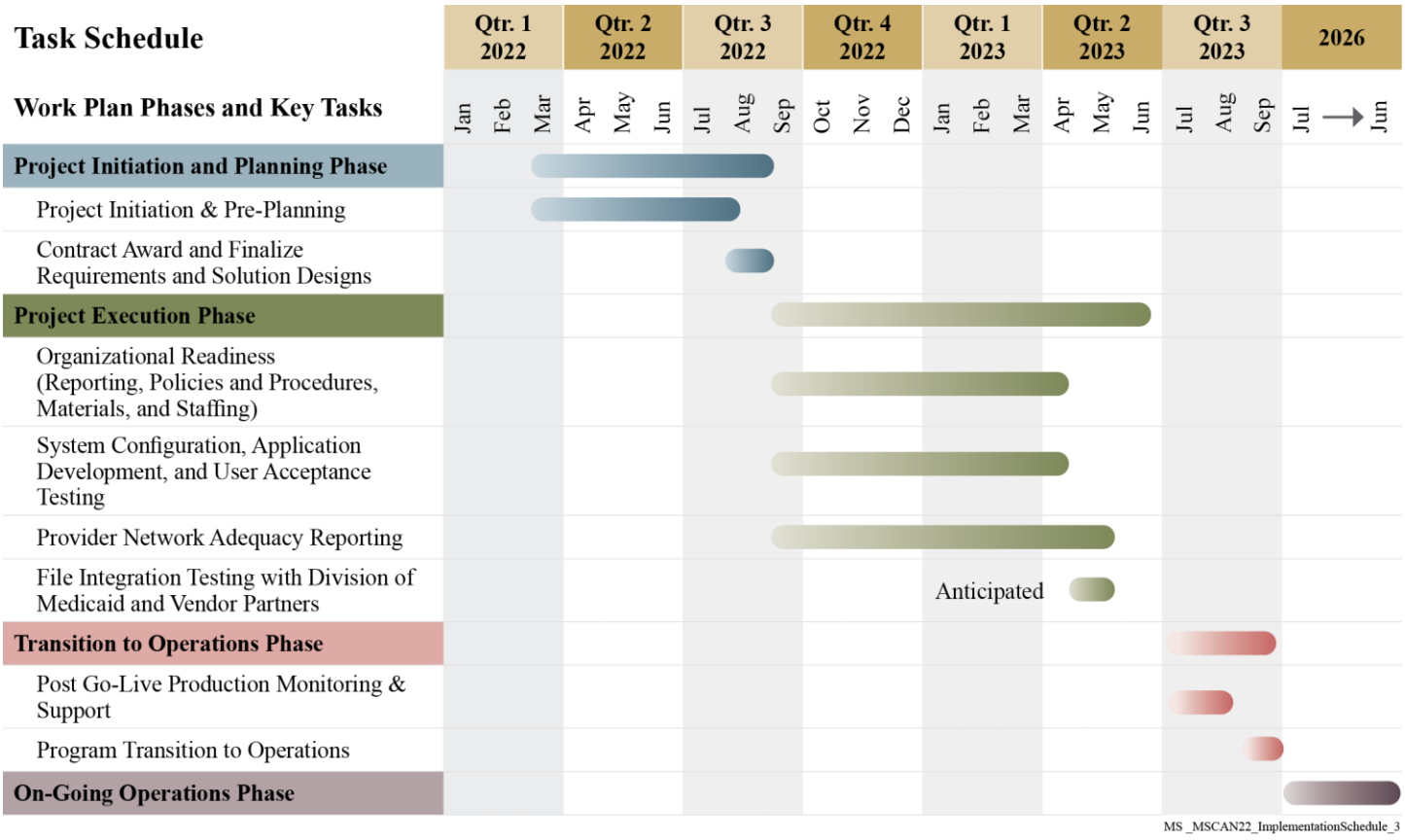
1. Proposed work plan

We will follow a disciplined, experience-based approach for all phases of the program and contract, rooted in industry-standard methodologies, including the Project Management Institute's (PMI) Project Management Body of Knowledge (PMBOK) standards and guidelines, the International Institute of Business Analysis's (IIBA) Business Analysis Body of Knowledge (BABOK) guide, and Scaled Agile Framework (SAFe) methodology. Most importantly, we will practice transparency, accountability, and consistency to provide a low-risk solution, while meeting the Division's objectives for quality managed care.

We plan and track all activities using comprehensive implementation and project work plans, which includes a detailed schedule, tasks and subtasks in a work breakdown structure, predecessors and dependencies, and responsible parties. Our work plans will be shared with the Division and will include all tasks, milestones, and deliverables required by the contract. Figure 4.2.1_C provides a brief overview of the proposed work plan, illustrating key implementation tasks by project phase.

Figure 4.2.1_C: Summary of Our Task Schedule and Proposed Work Plan

We track all key tasks our comprehensive work plans to ensure achievement of all milestones in each phase, and a seamless project implementation.



Our Chief Executive Officer will serve as the Division's single point of contact for project management throughout the Implementation Phase. We will assign an Implementation Project Manager (PM) familiar with the MSCAN and CHIP landscape to manage the implementation workplan and related tasks under the direction of our Chief Executive Officer. Our Implementation Management Organization (IMO) team of Medicaid implementation specialists with decades of experience will support the Implementation Project Manager.

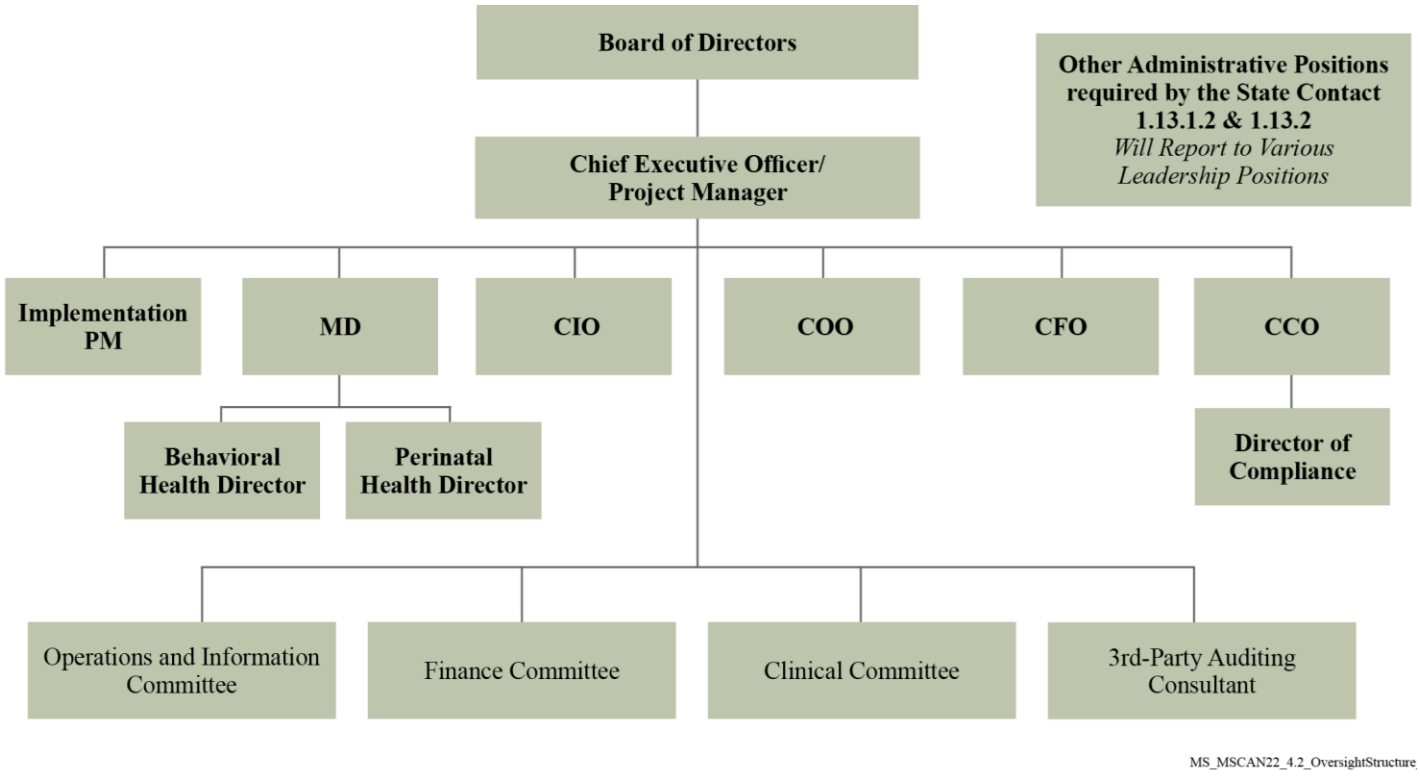
2. Staff organizational structure

Our leadership and staff understand the factors affecting the health status of Mississippians, the resources available to them in the local community through providers, government agencies and programs, and

community and faith-based resources. Figure 4.2.1_D summarizes our organizational structure and oversight of all MSCAN and CHIP operations and illustrates the reporting structure and lines of authority across health plan executive and administrative leaders. We further support the local health plan, leveraging experts from our national organization (e.g., enterprise leadership and medical directors our plans in other markets) and bringing robust resources for administrative services and supports for HIT, finance, and other areas.

Figure 4.2.1_D: Organizational Structure and Oversight

Our organizational structure and oversight of health plan operations ensure our ability to meet all requirements in Appendix A, while providing high quality service to our members and providers.



3. Key personnel

Our staffing approach places emphasis on recruiting key personnel who reside in Mississippi before looking out of state for personnel who we will relocate to Mississippi. We prioritize identifying candidates with a strong background in Medicaid managed care, who are dedicated to our mission of helping members, their families, and all Mississippians lead healthier lives. Our experienced local staff, many of whom are lifelong Mississippians, possess the knowledge, experience, and business acumen necessary to perform all MSCAN and CHIP program requirements. They are committed to serving the State, and its Medicaid beneficiaries for the full duration of the contract and beyond, creating consistency and fostering stronger relationships with the Division, providers, CBOs, and other stakeholders. Table 4.2.1_D summarizes the roles and responsibilities of our proposed key personnel, including executive and administrative positions, in accordance with Section 1.13.1 of Appendix A. In addition to all key personnel, we agree the staff required in Appendix A Section 1.13.2 will be in Mississippi by the beginning of the contract term.

Table 4.2.1_D: Key Personnel, Roles, and Responsibilities

Executive Positions	Role and Responsibilities
CEO and Project Manager	Full-time dedicated Mississippi based CEO with primary oversight of implementation and overarching decision-making authority for day-to-day business pursuant to the model contract; serves as contract officer for the plan; will oversee implementation of contract requirements during the implementation phase.
Chief Operating Officer (COO)	Full-time designated position located in Mississippi; oversees day-to day business activities pursuant to the model contract
Chief Financial Officer (CFO)	Full-time designated position located in Mississippi; oversees financial-related plan functions
Medical Director (MD)	Full-time, Mississippi-licensed physician responsible for all plan clinical decisions; oversees and is responsible for proper provision of covered services for members
Perinatal Health Director	Mississippi-licensed physician and actively practicing (or actively practicing in the last five years) provider specializing in obstetrics and gynecology; serves as perinatal health director reporting to plan medical director; responsible for the oversight, development, and implementation of perinatal health policy through covered member services
Behavioral Health Director	Mississippi-licensed physician and actively practicing (or actively practicing in the last five years) provider specializing in behavioral health; serves as behavioral health medical director reporting to plan medical director; responsible for the oversight, development, and implementation of behavioral health policy through covered member services
Chief Information Officer (COO)	Professional colleague who oversees information technology and systems to support plan operations, including submission of accurate and timely member encounter data
Compliance Officer	Full-time professional located in Mississippi; designated by the plan as the primary point-of-contact for the Division
Administrative Positions	▪ Provider Services manager ▪ Network/Contracting manager ▪ Member Services manager ▪ Quality Management director ▪ Care Management director ▪ Population Health director ▪ Utilization Management coordinator ▪ Grievance and Appeals coordinator ▪ Claims administrator ▪ Data and Analytics manager ▪ Clinical pharmacist

4. A brief discussion of the Offeror's understanding of the Mississippi environment and MississippiCAN and CHIP requirements.

We understand the Mississippi ecological and health care environment, the 10-year history of Medicaid managed care, the State's budgetary constraints, and the health status of the citizens of the state from a full range of sources including:

- One-to-one and group interactions with Medicaid beneficiaries, providers, CBOs, faith-based leaders, and other stakeholders
- The Mississippi External Quality Review report, the Mississippi State Department of Health Community Strengths and Themes and Forces of Change Assessment reports, state health assessments and improvement plans, and the Division's Comprehensive Quality Strategy, among other documents
- Public health data available from academic research centers.

Synthesizing information from across these sources of data, combined with our extensive experience serving Medicaid beneficiaries, we know the following key facts about the Mississippi environment:

- Mississippians experience a high incidence of health disparities and poor health outcomes affecting overall wellness and life expectancy
- The Mississippi Delta has poorer health outcomes than other areas of the state, disproportionately affecting Black residents of the region
- Obesity and associated chronic illnesses (e.g., diabetes, hypertension), exacerbated by poverty and food insecurity, are key issues facing Mississippians across age, race, and gender categories
- Maternal and child health (MCH) outcomes in the state, especially infant mortality and low birthweight, remain a top priority; Black families face significant disparities in MCH
- Access to behavioral health and substance use treatment remains an opportunity for improvement, especially in rural areas, for adolescents, and for pregnant individuals
- Local organizations have the desire and local knowledge to support Mississippians on their journey to health and wellness, but need assistance to develop their organizational capacity to be more effective

Understanding of the MSCAN and CHIP Requirements

We understand the Division's mission and vision of improving the delivery of services for MSCAN and CHIP members. We have thoroughly reviewed and will meet or exceed all general provisions and requirements outlined in Appendix A to meet the following priorities:

- **Quality – In direct alignment with the Division's comprehensive quality strategy,** our proposed population health management and quality improvement strategies, PIPs, VABs, VBP model, health literacy campaigns, and care management programs meet the regional and population-specific needs of Mississippians.
- **Collaborative Innovation –** We propose our methods for the delivery of the Division's quality-based initiatives, summarized prior, through which we ease providers' administrative burden and issues with navigating the health care delivery system for members. We welcome the opportunity to partner with the Division and other CCOs to implement uniform innovative systems, as selected by the Division.
- **Access –** We will address barriers to access through a comprehensive series of programs, including telehealth, closed-loop referrals, transportation, and our well-being, housing, and food programs.
- **Commitment** – Our proposal demonstrates our deep commitment to improving the health status and quality of life for MSCAN and CHIP members through our community reinvestment and strategic community partnership efforts, our employment support and workforce development programs, our commitment to paying a living wage for all staff and hiring locally, and the delivery of high-quality care.

Conclusion

We are a CCO committed to changing the trajectory of Mississippi's healthcare system and bringing a new era of provider collaboration. As demonstrated throughout our response, we are well-positioned to serve as an **accountable partner to the Division,** bringing a fully integrated, transparent service delivery model, which is fully integrated with most of our providers through real-time bidirectional data exchange, and quality Medicaid programs and services, as well as transparent IT systems (e.g., claims payment, data-sharing, reporting, interoperability, and enrollment) to MSCAN and CHIP members. With a firm commitment to the delivery of services through a localized, regional approach, we will leverage our close relationships with network providers, CBOs, the Division, and other stakeholders, coupled with a local team of Mississippians dedicated to member engagement and improved health outcomes while we prudently manage State resources. [redacted]

We are also committed to reinvesting in Mississippi, with a community reinvestment strategy that includes diversification of our funds to target those areas of greatest need and impact, including diversity and social impact; minority businesses; highly competitive total rewards package [redacted] monthly incentive programs, full time benefits, and career ladder progression opportunities; access to health care and social services; affordable housing; job creation; rural dentistry; workforce development; housing and food insecurity; behavioral health and substance use disorder; and infant and maternal health.

The broad array of programs and services proposed to the State are based on Medicaid industry best practices and tailored to meet the specific, community-level needs of Mississippians. With decades of Medicaid experience and significant understanding of the State and its residents, we stand eager and ready to assist the State with transforming the future of its population through programs and services that promote improved quality of live, improved outcomes, and that break the cycle of poverty.

[END OF RESPONSE]

[redacted]

4.2.2.1 MEMBER SERVICES AND BENEFITS

We are Mississippians taking care of Mississippians, and we share the Division's goals for improved member health outcomes and quality of life while being good stewards of State funds. We know that members who live in supportive neighborhoods and home environments, with parents and caregivers who are in good health, are less likely to experience adverse experiences – stressful or traumatic events that often have a lasting impact on their health and well-being. We also know that early detection and treatment of the developmental, language, or learning delays reduces long-term health consequences and the risk of costly future treatments.

The need for preventive health services begins at birth. Our strong network of Mississippi providers are known and trusted by our members. They will be vested partners in helping to ensure children in Mississippi receive age appropriate early and periodic screening, diagnosis, and treatment (EPSDT) screenings to establish good health habits at an early age, identify medical or developmental issues at the onset for appropriate treatment, and set children up for not just better health outcomes but better life outcomes.

We use three pillars to ensure we address current and emerging health needs of Mississippi Coordinated Access Network (MSCAN) and Mississippi Children's Health Insurance Program (CHIP) members, their families, and their communities:

- **Pillar 1:** Increase member, family, and caregiver knowledge, skills, and participation in health-promotion and prevention activities in a culturally appropriate way
- **Pillar 2:** Enhance provider knowledge and practice of developmentally and culturally appropriate health care by implementing innovative provider engagement, capacity, and education strategies; offering one-to-one provider support, evidence-based developmental screening tools, and Early Intervention referral sources; and delivering actionable data analytics and reports to assist with closing care gaps
- **Pillar 3:** Foster partnerships between families and caregivers, providers, and community stakeholders to promote desired social, developmental, and health outcomes

These pillars are important to our mission of ensuring children in Mississippi receive timely services, periodic health screenings, and up-to-date immunizations, thereby improving member health and reducing long term healthcare costs.

We commit to providing Mississippi with a comprehensive system of care that includes a broad spectrum of innovative member services and benefits tailored to meet the unique needs of our Mississippi neighbors; proactively addressing racial, ethnic, and geographic disparities. Our localized approach will leverage the resources of Mississippi providers, our well-being program that addresses social determinants of health (SDOH), and strategic community and social services partnerships to promote healthy living and health equity best practices.

We confirm we will comply with all requirements outlined in the RFQ, Section 4.2.2.1. Our facilities, service locations, and personnel are accessible and sufficient to provide covered services consistent with the requirements specified in Appendix A, Section 4. In accordance with 42 C.F.R. § 440.230, we will provide all medically necessary covered services allowed under MSCAN and CHIP, and ensure all covered services are sufficient in an amount, duration, and scope to achieve the programs' purpose. We have policies and procedures in place to address states of emergencies, public health emergencies and natural disasters, including hurricanes, tornadoes, fire, floods, and snow/ice storms.

4.2.2.1.A.1 Children

a. The Division has a special interest in ensuring timely and robust developmental screening and early intervention for children. The Offeror should keep that in mind in answering the following:

i. MississippiCAN Services: Describe the Offeror's proposed approach to ensure children receive timely services, periodic health screenings and appropriate and up-to-date immunizations using the ACIP Recommended Immunization Schedule and AAP Bright Futures for all MississippiCAN Members including periodic examinations for vision, dental, and hearing and all medically necessary services. Include the following: 1. An overview of related policies, procedures, and processes

Our early and periodic screening, diagnosis, and treatment (EPSDT) program details policies, procedures, and processes to ensure children receive timely services, health screenings, and appropriate and up-to-date immunizations. Our EPSDT program follows the American Academy of Pediatrics (AAP) Bright Futures™ guidelines for recommended visits, screenings, and immunization frequencies; Advisory Committee on Immunization Practices (ACIP) vaccine recommendations and schedules; and the American Academy of Pediatric Dentistry's (AAPD) Periodicity Schedule for dental screenings. Our program includes a service provision tracking system and established processes for member/family/caregiver reminders, follow-ups, and outreach as outlined in Appendix A, Section 4.1.3; provider education and support including utilization review requirements outlined in Appendix A, Section 8.16; and strategies involving community stakeholders such as daycare centers and schools to increase access to services.

Policies. Our EPSDT policies fully align with State and federal requirements related to periodic health screenings, immunizations, and periodic vision, dental, and hearing exams. Per our policies, we arrange or refer eligible members for EPSDT services, which includes contacting parents of newly enrolled children to make appointments for EPSDT checkups; providing education and information on how to access EPSDT services; and contacting and assisting members who are overdue for EPSDT services helping them to make necessary appointments. We work with our members and/or their caregivers to find EPSDT service providers in their area, including physician offices, federally qualified health centers (FQHCs), rural health clinics, comprehensive health clinics, Mississippi State Department of Health clinics, Mississippi Department of Education certified public schools or school districts; and Division approved off-site locations including daycare centers and Head Start locations.

Procedures. Our comprehensive system generates an EPSDT dashboard that displays key subsets of members needing EPSDT services. This allows our specialized teams to proactively outreach members/caregivers to educate on the program and facilitate timely service delivery. The call center outreach manager is focused on engaging all new enrollees and active MSCAN members, where an EPSDT gap in care (based on claims) has been identified based on the dashboard data. Additionally, our care management team responds directly to system alerts at the member level, notifying them of required EPSDT services for members already in case management programs. Each of these teams works with these designated subsets of members to facilitate services. Our outreach includes a minimum of three attempts by telephone within 30 days of reporting, to engage new and existing members who have not had an EPSDT checkup. Upon contact with member/caregiver, our teams provide education on the importance of the EPSDT visit and member incentives (with the Division's approval) available for completion. Our team also assists the member schedule a visit and arranges transportation if necessary.

Processes. Our processes are multi-pronged with multiple touchpoints:

- **Member Engagement**. We provide information about the importance of EPSDT with every interaction with a member, the member's family or caregiver, or the community at large. Our outreach includes informative materials that emphasize the importance of preventive care; the periodicity schedule with the depth and breadth of services; how and where to access services including transportation and scheduling services; and reminders that services are provided without cost. We educate our members who are pregnant on infant and child health, so parents understand the importance of preventive health and are aware of the importance of early detection for any developmental health issue. New mothers receive this information within five calendar days following their child's birth. We discuss member engagement in greater detail following. We hold member advisory councils to seek feedback from our members on the best approach to educate and support EPSDT.
- **Provider Engagement**. We educate our in-network providers on the importance of EPSDT services; guidelines for recommended visits, screenings, and immunization frequencies; and the opportunity to receive pay for performance bonuses through our value-based purchasing (VBP) incentives. Our wellness guide created in conjunction with Mississippi providers outlines EPSDT requirements by age interval to ensure EPSDT exams are conducted appropriately. We incent providers to conduct EPSDT exams, schedule follow-ups while the patient is in the office and offer after hours EPSDT screens on Saturdays and during school breaks to ensure access to care is available to working parents. **Our offering includes the use of a transparent service delivery**

model with a bidirectional data exchange, which is fully integrated with the majority of its providers including FQHCs. Through this arrangement, we provide member-specific gaps in care to the provider. In turn, the provider shares information about appointments and encounters in real-time.

- **Care Management Engagement.** Care Management is a bridge between members, their families, multiple systems including daycare facilities and schools, healthcare providers, and community-based organizations (CBOs). In coordinating care, our care managers and community health workers ensure effective communication between providers, members, and their families by arranging appointments, assisting with referral forms, arranging transportation as needed, providing reminder and follow-up calls (telephonic, mailed, intelligent text, email, and mobile application), and obtaining feedback reporting on access and services. We conduct a pre-health risk screening (HRS) review of members' utilization and use this information to initiate a conversation with the family about EPSDT services when completing the HRS. Within the HRS, there are questions regarding child immunizations that also prompt communication and encouragement of EPSDT services by the care management team. Care management ensures closed loop referrals and follow-up on appointments.
- **Utilization Management Engagement.** Our Utilization Management team monitors the utilization patterns of our members and refers to care management. They identify outstanding member needs while interacting with a provider to share real-time data and care gaps.
- **Stakeholder Engagement.** We will partner with CBOs, provider associations, state agencies, Head Start programs, schools, daycare centers, after school programs such as Boys and Girls Clubs, faith-based organizations, libraries, and family resource centers such as food and diaper banks and encourage trusted peer-to-peer communications between these organizations and members/families/caregivers.
- **Value-Added Benefits**. With Division approval, we offer non-cash member incentives and value-added benefits to reward compliance with immunizations and prenatal visits, such as our value-added benefit that provides gift cards for postpartum and well-baby visits.

Our EPSDT program prioritizes outreach and compliance monitoring for children and adolescents (young adults), considering the multilingual, multicultural nature of the unique characteristics of Mississippi residents including racial, ethnic, and geographic disparities. Our program includes an EPSDT Provider Education and Training Plan that clearly outlines all Division contractual requirements and covers all services. Our dedicated EPSDT training staff visits PCP offices regularly to educate PCPs, office, and support staff and provide technical assistance.

Our EPSDT program complies with all state and federal requirements. We update our EPSDT program based on written communication from the Division and submit program updates to the Division on at least an annual basis for approval. We also ensure EPSDT providers report member encounter data in a division-approved format and in accordance with contractual specifications and timelines.

2. An overview of how the Offeror will encourage Members to obtain services

We know that a successful population health management approach is centered on health education and interventions focused on preventive measures. Therefore, our approach uses enhanced, member-centered tools that are designed to strengthen engagement and encourage members to obtain services. We engage our MSCAN and CHIP members and their families through outbound calls from our member services team to remind them of upcoming member appointments and needed screenings; large-scale community events and health fairs where we offer complementary services; and easily accessible reference materials to educate our members, their families, and the community at large on the importance and benefits of managing their health. At every opportunity, we reinforce the importance of regular checkups, immunizations, and simply maintaining healthier lifestyle habits. We promote health within our local communities. Our team members are local; they live in the communities they serve and have an intimate understanding of culture, language, social norms, and available resources. For example, our member services team assists members with housing, food, employment, clothing,

heating, transportation, and financial resources offered by community-based programs. Our member services team also connects our members to their care manager and assists with scheduling appointments, medication refills, obtaining medical equipment, maintaining eligibility, and advocacy.

We use the latest in technology to communicate with our members. For example, our mobile application allows members to view upcoming appointments, needed immunizations or screenings; schedule transportation if needed; and access a wealth of health education materials in those areas that matter the most – with the swipe of a finger. Using our population health analytics approach to interventions, we segment populations by key age ranges, geography, and health equity, as well as by clinical condition, provider group, and acuity. Our performance dashboard is a robust interactive tool that targets specific age groups to evaluate SDOH and health disparities, as well as track and address gaps in care by measure and provider group.

We will also work closely with technology partners using artificial intelligence (AI) and machine learning (ML) to better understand the habits of our members and their parents/primary caregivers. We use a machine learning algorithm to look for patterns in historical data and identify clinical and social drivers that enable the prediction of potential adverse outcomes. Using these data, we tailor member communications and incentive campaigns to meet the unique needs of the segmented population to best influence change to more effective health behaviors, such as attending follow up appointments for screenings and immunization, and healthy lifestyles choices.

Collaboration and ongoing communication form the basis of our person-centered, holistic approach to care management. Our approach moves beyond episodic care and ensures our care managers are an active part of our members' lives for as long as it takes for them to become stable and proficient at managing their own health.

For our members who need more intensive care management, we offer health education and disease management programs that provide targeted, customized information, including high risk pregnancy, hypertension, neonatal care; and information for those dealing with serious conditions such as diabetes. These programs provide specialized resources designed to address those risk factors associated with a specific disease state and enable us to work more closely with our members. Our teams identify and address SDOH that may have created a barrier to help the member focus on health. When members know they have food, housing, and transportation security they can be active participants in their health journeys. Continuous education related to their condition, providing tips and tools, and empowering them to partner in their health journey helps them achieve self-management of their disease and ultimately results in better health outcomes.

We also offer multiple strategically targeted value-added benefits, with Division approval, to encourage our members to obtain services, including enhanced dental benefits and vision benefits and incentives in the form of gift cards for achieving vaccination, perinatal/prenatal care, disease management, weight loss, and smoking cessation milestones.

3. How the Offeror anticipates the approach will improve health outcomes

Based on our experience, we know timely and robust developmental screening and early intervention programs yield life-long benefits in academic achievement, behavior, educational progression and attainment, delinquency and crime avoidance, and labor market success. Additionally, interventions with better trained caregivers can offer even more favorable results. Our approach ensures members receive timely services, periodic health screenings, and appropriate and up-to-date immunizations to increase the early identification and treatment of autism, help prevent the development of chronic conditions, and the spread of communicable diseases. Our enhanced vision benefits aid in the identification and treatment of vision challenges, which have a major impact on school performance and the development of successful interpersonal relationships. Our enhanced dental benefits prevent health complications that may arise during pregnancy.

The screening protocols used by our providers are grounded in clinical literature and are trauma informed. They address developmental (including autism), cognitive, language, motor skills and language delays, growth challenges, behavioral health (BH) conditions, and the risk or presence of adverse childhood experiences,

including domestic violence and intimate partner violence. We recognize that Mississippi screened fewer young children for developmental delays than any other state in the country. Our partnership with Jackson State University will provide a local solution aimed at improving early childhood screening rates for the most vulnerable children in Mississippi. Jackson State University will help develop educational resources to use on member facing platforms; and when educating childcare centers and families about developmental disabilities, provide referral sources for assessments and ways to connect with advocacy groups. This public/private partnership will bring the best of Mississippi's resources together so families and caregivers can consult with early education professionals and clinicians to better understand developmental issues and have access to treatment. The early identification and treatment of these conditions establish good health habits at an early age, identify medical or developmental issues at the onset for appropriate treatment, and set children in Mississippi up for better health outcomes and better life outcomes.

4. The Offeror's process for reminders, follow-ups, and outreach to Members

We track MSCAN member EPSDT service utilization and gaps in care through our member tracker in our care management platform. The member tracker is a decision-support information technology tool that integrates claims and member demographic data with Division requirements to identify members in need of services or who missed critical EPSDT and immunization appointments. The tracker identifies the timing of immunizations, health examinations, and lead testing; utilization of services (including vision, dental, and hearing, and all medically necessary services); and identifies gaps in care. The member tracker pushes alerts to multiple systems including the member portal, care management, and the clinical practice registry on the provider portal where providers can access them. We provide access to the alerts for all member-facing staff so any employee who is working with a member can help support the closure of their gaps in care.

We tailor our approach for reminders, follow-ups, and outreach to each MSCAN and CHIP member, honoring each family's preferred method of contact, needs, and preferences. We take into consideration the cultural preferences, language, and literacy capabilities of our MSCAN and CHIP members and tailor our approach, accordingly. We offer translator services for over 200 languages, our materials are written at or below the third grade reading level, and are available in large print, audio, Braille, and accessible electronic formats.

5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance

As part of our value-added benefits, we waive all member copays and cost sharing, for all covered services, including family planning and pregnancy-related services. There are no limitations to this benefit and no prior authorization is required.

We advise both members and providers that they are not responsible for copays or cost sharing in our member handbook and on our member website. We also advise members and providers that cost-sharing in any form is unallowable for family planning or pregnancy-related assistance during member enrollment, upon learning about a member's pregnancy, during inbound and outbound member calls, through our interactive voice response system, and during care management.

We acknowledge that the Division of Medicaid covers family planning and family planning related State Plan services and supplies and that Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services in accordance with Miss. Admin. Code Part 200, Rule 3.6.

We also acknowledge that beneficiaries have freedom of choice to receive or reject family planning and family planning related services, choose family planning and family planning related services providers, and choose any method of birth control, including sterilization.

6. Any innovative methods that Offeror will use to augment its approach

We continuously review and identify opportunities to develop and scale supportive interventions that include enhanced services, innovations, and programs that augment our approach to delivering improvements in timely screenings and early interventions. These interventions encompass the integration of care, technology, empowering members, driving health equity, collaborating with providers, and building trust and transparency. Following we detail innovations we use to augment our approach to timely and robust developmental screening and early intervention for children.

Member Digital Engagement. Our member portal makes it easy to find a doctor, obtain an ID card, review claims, make payments, and engage with care managers. Our sophisticated member/mobile application offers a personalized health guide based on a member's specific health risk or condition. Our members enjoy secure communications with our care team or their provider. Our member chat community solution offers access to educational discussions to alleviate fears members, or their caregivers may have about vaccinations. Members who enable text messaging can complete their health risk screenings electronically.

Social Media Engagement. We leverage social media to provide two-way communication when, where, and how the member wants to engage. This includes a streamlined path to telehealth services and access to immediate online help, as well as coordination with the member's primary care provider. We offer dedicated MSCAN and CHIP Facebook pages, administered by dedicated social media staff during business hours, and customized chatbots to enable self-service 24 hours per day. We are available on Instagram, Twitter, LinkedIn, YouTube, Google Reviews, and Google Business Message. We also monitor and follow Reddit, Tumblr and TikTok, and other emerging platforms to determine changes in member sentiment. We find social media to be extremely effective in creating a customer care dialogue, as shown by the 1,100% increase in consumer care interactions (i.e., flu shot reminders) due to our social media presence in other Medicaid markets.

Creating a Statewide Network of Pediatric Accountable Care Organizations (ACOs) to Improve Children's Health and Well-Being. With a commitment to making population-level improvements through increased levels of integration and improved health care outcomes, we recently created a statewide network of pediatric accountable care organizations with several leading children's hospitals in another state. This collaborative offers access to every level of children's health care—from preventive services and well-child visits to the most sophisticated medical and surgical specialties. The alignment of strategies between our plan and children's hospitals maximizes the collective impact on this state's health care system, while serving as good stewards of its taxpayers' dollars. In collaboration with the statewide network of children's hospitals, we are collectively afforded the opportunity to deliver an integrated system focused on care quality and improved access and care coordination to our youngest members. This alliance is paramount to transforming children's health and well-being.

Leveraging Health Information Exchange for Providers. Through our Health Information Exchange (HIE) program, we utilize our fully integrated, transparent service delivery model with **a real-time bidirectional data sharing strategy focused on positively impacting health equity and member outcomes.** We offer direct electronic health record (EHR) data sharing with select large health systems and PCMH providers. Communication occurs directly with the provider's EHR vendor to tailor a solution for data sharing. This platform is used for bidirectional feeds; electronic medical records data from the EHR system to us and to deliver gaps in care including gaps closed at other provider locations as frequently as desired by both parties. This data exchange allows us to share member information and gaps in care directly into the provider's EHR.

ii. CHIP Services: Describe the Offeror's proposed approach to ensure CHIP Members receive timely services, Immunizations, Well-Child visits, and any other services described in the CHIP State Health Plan. Include the following:

1. An overview of related policies, procedures, and processes

Our policies, procedures, and processes for CHIP members are like those described prior for MSCAN members with few exceptions. We will have a comprehensive network of providers who will provide all medically covered services allowed under CHIP in accordance with the CHIP State Health Plan and as enumerated in the administrative code.

Policies. Our policies fully align with State and federal requirements related to periodic health screenings, immunizations, and periodic vision, dental, and hearing exams. Per our policies, and without limitation, we ensure CHIP members receive periodic health screenings and appropriate and up-to-date immunizations using the immunization schedule for all members recommended by the Advisory Committee on Immunization Practices (ACIP). We arrange or refer members up to age 19 for covered services, which includes contacting parents of newly enrolled members to make appointments for checkups; providing education and information on how to access covered and non-covered services; and contacting and assisting members who are overdue for services helping to make necessary appointments.

Procedures. Our comprehensive system generates a dashboard that displays key subsets of members needing well-baby and well-child care services, immunization services, and other services described in the State Health Plan, including behavioral health/substance used disorder, dental, and vision services. This allows our teams to proactively outreach members/caregivers to educate on covered services and facilitate timely service delivery. Our call center outreach manager is focused on engaging all new enrollees and active members under the age of 19, where a gap in care (based on claims) has been identified. Additionally, our care management team responds directly to system alerts at the member level, notifying them of required services for members already in case management programs. Each of these teams works with these designated subsets of members to facilitate access to services. Our outreach includes written notification of upcoming or missed appointments taking into consideration language and literacy capabilities of members. We also make a minimum of three attempts by telephone within 30 days of reporting, to engage new and existing members who have not had a scheduled service. Upon contact with member/caregiver, our teams provide education on the importance of the service and member incentives (with the Division's approval) available for completion. Our team also assists the member schedule a visit and arranges transportation if necessary.

Processes. Our processes are multi-pronged with multiple touchpoints that include member engagement, provider engagement, care management engagement, utilization management engagement, stakeholder engagement, and member incentives. We educate our in-network providers on covered services; as well as guidelines for recommended visits, screenings, and immunization frequencies; and the opportunity to receive pay for performance incentives through our VBP incentives. We incent providers to conduct exams, schedule follow-ups while the patient is in the office and offer after hours services on Saturdays and during school breaks to ensure access to care is available to working parents.

We prioritize outreach and compliance monitoring for CHIP members considering the multilingual, multicultural nature of the unique characteristics of Mississippi residents including racial, ethnic, and geographic disparities. Our program includes a CHIP Provider Education and Training Plan that clearly outlines all Division contractual requirements and covered services. Our dedicated training staff visits PCP offices regularly to educate PCPs, office, and support staff and provide technical assistance.

2. An overview of how the Offeror will encourage Members to obtain services

We employ the same rigorous population health approach to each population with the goal of identifying subsets of the population that we can target with specialized services designed to meet their individualized needs. In this group, engagement of the member/caregiver with a primary care provider and medical home is a priority. We conduct ongoing member outreach using education and incentives for all members, parents, and guardians to promote adherence to timely care including immunizations and well-child services. In addition, our

staff promote all CHIP services at local community health fairs and collaborate with community- and faith-based organizations to support our member education efforts about CHIP services. We continually monitor to determine members who have not yet completed well-child services to conduct targeted outreach. Our teams make reminder calls and send emails and interactive text messages to members or caregivers as appropriate about upcoming and overdue services. We also mail age-specific reminders to members at home. To reach members who fall behind in well-child visits, we send text messages with monthly reminders to encourage them to schedule their next appointment using an interactive text link or a phone number that we include. In addition, our care managers assigned to members with more complex needs share information about CHIP services in every outreach. We also conduct quarterly outreach via telephone to members who are not in care coordination about the importance of receiving preventive and well-care services to help them stay on track.

We cooperate with the Mississippi Department of Health (MSDH) in matching CHIP enrollment data with immunization records and work with our network providers to promote the MSDH system to maintain accurate, complete, and current vaccination records for our CHIP members to promote vaccine-preventable diseases. We support enrollment among our providers to help create more access points and work with our providers to increase the number of members receiving recommended immunizations.

3. How the Offeror anticipates the approach will improve health outcomes

As we detail previously, timely well-baby and well-child visits and immunizations, coupled with early intervention programs improve health outcomes. Our approach to ensuring CHIP members receive timely services, periodic health screenings, and appropriate and up-to-date immunizations increase the early identification and treatment of disorders such as autism, helps prevent the development of chronic conditions such as diabetes and helps prevent the spread of communicable diseases. Our enhanced vision benefits aid in the identification and treatment of vision challenges.

As part of our screening protocols, we address developmental (including autism), cognitive, language, motor skills and language delays, growth challenges, BH conditions, and the risk or presence of adverse childhood experiences, including domestic violence and intimate partner violence. The early identification and treatment of these conditions establish good health habits at an early age, identify medical or developmental issues at the onset for appropriate treatment and set children in Mississippi up for not just better health outcomes but better life outcomes.

4. The Offeror’s process for reminders, follow-ups, and outreach to Members

We track CHIP member service utilization and gaps in care through our interactive dashboard and member tracker in our care management platform. The member tracker is a decision-support information technology tool that integrates claims and member demographic data with Division requirements to identify members in need of services or who missed immunization appointments. The tracker identifies the timing of immunizations, health examinations, and lead testing; utilization of services, and identifies gaps in care. The member tracker pushes alerts to multiple systems including the member portal, care management, and the clinical practice registry on the provider portal where providers can access them. We provide access to the alerts for all member-facing staff so any employee who is working with a CHIP member can help support the closure of their care gaps. We tailor our approach for reminders, follow-ups, and outreach to each member, honoring each family’s preferred method of contact, needs, and preferences. We take into consideration the cultural preferences, language, and literacy capabilities of our members and tailor our approach, accordingly. We offer translator services for over 200 languages, our materials are written at or below the third grade reading level, and are available in large print, audio, Braille, and accessible electronic formats.

5. How the Offeror plans to communicate to the Member that Cost sharing in any form is not allowable on benefits for family-planning or pregnancy-related assistance

As part of our value-added benefits for CHIP members, we waive all copays and cost sharing, for all covered services. There are no limitations to this benefit and no prior authorization is required. We advise members that they are not responsible for copays or cost sharing in our member handbook and on our member website. We also advise members that cost-sharing in any form is unallowable for family planning or pregnancy-related assistance during member enrollment, upon learning about a member's pregnancy, during inbound and outbound member calls, through our interactive voice response system, and during care management.

6. Any innovative methods that Offeror will use to augment its approach

We continuously review and identify opportunities to develop and scale supportive interventions that include enhanced services, innovations, and programs that augment our approach to delivering improvements in timely screenings and early interventions. These interventions encompass integration of care, bidirectional data sharing, member engagement and empowerment, health equity, collaborating with providers and value-based contracting, building trust and transparency. Innovations we offer to augment our approach to timely and robust developmental screening and early intervention for CHIP members mirror those that we detail prior for MSCAN. These include our self-management technology, **member digital engagement, social media engagement, and our HIE program**, a real-time bidirectional data sharing strategy focused on positively impacting health equity and member outcomes.

b. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes for children?

We know that health disparities have an impact on everyone, causing higher illness and death rates and greater financial strain on communities and the State. We believe everyone deserves access to quality healthcare, stable housing, transportation, nutritious food, and that access leads to better health. Advancing health equity does not happen by chance. It requires a keen understanding of population nuances in the communities we serve, and programs and approaches that are intentionally crafted to address the unmet needs of the vulnerable populations in those communities.

In accordance with culturally and linguistically appropriate services (CLAS) standards, we employ a diverse, competent, and compassionate workforce that approaches the care of our MSCAN and CHIP members through a health equity lens. We recruit employees who reflect and share the various backgrounds and experiences of our MSCAN and CHIP members. This diversity enables us to be aware of and responsive to the specific needs of our members. In addition, our mandatory annual implicit bias training, and other ongoing professional development offerings, such as formal education on human trafficking and domestic violence affecting children, help to refine our understanding of the member experience, needs, and challenges.

We maintain a comprehensive, multi-faceted health equity plan to ensure the delivery of all services through a health equity lens; this includes health equity representatives, cross-departmental leadership, care management, and community health workers (CHWs) involved in improvement initiatives that reduce disparities. Our comprehensive health equity plan uses population health analytics to drive improved health outcomes in members experiencing health disparities.

Our Health Equity Committee fosters the health and well-being of members who experience health disparities due to race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Our Committee is composed of multiple health equity representatives, including a Health Equity Officer; Director of Diversity, Equity, and Inclusion; and representatives from our quality, behavioral health, and care management teams.

In accordance with CLAS standards and in alignment with our population health management approach, we use a full complement of strategies, technology, and tools to understand and address member experiences where

there are disparities in care that lead to health inequities. This includes the use of member race, ethnicity, and primary language data offered by the State at the time of enrollment.

We leverage sophisticated analytics and member experiences to quickly identify barriers that impact access to care and magnify disparities. For example, we use our high-risk pregnancy predictive model, a machine learning algorithm, which looks for patterns in historical high-risk pregnancies and identifies clinical, behavioral, and social drivers that enable the prediction of potential adverse outcomes for current pregnancies. Attributes include social determinants of health, age, race, ethnicity, chronic disease, behavioral health conditions, and past pregnancy outcomes. Our model focuses on the following birth outcomes: sick newborn, premature delivery, neonatal abstinence syndrome, failure to thrive, low birth weight, NICU admission, and stillbirth. Our valid, reliable predictive analytics model allows rapid stratification and care management prioritization of all pregnant members.

We host Member Advisory Committee (MAC) meetings that include families and caregivers. Feedback from these committees is essential to understanding barriers faced by our members, allowing us to refine our programs to reduce these challenges, and prevent adverse health outcomes. We use these committees to solicit feedback; for example, we conducted MAC meetings during the COVID-19 pandemic, following the initial authorization of the vaccines for children, to understand community concerns and challenges. Many attendees expressed concerns about the safety and potential side effects of the vaccines, especially on children, and the effect of the vaccine on existing chronic conditions. In addition, they expressed to us that they were awaiting instruction from their child's PCP prior to their child receiving the vaccine. We used this feedback to create social media posts, newsletter articles, provider outreach, and a bidirectional text messaging campaign to directly address those concerns and to provide targeted education to our members, their families, and their communities.

We will develop targeted interventions and measures based on root cause analysis of our population health assessment data, State data, State goals, and feedback from our members, providers, and community partners. Table 4.2.2.1_A outlines our targeted, member-facing interventions aimed at addressing health disparities and related measures or key performance indicators. Our Health Equity representatives are involved across initiatives in efforts to reduce health disparities in our Mississippi communities, offering guidance on implementing initiatives with department leaders or facilitating learning opportunities for our staff, providers, and community organizations. We collect and analyze key performance indicators using our quality assurance process to track the progress of our disparity reduction efforts.

Table 4.2.2.1_A: Health Disparities and Targeted Interventions

Health Disparity	Description of Intervention	Key Performance Indicators
Infant Mortality Rate for Black infants is nearly twice that for White infants	▪ Mobile Healthcare: Partner health systems will bring mobile clinics to provide prenatal, postpartum, and well-childcare in rural zip codes with high infant mortality, low birth weight births, and preterm births. ▪ Monthly support payments to select high-risk mothers for healthy diets. ▪ Face-to-face engagement of Black pregnant members by CHWs to engage in care management, coordinate care, educate on healthy pregnancy and well-child, and mitigate social barriers.	▪ Timeliness of Prenatal Care ▪ Number Prenatal Visits ▪ Postpartum Care ▪ Well-Child Visits ▪ Depression Screening ▪ Preterm Delivery ▪ Tobacco Use Rates ▪ Length of Gestation ▪ NICU Admissions
Underutilization of pediatric well-child visits	▪ Increase access to pediatric well-child visits through delivery in non-traditional settings. We will work with childcare facilities and Head Start locations across Mississippi to ensure that young children have easily accessible health screens available and the ability to address any issue at the onset to ensure appropriate treatment of preventable and corrective health conditions. ▪ Recognizing well child visits decline after a child enters primary school, we will work together with school districts and school nurses to provide opportunities for increased health screens and immunizations in the school setting. We will also work with the pediatricians in Mississippi to develop a collaborative between pediatricians and school nurses to provide a pathway for appropriate referrals and follow-up treatments.	HEDIS well-baby and well-child visit rates

Health Disparity	Description of Intervention	Key Performance Indicators
School Break Initiative & School-Based Clinics	Using our localized approach, our SDOH coordinators will work with area providers across Mississippi on our School Break Initiative which incents providers to offer health screens and immunizations during school breaks and encourages providers to hold at least one, but as many as five special events focused on well child visits during back-to-school events and school breaks. In another market, we initiated more than 70 school-based clinics across the state (42 comprehensive centers and 30 schools that provide comprehensive mobile services). We also initiated the "Adopt a School" program, which is a collaboration with Title I elementary schools to fund health services. The program promotes a presence at school events and has allowed us the opportunity to identify and fund resources in support of critical learning needs, such as a phonics lab, an autism sensory room, and books for the library, as well as grants for school nurses in rural elementary schools.	HEDIS measures including: ▪ Well-child visits ▪ Adolescent immunization ▪ Lead screening ▪ Dental visit ▪ Vision visit

4.2.2.1.A.2 Behavioral Health Services

Our approach to managing behavioral health (BH) care for our MSCAN and CHIP members is rooted in collaboration, deep integration, and holistic innovation. We stand shoulder to shoulder with the Division in building a person-centered, recovery-oriented BH system that serves individuals in the least restrictive settings through robust community-based services. Our approach seeks to improve member outcomes by empowering the development of self-directed care skills and providing person-centered planning for individuals with complex needs built on the member's strengths and goals; access to high quality preventive and specialty behavioral healthcare; intensive specialty provider support to ensure robust community-based services; and innovative services and service delivery models that leverage technology and local supports to improve health outcomes.

At the core of our approach is our belief that BH must be **fully integrated into managed care services** to improve health outcomes and manage the total cost of care. For this reason, **we do not delegate BH services**. We collaborate with our providers in the delivery of community based BH services and encourage and support integrated programming and recovery-based care to improve health outcomes and reduce total healthcare costs. Behavioral health considerations are extensively built into our data information systems and predictive models to provide member-facing staff real-time support in providing integrated care. Our staff are experienced in pediatric and adult BH, recovery, and community-based care to facilitate effective integrated care. We treat children, adolescents, and adults with BH and/or SUD challenges with the same focus as physical health (PH) needs in accordance with the Mental Health Parity and Addictions Equity Act (MHPAEA) and in compliance with federal statute 42 CFR 438.3, the SUPPORT Act and Appendix A, including 4.1.4 and 4.2.4.

a. Describe the Offeror's direct experience in service delivery and payment/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for Pediatric and adolescent behavioral health/substance use disorder, including compliance with the SUPPORT Act.

We are a leader in the development and expansion of community-based services to support families and reduce the need for out-of-home care and foster care. Our direct experience in a transparent, fully integrated service delivery model ensures our members receive the most operationally excellent care available. Preventive family support services and access to community-based services are central to our model. We strive to **help every child be successful in school, live with their families, graduate from high school, pursue post-secondary skill building and education, and become healthy and productive adults**. Our approach ensures children with BH/SUD treatment needs receive specialized services tailored to address their unique needs, remediate their experiences of trauma, and support caregivers. Through our integrated holistic approach to intensive care management, we partner with families to build person-centered plans that build on the strengths of the child and their family and identify services and supports to meet the unique needs of each child and family. Like our MSCAN members, we support our CHIP members in achieving their healthcare goals through innovative value-added benefits and member incentives aimed at encouraging members to engage in follow up care. Caregivers earn rewards for well-child visits, dental care, immunizations, and provider appointments to follow-up when providers prescribe medication for attention deficit/hyperactivity disorder (ADHD). During member outreach

calls, we use our incentive rewards to motivate members to act. As an example, in another market we launched an ADHD incentive in 2019 to reward for follow-up visits after receiving initial prescriptions. As a result, ADHD follow-up visits for the continuation of care increased by 38% from 2019 to 2020. Across our other markets, 15% of the children and adolescents we serve have an identified BH diagnosis.

Fifty percent of all mental illness begins by the age of 14 and often remains unidentified and untreated into adulthood. To improve the early identification of BH challenges and recognize that families often turn to their pediatrician for support and guidance, we educate primary care providers (PCPs) on the importance of screening, brief intervention, and treatment (SBIRT) and equip them with screening tools. We also incentivize PCPs to seek psychiatric consultation to screen for BH and developmental conditions, provide medication management services as appropriate, and refer for specialty BH care to meet the needs of children and adolescents. In another market, **our pediatric and adolescent members receiving BH services in 2020 averaged 13.4 services per member annually, compared to 11.4 services per member in 2019.** We attribute this 17% increase to our program efforts to engage members into care by promoting and training pediatric providers in the early assessment, identification, and referral to BH specialists.

Through our advanced analytics, we proactively identify children and adolescents at risk of BH or SUD challenges and provide outreach to families, caregivers, and providers to engage children, adolescents, and families into care. Through our provider portal, we offer providers real-time care gap alerts and resources to aid in the identification screening, assessment, and engagement of children, adolescents, and families at risk of BH and SUDs. This includes a member profile that provides a comprehensive view of the member's services, providers of care, pharmacy and prescribing provider, utilization, and care gaps. Our transparent service delivery model is fully integrated with most of our providers through real-time bidirectional data exchange.

Although we will not own the pharmacy retail dispensing network, we are committed to exploring ways to engage community pharmacies/pharmacists for enhanced pharmacy services (cognitive services, medication therapy management activities, gaps in care/adherence interventions and value-based reimbursement opportunities). We commit to partnering with community-based pharmacies and pharmacists in Mississippi to explore opportunities to develop a program that would create opportunities for pharmacies to be reimbursed outside of dispensing for activities that improve the care of MSCAN members. For this activity we will leverage a portal to manage bidirectional clinical interventions and outcomes activity.

We will also partner with community pharmacies to educate CHIP members and their families and providers at the point of sale about safe opioid use, review the use of atypical antipsychotics in children and discuss concurrent use of antipsychotic therapy for eligible members. The team contacts providers to facilitate coordination and referrals between BH and primary care prescribers resulting in a reduction in the percentage of children and adolescents actively prescribed multiple, concurrent antipsychotics.

In 2020, in another market, upon implementing provider outreach, **the rate of children and adolescents with two or more concurrent antipsychotics declined from 1.39% to 0.40%, well below the 1% target**. We successfully increased the use of first line psychosocial care for children on antipsychotics from 76.27% to 81.3% over the last three years. We will use this experience to collaborate with providers and the pharmacy benefit administrator (PBA) to have child psychiatrists and addiction psychiatrists available for peer-to-peer consultation with providers.

We **commit to supporting** the PBA to ensure compliance with the SUPPORT Act. We have a network of providers that apply best practices to meet SUPPORT Act requirements, including, evidenced based approaches to improve care for infants with neonatal abstinence syndrome and their families, and appropriate use of atypical antipsychotics with children. Our transparent service delivery model is fully integrated with most of our providers through real-time bidirectional data exchange.

b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for behavioral health/substance use disorder services for adult behavioral health/substance use disorder, including compliance with the SUPPORT Act.

In the context of family and community, we strive to **help every adult with BH, and SUD challenges recover and reach their highest level of functioning and independence**. We are a leader in the development and expansion of community-based services to support recovery and will help MSCAN members be productive adults employing our transparent service delivery model to provide operational excellence. Our community-based services include **peer recovery support services**; an evidence-based practice that has demonstrated the efficacy of people with lived recovery experiences helping people with BH and SUDs activate their personal goals of recovery. In addition to traditional counseling and medication assistance services, we are a leader in the promotion of **Assertive Community Treatment Teams (ACT),** employment, and housing support services. We fully recognize the role employment and housing support play in helping people recover from BH and SUDs. Our employment, housing support specialists, and life coaches as part of our well-being program assist our intensive care managers in working with local community-based organizations (CBOs) to match employment and housing opportunities to meet the needs of our MSCAN members. In addition to our community-based services, we provide a strong network of BH inpatient and residential treatment providers and reimburse for services provided by freestanding psychiatric hospitals as outlined in Appendix A.

Our intensive care managers focus care coordination and services on high-risk MSCAN members and populations, including, persons with suicidal behaviors, co-occurring disorders, and persons with nonfatal drug overdoses. As an example, our intensive care management team ensures MSCAN members with Serious Mental Illness (SMI), and opioid use disorders (OUD) receive specialized services tailored to address their unique needs, remediate their experiences of trauma, and support their recovery journey. We understand MSCAN members with BH, and SUDs including OUDs frequently experience co-morbid physical conditions, such as Hepatitis C, human immunodeficiency virus (HIV), and liver problems. Our data show nearly half of our MSCAN members with SUDs and OUDs have other BH concerns. Our MSCAN members with SUD and SMI have a higher rate of housing and food insecurity and need for support with employment and with community-based social determinants of health (SDOH) programs. In fact, 53% of our members who use our job and life coaching services in other markets have an underlying BH diagnosis of SMI and/or SUD. We also support our members with BH and SUDs by conducting visits with hospitals demonstrating low rates of follow-up appointments after discharge, discussing their discharge planning process, and identifying and helping remove barriers to obtaining follow-up appointments. **In 2020 in another market, our follow-up after hospitalization for mental health for Healthcare Effectiveness Data Information Set, Follow-Up After Hospitalization (HEDIS® FUH) measure scored at the 90th percentile.**

We will have a network of providers that apply best practices to meet SUPPORT Act requirements, including, evidenced based approaches to overcome barriers to care; providing medication-assisted treatment including buprenorphine, naltrexone, and methadone; and counseling services. We will support our providers serving adults with BH and SUDs in the successful submission of claims and receipt of payment through proactive training and outreach as explained in more detail in 4.2.2.1.A.2.C. **We consistently pay 99% of all BH/SUD claims within five days, with a three-day average speed of payment and a first pass accuracy rate greater than 99%**.

c. Describe the Offeror's approach to delivery and payment for behavioral health/substance use disorder services.

We take a **member and community approach** in designing and delivering BH and SUD services across our markets. By listening to each member, we learn about their strengths, needs, wants, and readiness for treatment. We will work with our local community partners and providers to understand the unique needs, resources, and challenges of each community. Our direct experience with a fully transparent, service delivery model enables us to take the feedback of our members and communities to design and deliver tailored programs, services, and resources to meet the needs of each member and community. Our approach to BH and SUD services is firmly rooted in recovery principles and our SUD recovery services are supported by the best practice models of the American

Society of Addiction Medicine (ASAM) and the Substance Abuse and Mental Health Services Administration (SAMHSA), which provides a framework to offer the most appropriate and medically necessary care for our MSCAN and CHIP members with SUDs. In addition, we support relapse prevention by collaborating with providers including CMHCs, and engaging members in self-management through follow-up calls, referrals to support groups, and extra visits. Our approach to BH and SUD services focuses on three key components: 1) **High quality BH and SUD network and programs**, 2) **High touch member/caregiver support**, 3) **Strong provider support**.

Strength of our BH and SUD provider network and programs: We have engaged most Mississippi providers in a fully integrated service delivery model that incentivizes providers to ensure Mississippians can access their benefits so they can live healthier lives. This model allows us to serve as a transparent and effective steward of taxpayer dollars. Recognizing the importance of recovery principles in the successful treatment of BH and SUDs, we ensure our network, services, programs, and facilities include a broad array of peer support, family support, medication assisted treatment (MAT), housing support, and employment support in addition to counseling and traditional BH and SUD services and facilities. In addition, recognizing the challenges of access to BH and SUD services in rural area, we use the hub and spoke model to bring services from centers of excellence to rural communities, including MAT. As an example, in one market we collaborated with a MAT partner to bring MAT providers to over 20 rural sites, filling an unmet need, and overcoming a geographic disparity. We supported the effort through data analysis and an innovative payment methodology.

In support of recovery principles, we pay and incent providers for the use of peer recovery specialists with lived experience to improve engagement and retention of MSCAN and CHIP members in treatment, especially for those identified with limited access to services or identified through inpatient and emergency department (ED) admissions to decrease re-hospitalization. In addition, we will **bring a first of its kind, SUD Home model to the delivery of SUD services to Mississippi** as an extension of our intensive care management services. The SUD Home brings additional prescribing practitioners serving members with SUDs to fill gaps in access to OUD replacement drugs and utilizes field-based peer recovery specialists (PRS) to reach out to members with BH and SUDs. Through consistent engagement, the PRSs serve as an extension of our intensive care managers by meeting members in their homes and communities, helping them increase their health literacy and move toward treatment and a life of recovery. They assist MSCAN and CHIP members in making informed treatment choices, identifying options, selecting providers, and obtaining resources; including supports to address SDOH needs such as housing and employment and to reduce barriers to engagement.

High touch member and/caregiver support: We train all member-facing staff in integrated recovery-focused care, including overcoming the stigma associated with BH and SUDs and identifying and supporting MSCAN and CHIP members with BH and SUDs. Our strength-based approach recognizes that focusing on member strengths supports recovery. Our intensive care managers support recovery with every interaction through reflective listening and motivational interviewing techniques. We hire staff with BH and SUD training and experience to be an integral part of all member-facing teams, providing team training and support to increase staff awareness and expertise in providing whole person care. In addition, we employ BH and SUD professionals and staff with the lived experience of recovering from BH and/or SUDs to help train and educate our staff about recovery principles and promote the hope of recovery. Our 24-hour BH/SUD crisis line and nurse advice line staffed with licensed professionals provides immediate support to MSCAN and CHIP members. This BH/SUD line is linked to intensive care management to assist our MSCAN and CHIP members, families, and caregivers with resources and connection to BH/SUD services and is available 24 hours with connection to our 24-hour nurse advice line. The line includes peer recovery support staff with the lived experience of recovery from alcoholism and drug use to engage callers more effectively. Staff are provided regular and ongoing training in local services including BH, detox, MAT, peer support, and outpatient SUD providers to assist MSCAN and CHIP members with receiving care. In addition, we support and promote the National Alliance on Mental Illness (NAMI) family to family and peer to peer programs to provide educational support to MSCAN and CHIP members and families regarding mental illness.

Our **intensive care management staff** coordinate PH, BH, SUD and OUD services, SDOH and support services, and recovery support services including peer support, employment, and housing support services. We identify MSCAN and CHIP members for referral to an intensive care manager through claims data, health needs screening, comprehensive health assessments, member services, BH crisis line, nurse advice line, utilization management, contracted vendors, other care managers, PCPs, and through various other ancillary providers of service. Our specialty BH care managers have a background and training in BH, SUD, OUD, or all three, and are available to assist adults and children with complex BH and co-occurring conditions. Our care managers and pharmacists monitor the utilization of services and pharmaceuticals for appropriateness and volume of services.

In addition, we will curate and promote nationally available self-management tools for our MSCAN and CHIP members, including an interactive application delivering evidence-based psychotherapy models, and cognitive behavioral therapy (CBT) approaches, to assist them in managing depression, anxiety, stress, substance use, chronic pain, and sleep issues.

Strong provider support: We proactively support our providers to enhance their effectiveness and success in delivering effective BH/SUD care in several different ways. First, we collaborate with our providers to develop and implement local BH/SUD programs to support recovery, with a focus on community-based recovery services. Second, we identify opportunities for program development, enhancement, improvement, or expansion and partner with providers to perform program fidelity reviews as needed to support adherence to best practices. Third, we monitor the utilization of services on the continuum, conduct retrospective drug utilization reviews and outreach providers to support appropriate and best practices. Fourth, we support our providers through our telehealth guide and a community resource library to encourage appropriate telehealth use. Our transparent service delivery model is fully integrated with most of our providers through real-time bidirectional data exchange. While less than 1% of our members in another market received tele-behavioral health care prior to the COVID pandemic, **63% of psychotherapy sessions used teletherapy during 2020.** This equates to two out of every three visits performed through telehealth, ensuring continued access to care during the pandemic. As a value add, we offer the use of our vendor’s platform to our providers who do not have telehealth capacity.

We expand access to BH and SUD services within **primary care settings** through provider training and billing guidance to screen for BH and SUD concerns and facilitate treatment. We ensure PCPs are equipped to screen for BH and SUDs, provide medication management services as appropriate, and refer for specialty BH care to meet the needs of the member. We will partner with the Child Access to Mental Health and Psychiatry (CHAMP) program, supporting pediatricians in addressing BH/SUDs. Our on-demand webinars provide education to PCPs on BH topics including screening for BH/SUD conditions. In addition, our provider portal offers providers access to a variety of assessment tools, access to member profiles that provide a comprehensive view of medical, BH/SUD, and pharmacy utilization and gaps in care.

We use three main methods to communicate data with our provider networks. First, our regional BH health plan staff share the data analysis in their regular meetings with the providers. Second, we use statewide listening sessions to hear from our provider groups on barriers and accomplishments in the community, encouraging cross-community collaboration on innovative initiatives. Third, we facilitate listening sessions with local community stakeholders that include BH, SUD, and OUD providers, hospital groups, trade organizations, advocacy, and peer recovery support groups to discuss trends, identify barriers and brainstorm solutions.

We employ provider representatives who educate and support providers, including large and small BH provider agencies, and Community Mental Health Centers with all operational processes including, contracting, onboarding, credentialing, prior authorization, and claims submission. Our team of BH licensed resolution specialists serves as **a single point of contact for providers** to bring individualized technical assistance and operational support and address claims issues. In addition, we support our BH/SUD providers in their claims payment processes through billing guides, benefit grids, and continuums of care used in group trainings to assist with provider concerns with contracting, credentialing, prior authorization, and claims billing. **We consistently**

pay 99% of BH claims within five days, with a three-day average speed of payment and a first pass accuracy rate greater than 99%. Our BH resolution specialist team is composed of licensed BH staff to provide. Our providers are given the ability to review submitted claims, review coordination of benefits (COB), and submit appeals online through the provider portal. We enhance collaboration with providers through a **Provider Innovations Collaborative** that is designed to proactively identify opportunities for systemic improvement, including the development and application of best practices and claims payment improvement opportunities.

d. Describe any innovative methods that Offeror will use to augment its approach.

Based on our decades of experience serving the BH community, we propose the BH innovations identified in Table 4.2.2.1_B to augment our approach to serving MSCAN and CHIP members with BH/SUDs.

Table 4.2.2.1_B: Behavioral Health Innovations

Innovation
Community Learning Collaboratives – We will work with community providers by region to review trends in utilization across the continuum of services, including gaps in specific levels of care or services, reviewing prescribing patterns, and opportunities for coordination of care. By bringing community providers together in a forum for interaction, we will establish networking opportunities and problem-solving. We will work regionally across the continuum of care providers and community stakeholders to build local solutions guided by utilization and outcomes data.
SUD Home – The SUD Home brings additional prescribing practitioners serving members with SUDs to fill gaps in access to OUD replacement drugs and utilizes field-based peer recovery specialists (PRS) to reach out to members with BH and SUDs. Through consistent engagement, the PRSs serve as an extension of our intensive care managers by meeting members in their homes and communities, helping them increase their health literacy and move toward treatment and a life of recovery. They assist MSCAN and CHIP members in making informed treatment choices, identifying options, selecting providers, and obtaining resources; including supports to address SDOH needs such as housing and employment and to reduce barriers to engagement.
Specialized MAT Education for Member-facing Staff – Specialized staff training related to Opioid Use Disorder, Tobacco Use Disorder, and Alcohol Use Disorder, including considerations for pregnant population and naloxone to focus on overcoming stigma and recovery principles.
ED Peer Support Transition Program – Peer support specialists embedded in high volume EDs connect with members to address unmet social needs and engage with care management and into aftercare to target hard to reach and engage members, including members with SMI
Teen-centric BH Platform – Program provides early intervention services to reduce teen crises and to help them engage in outpatient BH services. The platform has three components: tech, touch, and treatment to increase teen engagement through personalization, digital relevance, self-care resources (including compelling content about adolescent behavioral health issues), and automated check-ins. It provides teens with virtual self-care, as well as texting, coaching, and clinical treatment from BH, coaches, and licensed clinicians to support them
Community Hubs for BH Care – Members with BH and SUDs often use EDs to obtain urgent and routine services. This program empowers hospitals to become a hub for member engagement, wellness/health information and reduce the overutilization of ED services. The program incentivizes hospitals to become innovation labs to enhance member engagement in outpatient services
Community Reentry – Tailored re-entry program to address the whole person needs of returning citizens to address unmet social needs, the complex health conditions of individuals with SMI and SUD and reduce the likelihood of recidivism. We will focus on MSCAN and CHIP members with BH, SUDs, and SMI. The program includes intensive care management with peer support services, housing, and employment supports.

e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding behavioral health services?

We are dedicated to addressing racial, ethnic, and geographic disparities experienced by MSCAN and CHIP members with BH and SUDs. Recognizing that all healthcare is local, and the solutions are in Mississippi, we will fully partner with the Division to identify and proactively address disparities. In support of this effort, we hire regionally based staff members that mirror the populations we serve to increase our awareness of local racial, ethnic, and geographic disparities, including staff with the lived experience of BH challenges. Regional staff build and strengthen trusting relationships with MSCAN and CHIP members by delivering services and care within the context of members' cultural beliefs, behaviors, and primary languages. The staff bring an understanding of local resources and the ability to leverage those resources to help address geographic disparities. Our BH care management team identifies disparities impacting MSCAN and CHIP members as part of our annual BH program plan. We bring **operational excellence and a tailored multi-level approach** to address disparities, intervening at the member, provider, and community level, including:

- Established benchmarks, targets, and strategies for each major disparity and challenge
- High touch coaching targeted to support MSCAN and CHIP members identified as experiencing disparities
- Member focus groups to identify barriers to care, SDOH, and health literacy challenges and propose solutions and collaborative efforts to address the challenges and use recommendations to make CBO funding decisions
- Leverage social drivers of health data from the Screening and Assessment Tools and conduct care management and community-level outreach to identify and address key risk areas or unmet social needs in areas such as housing, transportation, or health literacy
- Support for CBOs, and local initiatives, and enhance community competencies to address disparities
- Partnerships with law enforcement, correctional institutions, detention facilities, probation and parole departments, Mississippi Department of Child Protective Services, and school systems to address BH disparities
- Provider training, incentives, and our provider innovation collaborative to address disparities.

Table 4.2.2.1_C identifies the BH disparities impacting Mississippi residents and our planned interventions.

Table 4.2.2.1_C: Mississippi Targeted BH Disparities and Interventions

Mississippi Targeted BH Racial, Ethnic and Geographic Disparities and Proposed Interventions	
Suicide (Adolescent): Increased suicide rate, the second leading cause of death in ages 10 to 18; increase in adolescent White male suicide in Mississippi, both Black and White male adolescent rates higher than the national average	▪ Safety plans to engage at-risk children, adolescents, and caregivers in identifying protective factors ▪ Deploy teen centric BH application with online coaching and crisis response ▪ AI technology tool assists providers in identifying adolescent risk of suicide ▪ Partnership with a national school-based suicide prevention program that fosters resilience by giving teens a safe space to share their mental health stories and obtain resources and support ▪ Training of school personnel to identify and intervene with teens at risk of depression, anxiety, and suicide, including mental health first aid
Opioid Overdose (Geographic): Highest rates of overdose that led to death: Harrison, Hinds, DeSoto counties	▪ Use community learning collaborative structure and continuum data to identify gaps in ambulatory detox and medicated assisted treatment (MAT) to increase coordination and access ▪ Deploy SUD Home model with peer supports to targeted areas to address MAT prescribing access issues
Minority Incarceration due to SUDs (Black and Latinx Communities): Correlated with population centers	▪ Use jail incarceration data to provide pre-and post-release coordination for MSCAN and CHIP members with SUDs and SMI ▪ Train law enforcement, correctional staff, and courts regarding Mental Health First Aid ▪ Utilize our employment, job coaching, and housing support to reduce recidivism ▪ Partner with providers and jail medical staff to improve community transition
SMI Members with Justice Involvement (Rural): Individuals with SMI are overrepresented in the criminal justice system, particularly in rural areas	▪ Enhance crisis intervention team (CIT) training to Mississippi law enforcement professionals, including targeted grant funds to support expansion to rural communities ▪ Provider training on evidence-based interventions including risk, need, responsivity (RNR) ▪ Support evidence-based interventions ACT teams, such as Forensic ACT teams

4.2.2.1.A.3 Perinatal and Neonatal

a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for perinatal and neonatal services.

Most of our experience is in a fully integrated service delivery and payment model across multiple markets. Based on our experience, we know that many women experience difficulties engaging in early care, getting additional help, and understanding and communicating with their providers, especially members with multiple health problems and living in difficult life circumstances. Meeting our members where they are, we focus on engagement strategies leveraging our early identification of pregnancy and prenatal care offerings to address current and related conditions; potential complications; and risks such as preeclampsia, gestational diabetes, and preterm labor with targeted intervention. Our experience shows that members engaged early are more likely to obtain prenatal care. When members receive prenatal care and enhanced community-based services, they are more likely to prioritize postpartum care and well-baby visits.

We also have experience in a fully integrated service delivery model which provides operational excellency. For example, our pregnancy care management programs consist of cross-functional teams, including a maternity and high-risk pregnancy care management team, pregnancy engagement team, neonatal intensive care management team, neonatal nurse practitioner, clinical pharmacist, and women's and children's health outcomes team. Working in an integrated manner, these teams provide support related to the physical, behavioral, and social needs of all pregnant members. This includes conducting health risk screenings (HRS), helping members complete prenatal and postpartum visits, and helping members complete additional trimester assessments, including depression screening and family planning options. Through our progressive program, we facilitate access to care; identify and address SDOH; educate our members for healthy mom and baby outcomes; and support our members through pregnancy, delivery, and follow-up care.

Key Results from our Perinatal and Neonatal Care Management Program

- 78% of women across all markets receive timely prenatal care exceeding the national median (75%)
- 38% increase in timeliness of prenatal care and 40% increase in postpartum visits (2019 over 2017)
- From February to August 2021, our targeted, multi-channel outreach campaign contributed to a 49% increase in the percent of women receiving postpartum care

We have developed a high-risk pregnancy predictive model, machine learning algorithm that looks for patterns in historical high-risk pregnancies and identifies clinical, behavioral, and social drivers that enable the prediction of potential adverse outcomes for current pregnancies. **Based on our predictive analytics, we have increased our identification of early pregnancies by 25%.**

We also leverage extensive community partnerships that support our pregnant members. For example, we have developed and implemented perinatal, postpartum, and neonatal programs across our markets that include health literacy campaigns, pregnancy engagement programs, community fairs, educational campaigns, incentive programs, educational materials, and brochures.

In one market, we developed a rental subsidy program for pregnant members who are experiencing housing insecurity. This program is a housing first model focused on providing stable housing as a primary intervention to care barriers. Participants receive rental assistance, support from a housing specialist, and access to our care manager and a life coach. With Division approval, we will bring this program to MSCAN and CHIP.

Rental Subsidies for Pregnant Members

- Reduced emergency department visits by 15%
- Reduced NICU admissions by 60%
- Reduced readmissions by 30%
- Reduced average length of NICU stay by 72%

In another market, we developed a pregnancy engagement initiative. We identified 97 high-risk pregnant members (members with a high BMI, women who used tobacco products, and Black women in rural areas). Of the 97 participants, 59 were engaged during their pregnancy, 20 were engaged during postpartum, and 18 received no engagement. We conducted face-to-face meetings despite the challenges of the COVID pandemic and offered incentives, diapers, checked their food pantry, and offered nutrition tips. **As a result, member prenatal care increased by 46.7% and postpartum visits increased by 37.5%.** With Division approval, we will bring this program to MSCAN and CHIP.

We have strong claims payment experience in a variety of service delivery models, including bundled, unbundled, and value-based models, and we collaborate with perinatal and neonatal providers to address barriers to care through innovative payment methods. We have developed a program that supports providers with claims questions and issues. It includes proactive calls to provider offices to offer support based on evaluation of key measures (e.g., denial volumes and rates). We also have a full-service hotline offering dedicated support to resolve provider payment issues.

b. Describe the Offeror's approach to delivery and payment for perinatal and neonatal services.

Our approach to delivery and payment for perinatal and neonatal services begins as soon as we become aware a member is pregnant. Our fully integrated, transparent service delivery model enables us to provide members top rated services. We leverage our predictive analytics and member experiences to quickly identify barriers that

impact access to care and magnify disparities. For example, we used our high-risk pregnancy predictive model, a machine learning algorithm, which looks for patterns in historical high-risk pregnancies and identifies clinical, behavioral, and social drivers that enable the prediction of potential adverse outcomes for current pregnancies. Attributes include social determinants of health, age, race, ethnicity, chronic disease, behavioral health conditions, and past pregnancy outcomes. Our model focuses on the following birth outcomes: sick newborn, premature delivery, neonatal abstinence syndrome, failure to thrive, low birth weight, NICU admission, and stillbirth. Our valid, reliable predictive analytics model accurately identifies members who are predisposed for high-risk pregnancy, allowing rapid stratification and care management prioritization.

As soon as we learn that a member is pregnant, our care management team reaches out to complete a comprehensive pregnancy health assessment (within five calendar days), including tobacco or other substance use, to assess additional risk. According to the Mississippi Department of Health 2018 Summary, the number one cause of infant mortality was preterm birth associated with the mother's obesity, hypertension, and diabetes. Therefore, we focus screening efforts for pre-existing conditions, prenatal conditions, and potential complications. All pregnant members are automatically enrolled in high-risk care management.

We ensure all pregnant members are assigned to a PCP or a PCMH to support access to regular perinatal, postpartum, and well-child care. We also educate members on the State's Perinatal High-Risk Management/Infant Services system (PHRM/ISS) and offer and honor the member's freedom of choice to participate in PHRM/ISS. We commit to working with the Division and the Mississippi State Department of Health to ensure PHRM/ISS reaches its full potential by delivering value to expectant mothers.

We focus on prevention. We ensure members have access to prenatal vitamins, and we educate members on our smoking cessation program, healthy eating for mom and baby program, and our increased dental value-added benefits. Our high-risk obstetrics care managers provide education on benefits available to members, including member incentives for following recommended prenatal and postpartum care. For example, as a value-added benefit, we offer mothers gift cards to attend routine postpartum and wellness visits to ensure both the mother and infant receive necessary screenings and checkups during the first stages of life.

We screen all women to assess risk for Intimate Partner Violence (IPV) using the Hurt, Insult, Threaten, and Scream (HITS) screening tool and scale. We integrate these assessments and interventions into the care plan and share them with the member's PCP and specialty providers. We also offer education on available IPV-related resources.

We screen, identify, and address SDOH needs. These may include resolving food and housing insecurities, helping with employment and education, and advocating for the member, if needed. Maternal health literacy is a key component to a healthy pregnancy and delivery. Our suite of value added benefits also addresses non-medical needs for our members, such as providing a car seat with instruction on how to safely install the seat.

Our program is comprised of a team of dedicated NICU nurses and a Neonatal Nurse Practitioner. All newborns admitted to the NICU are followed on admission, throughout their hospitalization, discharge, and through their safe transition to home. We leverage NICU specific review approaches and use facility-based assignments to promote relationship building with providers. We engage with members and their family/support system to ensure mom and baby remain connected and bonded. We arrange transportation to and from the NICU, support maternal health and postnatal follow-up, collaborate with facilities for proactive discharge planning, and ensure necessary baby supplies are in the home. Moms receive automatic breast pumps to promote breast-feeding and become part of nourishment in the NICU.

To reduce readmissions and promote a smooth transition to home, targeted caregiver outreach within 48 hours of discharge notification occurs to confirm that the first pediatrician (PCP) visit is scheduled or has occurred. We complete an additional HRS 30 days post-NICU discharge to identify needs and ensure appropriate ongoing support. Our program includes NICU support classes and on demand trainings. **We have over a 60%**

engagement rate of moms and caregivers in our NICU program and have successfully decreased NICU stays by five days and decreased admits per 1,000 from three to one in one of our markets.

We use our machine learning algorithm to look for patterns in historical high-risk pregnancies and identify clinical and social drivers that enable the prediction of potential adverse outcomes for current pregnancies. We overlay geospatial analytics with this predictive model to understand the specific disparities in access to care that exacerbate negative maternal health outcomes. Our model specifically leverages population health analytics software and other clinical factors, demographics, zip codes, health rankings, and SDOH to predict risk of premature birth, low-birth weight, maternal mortality, and postpartum depression. At the member level, the care management team uses the integrated population health dashboard to identify high-risk members to prioritize for outreach. For example, we can filter our membership to identify and locate pregnant members by age, ethnicity, or behavioral health condition, such as substance use disorder, to target specific high-risk cohorts for targeted outreach, education, and intervention.

c. Describe any innovative methods that Offeror will use to augment its approach.

Table 4.2.2.1_D identifies innovative methods we will offer to augment our approach and ensure members receive perinatal and neonatal care that improves birth outcomes and strengthens Mississippi communities.

Table 4.2.2.1_D: Innovations to Augment our Approach to Perinatal/Prenatal Service Delivery and Payment

Innovation	Description
Pregnancy Engagement Initiative	Our Pregnancy Engagement Initiative supports pregnant members who use tobacco, have a high body mass index, or are diagnosed with gestational diabetes, with a focus on addressing health disparities for Black women. Life coaches, peer support specialists, and community health workers support women with in-person visits, making sure they receive needed screenings; are connected to care management; and receive medical, behavioral, and social services they need to meet their whole-person and family needs. This initiative has an 81% engagement rate. Of engaged members: ▪ 67% attended an in-person meeting with the life coach ▪ 77% (of those without a life coach meeting) completed a health screening ▪ 85% enrolled in care management ▪ 100% of the women identified as tobacco users were referred to tobacco Quitline and or provided tobacco cessation education resources ▪ 100% of women engaged during their pregnancy had a live birth (6.7% with a pre-term birth, 2% with a low birth weight, and 5% with a very low birthweight).
Women's and Children's Health Outcomes (WCHO) Program	This program uses a locally based team of nurses with backgrounds in obstetrics and pediatrics who work with local community-based organizations (CBOs) to co-host events that support our members and all community members who are interested in whole-person, integrated pre-conception, pregnancy, and postpartum services. Our team also provides CBOs advanced education related to covered services and resources available to pregnant and postpartum members.
High Risk Maternity Center of Distinction	Our innovative high risk maternity center of distinction uses telehealth and in-person home visits to expand access to holistic care throughout high-risk pregnancy and postpartum periods. Care covers pregnancy, postpartum, and neonatal care to members using SMS, audio, video-based communication, and application based or home visits. ▪ Care includes one-to-one primary care, midwifery care, nutritional therapy, and behavioral healthcare to pregnant and postpartum members and their children. ▪ Care is conducted in one-to-one and group care settings, including implementation of a model of Group Prenatal Care facilitated by midwives trained in the Centering Pregnancy model of group care. ▪ Care complements in-person prenatal care with a focus on addressing the comorbid conditions (e.g., obesity, diabetes, hypertension, smoking, depression) and risk factors that drive poor outcomes. ▪ Education campaigns regarding Go the Full 40 for full term pregnancy goal, Count the Kicks to prevent still births, and breastfeeding. Additionally, the telehealth solution improves access to prenatal care by offering tele-visits for rural members when in-person visits are not required and provides immediate tele-neonatology post-NICU discharge to prevent emergency department utilization and hospital readmissions. Our high-risk maternity center of distinction collaborates closely with OBGYNs, who remain the primary prenatal care providers for members. Collaboration includes: ▪ Bidirectional referrals and clinical note sharing to maintain continuity of care across in-office prenatal care

Innovation	Description
	▪ Enhanced primary care, and group prenatal care programs This collaboration ensures that prenatal care providers have full awareness of our management of shared patients and provides an option for prenatal care providers to send their patients with additional clinical or social needs for support beyond what can be addressed in typical prenatal care office visits. Our high-risk maternity center of distinction also includes close coordination with hospital discharge planners and pediatric care providers for all infants, including those who have had a NICU stay. For infants admitted to the NICU, services begin during the NICU stay to assist the family with preparedness for discharge and continue for one year of infant life to support successful care at home, including with remote monitoring if needed, avoiding readmissions to the NICU. For well-babies, coordination supports families preparing the home (e.g., car seat, safe sleep environment, CPR training, etc.) and continues with access to telehealth services for postpartum care, including mental health and lactation counseling, infant urgent care, and home care for hyperbilirubinemia and other newborn conditions that can be safely and effectively managed at home.
Nurse Practitioner Telehealth Virtual Postpartum Care and Nurse Visit	We outreach 100% of identified postpartum members and offer virtual nurse practitioner assistance to help schedule appointments, educate members on Sudden Unexpected Infant Death (SUID) and safe infant sleep positions, help with lactation issues, address preventive health care, and address other clinical concerns. The member may have two postpartum visits for high-risk moms post-delivery with focus on lactation and safe sleep. We will provide a baby bed for safe sleep through member assistance funds to prevent SUID from use of adult beds or bed sharing.

d. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding perinatal and neonatal services?

We bring **operational excellence, a tailored multi-level approach, and a fully integrated service delivery model** to address racial, ethnic, and geographic disparities, intervening at the member, provider, and community level, as necessary, to ensure all members receive equitable care. We hire local, regionally based staff that mirrors the populations we serve, who possess a personal understanding of the disparities faced by members in their communities. Additionally, as our perinatal and neonatal care management team identifies disparities affecting members, they document them and include them in our annual Perinatal and Neonatal Program Plan. Our strategies for addressing disparities that affect our members receiving perinatal and neonatal services include:

- Engaging early with members to address physical health (such as obesity, hypertension, diabetes), behavioral health (such as risk for postpartum depression, substance use disorder), and SDOH needs (such as food insecurity, housing insecurity). We integrate these assessments and interventions into the care plan and share them with the member's providers.
- Working with local CBOs to co-host monthly educational events targeting members in counties with high infant mortality rates to provide education on available resources related to nutrition and breastfeeding for better outcomes.
- Offering providers a fully integrated service delivery model and value-based purchasing arrangements that incent such things as smoking cessation during pregnancy and lactation counseling.
- Understanding that more than 40 of Mississippi's 82 counties are considered "maternal deserts," we will partner with health systems to offer mobile clinics that bring prenatal, postpartum, and well-child care to rural zip codes with high infant mortality, low birthweight births, and preterm births.
- Using telehealth to expand access to care including telehealth kiosks in FQHCs and RHCs to ensure online access for members. Additionally, we will work with area CBOs in those counties to provide pregnancy education classes and appropriate in-person follow-up care.

4.2.2.1.A.4 Chronic Conditions

a. Describe how the Offeror will implement innovative programs to improve the health and well-being of Members diagnosed with diabetes and pre-diabetes.

Mississippi ranks near first in the nation for overall diabetes prevalence. Additionally, Black and rural Mississippians, and those with lower income and less education are two to four times more likely to develop

diabetes than more advantaged individuals are[1]. According to 2020 county health rankings released by Robert Wood Johnson Foundation, Tippah County Mississippi has the highest rate of diabetes in the country and while Black Mississippians do not make up the majority of the population in this county, the number of diabetics is above the national prevalence for adults. Approximately 13.6% of the population has diagnosed diabetes and approximately 35.6% of the adult population has prediabetes. The burden of diagnosed diabetes costs an estimated $3.4 billion in Mississippi in each year. Complications from diabetes are impactful physically, mentally, and socially, and can have lasting effects.

Our deep experience and knowledge of Mississippi, proven success managing both diabetes and prediabetes with our members, fully integrated service delivery model, provider value-based purchasing (VBP) arrangements, member incentives, and community-based and faith-based affiliations, maximizes participation and the effectiveness of our Diabetes Disease Management Program.

Our Diabetes Disease Management Program is a component of our whole person population health management model. It includes a diabetes disease management plan that is evaluated and updated annually under the direction of our local medical director. This plan includes specific programs based on the level of need of the member, including members at rising risk for diabetes, members with prediabetes, members with managed diabetes, and members with chronic unmanaged diabetes.

We target social determinants of health (SDOH) as part of our approach to improve the health and well-being of our members diagnosed with diabetes and prediabetes, recognizing SDOH significantly impact a member's ability to manage their diabetes. Targeting SDOH ensures our members have access to secure housing, healthy food options, transportation for medical appointments, ease of access to medication, and diabetic self-management education. Our "Meeting YOU Where Your Pantry Is" value-added benefit program will offer members and their families virtual health coaching sessions including how to read nutrition labels.

Our specialized care managers oversee the care of members enrolled in our Diabetes Disease Management Program, providing the right individualized support based on the member's particular needs, strengths, and resources. Our care managers collaborate with all treating providers as part of a fully integrated service delivery model to facilitate coordinated and integrated whole person care. We collaborate with community-based organizations (CBOs) to develop and implement initiatives to screen members and educate them about diabetes. We provide training and support to PCPs to enhance service delivery and coordination of care.

To meet members where there are on their disease management journey, we support remote patient monitoring (RPM) as part of our Diabetes Disease Management Program. RPM enables monitoring of patients outside of conventional clinical settings, such as in the home or in a remote area, which increases access to care and decreases healthcare delivery costs. As a value-added benefit, we provide RPM equipment specific to each member's needs and other chronic conditions. For example, in addition to real-time coaching (either telephonic or in person) and daily glucometers, if the member has other conditions such as hypertension, chronic obstructive pulmonary disease (COPD), or high body mass index (BMI), we also offer a full complement of automatic blood pressure machines, smart weight scales, spirometry/pulse oximetry, and inhaler/controller sensors. Through RPM, members have access to a cloud-based connection on their smart phones or tablets. For high-risk populations we also provide the needed devices to stay connected. Our suite of RPM devices offers the ability to collect real-time biometric data that is shared with the member's PCP or identified medical home and our disease management coaches for real-time intervention, giving us the ability to track and trend achievements and set progressive goals with our members for better health outcomes.

As part of our Diabetes Disease Management Program, we also provide member education. Topics are designed to enhance member awareness, increase physical activity, maintain a health BMI, and improve healthy food choices. We walk with members as they advance toward self-management, and we continue to monitor their

[1] 2018 Mississippi Diabetes Action Plan.pdf

success, removing any barriers. Our programs help members identify (through health literacy) and understand common risk factors and evidence-based strategies to manage and reduce their risk. We use multiple sources to educate members and their family/support systems, including social media, web-based initiatives, mobile applications (apps), text messages, telephonic and disease management booklets, routine paper-based resources, and in-person events.

Our digital experience allows members to use our portal, app solutions, and interactive tools to support self-management activities and improve health outcomes. We will work collaboratively and link our members to community resources such as the Diabetes Coalition of Mississippi, the Diabetes Foundation of Mississippi, and the Mississippi State Department of Health.

Our Diabetes Disease Management Program leverages our in-home Nurse Practitioner to complete diabetic comprehensive testing and education in the member's preferred setting, expanding the PCP's capacity.

Our established value-based payment (VBP) arrangements include quality enhancers, quality rewards, total cost of care, and medical loss ratio driven programs for providers serving members with diabetes. For example, our pay-for-performance arrangements reward providers for meeting performance targets aligned with select HEDIS and utilization measures including A1C rates, yearly diabetes eye exams, and monitoring of kidney health. Our patient centered medical home (PCMH) arrangements incent providers for controlling diabetes and testing and diagnostics. This incentive uses targets for PCMH providers based on baseline rates for their members and provides bonus payments for improvements to those targets. Our Episodic Payment VBP arrangements incorporate episodic/bundled payments for specific care pathways. These incentives are available to hospitals and providers across specific episodes of care. The mechanism used determines the total cost of care for selected conditions as the target from the pre-initiating and post 90 days service period. With improved coordination, integrated service delivery, and focus for these episodes, providers can drive better outcomes at lower cost relative to historical outcomes.

Member Incentives. Our member incentives encourage our members to participate in their health care. For example, as a value-added benefit, we offer members incentives to promote engagement in preventive health activities and encourage ongoing management of chronic health conditions, including diabetes. As members complete wellness and incentive activities, they can earn gift cards for completing an HbA1c test and achieving a controlled HbA1c test result.

Our Diabetes Disease Management Program has proven effective across our markets. For example, in our largest market, we **achieved a 22% improvement in the number of members with diabetes disease control, measured by A1c <9mg/dl** by implementing self-management education and interventions targeting high-risk members with elevated A1c. We also improved the **overall rate of HbA1c testing within our applicable membership by 25%** and our **diabetic self-management class completion increased over 40%** using our proven member engagement strategies.

b. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for services for Members with chronic health conditions generally.

We bring **operational excellence, a tailored multi-level approach, and a fully integrated service delivery model** to provide top rated services to all members, including those diagnosed with chronic conditions. Based on our experience, we know chronic conditions require thorough data analytics and measurement, application of interventions based on best practices, and effective member engagement with collaborative community partners and providers to achieve service delivery excellence. We also know, based on our experience, a fully integrated service delivery model, which includes integrated primary care, produces superior results and member outcomes. Therefore, our Disease Management Program focuses on ensuring our members understand their disease/chronic condition and the required journey to living well with diseases/chronic conditions. We empower members to partner in their health care by ensuring they receive exceptional evidence-based education and interventions. As trusted partners, our

disease management coaches and care managers meet our members where they are in their journey. **We complete an average of 360,000 engagements per quarter in our Disease Management Program.**

We know that members may have more than one chronic disease or condition, and as part of our integrated service delivery model, we tailor our interventions within each programmatic level to a member's identified acuity to enhance their ability to self-manage their condition and improve their health literacy. Members are encouraged to engage with care managers who promote stability and optimize health outcomes. Materials are condition-specific to provide awareness of disease information on healthy behaviors through nutrition and physical activity, and we facilitate and encourage engagement with a practitioner and provide education related to potential complications. Our care managers identify common barriers, address SDOH, and provide additional resources and linkage to accredited organizations.

Sickle Cell Disease (SCD) can plague mental health; the concerns of triggering an acute pain crisis can be debilitating, and SCD impacts our members' support systems. Our comprehensive Disease Management Program addresses the impact of physical health conditions on mental and behavioral health to achieve optimal wellness in living with a managed disease versus being defined by the disease. For example, our targeted SCD program focuses on helping members manage their SCD, and identify, address, and resolve SDOH to improve both physical and behavioral health outcomes. We recognize that members with SCD typically experience poorer health outcomes and have access to fewer health resources compared to members with other diseases. Because of this inequity, we provide care coordination interventions and evidence-based education to increase awareness and timely treatment of our SCD members' main health concerns. We address our members' immediate needs to create trust and room in their lives to focus on physical and behavioral health. Our disease management teams work closely with our care managers to address resource needs by facilitating, making, or attending appointments with members, ensuring transportation is available, and securing food and housing for our members as needed. We also ensure our members have access to preventive screenings for ischemic retinopathy, renal disease, vascular disease, and risk of stroke to mitigate multiple complications that can be experienced with SCD. Our clinical pharmacist is a part of our Disease Management Program, working closely with members and providers to ensure prophylaxis of Hydroxyurea management and penicillin management for children. We emphasize the importance of supporting members as they transition from adolescence to adulthood by encouraging age-appropriate health screenings such as transcranial doppler ultrasound (TCD), medication management of hydroxyurea, vaccinations, and management of anxiety and distress of members and caregivers.

We have developed a data rich dashboard that gives our member-facing staff immediate access to real-time information about our members with chronic conditions to support their health care goals. Our dashboard incorporates chronic conditions, geographic access to care information, health disparities, high utilization of services, and SDOH member information. It integrates predictive analytics to identify members with rising risk for developing chronic conditions. We will use these dashboards to match interventions and programs to meet the individual needs of members with chronic conditions, identify the need for innovations and approaches to address unmet member needs, and promote successful treatment and disease management practices that achieve results.

We recognize SDOH are key drivers of health care access, utilization, and outcomes and addressing SDOH is essential to the effective treatment of chronic conditions. We integrate these non-clinical aspects into every member interaction as part of our fully integrated service delivery model. Our dashboard identifies gaps in care for our members and we share the information with our providers through the provider portal, including, missed medication refills, and missed visits. We integrate within our system a reminder/notification system that allows for timely member notifications of both upcoming and missed appointments. We drive treatment adherence through our "high touch" intensive care management program where members with chronic conditions receive a single point of contact coordinator who manages all levels of care in all settings, including transitions from higher to lower levels of care, coordinating funded and unfunded services.

c. Describe the Offeror's approach to delivery and payment for chronic health conditions services generally.

We recognize members with chronic conditions are those with the highest need and have the highest cost and the poorest outcomes. We organize our approach to serving these members through our Disease Management Program as part of our whole person population health management and fully integrated service delivery model. Our annual Disease Management plan targets the top four to five chronic conditions present in each of our markets. In Mississippi, these are obesity, asthma, hypertension/heart disease/stroke, diabetes, and sickle cell. Our local Disease Management team, under the direction of our medical director, develops the Disease Management plan and directs the Disease Management Program.

A key component of our Disease Management Program is our focus on **health literacy in critical topics affecting health behaviors**. We actively work with members, their families and across the health system to provide programs and multi-channel materials that increase their knowledge and understanding of chronic conditions and risk factors, as well as prevention and effective management of them. These efforts include education and outreach to our members who are children and their families based on the link between childhood obesity and prediabetes. Additionally, we have implemented the use of artificial intelligence (AI) and machine learning analytics to better understand the behaviors and preferences of our members. Using technology that captures social media preferences and buying behaviors of our target populations (i.e., rising risk non-diabetics), we identify specific ways to tailor messaging and reward programs most meaningful and effective in support of better disease management.

We identify members with chronic conditions through algorithms, using member and claims data from our data warehouse as well as incoming provider data from health information exchanges and other data feeds. We employ a complete data analytics warehouse that provides our member facing teams with **real-time member information** related to chronic conditions to direct our interventions with members. We stratify member populations with chronic conditions through our population health risk dashboard. We attach risk scores to member profiles to target appropriate interventions based upon chronic conditions, level of treatment adherence, SDOH needs, and clinical concerns.

We use a multi-dimensional tool to assess and evaluate all the domains of health, including SDOH, caregiver support, chronic conditions, health literacy, emergency department utilization, and inpatient readmissions. We conduct root cause analyses of reasons for non-adherence to treatment through our assessment tool. We identify individualized interventions tied to each identified root cause, and care guidelines. We customize the interventions based on the unique needs of the members, personal preferences, support systems, SDOH, physical and behavioral health, substance use disorder, and clinical needs. We measure our performance with each targeted disease group quarterly and report the results into our quality management committee for review and feedback. We identify trends, successes, and issues to address with each disease group. We use transition coaches to develop an individualized care plan and follow-up immediately and at seven, 14, and 30 days after inpatient discharges.

Provider management of chronic conditions is an integral element of our fully integrated service delivery model and our VBP programs. We offer direct incentives based on the number of members who achieve control of their diabetes and hypertension and offer additional incentives for providers when members remain medication adherent toward better control. We couple these incentives with the opportunity to achieve per member per month (PMPM) reimbursement linked to reductions in total cost of care.

d. Describe any innovative methods that Offeror will use to augment its approach.

An innovation we will use to augment our approach to chronic conditions is our Pharmacy Solutions Center Services team. This team is comprised of pharmacists and certified pharmacy technicians that lead our clinical pharmacy intervention initiatives and outreach to members and providers. They use medical and pharmacy data to identify opportunities to improve medication adherence and close medication gaps in care that ultimately improve care and quality and reduce costs. These capabilities include outreach phone calls, text messages,

mailed letters, and emails. This approach allows us to provide high quality care to meet the needs of MSCAN and CHIP members, and especially those with chronic conditions.

Focusing on adherence, this team sends members a medication adherence kit via US mail when a member begins a targeted medication, for example the Diabetes drug Metformin. This adherence kit includes a weekly pillbox with removable compartments, a welcome to therapy letter, a medication list template, and a White board for tracking doses and medical appointments. **Our year-over-year data shows that members who received these kits showed consistent proportion of days covered (a widely accepted medication measure of adherence) improvement across various disease states of 14.26 on average.** For all maintenance medications, our team sends members push notifications, through our mobile app or online portal, when a medication is nearing refill (90% depletion), and a second notification to remind the member after a missed refill.

Our team also focuses on closing gaps in care, and we engage the member and prescriber when we identify opportunities, such as members who are at highest risk for heart attacks and strokes, and in accordance with HEDIS® technical standards and clinical guidelines. When we identify members who qualify for statin therapy based on diabetes and/or cardiovascular diseases, a clinical team member outreach to members and providers specific to the statin opportunity. **In 2021, the members who were eligible for opportunity had a compliance rate of 87%, which was a 3% improvement compared to 2020 performance.** Our Pharmacy Solutions Center team can quickly create new campaigns and programs, coordinate with the pharmacy benefits administrator, and adapt to the needs of members to drive the best health outcomes for this population.

e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding Members with chronic conditions?

We offer both a macro and micro level approach to address the racial, ethnic, and geographic disparities in Mississippi. For example, based on the population, our talent and acquisition team identifies staff members who mirror the population. We work with established trusted partners in each community, such as churches, barbershops, and beauty shops. We offer consistent mobile clinics to address and close gaps in care in rural communities. We use a tailored multi-level approach to address disparities, intervening at the member, provider, and community level, as necessary. In addition, we:

- Establish benchmarks, targets, and strategies for each major disparity and challenge, per county.
- Implement organized interventions to remediate immediate barriers to care and facilitate gap closure.
- Employ high touch coaching to increase health literacy.
- Conduct member focus groups; facilitate councils such as living with members who have disease and living with diabetes councils; sponsor support groups to help identify barriers to care, SDOH, and health literacy challenges; and inform our value-added benefits strategy.
- Support CBOs, local initiatives, community resources, and competencies to address disparities.
- Offer provider incentives centered on health equity.

Table 4.2.2.1_E identifies disparities affecting Mississippi residents with chronic conditions and our planned interventions. In addition, we will offer members the opportunity to enroll in our disease management program, use telehealth or in-home care options, use our member portal and app to help manage their condition(s), and provide new to therapy kits.

Table 4.2.2.1_E: Disparities and Interventions

Chronic Condition	Targeted Racial, Ethnic, and Geographic Disparities and Interventions	
Obesity	Black and rural communities	▪ Partner with CBOs, faith-based entities, and schools to facilitate access to recreational resources and activities ▪ Encourage community gardens, conduct produce distributions, provide training on nutrition, and conduct healthy foods health literacy campaigns ▪ Member incentives for recreational activities and weight management class vouchers

Chronic Condition	Targeted Racial, Ethnic, and Geographic Disparities and Interventions	
Asthma	Children and families with asthma	▪ Conduct targeted household environmental scans and remediation plans (mold, lead) ▪ Member incentives including hypoallergenic sheets ▪ Asthma action plans and new to therapy kits ▪ Clinical pharmacist consults and education
Hypertension	Rural adults, Claiborne County has the highest prevalence	▪ Partner with CBOs to educate about hypertension, diet, and exercise ▪ Conduct community health fairs in rural communities that include blood pressure checks and BMI screens ▪ Consistent tracking and monitoring of blood pressure using RPM technology, empowering members to develop self-management skills and medication adherence ▪ Member incentives for in-home blood pressure cuff, new to medication therapy kits
Diabetes	Black and rural adults	▪ Online cooking classes ▪ Partner with the Mississippi Food Network to offer diabetic friendly food pantries in select schools ▪ Consistent tracking and monitoring of daily blood glucose levels using RPM technology ▪ Member value added benefits including our “Meeting YOU Where Your Pantry Is” program ▪ Enrollment of members into our Diabetes Prevention Program
Sickle Cell (SCD)	Black communities	▪ School based SCD program approaches: educate school employees, create tutoring opportunities or virtual education for missed days supported with electronic tablets ▪ Educate family members about triggers (extreme temperatures, alcohol, tobacco use, dehydration, etc.) ▪ Alternative pain management techniques: use of apps and portal, over the counter value-added benefits ▪ Ensure members with SCD are prepared to effectively self-manage their condition as adults, including working with care providers, understanding and managing crisis trigger condition, and pain management therapies ▪ Support and connect members to the Mississippi Sickle Cell Foundation

4.2.2.1.A.5 Foster Children

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

Through collaboration, a fully integrated service delivery model, deep integration, and holistic innovation, we will transform services to achieve excellent outcomes for children involved in the foster care system. We are a leader in collaborative efforts to effectively coordinate and deliver community-based services to meet the needs of children in foster care and their circle of support. We are the **preferred provider of Medicaid managed care services in the other markets where we serve children in foster care**, as evidenced by having the highest percentage of children in foster care enrolled in our plans. By developing a deep understanding of our state partners’ needs and collaborating with all stakeholders including multi systems, advocates, providers, and families, we **tailor our approach to each state**. For example, one of our states asked for assistance in combating the negative assumption that families must surrender their child(ren) to foster care to get comprehensive behavioral health (BH) services and requested the availability of more BH services for families, particularly services in the home. In response, we helped community-based support providers with expertise in delivering home-based services to become Medicaid providers.

In 2021, we conducted a multistate, multi-health plan survey of caregivers/guardians of children in the foster care system. We surveyed a total of 528 individuals (including kin and non-kin caregivers) including 46 participants from Mississippi. We took the input and used it to refine our program design and approach and expansion of the continuum of care and development of value-added benefits. The feedback from caregivers was clear: **building capacity across systems and communities is imperative**.

Recognizing that a **shared vision** with our state partners is essential, we commit to providing services to children in foster care that meet and exceed all requirements outlined in Appendix A, including Section 3.2.8 and 4.1.8. We will coordinate closely with the MDCPS and the Division through regular meetings of a task force. We have engaged most Mississippi providers in a fully integrated service delivery model that incentivizes providers to ensure Mississippians can access their integrated and holistic benefits so they can live healthier lives. This model allows us to serve as a transparent and effective steward of taxpayer dollars. Our continuum of care includes supportive services for children and families, such as Mississippi’s Safe at Home Initiative that

work to prevent the need for foster placement. While preventing the need for foster care is our goal, we proactively support children in foster care and their caregivers. We know caregivers face an array of challenges; including navigating the health and foster care systems; identifying and accessing social supports; and managing medication administration, provider appointments, high stress, and personal health issues. Due to some children in foster care experiencing frequent placement moves, we commit to enhancing continuity of care and offering telehealth services to ensure these children can stay with their current providers instead of frequently having to change providers, especially for behavioral health services.

We take a multigenerational approach by helping caregivers find employment, childcare when needed to gain employment, and address other social determinants of health (SDOH). Our multigenerational approach is an integrated care model that focuses not only on meeting the needs of youth in foster care, but also aims to serve the whole family. Our multigenerational approach integrates child-focused services, as well as caregiver, supports that focus on family and parental well-being as well as parent education to connect families to supportive services, economic, and social supports. Caregiver support is both essential to prevent the need for foster care, and to ensure placement stability, timely permanency, and positive health and well-being outcomes for children and families experiencing foster care. We have a **caregiver coordination program** that targets our highest risk members and those that care for them. The services provided include: 1) additional transportation to the grocery store two times per month, 2) assistance with food access, 3) assessment to identify stress and burnout and referral to resources or support groups, 4) home assessments and minor home modifications to ensure safety, 5) medication review to ensure adherence, 6) coaching to address and manage caregiver chronic conditions, 7) homemaker and personal support services, 8) life coaching, 9) post discharge visits, 10) member assistance fund, 11) [redacted], and 12) technology support to have access to national web-based information and support. We leverage sophisticated analytics and member experiences to quickly identify barriers that impact access to care and magnify disparities. For example, we use a predictive model, a machine learning algorithm that looks for patterns in historical data and identifies clinical, behavioral, and social drivers that enable the prediction of potential adverse outcomes.

Effective Coordination

We will embed care coordinators into MDCPS teams, provide a single point of contact for the Division, and a single toll-free number and email to enhance coordination of care.

Our national team of experts supporting each of our plans includes a nationally recognized director and manager of child and family health. We provide a **comprehensive continuum of care** that addresses the complex needs of youth in foster care and their caregivers. We maintain the same providers for youth regardless of where they move around the state through telehealth as needed to ensure continuity of care. In addition, we work with MDCPS to identify high quality intensive in home service providers, work with those providers to become Medicaid providers, and develop reimbursement packages that expand access to families at risk and ensure sustainability for the providers.

Supporting families and caregivers, and integrated care delivery, is central to our model. As a value-added benefit, we include respite services in our continuum. Our respite program, in another market, has demonstrated a ninety-three (93%) decrease in inpatient spending and 73% in ED spending. Using our **Provider Innovation Collaborative**, we work with respite and intensive in-home service providers to enhance their capacity to serve more families to help prevent the need for foster care. In addition, we collaborate with providers by offering alternative payment models, bundled payments, and other benefits as incentives to increase timely access to services for families who are trying to reunite with their children. We work with residential providers to develop specialty programs with a negotiated bundled rate to help prevent the need for that level of service, support the transition out of a treatment facility back to the community, and prevent recidivism. In addition, we work with families post reunification and adoption, so they have access to all necessary services to remain safely together. Our collaboration with Southern Christian Services will also ensure supportive services are available to youth experiencing

homelessness or transitioning out of foster care. We provide continuous technical assistance, training, and program support to providers to help transition aged youth locate and obtain a network of supportive adults and reduce social isolation and support them through adulthood. Our continuum will include services to prevent and address human trafficking, teen pregnancy, incarceration, homelessness, isolation, substance abuse, evaluations, and services for youth with intellectual and developmental disabilities.

b. Describe how you would work collaboratively with the State of Mississippi through the Mississippi Department of Child Protection Services to determine medical necessity and provide documentation of medical services for foster children in a manner that considers the unique medical and mental health needs of the population.

Recognizing and embracing the opportunity and role we serve to effectively coordinate Medicaid services for children in foster care, **we will proactively collaborate with MDCPS to become the entity of choice to serve children in foster care in Mississippi**. As partners of the Division and MDCPS, our goal is to generate efficiencies and effective coordination of care to produce a positive experience for children in foster care and MDCPS workers. We see it as our responsibility to help prevent the need for child removals and the need for foster care through proactively promoting the health and safety of families. We are committed to fully participating with the Division in delivering services to children and caregivers in a culturally sensitive manner, including ensuring we meet the needs of children and caregivers with limited English proficiency and diverse backgrounds. Recognizing our role, we own our responsibility and **commit to bringing together the whole system** to create a cohesive and comprehensive support system for children and their families. We will review the recommendations and feedback of Mississippi Youth Voice, foster parent focus groups, parent focus groups, and tribal partners to incorporate those suggestions into our program design. In the interest of collaboration, we facilitate a children's **Foster Care Child Advisory Council** to enhance effective coordination with state agencies, providers, identified barriers to care, and seek solutions. The Council facilitates the identification of service gaps, barriers to receiving services, and coordination of care challenges and proposes solutions. Our team will also partner with the National Federation of Families to train parent leaders to support families and foster parents and facilitate our youth and family advisory committees, and certification program for parent peers.

Connect Our Kids

Our web-based tool allows child welfare professionals to work in a cloud based platform as individuals or within teams, bringing together innovation and collaboration child welfare has never seen before.

Our care managers conduct **risk identification through predictive modeling** in the early identification of children and families who may need additional supports and resources to promote the stability, safety, and wellbeing of the whole family. Factors correlated with higher risk custody issues for children, youth, and families include: 1) children with special needs that may increase caregiver burden, including disabilities, developmental issues, mental health issues, and chronic physical illnesses, 2) substance use disorder (SUD) issues, 3) criminal history/juvenile justice involvement, 4) homelessness or inadequate living conditions, 5) living in kinship care, 6) significant BH issues, 7) aggressive disorders, and 8) intellectual and developmental disabilities. We build the risk identification triggers into assessments and train staff in core competencies for supporting members with identified risks for entering the foster system.

Our dedicated care managers serving children in foster care work closely with our utilization management (UM) team to ensure medically necessary services and placements occur timely, including expediting medical necessity reviews. Our UM team collaborates with treating providers and MDCPS staff prior to making medical necessity decisions to be sure we review all relevant information. We ensure frequent and effective communication occurs throughout so that MDCPS is never surprised by a decision. If a denial is necessary,

MDCPS is informed fully of the reasons for the denial. Our **specialized hotline gives MDCPS administrators direct access to our child psychiatrist** to discuss any concerns related to denials and facilitate discussions about alternative treatment options. In addition, we give MDCPS staff the opportunity to consult with our

pharmacists and child psychiatrist about complex psychotropic medication decisions. In addition, we provide a dedicated phone line and email for MDCPS as a single point of contact for questions and concerns.

We **automatically enroll all children in foster care** (as members with special health care needs) **into our intensive care management program** to address their unique needs, recognizing they are a high-risk population. Our dedicated and intensive care management team serving children in foster care includes:

- A child and family health manager oversees the team providing specialized care coordination for children, participates in MDCPS's Rapid Permanency Supports and hosts collaborative meetings
- Dedicated care managers with experience working with families, 1:40 ratio
- Family liaison assigned as the single point of contact for collaboration and alignment with MDCPS
- Transition liaison to work collaboratively with MDCPS's therapeutic placement unit
- Adoption support care managers with specific experience and knowledge of the unique needs associated with adoptions who connect families to support groups and adoption, competent therapists. This position will collaborate with Southern Christian Services
- Transition age youth care manager who specializes in working with youth aged 14 to 26 and will collaborate with Mississippi Youth Transition Support Services

Our care managers engage in **person centered planning** as a part of a multidisciplinary care team that includes the youth (if age appropriate), supportive members identified by the family, caregivers, supportive loved ones, providers, social services agencies, psychiatrists, social workers, education partners, and primary care providers (PCPs), and other health related providers based on the child's needs. Our staff remove the burden from MDCPS workers by making all the connections, arranging the team meetings, and co-facilitating the multidisciplinary care team. We ensure MDCPS staff are made aware of screenings, follow-up treatment, and immunizations, and we proactively collaborate to arrange services. In addition, we retrospectively monitor prescribing practices, educate families and providers about medications, and collaborate with the pharmacy benefit administrator (PBA) to ensure children in foster care are receiving appropriate medications and medication levels in alignment with the SUPPORT Act. As an example, last year in another market we reviewed 1436 children in foster care concerning BH treatment regimens and had a BH pharmacist perform a comprehensive chart review on all of them and outreached the provider if deemed necessary. Of the members that were reviewed, we outreached to 35% of those providers to discuss prescribing practices and provide guidance.

Our care managers conduct **family-centered care meetings**, at a frequency level individualized to the child's needs. The conferences assist child protective services to 1) find appropriate placements for children, 2) coordinate services and sharing of records and documents to new providers when a child experiences a placement move, 3) prevent a placement disruption or ensure supports are in place to make the placement successful, 4) set up services and authorizations for services, 5) overcome barriers, including staffing, bed capacity, and facilities not accepting Medicaid, 6) develop a safety plan to keep the member safe, identify triggers and safety strategies, list resources and supportive adults to contact when in need, and share this plan with the entire team to ensure and promote safety, and 7) address special health care needs such as aggression, sexual maladaptive behaviors, seizure disorders, low intelligence quotient (IQ) and developmental disabilities, suicidal behaviors, addictions, and eating disorders. In addition, we collaborate with MDCPS through our Transitional Care Management Program to ensure effective coordination of care and services as children in foster care transition between programs and out of facilities.

c. Describe your capacity to provide MDCPS access to all data and documentation (withstanding proprietary technology) to support the State in its efforts to accurately identify and subsequently serve the medical needs of foster children and youth.

As part of our integrated care model, we coordinate multiple teams across multiple systems to create a robust data platform and a clear understanding of the uniqueness of the child welfare system. To enhance our collaboration with MDCPS we will offer to **embed our family liaison and our dedicated care coordinators into each**

MDCPS regional field operations team as consultants to ease and expedite access to data and documentation as well as streamline processes for communication, consents, approvals, and denials. This opportunity is available if agreeable to MDCPS to reduce the workload of the caseworkers as well as accelerate needed evaluations and entry into services for youth. It will also assist to ensure initial physical health and mental health assessments are completed timely and ensure the collection of all pertinent health records and information. When a child initially comes into foster care, we gather all pertinent health records and information, including treating providers, well-child visits, prescriptions, treatments, immunizations, allergies, procedures, and diagnoses. Our care managers track when youth need dental or well-child checks, post hospital discharge follow-up, crisis contact follow-up, inpatient follow-up, and physical and mental health assessment within 30 days of entering foster care. We share all this information with MDCPS and authorized caregivers. These embedded staff will continue to assist throughout the child's placement in foster care by tracking needed dental or well-child checks, post hospital discharge follow up, and crisis follow up. We will work to ensure the wellbeing of each child upon entering, and while in, the foster care system; track those data points, share the information with MDCPS and collaborate with MDCPS to ensure children in foster care are receiving timely assessments and services.

We will provide the Division reports as required and requested, ensuring all personal identifying information and protected health information (PHI) is removed once the child is no longer in MDCPS custody at the time of the report. In addition, we provide reports monthly detailing children in foster care who are nearing or overdue on these necessary appointments. The monthly reports reduce duplicative well-child checks that often occur due to the frequent moves of children in care. We ensure all assessments and screenings are shared between treating pediatricians, BH providers, MDCPS, and caregivers, and help set up services recommended by those assessments. In addition, we will make available a MDCPS data portal to make member treatment information readily available to MDCPS. We will collaborate with MDCPS to develop the portal and define the fields reported in the portal and meet with MDCPS regularly to address what data is most useful to them and work to include it in the data portal.

d. Describe any innovative methods that Offeror will use to augment its approach.

We will bring innovations identified in Section 4.2.2.1.A.1, which apply to all populations, and we will bring the innovations identified in Table 4.2.2.1_F to augment our approach to serving children and youth in foster care.

Table 4.2.2.1_F: Innovations We Will Bring to Augment our Approach to Serving Children in Foster Care

Innovation	Description
After-hours Nurse Response Team	Support after-hours facility placements, medication overrides and medical equipment and supply refills
Partner with National Faith-based Organizations	Incorporates churches and faith communities in projects to strengthen families, support reunification, prevent placement disruption and reduce the need for foster care; community training will be provided
Family and Placement Preservation Team	Three-week intensive field-based, in-home care management program to respond to family and placement challenges and prevent disruption
Specialized Member Handbooks	Specialized handbooks geared toward the needs of children in foster care and caregivers; information and education tailored to their needs, including specialized providers
Specialty Foster Care Clinic	Partnership with a local regional hospital to set up a one-stop foster care clinic that will provide necessary evaluations and assessments for children when they come into foster care. In addition, the facility will make referrals for follow-up services, and facilitate expedited referrals to specialty clinics to ensure timely access to services
Specialized Health Training Institute	Best-in-class training and technical assistance to the system of care supporting children and families involved with the child welfare system. The training institute brings together key stakeholders, including child welfare professionals, primary, secondary, and higher education communities, trusted advocacy groups, and top providers to promote emerging and evidence-based practices, including trauma-informed care, and to ensure lived experience, cultural sensitivity and an appreciation of their unique needs are core understandings of staff who serve children in foster care. The institute will assist providers with the goal of preventing removal by supporting youth and families safely in their own homes through expanded service capacity and by addressing SDOH needs. Additionally, the training includes education on the experiences of youth in foster care, and the impact of adverse childhood experiences (ACEs) on life trajectory and health outcomes

Innovation	Description
Family Engagement Training	Training for providers and staff to the Strengthening Family Protective Factors model. National training created and presented by parents with lived experience on how to engage families
Fidelity to Person-centered Planning	Train and monitor application of person-centered planning in alignment with the University of Southern Mississippi's (USM) nationally recognized, evidence-based person-centered planning model developed through the Person-Centered Practices Initiative. This holistic framework offers best-in-class intensive care coordination as needed for complex health populations. We will collaborate with USM and MDCPS to adapt the approach and model to fully meet the needs of children in foster care
Family Reunification Support Program	The program provides additional BH supports for parents attempting to reunify with their children that includes SUD support and family therapy to help give parents the skills they need to safely have their children return home and address the cause of removal; Program uses family support staff with the lived experience of having successfully regained custody of their children after removal due to SUDs and neglect

e. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding services for Foster Children?

We are dedicated to addressing racial, ethnic, and geographic disparities experienced by children in foster care. Recognizing that all healthcare is local, and the solutions to addressing disparities are in Mississippi we will fully partner with the Division and MDCPS to identify and proactively address disparities. In support of this effort, we hire regionally based staff that mirror the populations we serve to increase our awareness of local disparities, including staff with lived experience in the foster care system. Our team identifies disparities impacting members as part of our annual foster care program plan. We bring **operational excellence, a fully integrated service model, and a tailored multilevel approach** to addressing disparities, intervening at the member, provider, and community level, including:

- Establishing benchmarks, targets, and strategies for each major disparity and challenge
- A high touch coaching targeted to support members experiencing disparities and increase health literacy
- Member focus groups to identify barriers to care, SDOH, and health literacy challenges and propose solutions and collaborative efforts to address the challenges and use recommendations to make CBO funding decisions
- Support for CBOs, local initiatives, and enhanced community resources and competencies to address disparities
- Incentives for providers related to disparities; service integration, provider training; and our provider innovation collaborative which builds provider capacity to address disparities

Table 4.2.2.1_G identifies disparities impacting Mississippi children in foster care and our planned interventions.

Table 4.2.2.1_G: Racial, Ethnic, and Geographic Disparities Impacting Children in Foster Care

Targeted Mississippi Racial, Ethnic and Geographic Disparities and Interventions	
High Rate of Developmental and BH Problems Among Children in Foster Care: (Northeast area of the state-White children; and Black and Latinx children tied to population centers)	**Intensive Care Management:** Program provides physical health (PH) and BH screening within 72 hours of entering foster care and assigned to our plan, and comprehensive PH, BH, and developmental evaluations within 30 days. The program also evaluates for ethnic, cultural, and language Comprehensive Individualized Treatment Plan: The plan identifies PH, BH, and developmental needs and documents initial treatment and referrals to appropriate services. Ongoing, at least quarterly, monitoring of the PH, BH, developmental, and mental health status of children in foster care
Black Adolescent Males have Longer Lengths of Stay in Residential Facilities	**Increase Access to BH Services:** Partner with BH providers to collaborate with residential facilities and group homes to provide greater access to culturally sensitive BH treatment to ensure adolescents in placements have the services and supports they need to successfully return to a family setting
Disproportionate Representation of Poor White Children in Foster Care and Awaiting Adoption: Focus on the Northeast area of the State and Clarke, Pike, Choctaw, and Adams counties. The highest rate of child abuse in the state is in Tishomingo County	**MDCPS Early Identification Partnership:** Partner with MDCPS to early identify children at risk of removal and assist them in accessing family preservation services through our plan **Kinship Placements:** Educate faith-based organizations and CBOs about kinship placements; identify our families providing kinship placement and provide comprehensive caregiver support. Kinship placements help ensure that kids in foster care are cared for by people who represent their racial, ethnic, religious backgrounds **Relational Health Initiative:** Identify families with high-risk scores of removal and limited social connection and provide national family engagement training to our staff and providers to better identify opportunities to help families develop social connections and protective factors; connect families to parent peer support services

Targeted Mississippi Racial, Ethnic and Geographic Disparities and Interventions	
	Housing Support: Identify our families with housing insecurity and housing environmental challenges; help families obtain safe, stable housing and healthy living environments **Employment Support:** Identify our families that are unemployed; help them obtain training and employment Mississippi Racial Equality Collaborative: Online curriculum to address health literacy and racial, ethnic, and geographic misconceptions to reduce removals and increase adoptions and relative placements

4.2.2.1.A.6 Dental Services

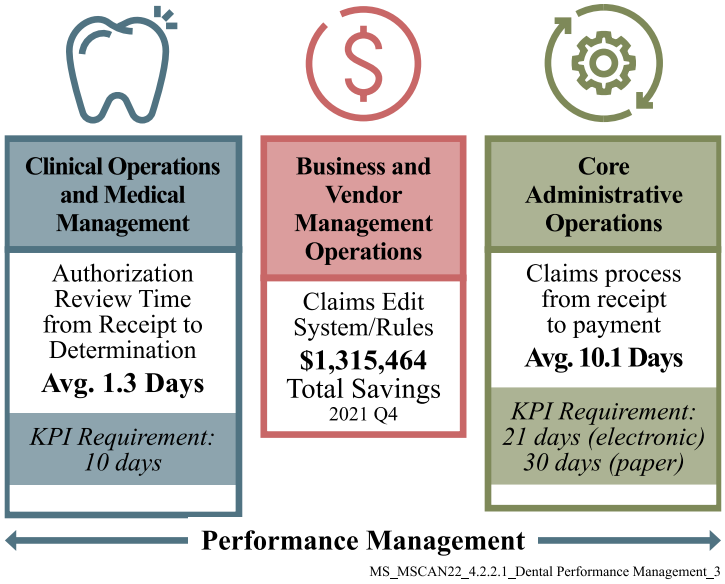
a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for dental services as a medical service

We are an industry leader in providing **innovative oral health programs**, benefits, and services tailored to not only promote the oral health of our members but also advance oral health equity in the communities we serve. Our experience and capacity to manage dental services for the state's members is demonstrated by our oral health strategy that includes **integrated service delivery, collaborative engagement; exceptional operational performance; delivering optimal member and provider experience, and innovative quality initiatives**. Our oral health strategy reflects the collective vision of our organization, providers, and government agencies, including Mississippi's stated oral health vision, "where every person enjoys optimal oral health." We commit to cooperating fully with the Division if the decision is made to transfer to a centralized dental administrator.

Collaborative Engagement: Fully integrated service delivery depends on collaborative teamwork. Our accountable and experienced leadership will include a dentist licensed in Mississippi with extensive clinical and managerial experience as the state dental director, supported by national clinical and executive dental leadership. Our dental director serves as the liaison to key stakeholders, such as the Mississippi Division of Medicaid, providers, communities, professional dental associations, and coordinates with our medical director. Together, they will ensure the dental benefit managed by us and our subcontractor is compliant with standards of care and consistent with Appendix A.

Exceptional Operational Performance - Subcontractor Strategy: With the approval of the Division, we will subcontract dental benefits administration to a national vendor with proven results. We facilitate effective service delivery integration that affords a seamless experience for our members and providers, optimizing our dental services. We include our vendors in implementation, end-to-end testing, and go-live command centers to ensure any risk or issue is quickly identified and swiftly mitigated. Our goals center on performance management that exceed National Committee for Quality Assurance (NCQA) standards. Our strategic use of performance standards and continuous monitoring, in-depth market and benefit analysis, and quality improvement efforts through Joint Operating Committees (JOC) and a delegated vendor oversight team, ensure operations flow seamlessly to promote appropriate care, cost efficiency, and timely provider payments. We have historically achieved high performance on all indicators, including 100% prompt payment of clean claims and claims payment accuracy. (Refer to Figure 4.2.2.1_A)

Figure 4.2.2.1_A: Operational Excellence



Delivering Optimal Member Experience: Our strategy to create an optimal member experience in service delivery includes 1) providing and promoting **care coordination** and utilization of essential **member benefits** to promote healthy outcomes; 2) ensuring **access and availability** to a consistent and continuous source of

routine dental care; and 3) providing culturally, linguistically, and health literate, **member service**, educational and self-management tools to promote healthy lifestyles.

Member Benefits and Care Coordination: We offer and comply with all contractually required dental benefits to promote healthy growth and dental development for beneficiaries.

In addition to standard benefits, through an innovative **collaborative medical-dental coordinated care program**, we will offer a proactive approach to fully integrated service delivery, identifying and tracking members with special needs or at-risk for chronic medical, physical, or behavioral health conditions and at high oral disease risk that can benefit from specific collaborative medical-dental care support. Members identified through the program receive medical-dental care management to engage the member in care, including covered dental services and our **enhanced dental benefits** inclusive for **all adults** per applicable plan with routine dental cleanings and an allowance towards periodontal services and other therapeutic services that have been linked to improved oral-systemic health outcomes. Providers are supported with resource toolkits and intervention training as obtaining blood pressure and other vital readings before dental treatment and are often the first to observe the overt oral health effects of both mental and physical illness, our oral health partners play a fundamental role in prevention and health outcomes.

Access and Availability: Our state dental director in partnership with our subcontractor, will engage dentists to ensure access to care through a sufficient network of both rural and urban access points of diverse individual and group practices, school-based health centers, and Federally Qualified Health Centers (FQHCs), in accordance with Appendix A requirements. Members can access dental services at any point. Recognizing the critical role that providers play in counseling our members about oral health, we offer provider education on all programs, covered and value-added services. To enhance the opportunity for receiving an annual preventive dental visit, we provide **member incentives and free oral hygiene gift packs to CHIP members,** with the approval of the Division and work to ensure each member has access to a dental home. Establishing a fully integrated ***Dental Home*** means that a child's oral health care is managed in a comprehensive, continuously accessible, coordinated, culturally effective, and family-centered way by a trusted licensed dentist (primary dental provider) assigned or chosen by that member. The concept of the dental home reflects the American Academy of Pediatric Dentistry and American Dental Association's best principles for the proper delivery of quality oral health care, with an emphasis on initiating preventive strategies.

A Key Differentiator

Addressing Mississippi health disparities saving smiles and lives through our **enhanced dental benefits** and **collaborative care program**. In implemented markets outside of Mississippi, 44% percent of our adult members aged 21 to 64, had a dental visit in the past 12 months as compared to 21% nationally among Medicaid enrolled adults.

Source: American Dental Association Health Policy Institute

Member Service: We use technology and outreach strategies such as text messaging and telephonic outreach to address care gaps. In other markets, **thirty percent (30%) of Members who received outreach had a dental visit in a 12-Month period.**

b. Describe any innovative methods that Offeror will use to augment its approach

As a component of our oral health strategy, our innovative **quality initiatives** are key differentiators to improve member/provider experience and delivery of services. Some of our innovations are identified in (Table 4.2.2.1_H).

Table 4.2.2.1_H: Innovations We Will Use to Augment our Approach to Dental Service Delivery and Outcomes

Innovation	Program Description
Primary Care Dental Home (PCDH) Program	Evidenced-Based Program Model uses the principles of person-centered continuous, comprehensive care. Emphasizes preventive care, healthy behaviors, and collaboration with the Primary Care Medical Home (PCMH). The program delivered in another market resulted in an increase in HEDIS and CMS-416 Preventive Dental Services by at least 15 %

Innovation	Program Description
Hospital Diversion and Office Sedation Program	A program identifying services consistently and inefficiently performed in outpatient facilities that can be completed safely in a dental office under less invasive means. Other market program efforts have resulted in decreased medical costs for hospital pediatric dental cases by 42% per measurement year
Medical-Dental Coordination and Emergency Department (ED) Diversion Program	Syndromic and disease tracking program that identifies members with chronic medical or behavioral health conditions, pregnant or at high- risk for oral disease connecting them with specific care support through enhanced dental benefits, and collaborative, coordinated care. Provides brief intervention counseling, tobacco, and other risk behavior cessation tools. The program additionally focuses on ED Diversion with proactive member education and identifying members using the ED for non-traumatic dental conditions, follow-up, and redirecting them for dental care. Programs delivered in other markets resulted in less than 1% ED utilization for non-traumatic dental conditions across markets; Over 28% of members with an ICD 10 target condition had a dental visit, lowered acute medical costs
Caries Prevention Initiative	A value-based intervention incorporating promotion of Caries Preventive/Arresting Medicaments (an evidenced-based preventive technique for high caries-risk) into oral health delivery models and for members with inconsistent access to dental treatment services Recommended by **Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP Learning Collaborative.** Implemented in our current markets and proposed **Mississippi Enhanced Benefit**

c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding dental services

Through population health assessments we identify distinct member oral health disparities, including disproportionate burden of dental caries among minority children and those residing in geographic dentally underserved areas of Mississippi. We additionally identify disparities in the comorbidity of oral disease, chronic medical disease, mental illness, and pregnancy. Dental caries and periodontal disease rank as two of the most common chronic conditions among children and adults, surpassing the national rate of diabetes. Among children and adolescents, dental caries is 4 to 5 times more common than asthma. Dental decay is a significant health problem for Mississippi children and Mississippi ranks 49th out of 50 states for adults with a dental visit in the past 12 months (County Health Rankings, 2021), with a greater burden in minorities, those with less than a high school education and those in dentally underserved areas. We will invest in a dental scholarship program to grow services for minority dental providers as a tool to fight oral health disparities within Mississippi. Table 4.2.2.1_I identifies the oral health disparities impacting Mississippi residents and our planned interventions.

Table 4.2.2.1_I: Mississippi Targeted Racial, Ethnic and Geographic Oral Health Disparities and Interventions

Target Disparities	Intervention/Strategy
Access to Dentists (Rural): (HRSA statewide survey indicated that 80 counties out of 82 in the state have Dental Health Professional Shortage Areas (DHPSA), with 8 of these counties being urban and 72 rural)	▪ Work with FQHCs, community centers, the Mississippi State Department of Health, mobile clinics such as MHS Mobile Dental, and the newly launched Smiles on Broadway Dental Care Mobile Clinic addressing underserved children in the Mississippi Delta, and the University of Mississippi School of Dentistry to address access issues and strategies ▪ Identify alternative dental delivery systems, technology, and workforce models to address access in these areas, including opportunities to integrate oral health into primary care settings; working with allied schools and stakeholders on oral health workforce models to provide preventive services in dentally underserved communities and seeking opportunities to incorporate teledentistry within the scope of practice ▪ Assist with healthcare appointment attendance, as an innovative approach to reduce transportation as a barrier to care across Mississippi regions, we will partner with a Medicaid enrolled non-emergency transportation (NET) rideshare provider, to offer our members allowing them access to free rides to dental appointments in both urban and rural regions of Mississippi
Utilization of Oral Health Services (Black and Latinx Children): Higher caries rates, lower utilization of preventive dental services (dental sealants), and greater need for urgent care because of pain or infection	▪ Promote the use of the **dental home** as a continuous, available, and patient trusted source of preventive and routine dental services and promote healthy behaviors ▪ Member incentives as well as provider incentives and value-based reimbursement models to promote preventive dental services and dental sealants ▪ Employ school-based clinics and other oral health workforce models within the scope of practice for preventive services such as fluoride application and sealant placement. Launch Seal-A-Deal campaign to promote dental sealant as a best practice approach and ensure that our member oral health educational materials are audited and tested to promote culturally sensitive and appropriately targeted messaging ▪ Support with minority dental associations in Mississippi to garner diversity and inclusion in our provider community to reflect the communities served ▪ Community partnerships, bilingual oral health education events, sponsorships, grants, and donated resources to community centers, schools, and clinics to enhance screenings and preventive care

Target Disparities	Intervention/Strategy
Mississippi Residents with Chronic Medical Conditions or Pregnancy (Black and Latinx Communities): Black and Latinx residents with less than a high school education lose permanent teeth due to (gum) disease at much higher rates. Black women are less likely to have visited a dentist during their last pregnancy	▪ Implement our medical-dental disease tracking collaborative coordinated care program and enhanced adult dental benefits identifying racial ethnic minorities and those in target disparate **Mississippi counties** with chronic medical disease, behavioral health (BH), special needs, pregnant or at-risk behaviors and connect them with a dental visit, preventive and periodontal (gum) services as medically necessary ▪ Collaborate and establish partnerships with faith-based and community-based organizations to educate members about oral health and connections to physical and mental health and pregnancy outcomes and help members access health-related social needs, such as healthy food, transportation services, and health education resources, all contributors to support good oral health outcomes ▪ Promote cultural competency training for oral health professionals as a foundational pillar for reducing disparities through culturally sensitive and unbiased quality care

4.2.2.1.A.7 Vision Services

a. Describe the Offeror's direct experience in service delivery and payment and/or capacity to manage service delivery and payment for vision services.

With the approval of the Division, we subcontract vision benefits administration to a national vendor with proven results. We facilitate effective integration that affords a seamless experience for our members and providers, optimizing our vision services. We include our vendors in implementation, end-to-end testing, and go-live command centers to ensure any risk or issue is quickly identified and swiftly mitigated. Our goals center on performance management exceeds National Committee for Quality Assurance (NCQA) standards. Our strategic use of performance standards and continuous monitoring, in-depth market and benefit analysis, and quality improvement efforts through Joint Operating Committees (JOC) and a delegated vendor oversight team, ensure operations flow seamlessly to promote appropriate care, cost efficiency, timely provider payments, and ensure the vision benefit managed by us and our subcontractor is compliant with standards of care and consistent with Appendix A. We have historically achieved high performance on all indicators, including **100% prompt payment for vision service claims, 100% accuracy for encounter submission, and 100% compliance rate on all processed grievances and appeals.** To ensure service delivery, a broad network of providers including ophthalmologists, optometrists, and opticians, provide members with convenient access to services. We offer and comply with all contractually required vision benefits to promote eye health for eligible beneficiaries. We additionally offer an **enhanced vision benefit**. Adults 21 and older, can receive a pair of eyeglasses every two years. We promote vision screenings as part of our well-baby and well-child services to identify vision problems early, provide education, and referrals. We describe all benefits in relevant member materials and educate the importance during interactions with members. Recognizing the critical role that providers play in counseling our members about vision health, we offer provider education on all programs, and services.

b. Describe any innovative methods that Offeror will use to augment its approach.

We will implement the following innovations Table 4.2.2.1_J to improve service delivery and vision health in the state.

Table 4.2.2.1_J: Innovations We Will Use to Augment our Approach to Vision Service Delivery and Outcomes

Innovation	Program Description
Member Incentives for Retinal Eye Exams	As part of our wellness incentives program, with Division approval, adult MSCAN members can receive up to $50 in incentives, one per calendar year when they receive a Retinal Eye Exam with an Eye Care Provider. A Diagnosis for diabetes required.
Integrated Diabetes Care	An initiative to help members with diabetes understand the importance of monitoring related health issues.
Clinical Practice Registry	Improve PCP and PDP referrals and coordination with Eye Care Specialists through a Clinical Practice Registry and provider incentives.

c. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding visions services?

Through population health assessments we identify distinct member eye health disparities as part of our annual vision program and in partnership with our vendor, we will develop strategies to address the disparities in access to routine vision care, early and well-child vision screenings, eye health outcomes, and connections with

diseases such as diabetes and other medical conditions related disparities. Table 4.2.2.1_K identifies the vision care disparities impacting Mississippi residents and our planned interventions.

Table 4.2.2.1_K: Mississippi Targeted Racial, Ethnic and Geographic Vision Care Disparities and Interventions

Target Disparities	Intervention/Strategy
Geographic (Rural): Limited access to vision care in rural communities	▪ Engage and work with FQHCs, community centers, mobile clinics, and school-based health centers to deliver onsite vision exams in rural and health professional shortage areas ▪ Provide transportation options to help reduce barriers to accessing and keeping appointments
Racial, Ethnic Minorities: Black and Latinx children are less likely to have had a vision screening (CDC)	▪ Work with schools and community events on well-child screenings inclusive of vision, hearing, dental, and nutrition ▪ Partner with the community- and faith-based organizations to address vision health disparities through events to provide both exams and increase member and community understanding of the importance of eye health as it relates to chronic diseases, particularly among racial and ethnic minorities who have higher rates of diabetes and hypertension ▪ Employ local community representatives as valuable resources to help address barriers to receiving regular eye appointments in communities of color

4.2.2.1.A.8 Additional Items

a. State whether the Offeror will require any cost-sharing or copayments from MississippiCAN and/or CHIP Members. i. If yes, please describe what these cost-sharing/copayment requirements will be.

We **will not** require any cost sharing or copayments from any MSCAN and/or CHIP members.

b. Describe practices and policies the Offeror would plan to use to ensure that rural MississippiCAN Members would have adequate access to Non-Emergency Transportation (NET) and any innovations that the Offeror may bring to MississippiCAN in this area (Note: NET is not a covered service under CHIP).

We are a leader in providing **broad and accessible transportation options** that ensure members get to and from their appointments on time. To foster independence and resiliency and **improve health equity and access to care,** we provide our MSCAN members who have no other means of transportation unlimited transportation to and from healthcare appointments and pharmacies to fill prescriptions **at no charge.** Our approach to promoting health equity, providing **culturally sensitive care,** and meeting the needs of members with **limited English proficiency** includes the proactive identification of members with limited English proficiency and recording member preferences in our member information systems, providing interpreter services as needed, training staff and providers regarding cultural sensitivity and monitoring provide performance.

In addition, we provide transportation to address barriers to accessing social determinants of health (SDOH) such as education and seeking employment, at no charge to members. Our Member Handbook and online member and provider portals provide information regarding all transportation benefits. Our procedures are written to **ensure rural members have access to NET services,** clearly identifying our processes and responsible parties. We outline key elements of our procedures in Table 4.2.2.1_L to ensure our NET services are available to all rural members and compliant with Appendix A and Division requirements.

Table 4.2.2.1_L: Procedure and Methods to Ensure Compliance

Procedure	Method
NET network adequacy, with particular focus on rural areas of the state	Annual review of Network adequacy, including analysis of wait times and complaints
All components of NET brokerage program are available to rural members	Annual review of Member Handbook, audit of NET provider
Rural members understand transportation options and availability	Annual survey of members, NET provider member satisfaction surveys
Compliant NET provider selection and retention processes	Annual audit of vendor contracted providers, trending results
Screen all NET request types; denial procedures for ineligible requests	Quarterly audit of NET logs and denials
Transporting rural members and their minor child(ren) at the time of scheduled appointments	Annual audit of NET provider procedures, review of complaints and transport logs
Compliance with contractually required scheduling and dispatching expectations and timelines	Quarterly audit of NET schedules, wait times, transport logs

Procedure	Method
Overseeing NET providers regarding the transport of additional rural passengers not covered under the contract and how we handle urgent trips, high risk trips, last minute requests from rural members, family members, guardians, or representatives	Annual audit of NET provider procedures, review of complaints and grievances, and transport logs
Addressing and taking corrective action when NET providers do not arrive for scheduled pickups	Proactive processing of complaints/grievances; quarterly review of transportation logs; formal process improvement plans

Our member-facing and field-based staff educate members and parents/caregivers regarding our transportation offerings and ensure members have access to NET to meet their treatment needs. This includes transportation to and from our sponsored educational events, such as mom and baby fairs; high school equivalency classes, job interviews, and other approved activities; unlimited roundtrip transportation to clinics for members who receive methadone treatment; transportation to local Women, Infants, and Children (WIC) offices and Medicaid offices for eligibility and redetermination appointments; and daily trips for families to visit their infants in the Neonatal Intensive Care Unit (NICU). We provide mileage reimbursement for families, including rural members and areas designated as maternal care deserts. Recognizing the significant impact of food insecurity on members' health and well-being, therefore pending approval from the Division, we offer roundtrip transportation to food banks and food pantries and for up to five grocery trips per month so members can pick up healthy food and personal care items.

We will **ensure rural members receive NET** through individualized arrangements and by increasing access to care. Our vendor uses local subcontracted transportation providers in rural areas to supply ride services. We are including a Medicaid enrolled non-emergency transportation (NET) rideshare provider, to offer our members access to free rides in both urban and rural regions of Mississippi. These additional providers are critically important in rural counties in Mississippi where other resources are not available. We incorporate on demand services to increase the availability and fulfillment of last-minute requests when members have an urgent need to get to a provider's office. Generally, a parent or guardian must accompany members under the age of 16, but we make exceptions for a pregnant minor or young parent taking a child to a medical appointment. Our vendor typically permits only one rider to accompany the member on the trip; however, if a parent needs to bring along additional family members or children, or additional riders also have medical appointments, they are permitted to accompany the member. If in an unusual circumstance, our NET provider is unable to provide timely transportation, we will reimburse the members directly.

Our **provider services manager (PSM)** oversees our program, ensures compliance with all Appendix A and Division requirements, meets quarterly with the Division regarding NET services, collaborates to address NET challenges, and provides copies of our policies, procedures, and informational material to the Division upon request. Our PSM produces and distributes informational material specific to rural members concerning how to request NET services to members, families, guardians, or representatives; and provides educational materials to members, family members, guardians, or representatives who habitually request transportation less than three business days in advance of an anticipated appointment. Our PSM updates providers and community representatives about NET services and expectations, ensures our rural members' expectations are consistently met and exceeded, and monitors authorization processes to ensure timely access to services to rural members.

We **oversee the delivery of NET through daily follow up** to address questions about benefits or issues via a dedicated team of analysts monitoring our transportation email inbox; biweekly checkpoint meetings with vendor leadership; daily monitoring of member complaints; monthly reports that detail all requests and trips made; and monthly call quality calibration sessions to monitor vendor performance. In addition, as a **value-added benefit**, we **will provide transportation to all CHIP members** and we will **contract with region six community mental health center, Life Help, to provide transportation for members with significant BH needs**.

c. Describe any additional proposed innovations for delivery of Member services or benefits that the Offeror would bring to MississippiCAN and/or CHIP that are not otherwise covered in this section.

In addition to the innovations and value-added benefits identified throughout section 4.2.2.1.A, we will identify additional innovative activities we will bring to support MSCAN and/or CHIP members in Table 4.2.2.1_M.

Table 4.2.2.1_M: Innovative Activities Designed to Demonstrate Improved Service Delivery and Outcomes

Institute for Relational Health: We will establish a national center of excellence with the support of national experts to address the impact of stress on members by developing safe, stable, and nurturing relationships. The Institute will provide Mississippi evidence-based practices to address stress and adverse childhood experiences which will be available to all members, families, and providers.
Increase in telehealth access in rural areas: We will provide a video platform for use by small, rural, and independent providers to gain the capacity to use web-based applications through smartphones and similar devices that allow scheduling of appointments and provide telehealth services.
Children's community activity membership: We will offer up to $100 annually toward the cost of a single membership for members to engage in community-based activities to address social isolation and promote active lifestyles such as Boys and Girls Club, YMCA.
Community-based organizations (CBOs): For our strategic CBO partners and those who are a part of our community reinvestment programs, we will establish specific metrics with support of the Division. Our incentive structure ensures our community partners help us drive better health outcomes for our members and are appropriately rewarded for progress on shared goals. Our current CBO value-based payment arrangements include metrics on member engagement, care management engagement, and overall changes in utilization and cost of care. We will also assess changes in the gaps in care among members engaged with CBO partners to capture any broader impacts on engagement. We will work with the Division and our CBO strategic partners to establish realistic benchmarks and measures that will drive overall improvements.
Enhanced crisis response services: We will provide a focused comprehensive suite of crisis services facilitating rapid crisis resolution, engagement into care, and coordination of crisis aftercare services; including our rapid response program that dispatches care managers, peer support staff, and life coaches into the community to support crisis stabilization and provide immediate access to services.
Real-time claims payment for select rural providers: We will facilitate immediate payment of claims for select rural providers where cash flow concerns can negatively impact service delivery in areas with limited access to providers.

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

We know, based on our experience, a fully integrated service delivery model is key for system transformation and addressing disparities in Mississippi. We will **champion the Division's efforts** and provide statewide leadership to advance the capacity of all CCOs, providers, and stakeholders to proactively identify and overcome racial, ethnic, and geographic disparities in Mississippi. We will lead this effort through **tailored regional experiential community training on health equity and cultural competency** to all partners. The experience will be based on the experience of residents in each region. In the first year, we will **conduct at least one training in each region**. This nationally recognized experiential community training is designed to increase staff, community, and system partner awareness about the lives and challenges of those with limited resources. The training experience equips organizations to engage members with limited resources into care and design effective intervention strategies. These immersive simulations allow providers, community partners, and other stakeholders to experience the challenges faced daily by our members to meet their housing, clothing, employment, food, and childcare needs with limited resources. Individuals with lived experiences attend these events, including our staff with the lived experience of growing up in households with limited resources, adding to the authenticity of the simulation. These events are designed to **raise awareness of the challenges faced by our members, reduce implicit biases, build empathy, and foster equitable health care**. In addition, we will conduct two specialized experiential learning initiatives, one addressing the **unique challenges and obstacles children with limited means encounter** and another one that highlights the **unique obstacles encountered by persons with justice system involvement**.

We will support health care workforce development through scholarships with the **University of Mississippi, Mississippi University for Women, University of Southern Mississippi, Hinds Community College, Jackson State University, and the Mississippi State Extension office** to encourage students to enroll in allied health programs with a special emphasis on working with rural, minority, and low-income populations. We will also demonstrate operational excellence through participating with and financially supporting diverse local community

partnerships and alliances, including **HEAL Non-profit Alliance, Mississippi Health Disparities Conference, Mississippi Department of Health (MSDH) Health Equity Initiative, Mississippi Rural Health Association, and the Mississippi Partnership for Comprehensive Cancer Control** and use these relationships to address disparities. We are also working to achieve the National Committee for Quality Assurance (NCQA) health equity accreditation. This is the next evolution by NCQA replacing the distinction for multicultural excellence.

4.2.2.1.B. Member Services Call Center

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

a. Confirming that the location of the proposed operations will be within the state of Mississippi (provide a yes or no answer; do not include address);

Yes, our proposed member services call center operation will be located within the state of Mississippi, and it meets our members' information needs accurately, efficiently, and with compassion. We know our members turn to our member services team as the first line of support. We embrace this interaction and strive to ensure it is the best possible experience. Member services, our 24-hour nurse advise line and our 24-hour behavioral health (BH)/substance use disorder (SUD) crisis line can all be reached through one dedicated toll-free number, which is separate and distinct from our provider services number. Our automatic call distribution (ACD) and Integrated Voice Response (IVR) offer intelligent call routing, ensuring members can seamlessly reach the right resource to support their needs, and our interactive chat option is available on our website and mobile app.

Dedicated, local staff. Our member services staff live and work in the communities they serve and are committed to assisting our members in the successful navigation of their health care needs. We are committed to hiring a diverse local workforce, including bilingual member services call center staff members who speak fluent Spanish. Our Mississippi-based member services call center manager will lead our staff members overseeing inbound and outbound operations and ensuring our call center will comply with all state and federal requirements.

Engaging with our members. Our call center staff will use interactive call scripts to assist members with questions such as member eligibility status, prior authorization, benefits, addressing gaps in care, finding a provider, scheduling an appointment, grievances, and appeals, and locating community resources. We will use special scripts for emergency and unusual situations, and all processes and scripts are updated annually to ensure they are clear, easily understood, and responsive to diversity in culture, language, and special populations. We will submit call center scripts to the Division for review and approval 60 calendar days prior to use.

Connecting to clinical resources. For clinical needs, our call center staff will take great care in connecting our members to our care management staff, 24-hour nurse advice line, and 24-hour BH/SUD crisis line. Call center staff will also help members locate a provider and schedule appointments, collaborate with our care management team to facilitate member self-referrals to our care management program, and they will receive enhanced training to protect and meet the needs of children, families, parents, and caregivers of foster children.

Making our services available. Our member call center will be available between 7:00 a.m. and 8:00 p.m. CT, Monday through Friday, except for Division-approved holidays. Live voice coverage will be available every business day apart from approved Mississippi state holidays. Our member services staff will may also be reached during regular business hours via our interactive chat option on our website and mobile app. We ensure call center closures, staffing, and early closures will not burden member access to care. For all days with a closure, early closing, or limited staff attendance, our members will still have access to our 24-hour nurse advice line and our 24-hour BH/SUD crisis line. We understand life does not stop at 8:00 p.m. After-hours callers will be able to access our nurse advice line and our BH/SUD crisis line 24 hours per day, 7 days per week for immediate needs. For non-critical or clinical concerns, members will be able to utilize our IVR technology for insight on their account, or they will be able to leave a message in our voicemail. To assure all voicemail messages are returned before the end of the following business day, we perform hourly tracking and reporting of new voicemails. Our after-hours voicemail provides information on obtaining emergency assistance and detailed instructions on how to leave a message for non-urgent services. In the event a member leaves a

voicemail message in a language besides Spanish or English, our translation services provide support before the end of the following business day. Members are directed to call 911 in case of an emergency.

b. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call) and measures to ensure standards are met (the Division retains the right to approve all call center standards);

We ensure call center performance standards from Draft Contract, Section 6.9.1.2 are met, as well as any additional standards the Division develops. As described in Figure 4.2.2.1_B, our workforce management strategy ensures standards are met and exceeded, regardless of the numerous variables that impact state standards, including fluctuations in call volume, membership, season, time of day, planned events, and unplanned events. Our telephone and call routing system are enabled with a callback feature, holding a member's place in line in the event we experience spikes in volume, allowing us to call them back. **Our ability to deliver operational excellence demonstrates that we respect members and providers and are a worry-free partner of the Division.**

Figure 4.2.2.1_B: Workforce Management Strategy

Our workforce planning and monitoring tools provide reporting and analytics that deliver a transparent and real-time view so team leaders can make appropriate decisions.

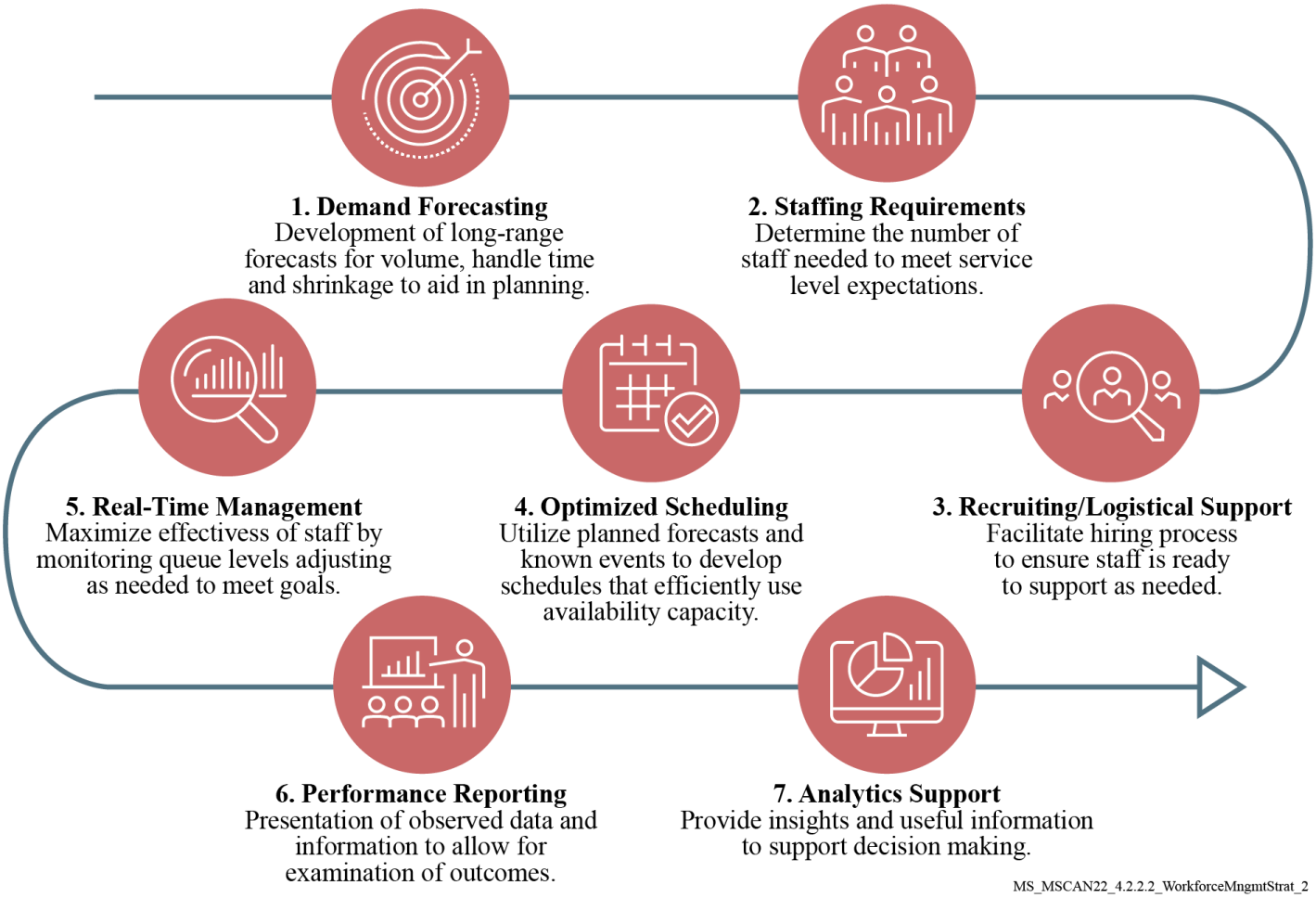


Table 4.2.2.1_N provides examples of recent member services call center performance.

Table 4.2.2.1_N: Examples of Recent Member Services Telephone Performance

	2020				2021			
	Qtr. 1	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**	**Qtr. 1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**
Live Answer (Average Speed of Answer)	17 sec	4 sec	9 sec	19 sec	15 sec	15 sec	14 sec	19 sec
Percent of calls answered within 120 seconds	90.50%	96.41%	94.95%	90.59%	92.86%	93.06%	94.61%	93.22%
Incomplete Calls (Abandonment Rate)	1.53%	0.30%	0.77%	1.83%	1.37%	1.79%	1.28%	1.59%
Average Length of Call (MM: SS)	7:49	8:29	7:45	11:18	8:42	10:50	9:11	8:44

Quality Assurance is Fundamental to Our Operations. We will incorporate all call center sufficiency standards from Draft Contract, Section 5.1, as well as any additional standards the Division develops. Our quality program is designed to promote first call resolution using a positive member-centered relationship along with informed and accurate information. Our call recording solution has a speech and data analytics component allowing 100% call recording and analysis. We will maintain call recordings for three years, exceeding the Division's 12-month requirement. Our analytics allow for call targeting for opportunities based on data attributes such as tone, word choice, volume, hold time, and length of call. We complete evaluations on 3% of calls targeted for trends and themes. We will fully cooperate with all reporting and auditing requirements with the Division, including the monthly and quarterly deliverable reports, and all requested recordings are available within five business days. Our monthly deliverable report will include call center staffing ratios and our recommendations to the Division regarding appropriate staffing based on call center sufficiency standards. **Our post-call survey member satisfaction rate is 90%, and our first call resolution rate consistently averages 97%.**

We leverage advanced technology and cross-department collaboration to increase member satisfaction. Technology is a key enabler of innovation and strong processes. We provide staff member support by using our customer relationship management (CRM) system with an integrated interactive knowledge management database which will provide immediate consistent answers for our members. Supporting all member needs, our teams can easily navigate provider networks; close gaps in care; and provide benefits, eligibility, claims, and grievance and appeals information. Our departmental systems feed into the system using enhanced application programming interfaces (APIs), making real-time information available, and reducing any risk of inaccuracies. To ensure members have a supportive and consistent experience each time they call we leverage our extensive and interactive knowledge management database. This system is also used to maintain reporting and tracking of members' calls and inquiries received during business and non-business hours.

Insights into action. Our goal is to constantly evaluate and improve our members' experience. Our member services call center will be the primary point of contact for new and existing members, therefore we will offer a brief post-call survey to capture the voice of the member by collecting immediate and actionable feedback from members about their interactions with our member services staff. If the survey includes a negative response indicating the member's issue is not fully addressed, a team lead will conduct an outbound call within 48 hours to resolve the issue. We track, trend, and monitor survey results and other member touchpoints across the organization to understand the reasons our members contact us and address root causes as appropriate.

c. Accommodations for non-English speaking, hearing impaired, and visually impaired callers, including what languages will be available

We believe everyone should have full access to quality health care, and we are committed to breaking down communication barriers. Non-English-speaking members are immediately connected through our IVR system with a member services staff member who are either native speakers themselves (for members who speak Spanish) or connects the member with an interpreter. If members should call us after business hours, our IVR system will offer messaging in both English and Spanish. We offer over-the-phone interpreters for any limited

English proficient (LEP) member when speaking to anyone at our organization. Members will be able to access in-person/onsite, video, or over-the-phone interpreters in more than 200 languages, including American Sign Language (ASL) for medical appointments, and we will provide materials in alternative format upon request.

We will ensure our members who are deaf or hard of hearing receive excellent service when calling our member services call center by using Mississippi Relay Services. Members will also be able to ask for an ASL interpreter to engage with via an appropriate HIPAA compliant device. For our members who are blind or visually impaired, we will make our member materials available in Braille, large print, or verbal explanation. We will post these materials on our website, compliant with section 508 of the Rehabilitation Act, so members will be able to receive the contents electronically or print them from a remote location. Members will also be able to communicate in writing with us via web chat, email, social media, or submissions through our website.

d. The process to ensure that Member calls pertaining to immediate medical needs are properly handled;

Member services staff is trained to skillfully triage incoming calls assess members' needs and identify resources to support medical needs. Most importantly, if a member is at immediate risk, staff members immediately connect them to 911 emergency services. As a part of new hire and quarterly refreshers, member services staff will receive scenario-based modules that will teach how to immediately guide our members to the appropriate resource. We will use our 24-hour nurse advice line, 24-hour BH/SUD crisis line, or escalate the call with a warm handoff to our care managers. We will also instruct our call center staff to provide warm handoffs to the state's pharmacy benefit administrator for medication issues, and we will be able to connect members to vision and dental providers as well as transportation when needed. Our 24-hour nurse advice line and 24-hour BH/SUD crisis line can warm transfer members to our telehealth platform for an immediate consult with a behavioral health provider.

e. Training program for call center employees including cultural competency and Care Management;

Our member services staff training emphasizes positive member engagement throughout our 10–12-week foundational call center training program, assuring that staff are trained to effectively respond to any member question or concern in a caring, respectful manner. Our curriculum includes modules that educate call center staff about covered services such as benefits, preventive care, care management, and appropriate instances for transfer to a care manager. To ensure our new member services call center staff are comfortable before graduating from the program, we incorporate structured in-person and virtual training, role playing, mock calls, and live calls. A post training transitional coach is also assigned to our staff members for 30 days, further ensuring new hire success. Beyond new hire onboarding, ongoing training and updates will include "Late Breaking News" articles, State Plan Amendments, and other MSCAN and CHIP updates. We will provide quarterly reports detailing the trainings conducted, topics covered, and the number and positions of staff members completing the trainings to the Division.

Local and Statewide Cultural Competency Training. To best understand our members, we will require successful member services support balanced with product and process knowledge and technical fluency. Our Mississippi focused training will begin at hire and continue with annual and quarterly events, as well as continuous education and reinforcement programs. Our training model will address the National Standards for Culturally & Linguistically Appropriate Services (CLAS), with a focus on social determinants of health, health disparities, health inequities, and the importance of cultural competency. We will address cultural, linguistic, and health literacy barriers by proactively requiring staff members to attend cultural sensitivity training programs, including an experiential poverty simulation called the poverty simulation. The curriculum includes health literacy, CLAS, commitment to health equity, culture, and diversity awareness, member health, safety, religion and culture, and their influence on health care.

Upon hire, we will require all staff members to take Implicit Bias and Mitigating Bias courses offered through a large state university. Annual training requirements for all staff include diversity, equity, inclusion (DE&I), and cultural competency. We will also require that all staff members complete our complex population course series designed to inform our staff members about the changing needs of our members, and the providers that serve

them. We will refresh courses quarterly as nuances change for our members. Additional DE&I courses that will be provided throughout the year include Understand and Embrace Diversity, How to Create a Respectful Workplace, Fostering Inclusion in the Workplace, and Unconscious Bias. We will provide staff members with ongoing content training as shown in Table 4.2.2.1_O, and as required in the Draft Contract Section 5.1.5

Table 4.2.2.1_O: Member Services Staff Training Topics

Key Training Areas	Training Topic	
Skills & People Competencies	▪ Cultural competency, health equity, DE&I, and implicit bias ▪ Mental health first aid and crisis situations, including callers who may be suicidal ▪ Interacting with members in a compassionate, empathetic, and trauma-informed way	▪ Cultural sensitivity, including assisting members with limited English proficiency (LEP), members who are deaf or hard of hearing, and responding to members with communication difficulties or challenging behaviors ▪ Members with specialized healthcare needs
Programs	▪ Medicaid, CHIP, and managed care ▪ Covered benefits and services, including physical health, BH/SUD, CM, and enhanced services and member incentive programs ▪ Care management programs and services, and appropriate instances for transfer to a care manager ▪ MSCAN and CHIP populations	▪ Enrollment and eligibility policies ▪ Member rights and responsibilities ▪ Preventive care services ▪ Plan structure, contract, and program requirements ▪ Fraud, waste, and abuse and the False Claims Act ▪ Advance directives
Processes	▪ Caller verification process ▪ How to handle ID card replacements ▪ How to process member changes in PCPs/PCMH ▪ How to access care, assist members to schedule appointments, and arrange transportation ▪ Systems training and online resource tools ▪ Referrals to community-based resources	▪ Internal warm transfers to care management, 24-hour nurse line, and 24-hour BH/SUD line ▪ External warm transfers to the pharmacy benefit administrator, community resources, and providers ▪ Identifying care gaps and completion of Health Risk Screening ▪ Policies and procedures for member complaints, grievances, and appeals ▪ How to handle disenrollment requests

f. How the Offeror will address service interruption through fail-over to an alternative site, redundant connectivity, and/or other options to mitigate downtime;

In the unlikely event of a call center service disruption, our command center gives real-time monitoring of our entire call network, allowing us to dynamically route calls to ensure top-level service. We automatically redirect calls to experienced call center staff members in multiple locations, including individuals working remotely. As required by the Division, each department within the enterprise will maintain and test a business continuity plan, ensuring we operate the telephone system for a minimum of eight hours each day at full capacity with no interruption of data. Our business continuity model also defines the process for communicating with state agencies and summarizes backup processes. Our telephonic service continuity backup solution is reviewed monthly across the organization ensuring we continue providing services in the event of a natural disaster, any interruption in service, or power failure. We will notify the Division immediately when our phone system is inoperative, or our backup solution is needed. In a disaster scenario, and after engagement with the Division, we will easily transition calls for a defined period to work from home staff, and alternate sites and locations, without negatively affecting service for members and providers.

Our call quality stayed strong during the COVID-19 public health emergency

Our call quality rose 6% from May 2020 to December 2020. Additionally, regulatory call metrics remained significantly above contractual commitments during the 2020 calendar year.

If a business continuity incident is identified, our member services call center supervisors escalate the issue to our incident management team. The incident management team is responsible for restoring business functioning and collaborates with department leadership to assess the impact, determine risk areas, and notify state and

federal agencies, as necessary. Using our written procedures, the incident management team notifies designated leadership within our organization and communicates updates. The business continuity incident is monitored until services are restored to normal operation.

Another key component of our business continuity plan is that our technology enables us to easily transition to working from home. This flexibility is important should it become necessary to quickly ramp up staffing during a natural disaster or business continuity situation without disruption to services. Combining local service centers, with multiple sites for redundancy, with a work-from-home strategy also affords employment opportunities for the local community. We will continuously monitor our member services call center volume, and we will be prepared to hire and train additional member services staff, as needed, to assure responsive and high-quality services to our members.

While we employ a robust business continuity plan, we limit the volume of calls sent to out-of-state member services staff members to a minimum, except when an emergency rollover is required. We will promptly notify the Division if such an emergency takes place. It is very important to us that our members will be able to reach member services staff who are familiar with the geography, provider network, communities, and culture of the state of Mississippi.

Our approach to call center technology utilizes virtual desktop technology to provide the same functionality as the agent's desktop at the office. Combining this with a softphone technology allows the agents to work virtually and securely from almost anywhere. This enabled our agents in other markets to work from home during the early stages of the pandemic in 2020 with no impact on productivity. Agents simply took their systems home and connected them using the documented process provided by the client services team. Once connected to the Internet, the agents were back online securely with no loss in functionality or service disruption.

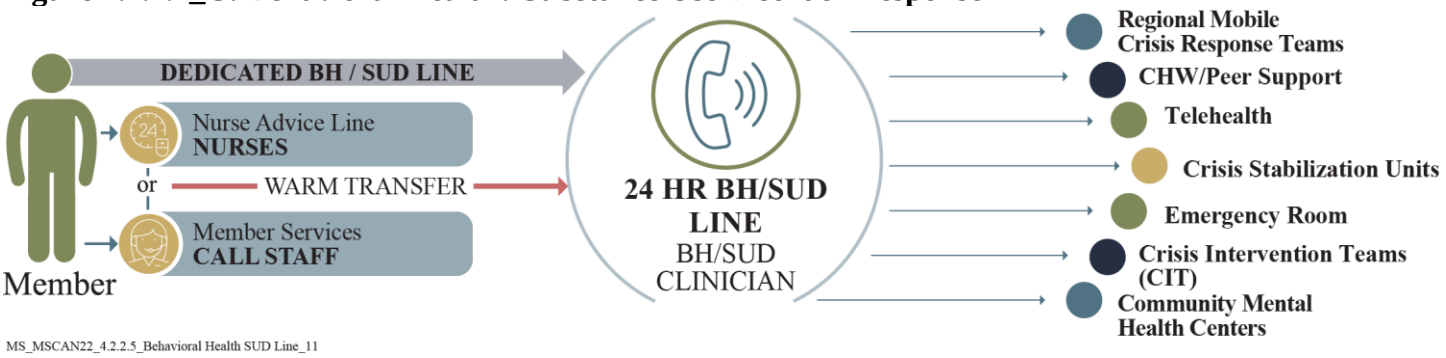
During emergency events, the crisis management team will work with departments to identify available resources for activities outside their normal work. For instance, resources from across the enterprise were mobilized in support of the pandemic response to provide vaccination support at clinics across our markets. This approach ensures employee resources are best utilized in support of our members during an emergency.

g. For behavioral health/substance use disorder, how the Offeror will provide crisis intervention and other telephone access twenty-four (24) hours per day, seven (7) days per week

To respond to our members' urgent BH/SUD needs, we will offer a 24-hour BH/SUD crisis line staffed by licensed BH/SUD professionals to assist our members. We will train the BH clinicians supporting the 24-hour BH/SUD crisis line in crisis intervention, including the National Suicide Prevention Lifeline guidelines regarding suicide risk assessment and engagement. Further, the staff operating our 24-hour nurse advice line and our member services call center will be trained in trauma-informed care and mental health first aid to facilitate the identification of a member in crisis. We have protocols in place to utilize a warm transfer of the member to the 24-hour BH/SUD crisis line to enable rapid response and ensure the health and safety of the member.

When a member is connected to the 24-hour BH/SUD crisis line, our BH clinicians coordinate crisis care on behalf of the member in real-time, accessing the member's documented health record and safety plan, if available. Our BH/SUD crisis line staff will have a working relationship with the local crisis resources available in the community, including mobile crisis providers, and crisis stabilization units at local community mental health centers (CMHCs) that operate 24-hours a day, and will activate them to meet the health and safety needs of our members. We will also use technology and tools to identify immediate treatment options meeting the member's needs and preferences, such as a BH provider via telehealth if applicable. We will partner with local first responders to dispatch crisis intervention teams or trained law enforcement officers where community-based crisis services are not readily available (Figure 4.2.2.1_C). After every call, our BH/SUD care managers will follow-up with the member to be sure needs were met and a care plan is in place.

Figure 4.2.2.1_C: Behavioral Health / Substance Use Disorder Response



Once the member is safe with appropriate crisis intervention services dispatched, the BH/SUD line staff members notify the member's care manager or make a referral to care management. All members calling the BH/SUD line will be assigned a behavioral health specialist care manager who will receive an urgent task through the clinical platform alerting them to the BH/SUD line call summary as well as admissions, discharges, and transfers. As the care manager works with the member to ensure necessary treatment and follow up, they will use an interdisciplinary care team to partner with the member to build a safety plan that is accessible to care management staff members, including the BH/SUD line, enabling a rapid response tailored to the individual if they experience a future need.

We will cooperate with the division's selected pharmacy benefit administrator (PBA) and develop a process to ensure a member obtains the medication(s) they need in a timely manner. We will collaborate with local pharmacies to ensure a 3-day emergency medication supply is available to our members contacting the BH/SUD line until a prior authorization can be reviewed, and work with the PBA to explore similar opportunities with their pharmacy network if allowed by the Division. Our BH/SUD line clinicians will also coordinate connections to the Mississippi Mobile Crisis Response Team**,** a state service available in all 82 counties that allows a member to speak to a trained counselor for short-term crisis counseling and connection to CHMCs or other local providers for services.

4.2.2.1.B.2. Describe the Offeror's proposed automatic call distribution (ACD) system and its capabilities and capacities.

We will use a suite of best-in-class call center technologies to ensure members reach the appropriate resource to address their inquiry, on their first call, without any unnecessary wait time. We will assign separate toll-free numbers to member services and provider services. However, with us, there is no wrong door – our ACD and call routing technology ensures a member or provider reaches the appropriate team members to support their inquiry.

Our system uses natural language, skills-based routing to direct callers to the appropriate resource equipped to provide timely and accurate responses to a range of inquiries. Upon calling, members will interact with our IVR, which is translated in both English and Spanish. Our IVR will allow members to describe their questions and quickly connect to member services staff members or use self-service options for simple tasks like checking eligibility or ordering a new identification card. An interpreter will connect with members who require language assistance. If a member has immediate needs, they will be routed to our 24-hour nurse advice line or our BH/SUD line.

The IVR will pass the call to our ACD supported by intelligent call routing, which employs precision queuing technology and connects the member with the best trained specialist to assist with their question. Our workforce management team proactively manages our IVR and ACD technology to ensure any issues are quickly identified and resolved to prevent any impact to member experience. Speech analytics technology allows us to quickly identify drivers causing a volume spike. By monitoring trends in keywords mentioned during calls and members' tones, we can quickly respond to that insight and update call center communication internally. The team will also launch queue messaging in our IVR that equips members with a summary of the issue and how we will address it.

We will use queue messaging and a courtesy call back technology to alert members to potential hold times and to offer members the option for us to call them back, instead of holding in a queue, while maintaining their place in line. We manage capacity in real-time. The team produces intraday (every hour of the day), daily, weekly, and monthly reporting on call volumes, arrival patterns, and call topics. This reporting informs future forecasts and staffing assessments in addition to the root cause and continuous improvement exercises. This ACD and reporting system records and aggregates all call information, which will enable us to produce reports required by the Division. Our technologies will aid us in accomplishing our mission of ensuring Mississippians can easily access their benefits to live healthier lives, while prudently managing state resources.

4.2.2.1.C. Member Handbook

4.2.2.1.C.1 Describe how the Offeror's Member Handbook will inform Members about the process for accessing physical and behavioral health/substance use disorder services.

Informing members how to access physical health, BH/SUD, and care management services is a responsibility we take very seriously. Our member handbook introduces members to these services in a way that invites and encourages action while reducing any stigma that may exist. We use our member handbook sections regarding physical health, BH/SUD, and CM to create specific campaigns that we proactively communicate to members using our next generation artificial intelligence (AI) driven analytics platforms.

Our member handbook provides a practical guide for members, their family members and caregivers, and others seeking information about covered benefits. Our member handbook is based on guidance provided by the Division and adapted to include material specific to our plan and programs. The information included in our member handbook complies with 42 CFR 428.10(f) and Draft Contract section 5.4. Our member handbook is written at or below a third grade reading level in English and Spanish, and other languages on request. We mail every member a printed **Member Handbooks within 10 days of notification of their enrollment**, exceeding the Division's requirements. Additionally, members who log into our member portal have immediate access to our member handbook. Our fully integrated, transparent service delivery model enables provider collaboration to ensure members can easily access their benefits to live healthier lives, while prudently managing the state resources.

We ensure our member handbook remains up to date knowing it is an important ongoing reference for members. Information in the handbook includes specifics related to BH/SUD, and CM services. For example:

- Ways to reach our 24 - hour **BH/SUD Crisis Line**, staffed with trained, licensed professionals prepared with tools and knowledge to connect members with local resources and provide immediate telephonic intervention.
- Information related to self-management including our **online resource tool, available 24 hours per day, to help members incorporate cognitive behavioral therapy and mindfulness techniques** designed to improve emotional well-being. This tool offers features such as a mood tracker, daily inspirational quotes, and educational videos about depression, anxiety, SUD, and other BH conditions.

We remove barriers to care by extending connection points with members, particularly younger members, and those in rural areas, with innovative tools and resources designed to engage members in ways they prefer. **For teens and young adults** who often are not engaged in mental health care, we are proud to be an early adopter of an online platform to increase access and engagement with appropriate BH services. The platform contains compelling content about adolescent BH issues and sends tailored text messages to teens, with pertinent content from BH coaches and licensed clinicians, providing emotional support.

The member handbook provides information about our **telehealth platform** supporting on demand video-chat and scheduling capability accessible through our website and mobile app. This will provide members with expanded access to their providers, which is key for access to BH and rural health providers.

4.2.2.1.C.2 Describe how the Offeror's Member Handbook will inform Members about the Offeror's Care Management System

We use our **AI driven analytics platforms to create specific campaigns to proactively communicate to members about our care management system** and how to access it, including member assignment, coordination

of care, the member's role in CM, and how to initiate a self-referral into CM, a vital service available to all members. Our member handbook also provides information about the tools and incentives we offer for members to complete their health risk screening, which may trigger the need for CM services. The goal of our member handbook is to ensure members are informed of their rights and care options and how they can access the services available to them.

4.2.2.1.D. Website and Mobile Application

4.2.2.1.D.1 Describe how the Offeror will ensure that Members are well-informed about the existence and functions of its Member Web Portal and Mobile Application.

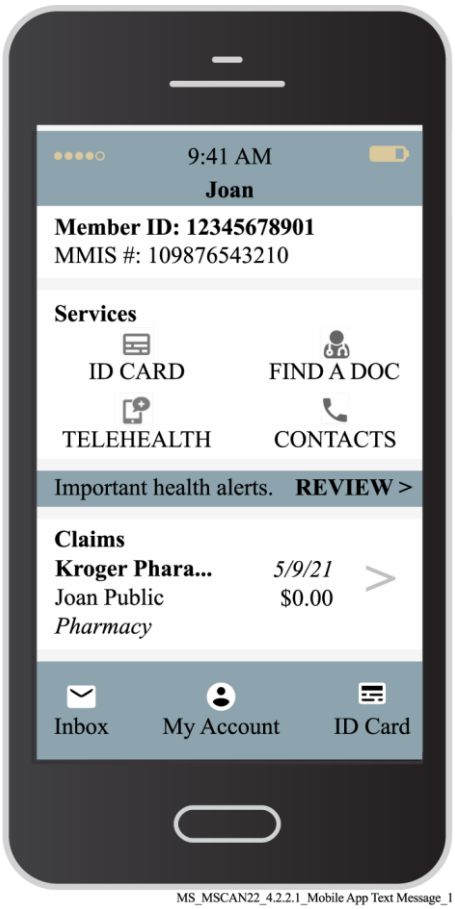
Our secure member portal, accessible through our website and mobile app is a front door to all our resources. It delivers immediate connection, comprehensive up-to-date information, and user-friendly access to our members, meeting all requirements of the Draft Contract section 5.8. To ensure our members are well-informed about the existence and functions of our member portal and mobile app (i.e., how to access and use), we provide instructions via our member welcome call, welcome packet, welcome email, pre-enrollment marketing materials and through social media engagement. Our welcome emails encouraging members to register for the member portal and download the mobile app have one of the highest open rates of any campaign we conduct. For example, in a recent campaign, the open rates ranged as high as 63% with click-through rates as high as 9%.

Our member and provider call center staff, care managers, community health workers, and peer support staff also receive training on the web portals and apps so they can guide members to the tools and how to use them.

Experience has shown us that members do not always keep their own up to date medical records, including knowing the names of their medications or their children's vaccine history, for example. Especially in times of crisis, like a hurricane or other natural disaster, our member portal and mobile app are critical immediate access points that put vital records in the hands of our members.

Our intelligent mobile app provides a simple, intuitive interface to the member portal, offering members and their family useful information to live healthier lives (Figure 4.2.2.1_D). Our members are presented with immediate value as the app provides customized information upon login. Through the app, members have instant access to their digital ID card, confirm enrollment status, view benefit information, update their contact information, reach member services by phone or chat, and link to our social media sites. Members needing care can connect to the 24-hr BH/SUD crisis line and our 24-hr Nurse line, get assistance making health appointments including dental and vision, and launch our telehealth platform. Members can use the app to find a provider and change their PCP/PCMH, view gaps in care such as mammograms and well child visits, see a listing of their medications and be notified by text when a refill is needed, view their claims information, read notifications, view their COVID-19 vaccinations, as well as their full immunization history. The app provides links for completing the health risk screening and self-referral to care management, as well as available incentives. [redacted]

Figure 4.2.2.1_D: Member App



MS_MSCAN22_4.2.2.1_Mobile App Text Message_1

[redacted]

To access our secure member portal, our members sign in using unique credentials. Our app is available in Google Play, the Apple App Store, and many other commonly used mobile application platforms.

Our app is accessible in English and Spanish and the top regionally contextually relevant language. We maintain Section 508 compliance, using automated as well as human review by people with disabilities. To ensure member-facing information is consistently up to date and accurate, we immediately update our website, portal, and app with all content changes, including automatic updates to changes in member-specific information. We conduct monthly enhancement updates to functionality, incorporating industry innovations and our members' feedback.

Our members prefer to connect with us using our web portal or mobile application.

In a 2020 member survey asking, "What is your most preferred way of receiving information from us", 92% of respondents chose a digital method first. In 2021, 81% of our total member population across all markets and products used our digital tools (mobile app and member portal) to access their member data.

4.2.2.1.D.2 Describe any functions beyond those required in Appendix A, Draft Contract, that the Offeror will make available to Members through its website and Mobile Application (if any).

Our proposed innovative programs and services will consistently improve outcomes for the Division's priority areas, including maternal health, behavioral health, and social determinants of health. All functions listed in Table 4.2.2.1_P are accessible through our website and mobile app.

Table 4.2.2.1_P: Innovative Programs

Program	Description
Telehealth Platform	We provide a telehealth platform giving members expanded access to their providers, particularly useful for behavioral health and rural health providers. The telehealth platform supports on demand video chat and scheduling capability.
Employment Support Program	Our successful employment support program links members, parents, and guardians of children who are members, to educational and high-quality employment opportunities.
Schedule a Ride	MSCAN and CHIP members can request a ride, check on the status of a scheduled ride, or cancel a ride they no longer need. This is all performed from their computer or mobile device.
Immunizations	We will provide a connection to the Mississippi Health Department allowing members to review their immunization history, get reminders for future immunizations, and even print their own official immunization record.
[redacted]	[redacted]
Maternity Virtual Care	We offer an innovative virtual care platform providing education and resources spanning pregnancy, post-partum, and neonatal care. It is proven to reduce racial disparities in maternal health by providing access to comprehensive support. In addition to resources and information, members can talk to a doula, schedule an appointment with their OB/GYN provider, and connect with their interdisciplinary care team.
Online Emotional Health Tool	Available 24 hours per day to help members incorporate cognitive behavioral therapy and mindfulness techniques improving emotional regulation and well-being.
For Teens and Young Adults Needing Mental Health Care	We are proud to be an early adopter of an online platform to increase access and engagement with appropriate BH services. The platform contains compelling content about adolescent BH issues and will send tailored text messages to teens, with pertinent content from BH coaches and licensed clinicians, providing emotional support.
Informational Videos	We offer customized, user-friendly health education videos designed to inform our members about important topics, including our care management program, common healthcare terms, children's health topics, and HIPAA privacy protections.

4.2.2.1.E. Member Education and Communication

4.2.2.1.E.1 Describe what methods the Offeror will use to inform Members of the functions of the Member services call center and encourage use

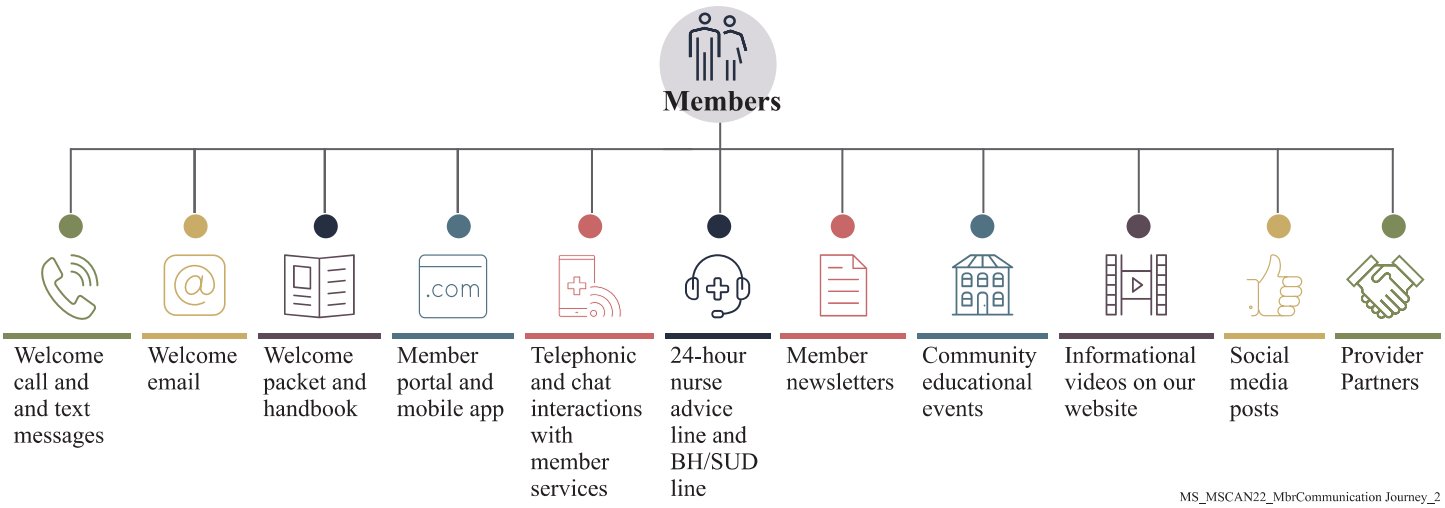
We know that members who engage with our staff are more likely to use their full benefits, resulting in better health outcomes for Mississippians. Therefore, we actively engage members, directing them to our member services call center, which is a central source where they can speak with our highly trained staff, ask questions,

and have their needs fully addressed. We also use multiple member communication modes. Members receive next generation member engagement and education, community-based coordinated care, and operational excellence through our member services call center, our 24-hour nurse advice line, and our 24-hour behavioral health/substance use disorder crisis line. We encourage use of the member services call center in our member welcome call, mailed member welcome packet, text and email welcome messages, member handbook, member ID card, our mobile app, member newsletters, our website and social media sites, and through face-to-face encounters with care managers, community health workers (CHWs), and other member-facing staff. Our mobile app and website, which are available in fully integrated, optimized formats for ease of use, also offer an interactive live chat option, during regular business hours, which provides convenient access to our member services staff members and helps to ensure that members get the care they need to live healthier lives.

4.2.2.1.E.2 Describe what methods the Offeror will use to inform Member of the functions of Care Management (including the ability to self-refer) and encourage use.

We provide next generation member education to members and their support systems on our 'no wrong door' approach to self-referral, including care management. Figure 4.2.2.1_E outlines methods we use to inform members of the functions of care management and the ability to self-refer. Our mission is to ensure members can easily access their benefits.

Figure 4.2.2.1_E: Member Communication

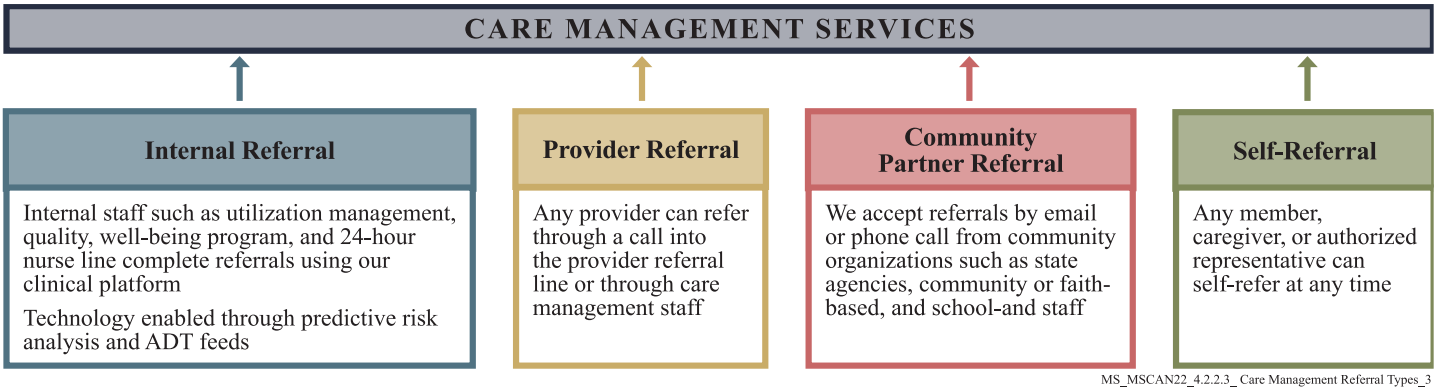


Care management is available to all members. We use members' preferred communication channels, such as targeted texting, electronic, and social media campaigns, as well as direct outreach by care managers, CHWs, and peer support staff. We use our welcome communications and the formal health risk screening (HRS) to ensure all members understand it is their right to ask for and receive these services. Members who are high or medium risk are immediately assigned care managers to proactively address their health needs.

We educate members, their caregivers and representatives, and providers about self-referral to services creating opportunities for members to become informed about their rights and available options to engage in care at the best level for them. We describe the benefits of care management, including how our care managers, who live and work in the communities they serve, can be the member's personal point of contact, empowering the member to be responsible for and to lead their own health care journey. We explain how members are assigned to a care management acuity category, outline our responsibilities for helping to coordinate member care, and encourage engagement by sharing the member's role in the care management process. Our care managers conduct comprehensive assessments to identify needs and gaps in care, create a member-driven personalized care plan to set goals and make plans to meet them, they assemble an interdisciplinary team of professionals to help remove barriers to care and address physical, behavioral, and social needs, and they provide compassionate encouragement to our members. Figure 4.2.2.1_F outlines the methods members can use to obtain care management services.

Figure 4.2.2.1_F: Referrals into Care Management Services

There are no wrong doors for members to engage in care management services



We know that providers can be the best champion to inform members about available services and get them to engage, so we partner with providers to promote awareness. We educate our providers about self-referral services to create more opportunities for our members to receive the services they want, when and where they need them and to take additional ownership of their own health outcomes. We outline self-referral services in our provider orientation materials and through virtual and onsite new provider orientation sessions conducted by provider relations representatives, and during presentations at quarterly provider forums, provider advisory council meetings, and joint operations committee meetings. We will collaborate closely with the Community Health Center Association of Mississippi, the Mississippi Rural Health Association, and the Mississippi Association of Community Mental Health Centers, as well as other provider stakeholder associations and interest groups, to engage with providers and ensure they understand member self-referral options. We also share information on member self-referral options in our provider manual, through our provider call center, through our online provider portal, and in periodic provider newsletters. We will develop innovative practices in collaboration with partners such as hospital emergency departments, where our staff interacts with our members at the time and place, they most need guidance and information to make the best choices for their health and the health of their family members.

4.2.2.1.E.3. Describe how the Offeror will develop and maintain a comprehensive, evidence-based health education program for Members, including:

a. An overview of the program, including accountabilities and proposed activities;

Our approach to developing and implementing evidence-based health education strategies to improve member health outcomes is to use advanced population health assessment tools in collaboration with community partners, leveraging our resources to develop tailored and targeted initiatives to best meet the needs in Mississippi. We make health education a priority for our members and take a distinct, individualized fully integrated service delivery approach as we implement evidence-based programs that promote and enhance member participation, retention, and ongoing engagement. We are accountable to the communities we serve; therefore, our health education program uses up to date community health needs assessments to develop fully responsive health education programs. We target key populations and high-risk areas and deploy health education programs and resources where there is a concentration of members with specific health concerns such as asthma, diabetes, dental health, or teen pregnancy, based on thorough data analytics within our population health program.

We understand that the people who spend the most time with our members, such as their immediate family as well as extended family such as grandparents, aunts, uncles, pastors, coaches, and other informal influencers need to be included in our communication efforts. Therefore, we employ an empowerment model that focuses on member-centered and culturally sensitive wellness promotion, health education, and self-management tools. Our local staff, providers, and community-based organization partners are key to delivering face-to-face health education as well as digital messaging and written materials that our members and the people in their social support systems can keep for later reference. We will partner with a wireless internet provider operating in Mississippi to ensure

members who lack broadband connectivity have internet access as well as a device, such as a smartphone or a tablet, so they can access our digital resources.

Health Education Workplan. Building on the foundation and structure of our robust and highly effective population health program, we develop annual health education and prevention work plan based on the needs of our Mississippi members that support and complement our care management program. Using Mississippi-specific data and our experience in other markets, we develop health education offerings that align with the Division's 2021 Comprehensive Quality Strategy, with attention to economics, race, ethnicity, education level, and other drivers of health disparities. Our proposed health literacy campaigns address issues such as child obesity, maternal health, diabetes, and behavioral health for teens and young adults. In accordance with the Draft Contract section 5.2, our annual health education and prevention work plan describe topics, methods of communicating with members, methods to identify members who would benefit from the program, and timeframes for outreach and material distribution. Additionally, we will collaborate with the Division and other contractors to conduct a minimum of 10 health education workshops for MSCAN and 10 workshops for CHIP. All our member education ties seamlessly with our marketing, is available in print and digital, and is accessible to all members regardless of their literacy level, preference of language, and the way in which they want to receive information. Our annual health education and prevention work plan will be submitted for Division review and approval prior to implementation, with quarterly updates ongoing. (Refer to Table 4.2.2.1_Q)

Table 4.2.2.1_Q: Examples of our Health Education Offerings

Program	Description
Healthy Eating and Active Living	We offer branded programs to assist adult MSCAN members with managing their weight. We accomplish this through monthly education packets and health coaching calls. Topics covered in the program include goal setting, reading food labels, moving more, as well as dealing with emotions, and behaviors that contribute to weight gain. Members are invited to join our private online community to share their thoughts and ideas through surveys, polls, and discussions boards. We equip our health partners to have these resources on hand to encourage our members to connect with us or to initiate a direct referral to our care management team.
Childhood Obesity	This program includes interventions to support children in developing healthy habits in weight management, nutrition, physical activity, and emotions/behavior. We stress a family approach because outcomes improve when the entire family is involved. The program consists of four topic-driven educational packets and four corresponding health coaching sessions. Educational materials include information on making healthier food choices, energy balance (energy in and energy out), non-food rewards, getting kids in the kitchen, and tips on recreational activities. The program focuses on promoting healthy lifestyles to reduce childhood obesity and prevent or reduce obesity-related chronic disease. We will partner with schools, Head Start, and other childcare centers to help us deliver the educational content, collaborating to achieve similar goals for our shared members.
Targeted Asthma Program	This program provides interventions to increase awareness around asthma, decrease emergency department (ED) visits, address social determinants of health (SDOH), and close disparity gaps for our members faced with disease. Black members are three times as likely to die from asthma as White and have a five times greater risk of using the ED for asthma related issues[2]. Several counties in the rural parts of Mississippi have a population of greater than 70% Black individuals, so we hire regionally based staff that live and work in these communities as life coaches, peer support staff, and care managers, ensuring our members have full access to needed education, benefits, and services.
Postpartum Text and Video Campaign	This campaign reaches out to members who have recently given birth. The text message includes a link to an educational video on the importance of postpartum care. The video is produced in both English and Spanish. The text message is generic to protect member privacy and is sent in the member's preferred language.

We use artificial intelligence (AI) enabled text messaging campaigns to help members access resources, including **our member newsletter, an educational tool that we distribute quarterly**. Our member newsletter offers information about healthy habits that go beyond trips to their provider. Understanding healthy eating and preventive exercise, the importance of fathers, dental health, effective parenting, managing chronic pain, addressing behavioral health issues, or knowing when to get a flu vaccine are examples of the topics explored. We pair best practice clinical guidelines with creative messaging techniques, such as relatable and engaging member stories, to illustrate success and guide our members and their families toward improved health and wellbeing.

[2] [2] https://www.aafa.org/media/2743/asthma-disparities-in-america-burden-on-racial-ethnic-minorities.pdf

b. The Offeror's rationale for selecting areas of focus;

In addition to enrollment file analysis, and using the Division's priority areas, we use a multi-modal, data-driven strategy to select areas of focus and populations with needs, such as residents of the Mississippi Delta region, with high rates of chronic disease, physical and behavioral health disability, poor health outcomes, and health disparities. Our approach includes an aggregation of patient data across multiple health IT platforms, analysis of the data, and identification of actions to improve outcomes. Our centralized modern data platform (MDP) will serve as a sole source of truth for our organization and the Division. The MDP uses sophisticated AI/ML and predictive analytics capabilities to provide insight and transparency to the Division on data-gathering and analysis and program efficacy.

We monitor trends, such as the prevalence of pre-term births, or asthma rates in certain regions, to inform the development and implementation of health education initiatives, which we then review with our member advisory groups. We use population health management tools to design and target the audience for our educational programs; this includes the HRS and comprehensive risk assessment for our moderate to high-risk members. Our aim is to build upon successful clinical programs and population health strategies by designing initiatives that enhance each member's ongoing participation in their own health and well-being.

c. How the Offeror will ensure that materials are at a third (3rd) grade reading level;

We harness our experience across Medicaid markets to create accessible and understandable health education materials using the Flesch-Kincaid readability score, which measures readability as well as provides alternative wording. We ensure the presentation of written and oral health information is understood in a manner and format for a third grade reading level, using graphics and videos for ease of understanding. Our multi-channel approach to our program and proposed activities prioritizes member understanding and comprehension.

d. The language alternatives available to non-English speakers/readers; and

We provide written materials in English, Spanish, and other languages, as indicated by our membership. We ensure the availability of materials in common, non-English languages spoken by 5% or more of our members. For online health education materials, we optimize our website interface by making it easily available in English or Spanish and including a link to our nondiscrimination page, which offers taglines in 18 different languages, allowing members to request plan materials in alternative languages. It also provides instructions for using our member call center, where members can access language interpretation and translation services in 240 languages.

e. How Members who are visually and/or hearing impaired will be accommodated.

We ensure printed materials for our educational programs are prepared in large print and Braille and are available with verbal explanation upon request, at no cost. Our educational materials are provided on our website in a format compliant with Section 508 of the Rehabilitation Act, making it convenient for deaf and hard of hearing members to view them electronically or print them from a remote location.

4.2.2.1.E.4. Describe how the Offeror will employ creative solutions to encourage participation in Member outreach and education activities.

We conduct ongoing, next generation, member outreach using education and incentives for all members, parents, and guardians to promote the use of services and encourage healthy behaviors. Our staff promotes health education and services at local community health fairs and collaborates with the community- and faith-based organizations to support our efforts in reaching all our members regardless of location. We will offer a unique service delivery model and propose to bring the first real-time bidirectional data exchange capability through our HIE connection to hospitals, CMHCs, PCMHs, FQHCs, RHCs, and private practice providers. A key element of our strategy to ensure member education about covered benefits, programs, and services is the use of interactive text messaging and call campaigns. These are designed to educate members and their caregivers or parents on relevant health and wellness needs and motivate them to act, whether it is scheduling an annual screening or follow-up care related to a chronic condition. The messages are customized and directly address member-specific needs and conditions. Examples of our text campaigns:

- We completed an AI-enabled text campaign in partnership with a health provider system in another market that served a very rural area. The focus of the campaign was to advise members to follow up to make a breast screening exam and to connect the member directly with an in-network service provider. **This resulted in a 70% increase in the call volume of members who wanted to request an exam.** With just one link click, the member was immediately connected with an available, in-network provider, who was ready to serve them in their area.
- In another market, a text campaign was targeted to a group of Medicaid members to achieve well-child exam milestones. Recipients received a link to a video featuring a local market vice president and medical director (a female pediatrician of color). The medical director made a personal appeal on the importance of meeting these milestones. **Two months following the launch of this campaign members who clicked on the link to the video were two and a half times more adherent with multiple well-child measures than members who did not click on the link (21.9% versus 8.8%).** (Refer to Figure 4.2.2.1_G)
- We have launched an initiative to encourage members with serious mental illness in another market to engage in care coordination and treatment through conversational text messaging capability. We are utilizing the power of AI to identify text patterns in member responses that indicate a member is in crisis and immediately connect that member to their care coordinator, our 24-hour nurse advice line, our 24-hour behavioral health/substance use disorder crisis line, or 911, as appropriate.

Figure 4.2.2.1_G: Text Messaging

MS_MSCAN22_4.2.2.1_Mobile App Text Message_1

Collaborating with local partners. As trusted partners with Mississippi community-based organizations, we will carefully choose quality partners that provide support at a level above and beyond what is required by the Division. We will help develop their capacity to collaborate with us on creative solutions for member outreach, education, and ways to meet member social service needs. Examples of local partnerships include Head Start in Mississippi, which serves approximately 25,000 Mississippi children. Head Start assists family members of these children with targeted educational outreach, connections to resources, and encouragement to access well child visits and other crucial preventive care. Our partnership with Jackson State University will bring collaboration in the development and implementation of educational materials and resources to use on member facing platforms and community events. Through our local partnerships, key stakeholders will be tapped for feedback on how best to reach members to reduce health disparities. We will also partner with local community-based organizations and small business owners to co-host neighborhood health fairs and collaborate with local community mental health centers to expand their capacity through mobile clinics, including offering mammography screening in under-served areas.

Connecting with members through social media. We successfully use social media channels to direct members to our member services call center, share tips for healthy living, promote community activities, guide members to social services, share information on programs and services, and broadcast health and wellness news. Our staff continuously monitor social media, including weekends and holidays, and use locally customized chatbots to enable self-service 24 hours per day. When needed, we move seamlessly from engagements on social media to private member interactions and keep members on the device they choose.

Since 2019, our social consumer engagement strategies, in other markets, have resulted in a 1,100% increase in social consumer care across all social media channels, with two to five times the industry gold standard for social media engagement rate, and our Facebook content is 10 times more engaging than the industry gold standard. In addition to Facebook, we interact using Instagram, Twitter, LinkedIn, Google

Reviews, and Google Business Messages. We also tune into changing topics and trends by following Reddit, Tumblr, and YouTube.

4.2.2.1.E.5. Describe the Offeror's proposed process for maintaining both online and print Provider Directories that include names, locations, telephone numbers, and non-English languages spoken by contracted Providers located near the Member and identifies PCPs/PCMHs and specialists that are and are not accepting new patients, as well as how the Offeror will update and notify Members of changes to the Provider directory in the required timeframe.

We ensure our enrollment packets include information about our provider networks in accordance with 42 CFR 438.10(h). Members can also access the provider network directory online through our publicly accessible tool for finding a doctor, which conforms with the requirements of 42 C.F.R. § 431.70. Our find a doctor tool allows members to filter criteria, including specific fields such as PCP, PCMH, accepting new patients, language, specialty, and accommodations for members with disabilities. Any recent changes to a provider's information is highlighted providing member visibility. Members can print the results of their search from remote locations for their convenience or share with their families, care managers, supporting agencies, and others.

We understand how frustrating inaccurate provider directory information can be for members, their caregivers, care managers, and other providers on their team of care. We collaborate with the Division to ensure all provider directory changes are received and shared, and **we have implemented a thorough daily monitoring and updating capability** with a vendor that has demonstrated success. Our fully integrated service delivery model is supported by the following processes:

- We process provider data maintenance requests received via provider portal, fax, and mail no later than 25 days after receipt with updates to claims platform and online directory (updates to the directory are processed within 24 hours after data is changed in the claims system).
- We update delegated rosters (for delegated self-credentialed entities) within 10 days to 25 days of receipt; the provider entity submits delegated roster updates each month for any adds, changes, or terminations, as well as quarterly full files for data reconciliation.
- Our quarterly attestation process is continuous, but providers are contacted quarterly with the non-delegated roster providers electronically collects changes and/or validations of directory attributes.
- Our AI/ML analytics process evaluates our provider directory attributes against all available CCO directories, claims data and multiple publicly available source data to identify potential anomalies to evaluate and outreach for validation, especially effective in resolving issues with phone numbers and location addresses no longer active (top issues with accurate maintenance of directories).
- We update printed provider directories monthly and show the date of the information update as well as a statement that the most up-to-date information can be found in our online directory with guidance on how it can be accessed.

Members may contact our member services call center to request a printed copy of the provider directory with copies available at Mississippi Medicaid Regional Offices, our offices, WIC offices, and other locations as directed by the Division. Our digital searchable provider directory is compliant with Section 508 of the Rehabilitation Act and available online through our tool for finding a doctor. The most recent update is made visible at the bottom of each page. We empower our members to maximize their use of the tool, offering an interactive tutorial on the landing page, and displaying our member services call center contact information were easily found.

We engage and educate members when there are provider changes from the network or directory. We notify members via the communication channel of their choice when there is a change to the phone number or address of their PCP/PCMH to reduce possible access to care issues. When providers are identified for termination, we query our records for any member who was treated by the provider during the previous twelve months and send a notification letter to the member informing them of the pending termination. For plan-terminated action, we provide notice no later than 30 calendar days prior to the effective date of the termination.

For provider-driven terminations, we provide notice no later than 15 days after receipt of the termination notice. Our fully integrated service delivery model ensures members are always kept apprised on provider changes.

4.2.2.1.E.6. Describe the Offeror's proposed policies, procedures, and processes regarding the Member's rights specified in Section 5.10, Member Rights and Responsibilities of Appendix A, Draft Contract.

We understand that educating our members on their rights is not just a contractual requirement; it is essential to helping members and their families understand their choices and take an active role in their own healthcare. Therefore, we prioritize educating our members, providers, employees, and subcontractors on the full range of rights afforded to our members. Our written policy, "Member Rights and Responsibilities," promotes and protects member rights. We never discriminate against a member who chooses to exercise their rights. This policy is maintained in accordance with state and federal requirements, including 42 CFR 438.100(d), and NCQA accreditation standards.

We understand that members, particularly new members, may be overwhelmed with forms, documents, and other types of information upon enrollment. Because we believe it is critically important that members always know and understand their rights, we publicize their rights in a variety of ways:

- Member rights are included in our member information packet, member handbook, website, and our secure member portal and mobile app.
- Member grievance and appeals correspondence includes member rights and informs members of how to seek assistance, which we provide based on member needs and choices.
- Information about member rights is included in educational presentations and outreach events, in addition to printed materials distributed during our advisory committee meetings.
- Periodic notices are posted on our social media sites, directing members to key information sources that describe member rights.

We explain member rights in plain language at or below a third grade reading level. We publish the member rights in English and Spanish and will translate the rights upon request in other languages and formats, such as auditory translation, braille, and large-print format, at no cost to the member. We also track members who request alternative formats to help assure ongoing materials are provided to them in their preferred format.

4.2.2.1.E.7 Describe the Offeror's proposed policies, procedures, and processes to ensure Marketing requirements are met in accordance with 42 C.F.R. § 438.104. Include a description of Marketing materials the Offeror proposes to send to Members. Provide samples of Marketing materials the Offeror has used for other Medicaid programs (e.g., materials included in the Member Information Packet and other educational materials sent to members after enrollment) as available.

We create marketing materials in a transparent, accurate, and engaging manner, focusing tailored content on what is most important to our members. Our approach will use our local Mississippi resources, our well-being program, and community partnerships to develop marketing materials that promote healthy living and health equity best practices. To ensure age appropriate, gender appropriate, and culturally appropriate materials that also address ethnic diversity and geographic distribution of our members, we employ a broad range of marketing communications, tools, and media channels. Our comprehensive marketing and communications approach include our website, broadcast (TV and radio), print publications such as local newspapers and relevant community newsletters, outdoor billboards, sports sponsorships, and interior and exterior transit signage. We also incorporate a wide range of digital strategies, email, text messaging, and social media postings. Printed materials are in English and available in other languages or formats (including Braille) upon request at no charge. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while sensibly managing state resources.

Our state regulators rank us as their top health plan

Recently a state Medicaid department began to issue quarterly managed care organization report cards to ensure that all regulations and guidelines were being followed, and member and provider materials were receiving the required reviews. The report cards have consistently ranked us as the top health plan, demonstrating our commitment to understanding and following regulations and being a worry-free state partner.

Our proposed marketing policies, procedures, and processes, which are summarized subsequently, **fully comply with** 42 C.F.R. § 438.10, 45 C.F.R. Part 92, 42 C.F.R. § 438.104 for MSCAN, and 42 C.F.R. § 457.1224, cross-referencing 42 C.F.R. § 438.104, for CHIP.

Process for Review and Approval of Member Communication Materials: Our compliance specialist submits all member and potential member communications to the Division for approval at least 30 calendar days prior to expected use and distribution. We also submit substantive changes to member and potential member communications to the Division for review and approval at least 30 calendar days prior to use.

Inventory Control Number: To facilitate the Division's review and approval of member materials and documents, we assign an inventory control number to all member and potential member marketing, education, training, outreach, and other member materials. We include a clearly marked issue and/or revision date. Every document distributed to members has an inventory control number and approval date before it is printed or published.

Additional Internal Controls: Once the Division approves the member or potential member communication, the compliance specialist and our marketing staff complete the following prior to distribution:

- Documenting the approval in our communications document management system
- Inserting and saving the appropriate inventory control number and Division approval date into the final version of the communication in the appropriate documentation system
- Notifying the business owner who submitted the request that the communication has been approved; the business owner works with our marketing and print fulfillment team for distribution
- Notifying digital marketing to upload the approved information to our member-facing website

Non-Use of State Names or Logo: We do not refer to or use state agency names or logos in our member and potential member communications without written approval. We request Division approval in writing for each desired reference or for use at least 30 calendar days prior to reference or use. We understand any approval given for the Division or other state agency name or logo use is specific to the use requested and shall not be interpreted as blanket approval. We include state program logo(s) in our marketing or other member communication materials upon Division request.

Logging and Resolving Marketing Complaints: Any marketing complaints, including complaints about our employees, subcontractors, or any affiliates, are addressed through our compliant member and provider grievance processes. We track and trend marketing complaints to identify and address root causes and submit a quarterly report to the Division, which includes a record of any complaints received by us or forwarded to us from the Division, as well as the associated resolution.

Marketing Activities: Our marketing plan orchestrates an omni-channel campaign, compliant with the Draft Contract Section 5.6. This consists of multiple touchpoints across a variety of channels to connect with eligible consumers within the entire service area. The program uses a multimedia campaign defined by consumer lifestyle, media usage habits/patterns, and geographically distributed marketing areas to cover Mississippi and to ensure inclusiveness and health equity for diverse populations. We submit our marketing materials to the Division for review and approval at least 60 calendar days prior to the planned distribution. Our marketing activities are designed to reflect consumer needs, increase engagement in health care decisions and connect with prospects where they live, work, play, and pray. To enhance engagement, we proactively ask our member population their preference in how materials are delivered. The marketing campaign includes the following:

Traditional Media Traditional: Media includes broadcast television, cable television, connected television, radio, and out-of-home (billboards, buses, and bus shelters). Media is planned and placed in a program that is market/regional appropriate.

Digital Media: The digital program includes search engine marketing (SEM), targeted display, sponsored ads, streaming video, streaming audio, organic search, and social media (e.g., Instagram, Facebook, Twitter).

Website: We provide and promote a website that contains educational information about healthy lifestyle programs and how to enroll information.

Marketing Support Materials: We distribute informational literature including but not limited to:

- Marketing brochure
- Open enrollment flier
- Interpreter services flier
- Medical consumer contact card
- Kid's health poster
- Pull up display
- Solicitation brochure
- Open enrollment letters
- Back to School event flier
- Tabletop display

Marketing Team Training: We require compliance training for all our team members, including marketing staff; temporary resources; subcontractors; and first tier, downstream, and related entities. Our compliance training provides an understanding of our compliance program including HIPAA; privacy and security; and fraud, waste, and abuse elements. The training is required for all team members within the first 90 days of hire and then annually thereafter. Our community marketing representatives (CMRs) and provider-facing staff are hired from within Mississippi and are representative of their regions, enabling them to fully address the nuances of the local demographics. We provide the Division with our training curriculum and activity reports on request.

Community Marketing Activities: Our CMRs will engage in face-to-face interactions to help educate and guide our prospective members. CMRs located throughout Mississippi provide "feet on the street," promote the reasons to select us as a CCO, and connect the community with resources, including state and community agencies across Mississippi. Our focus is to meet people where they are, such as county offices, government agencies, FQHCs, public and charter schools, job fairs, staffing agencies, local business chambers, food pantries, various cultural festivals, county fairs, Head Start programs, back to school events, Community Action events, YMCAs, and faith-based organizations. We offer health promotion activities and explain plan benefits at every event we attend. In addition, our CMRs are well trained on benefits and services and can direct current members to the appropriate resources. While we understand the composition and demographic differences of both rural and urban areas, our outreach strategies are very similar in that we look to partner with agencies and CBOs that are key assets in each community. For example, in rural settings, there may be multi-county agency meetings we connect with to distribute information and participate in events as they provide service and assistance to a region. In urban areas, multi-agency meetings may occur for a specific neighborhood or zip code, not the entire county. In both rural and urban areas, we seek to identify the needs of members in that area as those needs vary across the state. We are only able to gauge those needs by connecting with our members and partners. Essentially, rural areas (which may have a smaller population) outreach requires a broad strategic approach while larger, urban areas require a narrower, targeted approach to work with specific neighborhoods and zip codes. We may differentiate our marketing strategies (text, email, mail, and social media) for rural and urban areas if we find there are barriers in technology and the ability to access text messages, email, social media, etc. Our marketing activities (in both urban and rural areas) include gathering feedback from our members and partners regarding their needs in the community and information about how we might best support them. Samples of marketing materials we have used for other Medicaid programs are included at the end of section 4.2.2.1.

4.2.2.1.E.8 Describe the Offeror's proposed approach to inform Members about covered health services including: behavioral health/substance use disorder, perinatal, neonatal, Care Management, autism, and other developmental disabilities, well baby and well child, EPSDT screening, chronic health conditions, and pharmacy services.

We empower members to take control of their health, from making healthy choices to learning how to access covered services and benefits. We provide accessible and easy-to-understand information in multiple formats and languages. We design our Division-approved member materials to educate members about covered services, for example, behavioral/substance use disorder, perinatal, neonatal, care management, autism, and other developmental disabilities, well baby/well child visits, EPSDT screening (if eligible), chronic health conditions, and pharmacy services upon enrollment and periodically throughout the year using multiple outreach methods, including face-to-face outreach by care managers, community health workers, and peer support staff; collaboration with local partners, including providers, state agencies, and community-based organizations; telephone and text communications, including targeted interactive AI text campaigns; member website, secure portal, and mobile app; member handbook and newsletters; and online videos and other digital educational opportunities.

We know we can make the biggest impact on member health when they receive coordinated and reinforced messages from several different sources, so we work closely with providers, FQHCs, PCMHs, community advocates, support agencies, health departments, and other governmental agencies in to get the message out to members about covered services.

In addition to the member handbook where covered health services are outlined in detail and offered as part of the new member welcome mailing, we will also provide benefits-at-glance to help members review their covered health services in an easy to reference snapshot. During our member welcome call, we review covered benefits. Once the health risk screening and comprehensive risk assessments are completed, we will then provide targeted messages on specific benefits specific to the members' needs through care managers, PCP/PCMH's, and condition specific specialists.

Member Newsletters: We offer a variety of written materials members can keep for later reference. One such educational tool is our member newsletter that is distributed quarterly. We distribute member newsletters via U.S. Mail, email, on our website and mobile app, and offer links via text messaging campaigns. For example, we publish and share information about covered services such as well-child screenings, dental care, adult preventive screenings, behavioral health services, and tobacco and vaping cessation programs.

Online: Understanding members are unique and have different levels of comfort with accessing information online or digitally, our member website, member portal, and mobile app provide simple search options to help members learn more about covered services and how to access them. If members have support needs or questions, member service staff can be reached by phone or chat feature in the member portal to offer answers about benefits. The website and digital platforms tailored to members provide 24-hour, 7 days a week availability to health services information and benefit details, and on our social media sites, we post timely covered services such as back to school vaccines or an annual flu shot.

4.2.2.1.E.9 Describe the timely process by which media release, public announcement or public disclosure of any change affecting benefits and services will be organized, sent, and reviewed for approval by the Division.

As a trusted partner of the Division, we will ensure member and potential member communications are pre-approved by the Division. Further, we work closely with the Division to give advance notice of any public announcement regarding services and benefit changes. We will request review and approval for all member and potential member communications using an inventory control number to reduce the Division's administrative burden and to assist in tracking the receipt and approval of original and revised documents. Our team of compliance specialists will review all submitted member or potential member communication materials to ensure compliance with all state and federal requirements detailed in the Draft Contract section 5.6.

Our strict adherence to requirements serves to facilitate accurate, clear, and straightforward communication targeted to meet the needs of members and their families. Adherence to all marketing and Division requirements

is paramount to helping our members understand written materials and engage in their healthcare journey. We will use our member materials to promote the Division's goals of assuring the appropriate use of health care services and engaging in member outreach regarding preventive care, wellness, and our holistic approach.

4.2.2.1.F.1 Member Satisfaction

Describe the Offeror's proposed approach to assess Member satisfaction including tools the Offeror plans to use, frequency of assessment, and responsible parties.

We continuously strive to meet and exceed both member expectations. Our robust Consumer Experience (CX) team is responsible for managing member and provider surveys, advisory councils, a member online community, internal surveys, and research related to improving member experience.

Reports from cross-functional departments, such as appeals and grievances, member satisfaction surveys, member advisory committee feedback, etc., are used to track and trend data and identify opportunities for improvement. These channels provide valuable insight into how our members perceive their overall experience with the health plan and our provider partners. CX shares this information throughout the organization so all staff and leaders consider the voice of the members when making strategic decisions, building processes, and creating programs and materials.

We are proud of our track record showing we meet our members' needs

- We have consistently received high scores in the Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, particularly with CHIP populations.
- We are the members' preferred plan in many states, which is predominantly driven by voluntary (member choice) enrollment and very low voluntary disenrollment rates.

Our CX team will use the data from Table 4.2.2.1_R to build comprehensive, cross-functional, and multidisciplinary action plans to address identified opportunities for improvement. We will identify access trends and provider service delivery opportunities using cross-cutting data from access and availability surveys, CAHPS drill down surveys, the survey tool, our advisory council, and our private online community, which will drive innovative initiatives in provider education and network strategy.

Table 4.2.2.1_R: Consumer Experience Tools

Consumer Experience Tools	Frequency	Description
The Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Annual	A survey measuring member experience and satisfaction. All CMS protocols including participant anonymity are adhered to. We submit survey results and action plans to the Division within 90 days of receiving findings from our vendor.
CAHPS Drill Down Survey	Annual	We conduct a drill down survey to better understand CAHPS scores and inform interventions. We identify areas of opportunity from the CAHPS survey and ask additional questions to better understand the root cause of what is driving perceptions around topics such as care coordination or the rating of the health plan.
New Member Satisfaction	Annual	This survey measures new members' experience with the onboarding process and their understanding of plan benefits and utilization parameters. We use aggregated results to identify opportunities for improvement, such as enhancements to printed or online materials, phone scripting, benefits, etc.
Care Management Satisfaction	Annual	This survey measures satisfaction among members engaged with our care management team. We use aggregated results to identify opportunities for improvement and develop initiatives to improve the care and service we deliver, including scripting and engagement.
Disease Management	Quarterly	This survey is designed to measure members' satisfaction and experience with our disease management programs (asthma, diabetes, hypertension, etc.).
Behavioral Health Satisfaction	Annual	This survey measures satisfaction among members engaged with behavioral health services. We use aggregated results to identify opportunities for improvement and develop initiatives to improve the care and service we deliver, including access and information.
Private Online Community	Ongoing	The CX department uses a private online community composed of our market-specific members to provide real-time feedback and discover the unique health care journey of our members using a variety of insight tools – including surveys and discussion boards.

Consumer Experience Tools	Frequency	Description
Advisory Councils	Quarterly	Advisory Councils are small focus-group style meetings with established members who provide feedback on a variety of topics and explore ways to improve the member experience. We use multiple groups that reflect the racial and ethnic makeup of the state to account for health disparities and inequalities.
Survey Tool	Twice each year and ad hoc	This tool is used for internal and external use. Our staff can submit a survey request to better understand gaps or barriers that may negatively impact the member's experience.
Medicaid Provider Satisfaction	Annual	We know that our providers' experience with us translates and affects our members' experience as well, and so our Provider Satisfaction Survey is designed to measure the satisfaction of providers with the health plan. This feedback provides actionable insights to guide initiatives to improve the provider experience and to support NCQA accreditation.
Access and Availability Survey	Quarterly	A health plan vendor conducts a survey for a sample of in network primary care, behavioral health, and specialist providers to measure appointment availability for urgent and non-urgent medical care, which is an important indicator of member satisfaction.

To drive operational excellence, we cross reference data from our CX tools with our population health dashboards to identify and positively impact health equity with attention to race, ethnicity, socio-economic factors, and regional health disparities. We use this data to create targeted health literacy campaigns to support specific disease management programs and develop solutions such as increased telehealth capabilities and innovations such as our program to target childhood obesity. CX tools also help to inform gaps in communication of benefits and services to our members, resulting in improvements like the example highlighted.

4.2.2.1.G.1 Member Appeals

1. Describe the Offeror's proposed Member Grievance and Appeal process specifically addressing:

Our approach to ensuring careful oversight of member grievances and appeals includes our well-established grievances and appeals (G&A) system. Our G&A system includes a grievance process, an appeals process, expedited review procedures, external review procedures, and access to the state's fair hearing system. **Our ability to deliver operational excellence in this area demonstrates that we respect member rights and are a worry-free partner of the Division.** Our fully compliant G&A process is efficient, fair, and member-centric. If a member has an issue with the delivery of their healthcare services, their provider, or their CCO, our fully trained G&A coordinators work diligently to make sure the member's concerns are promptly addressed. Our G&A team closely monitors the quality of each grievance investigation and related member engagement according to NCQA accreditation standards. To ensure high quality G&A outcomes, we have a dedicated operational excellence team responsible for conducting bi-weekly reviews of G&A investigations, processes, and results. Table 4.2.2.1_S details our well-established G&A infrastructure, which exceeds performance requirements and timeframes for resolution. **Ninety percent of all our grievances are completed within 20 days, 10 days faster than the 30-day requirement.**

Table 4.2.2.1_S: 2021 Grievances and Appeals Data (Non-Expedited and Expedited)

Medicaid Process	Average Closure Time
Grievances	7 days (90% resolved within 20 days)
Clinical Appeals	18 days
State Fair Hearings	12 days

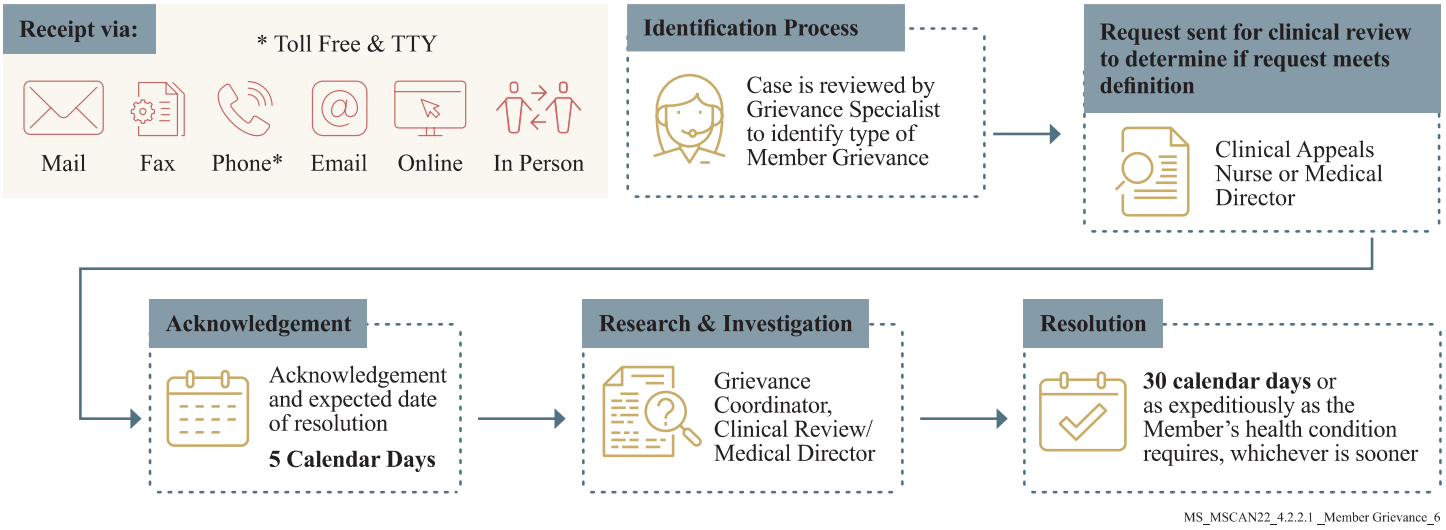
Over time our efforts have improved systems and member outcomes in identified grievances and appeals categories, positively affecting areas such as access to care, selective provider contracting, and developing needed provider network opportunities, which has resulted in fewer member grievances and appeals.

Member G&A Process Overview. The grievance or appeal process begins when a member or their representative submits a grievance or appeal in person, by mail, telephone, fax, email, or online via the secure member portal to any of our employees. Our G&A coordinators monitor for incoming expedited appeals and grievances seven days a week, 365 days a year, acknowledging 100% of standard grievances and appeals within 5 or fewer calendar days. The G&A coordinator, in line with our next generation member engagement, quickly

reviews each expedited and non-expedited request individually to determine the member's situation, in accordance with 42 CFR § 438.408, consulting with our medical director, providers, care managers, or other involved parties as needed. Our integrated real-time G&A platform enables our care managers, member services staff, and health plan representatives to have direct access to the G&A data that includes a 360 view of the member. This allows those staff to act on member needs, escalate an issue, or conduct more robust analytical reviews during interactions with members.

Grievance Process. Grievances may be filed anytime following the occurrence and all grievances are acknowledged in writing within 5 calendar days of receipt. Upon receipt, our G&A coordinators initiate an investigation, which includes working collaboratively with the members to gather any needed additional information as well as gathering applicable documentation and assistance from other departments or subcontractors. We ensure that the resolution of grievances involves the appropriate staff, including but not limited to care management, quality management, or utilization management departments. If the grievance involves a quality-of-care matter our nurses work closely with the provider involved, requesting medical records, reviewing clinical practice guidelines and standards of care, and engaging our medical director for further review if needed.

Figure 4.2.2.1_H: Member Grievance Process

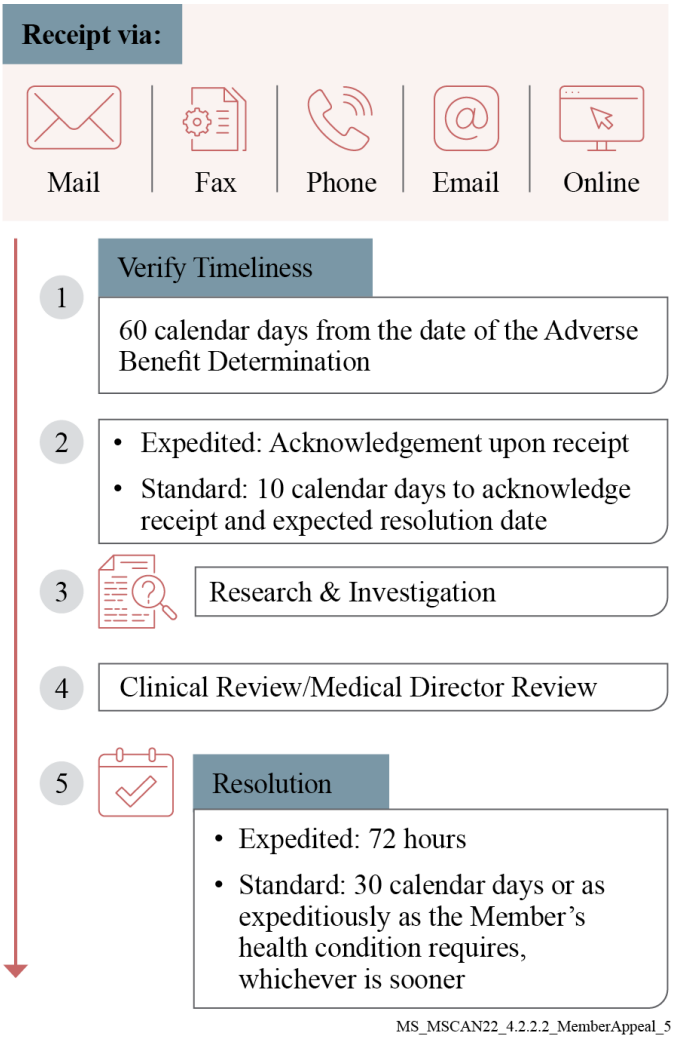


Resolution may include provider education or corrective action to address the member's matter. We resolve all grievances within 30 calendar days or as expeditiously as the member's health condition requires, and we historically have resolved 90% of grievances within 20 days. Non-expedited grievances may be extended up to 14 calendar days if resolution requires additional time. If an extension is taken, we provide the member with written notification that contains the specific reason for the delay, within two calendar days of the extension taken. Our notification includes the member's right to file a grievance if they disagree with the extension. Figure 4.2.2.1_H details our member grievance process.

Appeals Process. Our G&A staff involved in reviewing clinical and nonclinical appeals includes a variety of subject matter experts who can thoroughly investigate and resolve all appeals including G&A coordinators, claim specialists, nurses, medical directors, and medical coders. For each appeal, the assigned subject matter expert reviews the member's full history of claims and authorizations to ensure we are proactively addressing all unmet healthcare needs and needs identified in their care plan. We resolve all appeals within 30 calendar days or as expeditiously as the member's health condition requires and expedited appeals within 72 hours. Non-expedited appeals may be extended up to 14 calendar days if resolution requires additional time. If an extension is taken, we provide the member with written notification that contains the specific reason for the delay, within two calendar days of the extension taken. Our notification includes member's right to file a grievance if they disagree with the extension.

Members may appeal an Adverse Benefit Determination (ABD) we have issued within 60 days of the date of the ABD. Within 10 days we confirm receipt of the appeal in writing and provide an expected date of resolution. We make sure staff involved in the initial ABD are not involved in the appeal review. MSCAN members may make a written request for continuation of benefits within ten calendar days of notice of ABD, pending the determination of a State Fair Hearing. CHIP Members are not entitled to a continuation of benefits pending appeal. (Refer to Figure 4.2.2.1_I)

Figure 4.2.2.1_I: Member Appeals Process



Fair Hearing Process. When our MSCAN members have exhausted our internal appeals process, they may request a state fair hearing conducted by the division or its subcontractor within 120 calendar days from the date of the appeal resolution. As part of our next generation member engagement process, our G&A coordinator contacts the member to determine the underlying context and collaborates with the member and other involved parties to resolve the issue prior to the hearing date whenever possible. We work closely with the state fair hearing liaison to inform when we resolve a member's matter prior to the hearing. If the issue cannot be resolved, we provide all requested documentation to the Division and participate at the state fair hearing. If the ABD is reversed, we bear all associated fair hearing costs.

External Review Process. When our CHIP members have exhausted our internal appeals process, they may request an external review within 120 calendar days from the date of the appeal resolution. Our G&A coordinator contacts the member to determine the underlying context and collaborates with the member and other involved parties to resolve the issue prior to the external review date whenever possible. If the issue is not resolved, the G&A coordinator works with the clinical appeals nurse and medical director to ensure that the appropriate medical determination documentation is submitted to the external review vendor. Once the external review vendor returns their decision, the case is expeditiously resolved for the member.

a. Compliance with State requirements as described on the Division's Website and, Section 5.11, Member Grievance and Appeal Process of Appendix A, Draft Contract;

We comply with 42 C.F.R. Part 438, Subpart F, and the State's Quality Strategy, with the modifications that are incorporated in Appendix A, Section 5.11, including Exhibit D**.** We will review annually and submit to the Division for review and approval all policies and procedures for the receipt and adjudication of G&A or requests for an external review or a state fair hearing by members, and disseminate them to members, providers, and subcontractors.

b. Process for expedited review;

An expedited review is warranted if the time for a standard appeal resolution could seriously jeopardize the life or health of a member or their ability to attain, maintain, or regain maximum function. Our G&A coordinators are trained to recognize keywords and phrases that indicate a potential situation that will jeopardize the life and health of a member and therefore the appeal should be expedited. When this occurs, or if a member or their guardian or

authorized representative requests an expedited review, the case is referred to a nurse or medical director for additional research and investigation. If a provider submits a request on a member's behalf and indicates the request should be expedited, we treat their request as expedited and do not review to determine if the circumstances meet expedited criteria. Our expedited reviews are processed within 72 hours and in a manner as convenient and efficient for the member as possible. If we deny a request for an expedited review, we transfer the appeal to the 30-calendar day timeframe or we complete as expeditiously as needed based on the member's health status, whichever date is sooner. We do this by preserving the original received date throughout the process to ensure compliance with the required completion date. We make reasonable efforts to give the member prompt verbal notice of the denial and follow up with a written notice within 2 calendar days.

c. Involvement of Members and their families in the Grievance and Appeal process;

The right to file a grievance or appeal request is not limited to the members themselves. We understand the legal guardian for a minor member or incapacitated adult, a representative designated in writing by the member, or when necessary, providers, initiate grievances or appeals on behalf of members. For children in Foster Care, we work with the caseworker and other involved parties as authorized by the caseworker (such as resource parents and/or biological parents). We enlist members, their guardians, and authorized representatives to share information to assist in the resolution process and to advocate for themselves when necessary and appropriate. We offer guidance and coaching to members to communicate and strengthen relationships with their health care providers and resolve differences informally when possible, and we regularly seek input from our Member Advisory Council on how to improve the grievances and appeals process.

d. How Grievances are tracked and trended and how the Offeror uses data to make program improvements;

We take our responsibility to our members seriously and have systems to track and securely maintain all G&A records for 11 years, which is one year longer than required. We capture the following G&A information in our integrated clinical platform, enabling us to provide all data to the Division in the prescribed format:

- The name and Medicaid ID number of the member for whom the appeal or grievance was filed
- A general description of the reason for the appeal or grievance
- The date the appeal or grievance was received
- The date the appeal or grievance was reviewed
- The date and resolution of the appeal or grievance
- Information regarding the root cause analysis of the grievance or appeal

Our G&A team is closely coordinated with our Clinical Operations department, which includes UM and QM. The UM team proactively reviews grievances and appeals involving providers who are having UM issues such as high denial rates. Our G&A team also identifies and refers potential quality of care issues to our QM team for review, ensuring program continuity and coordination for our members.

We report outcomes of these activities to the QI committee on a quarterly basis to ensure all departments are aware of occurrences, frequency, and context of member concerns, and the status of remediation and subsequent policy actions. The QI Committee uses outcomes data to drive and oversee operational change in the organization and improve member satisfaction and health outcomes.

Using Grievance Data to Increase Member Satisfaction

Data seen through recent tracking and trending of our member grievances in another market indicated that the number of grievances associated with not receiving member ID cards was higher than expected. The G&A team presented the findings to the QI committee, which initiated a QI project to identify root causes and find opportunities for improvement. The QI project surfaced an unutilized indicator available in the process for determining invalid addresses in member eligibility and enrollment data. We then put the indicator back into our member eligibility and enrollment data review process. This triggered an automatic proactive outreach to members, which solved the problem of undelivered ID cards before it became an issue for our members. As a result, grievances for missing ID cards decreased by 50%.

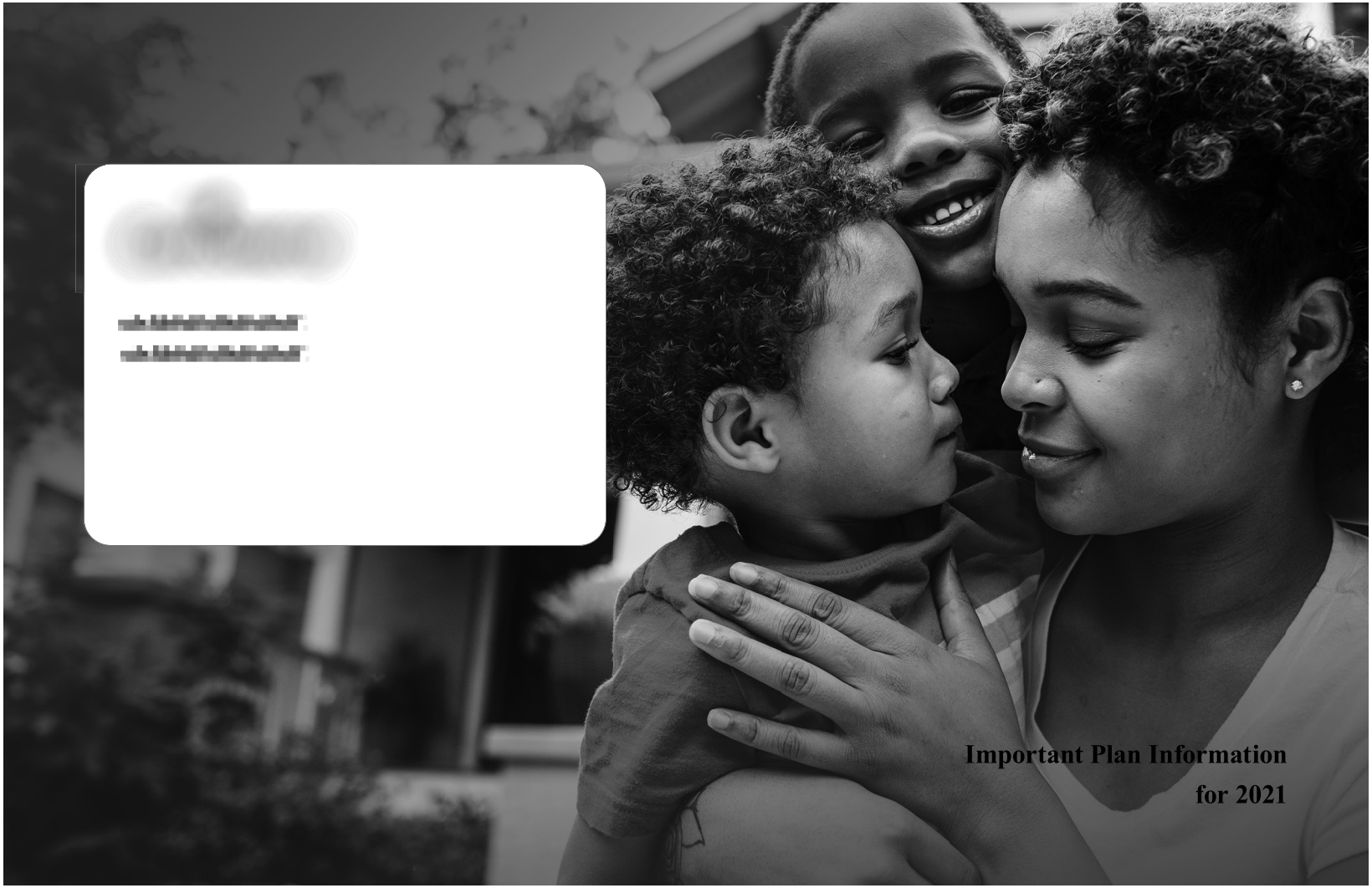
e. How Grievances are addressed prior to the filing of a Member appeal; and

Our objective is to resolve 100% of grievances so they do not become an appeal. Our skilled G&A coordinators work to resolve each grievance as swiftly as possible, avoiding an escalation to appeal whenever possible. We collaborate with each member or their representative to understand the root cause of the grievance and to determine if all policies and procedures were followed in support of the member's rights. We help members or their representatives to communicate and advocate for themselves where appropriate and step in to resolve issues on their behalf when required, enlisting care managers, medical directors, or other staff when needed to bring resolution quickly and fairly.

f. Process to review decisions overturned in external reviews and State Fair Hearings and the Offeror's approach to address any needed changes based on this review.

Once they have exhausted our internal appeal process, our Mississippi CHIP members, their guardians, or authorized representatives may request an independent external review of an adverse benefit determination by an independent review organization (IRO), in accordance with 42 C.F.R. §457.1150. Our MSCAN members may request a state fair hearing in accordance with 42 CFR 438.408 and Title 23, Part 300 of the Mississippi Administrative Code following our internal appeal process. In every IRO or fair hearing request, our G&A coordinator contacts the member to determine the underlying context and collaborates with the member and other involved parties to resolve the issue prior to the review or hearing date whenever possible. We work closely with the state fair hearing liaison to inform when we resolve a member's matter prior to the hearing.

When decisions are overturned in external reviews and state fair hearings, we reverse the denial, cover the denied service, and pay for it back to the date provided. We then work with our issue resolution team to conduct a root-cause analysis to understand if a process change is required. A process change is required when it is determined that the situation has the potential to generate repeat external reviews or state fair hearings. This process change determination triggers a remediation process, in which all related internal departments are engaged to develop an action plan to prevent a recurrence. The action plan includes identifying and implementing a modification, discontinuation, or replacement of the process or, at times, staff education. Where needed, there are also daily monitoring reports that are created to facilitate process improvement. A process change is not needed when, because of the root-cause analysis, a remediating action, rather than a process, is needed. We may collaborate with a provider or the Division on the development of an effective and appropriate remediating action. Results of the root cause analysis and subsequent actions are reported to the Division after any instance of an overturned external review or state fair hearing.


Important Plan Information
for 2021

Quick Start Steps

WHAT SHOULD YOU DO FIRST?

1. Get your [redacted] member ID card.

Included with this booklet is your member ID card. Your ID card lists the name and phone number of your primary care provider (PCP). Your PCP will treat you for most of your health care needs.

2. Set up a [redacted] account.

You can use your [redacted] account to change your PCP, ask for a new ID card, view claims and plan details, update your contact information and choose how you would like to hear from us. It's easy to do:

1. Go to [redacted]
2. Click [redacted] at the bottom of the page.
3. Answer the questions.
4. Click [redacted] You're all set!

3. Get the [redacted] Mobile App.

This mobile app lets you manage your [redacted] health plan on the go. The app is free. With the mobile app you can:

- Access your secure [redacted] account
- View your digital [redacted] member ID card
- Find a doctor, hospital, clinic, or urgent care near you through the [redacted] tool
- Call [redacted] our Nurse Advice Line, and speak with a registered nurse 24/7
- Call and speak with Member Services
- Connect with [redacted] and speak with a doctor anywhere, anytime
- And more!

Get the [redacted] mobile app through the App Store® for iPhone® or Google Play® for Android®*.

4. Make sure the providers you plan to use are in the [redacted] network.

Visit [redacted] to view the most up-to-date list of providers in the [redacted] network. You can also use the [redacted] tool on the [redacted] Mobile App. Providers in the [redacted] network are those who accept your [redacted] insurance plan. In most cases, [redacted] does not pay for charges from providers that are not part of our network.

5. Get a printed copy of your Member Handbook or Provider Directory.

You can ask to get either or both the Member Handbook and Provider Directory in paper form at no cost to you. Please follow the directions on the postcard in this booklet to tell us if you would like these mailed to you. There is no postage needed. You can also call Member Services at [redacted] to get these mailed to you.

6. Make Sure Your Prescriptions are on the [redacted] Drug List.

You can use the [redacted] search tool to see what drugs and medical supplies are covered. Just go to [redacted] click [redacted] and then click [redacted]

7. Complete your Health Risk Assessment (HRA).

[redacted] wants you to stay healthy. Using a few questions about your health and lifestyle, [redacted] can help your providers coordinate your care. You can even earn $15 on your [redacted] account when you complete the HRA! You can take the HRA in one of these ways:

- **Phone:** Call [redacted] between 7 a.m. to 6 p.m., Monday - Friday.
- **Online:** Just log into your secure [redacted] account and click on the [redacted]

[redacted]


Welcome to

We're
Glad
You're
With US

At [redacted], we care about you. We know that there is more to health and well-being than just great health care. That's why we have benefits and services that go beyond basic care.

Here are some of the ways we help our members:

Rewards Programs for making healthy choices.
- [redacted]®: earn up to [redacted]
- [redacted]: earn up to [redacted]
- [redacted]: earn up to [redacted]

Dental and Eye Care like yearly check-ups, [redacted] towards glasses or contacts, braces up to age 20, plus extra benefits up to [redacted]

Job Help with [redacted], free rides to trainings and interviews, plus GED testing and study help.

Kids Health and Fitness with free memberships to Boys and Girls Clubs*, YMCAs*, and Girl Scouts*.
*participating clubs only

Help for Moms and Babies like a free breast pump and free pregnancy tests. Plus you'll get health items like a welcome gift for new babies, toothbrushes for kids, and a blood pressure monitor, all at no cost to you.

Easy Access to Care with visits to health clinics at local stores inside Walmart®, CVS® and Kroger®.
Talk to a doctor 24/7 by phone or web with [redacted]. Or call [redacted]®, our 24/7 [redacted], for help when you need it.

Free [redacted] Membership
when you complete wellness checks!

We're Here for You
If you have any questions, please let us know.

Call Member Services:
[redacted]
Open Monday through Friday, from 7 a.m. to 7 p.m.

Online:
[redacted]

[redacted] complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

Si usted o alguien a quien ayuda tienen preguntas sobre [redacted], tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

如果您或者您在帮助的人对[redacted]存有疑问，您有权 免费获得以您的语言提供的帮助和信息. 如果您需要与一 位翻译交谈，请拨打您的会员 ID 卡上的会员服务电话号码.

[redacted]

[redacted]

[END OF RESPONSE]

4.2.2.2 PROVIDER NETWORK AND SERVICES

4.2.2.2.A. Provider Network

4.2.2.2.A.1. Explain the Offeror's plan to develop a comprehensive Provider Network to ensure it meets the Division's access and availability requirements for all covered benefits. Specifically include:

a. The Offeror's recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, contract processing and execution, and carrying out recruitment efforts;

We are a coordinated care organization (CCO) committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, and operational excellence which brings a new era of provider collaboration to Mississippi. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing state resources. We will center our provider network approach on ensuring providers have a trusted partner to support them and members have timely access to high quality covered services and culturally competent care for both the MSCAN and CHIP populations. For both MSCAN and CHIP members, we have a fully adequate network. We will continually look for opportunities to augment the network and increase member choice—maximizing availability and access to all covered services throughout the state's 82 counties. Our contracting will ensure we comply with all federal regulations regarding provider network adequacy as stated in 42 C.F.R. §§ 438.68, 438.206, 438.207, 457.1218, 457.1230, and any other applicable federal regulations, and we will comply with state regulations regarding reconsideration of inclusion per Miss. Code Ann. § 83-41-409. In addition to maintaining enough network providers to provide all services, we will also meet the Division's geographic access standards and timeframes for maximum number of days for an appointment as set forth in Tables 6.1 and 6.2 of the Draft Contract.

Recruitment Strategy

We will contract with any willing provider that wishes to be in our network and can meet the commitment to quality, cost and outcomes standards we use in building our provider network. Our recruitment strategy will entail connecting with and engaging Mississippi providers that are in the communities of the members we will serve. The foundation of our strategy will be to identify and prioritize the contracting of available providers by overlaying time, distance, and covered services requirements with member location and network needs. We will contract with providers to ensure access to all covered services for MSCAN and CHIP populations and exceed the Division's requirements. Guided by the Division's provider network composition requirements, we will apply a health equity lens to network development by analyzing member demographic, cultural and ethnic information to better understand our members' diverse social, racial, and linguistic needs. We will consider anticipated enrollment and the expected utilization of services given the characteristics and health care needs of our members. We will use this information to identify and contract with qualified Mississippi Medicaid providers who are available to serve members and can meet these needs. We will look at different data sources to capture all Medicaid approved providers including State Medicaid provider file, current Medicaid Plan directories, the NPI database, and public and commercially sold data.

Our recruitment strategy results in a network will give our members access to a full array of primary, specialty, ancillary, behavioral health (BH), and community-based providers. This will include safety net providers, including federally qualified health centers (FQHCs), school-based health centers (SBHCs), rural health centers (RHCs), and community mental health centers (CMHCs) which are key access points to providing primary care to Mississippians, particularly those living in underserved areas, and we will support them in their endeavor to serve low-income Mississippians. We purposely pursue contracts that maintain the standard referral patterns of our contracted providers, including those in contiguous states in support of continuity of care. We design our network with intent and ensure the availability and direct access to women's health specialists and family planning providers, access to Patient Centered Medical Homes (PCMH) and early and periodic screening, diagnostic, and treatment (EPSDT) providers. Our network will include providers who serve MSCAN and CHIP members with disabling conditions, chronic illnesses, or children with special health care needs, and when in the best interest of the member, we will allow these specialist providers to serve as the member's

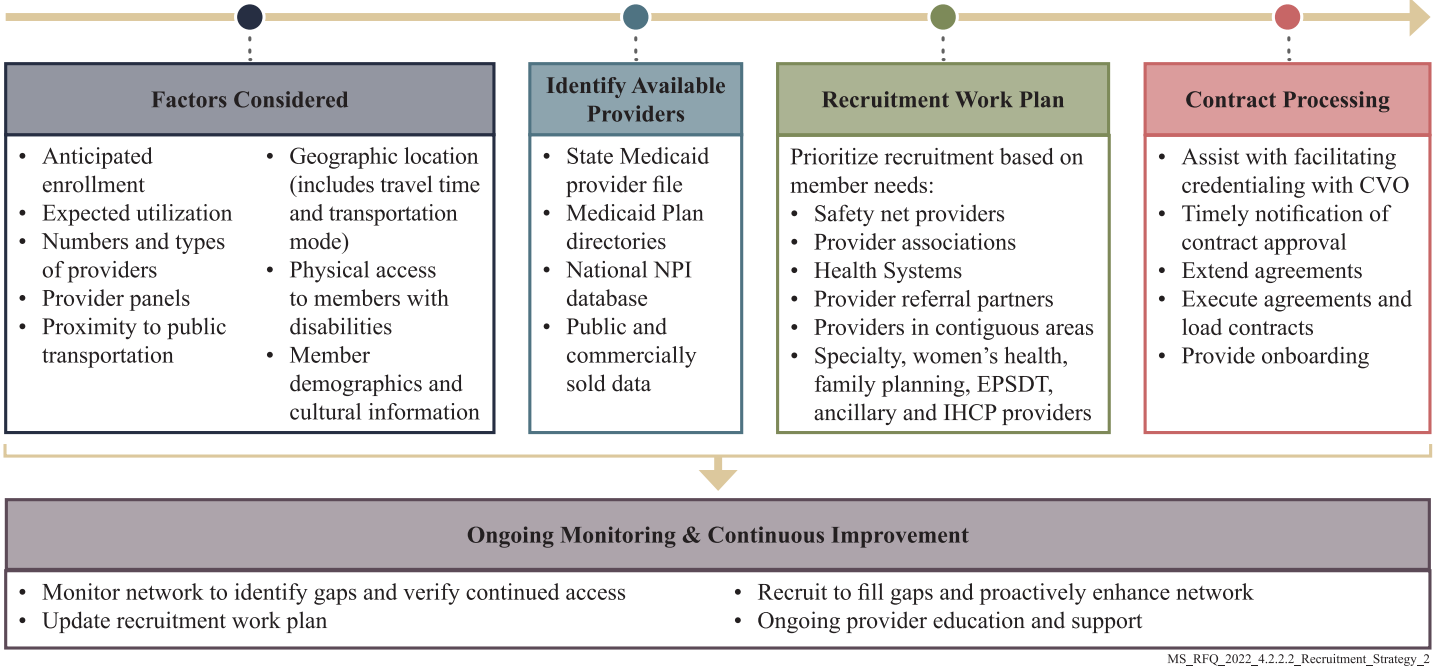
primary care provider (PCP). We will ensure network providers provide physical access and reasonable accommodations per the Americans with Disabilities Act, and accessible equipment, for members with physical and mental disabilities. Our network reflects the diverse cultural and ethnic backgrounds of our members, including those with limited English proficiency. We ensure providers maintain language access plans and provide members other meaningful access as required by Section 1557 of the PPACA.

We also recognize that Indian members can choose any Indian Health Care Provider (IHCP) as a provider whether they are in network or out of network. We treat all IHCPs as in network providers for Indian eligible members who have enrolled with us to receive services and have processes to pay IHCP providers in compliance with 42 C.F.R. § 438.14 and 42 C.F.R. § 457.1209. In addition, we offer contracts to all IHCPs to ensure timely access to services for eligible Indian members and have mechanism to pay IHCP providers in our network to ensure members have timely access to high-quality services.

We bolster our recruiting strategy by collaborating on initiatives aimed at improving access to care and gathering provider suggestions for operational improvements to our program. Collaborative efforts will include engaging with organizations including the Community Health Center Association, Mississippi Association of Community Mental Health Centers, the Mississippi Hospital Association and Mississippi Office of Rural Health to discuss quality incentive programs, grant based initiatives and value-based purchasing (VBP) models that align with providers' capabilities.

Through this approach and strategy, as summarized in Figure 4.2.2.2_A, we support our efforts.

Figure 4.2.2.2_A: Recruitment Strategy



Process for Identifying Network Gaps

We are committed to maintaining a provider network that will meet the needs of our MSCAN and CHIP populations and will go beyond the recommended standards for delivering quality care. Core to our strategy is a continued focus on the specific health care needs and characteristics of our MSCAN and CHIP populations to ensure access to the appropriate numbers and types of providers. Our network adequacy process measures network performance against these considerations and contractual requirements, allowing us to identify and resolve network gaps, address barriers to care, and enhance preventive care. We monitor network adequacy and gaps on an ongoing basis to ensure we meet members' needs and use several tools in these efforts including those listed in Table 4.2.2.2_A.

Table 4.2.2.2_A: Network Monitoring Tools

Tool	Description	Focus
Anticipated enrollment	We project potential changes in membership quarterly and use the information to evaluate network needs and adjust to our recruitment strategy. We consider provider count and need for specific providers.	Network-wide
Expected utilization of services	We identify our members' health care needs quarterly and evaluate the network to identify need for additional provider recruitment.	Network-wide
Number and types of providers	We generate monthly reports using provider types from State guidelines, Healthcare Effectiveness Data and Information Set (HEDIS®) requirements, and member needs, including an assessment of provider capacity.	Network-wide
Panel status and providers not accepting new members	We review the panel status of our PCPs by county and region quarterly and use this data to identify access barriers and implement additional targeted recruitment efforts. Upon identification of a closed panel, we review network PCPs in the same geographic area to ensure there are enough PCPs with open panels to provide appropriate access. We regularly monitor our network to confirm willingness to accept our members.	Network-wide
Proximity to public transportation	We collect information quarterly regarding provider proximity to public transportation and use this to identify recruitment opportunities and assist members in selecting a provider that is accessible via public transportation. If unable to use public transportation, we offer other solutions such as our non-emergency transportation (NET) vendor.	Network-wide
Geographic location of providers and members (GeoAccess)	We use GeoAccess software. GeoAccess maps help us review the geographic location of our providers compared to our members. The review considers distance, travel time, means of transportation used, and if the location provides physical access for members with disabilities. We submit GeoAccess reports to the Division on a quarterly basis.	Network-wide
Member-to-provider ratios	We incorporate member-to-provider ratios monthly to validate that access and availability are adequate for the membership. We use results to target geographic areas and/or specialty types in need of recruitment and pursue contracts with those providers.	Network-wide
Appointment Availability & After-Hours Accessibility Surveys	We conduct quarterly telephone surveys to ensure our contracted providers meet appointment availability and after-hours accessibility standards. Secret shopper surveys measure adherence to appointment timeframes and confirm whether a provider is accepting new members. After-hours access surveys confirm that PCPs/PCMHs are accessible to members around the clock.	Network-wide and individual providers
Member Inquiries and/or Grievances Related to Accessibility	For calls regarding accessibility or availability concerns, our clinical and provider services staff immediately works to resolve the matter and ensure access to services for the member. Our staff follows up with the provider to deliver education and/or corrective action. We also review trended member feedback data at least quarterly to help identify potential geographic areas where there may be insufficient access	Network-wide and individual providers
Requests for OON Providers	We review a weekly report of member requests for OON providers to determine if there are access concerns in the network and identify providers for recruitment.	Network-wide
Member Advisory Committee	Our Member Advisory Committee (MAC) meets quarterly to discuss members' experiences with network providers and review any gaps in access. The MAC is also a forum where members can make recommendations on how to better partner with providers and streamline access to care.	Network-wide
Provider Advisory Committee	We maintain a Provider Advisory Committee (PAC) to gain insight regarding what works well for providers and where they wish to see process improvements or additional support from us. We discuss challenges our providers face, including administrative and operational barriers, and work collaboratively toward resolution.	Network-wide

Resolving Network Gaps

While our network monitoring approach focuses on proactively identifying access issues, we have response mechanisms to rapidly facilitate provider access when necessary. In the unlikely event that a member is unable to access a pharmacy, hospital, PCP, or other specialist within the required travel distance, our provider services and member services teams take immediate action and implement short-term solutions such as executing a single case agreement (SCA) with an out-of-network provider (OON), arranging for transportation to a contracted provider in a neighboring area, or arranging for telehealth services with a contracted provider to provide access. Simultaneously, we initiate network development contracting strategies to mitigate any future

access issues. We will also submit documentation to the Division to verify the lack of providers, demonstrate our efforts to identify these providers, and we will work with the Division to remediate. We will continuously measure adequacy against access standards and submit quarterly reports to the Division.

Once we resolve a member's immediate need for access, the provider network team initiates a long-term resolution to mitigate future needs to access OON providers. These actions include recruiting OON providers with whom we executed SCAs, encouraging provider groups to recruit additional providers including physician extenders, working with PCPs to identify specialty providers they frequently refer to for recruitment to include in our network, using telemedicine when appropriate and available, and investing in healthcare workforce training and education programs. For example, we provide funding to FQHCs, RHCs and primary care associations to hire front-line staff in areas where there are network gaps. We offer funding to medical schools, scholarships for students in the medical field, and make residency program investments. We also offer grants and incentives to specific needed providers, such as CMHCs to expand capacity by offering non-interest loans for additional office space. We have an agreement with a physician group in another market where we fund two residency positions at a cost of $250,000 per year.

Table 4.2.2.2_B: Resolving Network Gaps – Immediate Needs

Key Options	Actions to Resolve Gap
Out of Network Provider	We have processes to allow OON providers to deliver care by providing authorization for OON services and/or executing a single case agreement (SCA) or Letter of Agreement with an OON Medicaid provider. Our workflow guides the execution of SCAs, tracks utilization, and reports on the need to recruit providers requesting authorization for services. We pay for services on an OON basis for the member if we are unable to provide services within the geographic access standards. Emergency services are always available without authorization.
Transportation	We provide transportation to a contracted provider in a neighboring area.
Telehealth	We have a record of success using telehealth to improve access to services with network providers through real time e-visits, consultations, education, or remote patient telemonitoring. This allows us to meet the needs of members, including those in underserved and rural communities where providers are not available or are unwilling to contract. Telehealth is especially important for BH services and other specialties with a shortage of providers willing to participate in Medicaid or present in the communities. For example, if we do not have an agreement with a key provider type within the geographic access standards, we can offer care to members through telehealth to a provider outside of the geographic access standards to bridge the gap. We support our providers in providing telehealth services by providing access to a telehealth platform if they do not already have their own.

Process for Developing Recruitment Work Plans

We develop and follow a provider network management work plan to guide our recruitment activities. Our vice president (VP) of network strategy oversees the work plan with the assistance of the director of network development. The VP and director gather input from multiple internal departments when creating the work plan. The director and provider services staff members are involved in the day-to-day execution of the work plan and hold meetings to review progress and adjust as needed. Our VP and director present the work plan to our executive quality/finance committee annually for review and approval and report monthly progress to the committee. The work plan includes key steps, accountable parties, and due dates as well as directions on activities related to generating network adequacy reports, identifying providers for recruitment, collaborating with provider advocacy groups, identifying providers to engage in VBP arrangements, and reviewing network monitoring reports.

Contract Processing and Execution

After we receive a contract request and prior to executing an approved Division provider contract, we will ensure all providers enroll with Mississippi Medicaid, credentialed by the Division's Credentialing Verification Organization (CVO), maintain current licenses, and have appropriate locations to provide covered services. We will process all contracting requests promptly and efficiently, providing support to providers throughout and guiding them on how to facilitate credentialing through the Division's CVO. We will make it easy to complete the contracting process with us and use a web-based application to issue contracts to providers which will allows us to track timeframes and status. Our process will allow us to monitor receipt, control the contract version, gather electronic signatures, and return a fully executed agreement to the provider. Providers will also be able to view their contracting status on our provider portal. For providers who prefer paper, to receive

documents via mail, our local provider services team will send a paper agreement to the provider and monitor the contracting process. These efficient processes will help us recruit providers with administrative ease and support our efforts to build a comprehensive network.

Upon receipt of a signed contract, we will counter-execute it and submit the agreement for configuration in our claims payment system. We will track timeframes to ensure we complete contract setup within 21 days of receipt of initial communication from the CVO of the provider's approved status and request to contract. Our credentialing and contract administration staff will use a daily dashboard to monitor adherence to timeframes, which will indicate the number and age of pending contract requests, along with the status. We provide reports regarding our contract activities and status to our Quality Improvement Committee and Compliance Committee.

Carrying Out Recruitment Efforts

Our recruitment work plan includes our contracting strategy guidelines, which ensure all agreements are complete, consistent, transparent, legally compliant, and contractually administrable. Our VP of network strategy and director of network development oversee and support the network contracting team responsible for negotiating agreements that are equitable and mutually beneficial to both parties, thereby maintaining successful ongoing provider relationships. Within 30 days of the date of the finalized, dually executed contract, our locally based, regionally assigned provider representative (PR) conducts new provider orientation to ensures network providers receive appropriate training and establishes a regular cadence for ongoing interaction.

b. The Offeror's strategy for retaining specialists and how the Offeror will provide access to specialists if not in the network;

Our specialist retention strategy focuses on4.2.2.2.A.6 administrative ease, operational excellence, and provider support. It begins before specialists become contracted, with support in facilitating contracting and timely processes, and continues through ongoing interactions that help retain specialists in our network. We focus on administrative ease so providers can concentrate on taking care of our members, and reduce administrative burden through:

- **Timely Claims Payment**: We consistently pay 99% of BH claims within five days, 98% of all other claims within five days with a three-day average speed of payment, and a first pass accuracy rate greater than 99%.
- **High-Performing Provider Recognition**: We offer a program that allows high-performing providers to bypass our standard outpatient prior authorizations process for specific qualifying services. Using our data analytics tools to review quality and performance measures, we identify providers who qualify for this status and who are part of a path to move along our VBP continuum.
- **Open Access**: We do not require referrals for in-network specialist services.

Offering provider incentives/VBP program participation is another strategy we employ to recruit and retain specialists to the network. Our VBP programs reward providers for high quality, cost-effective care, leading to increased provider satisfaction and retention. We support all providers who are interested in engaging with us to participate in VBP programs and offer a stepwise approach that helps providers achieve success in earning incentive payments above fee-for-service reimbursement.

Providing Access to Specialists not in Network

We retain our network of high-quality specialists because we make it administratively easy for providers to work with us and our members do not need a referral to see these in-network providers. However, if there is a reason a member would benefit from seeing an OON provider, or in the event there is not a network provider available within the access standards, we work with the member and their care team to ensure access to specialty services. as described in Table 4.2.2.2_B.

c. If Subcontractors will be used for certain service areas (e.g., dental, behavioral health/substance use disorder), how their network development efforts will be coordinated with the overall recruitment strategy and how the Offeror will provide oversight and monitoring of network development activities;

We subcontract for dental and vision services and incorporate network development activities for subcontractors into our recruitment strategy. We do not subcontract for BH, as we build and manage our

network and program. Through our established oversight structure, we will monitor subcontractor network development activities and ensure compliance with all requirements that are in our contract with the Division. We will submit subcontractor agreements to the Division for advance written approval.

Our relationships with our subcontractors are based on delegated service agreements. This framework ensures we have a written agreement with all entities with whom we subcontract that defines subcontractor activities, reporting, and penalties if the subcontractor does not meet the contract requirements.

We choose subcontractors that have demonstrated performance in areas that support our recruitment strategy, such as offering administrative ease and personalized support for providers. We will require our subcontractors to have significant network development and maintenance programs in place to ensure compliance with our contract with the Division. We monitor subcontractor activities using the same process we use for internal network development and maintenance, by assessing network adequacy on a continuous basis using GeoAccess reports. We continue monitoring throughout the term of the agreement as part of our oversight and monitoring of the subcontractor and include subcontractor network activities in our recruitment work plan.

We design our oversight to ensure delivery of high quality administrative and appropriate clinical services, in adherence to all state and federal laws. We understand that we are responsible for our subcontractors and the ultimate responsibility for program delivery and administration remains with us. To achieve this, we use our vetted subcontractor oversight process, supported by a qualified oversight team of dedicated staff members who keep committees informed through validated and timely reporting. Through this process, we monitor each subcontractor's performance on an ongoing basis, subject it to formal review at least once a year, and include the results of this review in our annual quality management program evaluation in accordance with the Reporting Manual of the model contract. We take corrective action in the event we identify deficiencies or areas for improvement regarding subcontractor performance.

Prior to submission to the Division for approval, our strategic sourcing, vendor risk and oversight, legal, information security, and quality and accreditation teams will vet all subcontractor candidates. Additionally, our vendor risk and oversight teams will continuously monitor and evaluate subcontractor operational and financial performance using proactive and pre-emptive processes to identify critical vendor issues. We will prepare and submit comprehensive reports to the Division, per the requirements in the Draft Contract.

d. Proposed methods to assess and ensure the network standards outlined in Appendix A, Draft Contract, are maintained for all Provider types, including using GeoAccess to ensure network adequacy;

We continuously evaluate network adequacy across all provider types to ensure we maintain an accessible network, using the various monitoring tools described in Table 4.2.2.2_A, including an industry leading reporting suite. This allows us to assess, monitor, and trend our network's performance through routine reporting and analysis, including GeoAccess. We maintain network standards by implementing both immediate actions to ensure access as depicted in Table 4.2.2.2_B regarding addressing gaps, as well as long term interventions to continually enhance the network as described in Table 4.2.2.2_A regarding monitoring tools.

e. The Offeror's process for continuous network improvement, including the approach for monitoring and evaluating PCPs'/PCMHs' compliance with availability and scheduling appointment requirements and ensuring Members have access to care if the Offeror lacks an agreement with a key Provider type in a given geographic area; and,

Through ongoing monitoring activities, we continuously assess the provider network to ensure ability to meet member needs. We regularly review PCPs'/PCMHs' compliance with availability and scheduling appointment requirements and other indicators of availability, and we have processes to ensure members have access to care in the event we do not have available contracted providers in each geographic area.

Compliance with Availability and Scheduling Appointments Requirements

We monitor appointment availability and after-hours availability to ensure access and availability of care. Our agreements will require that providers maintain a reasonable schedule of operating hours and adhere to the appointment scheduling timeframes indicated by the Division in Table 6.2 of the Draft Contract. In addition to

the agreement, we will share these requirements with providers during orientation and via continuing education, in the provider manual, and through published network notification reminders. Our provider services and quality departments conduct activities to monitor adherence to the standards, such as access/availability surveys, monitoring grievances, and reviewing requests for OON, and take actions to remediate any issues identified. We describe monitoring activities and actions in detail in Tables 4.2.2.2_A and 4.2.2.2_B.

Ensuring Access to Care if We Lack Agreement with a Key Provider Type
In the event we lack an agreement with a key provider type, we ensure access to care by implementing the activities for resolving gaps in care per Table 4.2.2.2_B.

f. How the Offeror will ensure appointment access standards are met when Members cannot access care within the Offeror's Provider Network.

We identify instances where members cannot access care within our network in several ways, including calls to our member or provider call center, feedback from providers looking for referral for a member, or a member contacting their care manager. When we have this issue, our care managers, member services and provider services teams take immediate action to resolve the member's concern and ensure access to care within the timeframes for appointment access, as indicated in Table 4.2.2.2_B. In addition, we implement corrective action with the member's current provider to resolve any access or availability issues that are causing difficulty in access to care. If there is a network provider available who does not comply with standards, our PR reaches out to the provider to conduct education and work with the provider on closing the gaps. We continue to monitor the provider and implement corrective action as needed.

g. Describe the role of the Contractor's Provider Representatives, how the Offeror will recruit and maintain these individuals, and how the Offeror will ensure that representatives stay current on Medicaid policy.

Our ability to recruit, support, and manage the provider network comes from our experienced, comprehensive provider services organization (PSO), which includes a proportional number of PRs, not less than 30, that we will appropriately train to assure successful management of our Mississippi provider network. We will employ a team-based approach to resolving issues in real-time or near real-time to ease the administrative load and improve provider satisfaction. The role of our PRs is to provide day-to-day support to providers with an emphasis on communication and collaboration. Our local provider-facing PRs assist providers with claims, enrollment, credentialing, and all other areas where providers may require assistance. In addition, they provide the following key functional supports to all providers:

- Conduct new provider orientation including reviewing and insuring providers' understanding of their contractual roles and responsibilities and CCO policies and procedures.
- Educate providers on the CHIP and Medicaid program, our care management programs, value-added benefits, and doing business with managed care, including claims, billing, and other administrative topics.
- One point-of-contact for issue resolution including response to claims and operational issues submitted by providers.
- Monitor network adequacy and accessibility and collaborate with the network contracting team to address network gaps.
- Assure providers receive prompt resolution to their issues, including those related to claims payment, prior authorizations, and referrals.
- Assist and support providers with adoption of bidirectional data exchange technologies including electronic medical records (EMRs) and health information exchanges (HIEs) to optimize our collaboration.
- Provide practice transformation consultation and technical assistance, including coaching and interpreting our VBP program reporting tools.

Provider Resolution Unit
Beyond provider-facing staff, we have an internal provider resolution unit (PRU) dedicated to resolving complex provider issues or concerns that require additional internal escalation. The PRU is comprised of

manager and director level staff who provide ombudsman-like services and serve as an additional level of support for our PRs if they encounter delays receiving timely or complete resolution through routine issue resolution processes. We empower our PRs to escalate issues as needed to the PRU, where the PRU team assumes responsibility for the issue and facilitates resolution through to completion. The PRU maintains communication with and advises the PR regarding status and timeframe for resolution. In addition to performing this level of internal support, the PRU will serve as a direct, single point of contact for the Division to relay any concerns it receives from providers and to obtain status and resolution.

Provider Innovation Collaborative (PIC)

Our provider innovation collaborative (PIC) offers providers tools and supports that constitute a further level of excellence in provider service. The PIC aligns internal operational and clinical teams across our organization into a framework of comprehensive provider tools and supports. We will collaborate with Mississippi providers and solicit their feedback to inform the PIC's tool and support design. Deep familiarity with the provider-informed PIC model will allow our PRs to be impactful and therefore satisfied with their relationship-based role. Our PRs enjoy educating providers about the PIC tools and assist in optimizing them. This model of collaboration spans the entire continuum of our organization and provider relationship and supports the maintenance and success of our highly qualified, culturally competent provider network.

We designed the PIC provider engagement model to achieve four objectives related to provider performance, growth, innovation, and community development. The four pillars of the PIC – Brilliance at the Basics, Care Partner Enablement and Education, Innovation and Community are the foundational philosophies that drive of our provider engagement and collaboration strategies.

1. **Brilliance at the Basics**: We will provide real-time technical assistance and issue resolution related to basic health plan interactions to reduce administrative friction for providers and the Division and improve overall operational performance.
2. **Care Partner Enablement and Education**: We take a coordinated approach to provider education and training by offering in-person, virtual, and hybrid options for weekly open office hours with the provider services team; ongoing provider education and trainings; "Lunch & Learn" series with nationally recognized experts on evidence-based practices; access to our clinical command center consisting of a multidisciplinary team of clinical professions for case consultation in real-time; and invitation to Institute for Relational Health Innovation Series events.
3. **Innovation**: We collaborate with providers to encourage innovative ideation, and we support investment in practice transformation activities related to improving the quality of member care through our value-based program design and provider incentive offerings.
4. **Community**: We define community as the interactions we have with providers, the Division, members, and community-based organizations (CBOs). We emphasize the critical nature CBOs will play in our members' lives, and we see our role as partner and bridge builder between our providers and CBOs to create linkages for solutions and sharing of resources to implement population health initiatives. We understand our members will trust and rely on CBOs, so we will work with CBOs to arrange on-premises health clinics.

Recruiting and Maintaining Provider Representatives

Our PSO will be composed of regionally assigned PRs who live in and actively engage with the Mississippi communities they serve. This approach promotes an in-depth understanding of local needs and resources. Our PRs have experience and training on regional health needs, provider accessibility, and resource availability in both rural and urban areas within their assigned territory. We staff our PSO with culturally diverse individuals who reflect their local communities and understand the health disparities and issues prevalent in their areas.

We provide our employees with specialized training, personalized learning, and talent management programs, and we foster a positive work culture by sponsoring bilateral staff feedback. This approach maximizes staff retention and ensures the consistent delivery of services to our members. In addition to weekly one-to-one

meetings with their manager, monthly departmental meetings, and quarterly team building events, we implement the following programs and activities that support our PR retention strategy:

- **Engagement Survey and Follow-Up Actions:** We administer employee engagement surveys. Following the survey, we require every leader to address department-specific trends and opportunities for their employees. Our last engagement cycle resulted in 94% employee participation. Our employees know that leaders will act upon the feedback they provide.
- **Recognition Program:** We enable leaders and peers to recognize those who demonstrate our mission and make a difference. Leaders award points, which employees may redeem for merchandise at an online store.
- **High Potential Program**: We offer a high potential program to employees at all levels. This program aligns with the talent management review process and supports succession planning. The purpose of the program is to provide skill building for employees identified as ready for the next level within the organization. The high potential program creates an internal pipeline and incorporates increased knowledge and skills application through case studies, scenarios, stretch projects, shadowing, and mentoring.
- **Leadership Training**: Team leaders, managers, and directors attend individual courses or learning programs focused on building strong teams through engagement, competency development, and coaching.
- **Mentoring**: Leaders identify high-performing employees for mentoring. The talent development team offers comprehensive group and individual mentoring programs, where seasoned leaders facilitate mentoring sessions to support employee growth and development.

Ensuring Representatives Stay Current on Medicaid and CHIP Policy

As our PRs are responsible for communicating new and updated policies and procedures to providers on a timely basis, we ensure they maintain in-depth knowledge of state Medicaid and CHIP policies. We will stay current by providing quarterly ongoing education about Medicaid, MSCAN, and CHIP, and confirm understanding and consistent provider messaging. We deliver PR training on a variety of topics including current Medicaid and CHIP policies through Cornerstone, a learning and performance management system administered by talent development. Talent development is an in-house training and development department focused on providing staff with learning opportunities geared toward advanced skill development and professional growth. To keep our training content up to date with changes to policies and procedures, all training materials are electronic, which allows instantaneous updates whenever needed.

In addition to content through Cornerstone, we will provide time sensitive training and education as necessary to provide updates about continued Medicaid and CHIP changes and requirements, including “Late Breaking News” articles, Provider Bulletins, State Plan Amendments, CHIP State Health Plan Amendments, and Administrative Code Filings, Provider Billing Handbook, and MSCAN and CHIP updates. We provide quarterly reports detailing all training completed, topics covered, and the number of staff, their positions, and the training completed.

4.2.2.2.A.2. Describe how the Offeror will develop and maintain collaborative relationships with low, medium, and high intensity residential treatment facilities and medically monitored inpatient treatment facilities.

Low, medium, and high intensity residential treatment facilities (RTFs, or ASAM Level 3 programs) and medically monitored inpatient treatment facilities, when indicated, play a critical role in a member’s recovery process. We forge collaborative relationships with these facilities to assure we coordinate all services our members receive across the continuum of care, and through our Health Information Exchange (HIE) program, we maintain a transparent, bidirectional data sharing strategy focused on positively impacting health equity and member outcomes.

Our serious mental illness (SMI) and substance use disorder (SUD) services provide a recovery-oriented fully integrated system of care that includes multiple clinical and non-clinical services, including crisis residential care. We have processes to provide care coordination with these RTFs through our Intensive Care Management (ICM) model in the event a member requires an ASAM Level 3 RTF, psychiatric rehabilitation treatment facility

(PRTF), or monitored inpatient care. Our model assures we coordinate all member services upon admission to a facility, and through transition and step-down to community outpatient services. Our intensive care managers provide support to certain high-risk populations, including members with SMI or SUD, and children in PRTFs. They are community-based and act as single points of contact for member needs when the member would otherwise have difficulty navigating the health care system. The care managers assist members with person-centered planning and, as part of our fully integrated service delivery model, they assist members to identify behavioral health, physical health, and community resources they need to be successful in their recovery.

We provide a fully integrated transition of care plan that includes outpatient follow up and/or continuing treatment prior to discharge for all members receiving PRTF services. Our intensive care manager partners with low, medium, and high intensity RTFs upon member admission and works with the RTF and member from day one to plan for discharge. Our fully integrated service model allows for collaborative discussions with facilities about a member's progress, barriers they may face, and discharge planning to ensure they receive care in the least restrictive community-based setting. Our intensive care manager remains assigned to our member through residential services and our member always knows who to reach out to and who coordinates their care. The intensive care manager assists the member to develop a person-centered care plan with the collaboration of the member's support system and identified treating providers. Intensive care managers have a direct connection to the utilization management team to assure they have the most up to date clinical information allowing for effective collaboration and discharge planning. This design allows the provider to focus on treating the person and ensures linkage to appropriate aftercare.

Developing Collaborative Relationships with RTFs

We will have a network of providers with existing on-the-ground collaborative relationships with RTFs across the state. Our hospitals will routinely work with RTF staff during discharge planning and transfers of care for individuals requiring residential SUD services. We will further build on these existing relationships to formalize communication and engagement channels between our network providers and residential treatment sites.

It is important to note that the State's Community Mental Health Centers (CMHC) operate many ASAM Level 3 programs in Mississippi. Based on SAMHSA's 2021 National Directory of Drug and Alcohol Abuse Treatment Facilities, Medicaid providers operate 17 of the 31 identified SUD residential treatment providers. We will solicit all CMHCs to participate in our network and help them form collaborative relationships through our intensive care managers. We will assign a specialized behavioral health provider representative (BHPR) to each CMHC. The BHPR serves as a single point of contact to identify and address issues that may arise as efficiently and effectively as possible. We use this relationship to help identify and address concerns or barriers that may occur pertaining to non-covered residential treatment services. In addition, we will offer non-contracted private and non-Medicaid RTFs the same opportunity to engage with dedicated provider and member-facing staff.

Using our experience building similar relationships with RTFs in other Medicaid markets, we will apply lessons learned from serving Medicaid members where coverage policies are like those in Mississippi. We deploy best practices from this collective experience to develop collaborative relationships with RTFs operated by both in and out-of-network providers. We use bidirectional data sharing to identify opportunities for improved collaboration with residential, inpatient, and outpatient providers across the continuum of care. Community learning collaboratives are structured engagements with local treatment and support continuums that are driven by data and analysis to identify gaps in access to levels of care. Through these collaboratives, and as part of our fully integrated service delivery model, we will work alongside residential and outpatient providers to address gaps and improve care for members. For example, we worked with residential treatment providers who voiced challenges in referring members to ongoing support services in their community, particularly members in need of ongoing outpatient SUD services. Upon reviewing member data specific to the county, we identified many members who leave residential treatment and do not step down to a lower level of care for ongoing support. We facilitated the participation of acute inpatient detoxification providers, the RTF, and outpatient SUD providers in developing relationships and coordinated referrals to ensure access to medication-assisted treatment (MAT) and intensive outpatient treatment programs. The community learning collaborative structure allows our staff to engage

providers and community partners to be active collaborators and advocates for the support needed to care for our members.

Maintaining Collaborative Relationships with RTFs

Regular engagement between RTFs and their assigned specialty BHPR plays a key role in maintaining collaborative relationships with RTFs. Our BHPRs are behavioral health clinicians with managed care experience who meet with RTFs quarterly to verify alignment on discharge planning and coordination for our members. Additionally, our structure directly embeds local care coordination staff to work in partnership with high-volume and/or low-performing inpatient providers. We also welcome RTF, PRTF, and inpatient hospital providers to participate in joint operating committees to identify and address implementation and operational barriers. Our ability to engage providers using local staff through regular in-person, face-to-face interactions, will help providers develop and maintain more meaningful relationships with our staff over time.

Our intensive care managers stay engaged with our SUD complex members throughout transitions of care, engaging RTFs in interdisciplinary team meetings and person-centered care planning activities regardless of the providers' network status. This engagement strengthens our ability to identify and follow up with a member who may voluntarily leave a residential treatment program early, allowing their intensive care manager or other ICM staff to rapidly re-engage the member and identify alternative treatment options that may be appropriate, such as MAT or intensive outpatient services. We also use this opportunity to engage with the member and RTF staff to obtain the necessary informed consent required to incorporate SUD treatment information in their person-centered care plan that is shared with their primary care provider.

Through a partnership, we will identify high impact geographic areas to increase availability of peer recovery specialists who have lived experiences with SUD and who assist us with engaging members in case management and treatment, while providing ongoing support throughout members' recovery processes. This partnership will enhance our assessment and monitoring of members who may benefit from or are currently in residential ASAM Level 3.1 or 3.5 treatment. As an extension of our ICM program, teams from our peer recovery specialist partner will work in concert with our intensive care manager and transition coordinator to coordinate care for members with SUD.

Together, we will support health equity by providing peer support, linking members to vital community resources, and supporting collaboration with RTFs. Our partnership will address treatment gaps across the spectrum of substance use, where other solutions may fail, by using aggregated data on the member's health history, directly educating the provider and member, and providing a clinical support team that uses high-touch, high-tech care. A complex problem requires an end-to-end solution to support our members' journey to recovery. Our collaborative relationship, which includes the RTF, medically monitor inpatient providers, and the member's family or support system affords the member a clear, connected path to improved outcomes. Our fully integrated, transparent service delivery model with the majority of our providers offers real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence, which brings a new era of provider collaboration to Mississippi. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources

Our purpose-driven process is aligned with the mission of RTF providers and sharing our model will help us achieve deeper collaboration. In our process, we train our staff to deliver culturally competent services to members with diverse languages, values, beliefs, and feelings, and to incorporate into each member's recovery plan their unique needs. We advocate on behalf of our members, ensuring they are prioritized, given adequate access to care, and treated fairly. We identify and address social inequities, such as employment, housing, transportation, food insecurity, and social isolation. Solving for these common barriers to stability and recovery helps to mitigate the disparate impact of SUD on vulnerable populations and provides a more equitable opportunity for members of all backgrounds to lead healthy, productive lives. **Our localized approach will leverage the resources of Mississippi providers and community partnerships to promote best practices of healthy living and health equity.**

Other Behavioral Health Residential Treatment Providers

We commit to the same approach described previously to develop and maintain collaborative relationships with other residential behavioral health providers across Mississippi, including PRTFs and providers with more than 16 beds who are excluded from Medicaid reimbursement due to the Institutions for Mental Disease (IMD) exclusion. Whether the services are covered or excluded, our specialized BHPRs and ICM staff collaborate with providers to address barriers or care gaps associated with entering or leaving treatment. Through these relationships, we collaborate with residential treatment providers to connect the member to covered community-based or intensive outpatient step-down services and supports (including certified peer support specialists) upon discharge.

4.2.2.2.A.3 Describe the Offeror's process for working with Providers and the Credentialing Verification Organization (CVO) to educate and assist Providers in completing the credentialing and recredentialing process with the CVO.

We understand the importance of an efficient, simplified process for the credentialing and recredentialing of providers, and coordinating with the Division's Centralized Credentialing Verification Organization (CVO). We have experience working with state CVOs where we have adapted our processes to ensure coordination and facilitate an easy experience for providers. Collaborating with the CVO and providers, and assisting providers through the process, is an important component of our recruitment strategy and helps us to maintain a comprehensive network of qualified, satisfied providers. Our processes comply with all applicable law and the requirements in Appendix A, Section 6.5.

Provider Education and Assistance

We will educate providers regarding the Division's CVO credentialing and recredentialing process during recruitment outreach activities, new provider orientation, ongoing provider education programs, as well as providing a link to those requirements on our website. We conduct training through face-to-face visits, phone calls, and provider forums or webinars, supported by resources and materials. We work closely with providers to assist them in understanding and navigating the process.

To support our provider education efforts related to Mississippi Coordinated Access Network (MSCAN) and Children's Health Insurance Program (CHIP) credentialing and recredentialing requirements, we offer various resources and supports, such as:

- Direct contact with our well-versed and trained, locally based provider representatives.
- Provider landing page on our MSCAN/CHIP website that outlines credentialing and recredentialing requirements, indicates who to contact for questions, and instructs providers how to contact the Division's CVO.
- Trained provider services call center staff.
- Detailed provider manual, which we share and review with providers.

Working with Providers and the CVO

Through all provider education activities and resources, we communicate that for MSCAN and CHIP providers, all credentialing and recredentialing processing and determinations must go through the Division's CVO. We refer providers to the CVO and help to facilitate that process. We make sure providers understand we do not conduct a separate credentialing process or require providers to submit any supplemental or additional credentialing information to us. We advise providers that upon successful completion of the credentialing process, the Division's Fiscal Agent sends the provider a welcome letter. The Division's Agent also notifies us, and we engage with and assist providers regarding next steps in the contracting process. We also inform providers that they can check status of their enrollment and contract-related activities on our provider portal.

Detailed Policy and Procedure

We maintain a detailed policy and procedure to guide our activities in coordinating with the CVO and assisting providers to facilitate timely credentialing and recredentialing. We educate providers about our process, explain the role of the CVO, explain our role in helping to coordinate with the CVO, and describe how we assist providers through the process. The policy, which we submit to the Division for advance approval, complies with Appendix A, Section 6.5.

By educating providers on the relevant policies and procedures, and assisting them to navigate the process, we are better able to enhance our network. Our efforts help facilitate quick and efficient provider credentialing and recredentialing through the CVO and help to minimize delays for reasons of misunderstanding the process or lack of assistance. **Our collaborative approach helps us retain long-term relationships with providers and improve member choice of available, qualified providers.**

4.2.2.2.A.4 Describe the Offeror's approach for timely contracting of Providers upon receipt of information from the CVO that a Provider's credentialing is complete.

A timely and efficient contracting process is essential to our recruitment efforts and helps ensure timely, accessible care for our members. As part of our strategy to continuously improve our comprehensive network, we proactively recruit providers and design our contract processes to offer administrative ease and ongoing proactive communication with providers. Our processes comply with all applicable law and the Draft Contract, including the requirements in Section 6.5 of Appendix A. We coordinate with the Division's Fiscal Agent to confirm the status of providers who request to enroll with our coordinated care organization (CCO), and to receive regular feeds of the provider file from the Division, which includes the provider's credentialing approval. We use the information to support our timely contracting of providers. Our operational protocols ensure that we notify providers regarding approval or denial of their request to contract with us within seven (7) calendar days of the provider file interface exchange, and take no later than 21 calendar days from the date the Division notifies us of credentialing approval to complete the contracting process and load provider information into our claims processing system.

We actively track the status and age of pending contract requests and provider contracts we issue and reach out to providers to facilitate timely return of the contract. If we experience a delay in receiving the provider signed contract, we continue to follow-up with the provider and track the timeframes and reason for delay.

Timely Contracting of Providers

At the beginning of the recruitment process with a provider, we review the provider file to determine if the provider is already credentialed through the Division's Credentialing Verification Organization (CVO) and currently enrolled as a MSCAN or CHIP provider. If the provider has not been credentialed, we assist the provider in facilitating credentialing and refer the provider to the Division's Fiscal Agent. We remind the provider to indicate their request to enroll with our CCO, and we coordinate with the CVO throughout the completion of credentialing. During this same time, we maintain discussions with the provider, review contract terms and language, and prepare for completing an agreement in anticipation of successful credentialing. Upon receipt that a provider's credentialing is complete (via provider file transfer from the Division to our CCO), we input information regarding the provider's request to contract into our contract processing system to track timeframes, guide our procedures and monitor status. If a provider is already enrolled as a MSCAN or CHIP provider and requests to contract with us, we engage in discussions and follow our operational protocols, including timeframes for notifying the provider of contract approval or denial and subsequent contract processing activities. To ensure an efficient and timely process, we have staff who monitor daily the provider file exchange and incoming requests to contract and coordinate with our Contracting team and Credentialing and Contract Administration team to promptly act upon the requests. **Our ability to deliver operational excellence demonstrates that we respect members and providers and will be a worry-free partner of the Division.**

Monitoring Adherence to Timeframes

Our Credentialing and Contract Administration team uses a daily dashboard to monitor adherence to timeframes and guide actions regarding contract requests that are in process. A summary report of the dashboard indicates the number and age of contract requests in process on any given day, categorized by status. For example, it will track all stages beginning with "Awaiting Contract Decision" through "Awaiting Loading" into the claims system. It shows number of contract requests by age, with Day 1 as the day we received the request to contract/provider file exchange indicating the provider's credentialing approval. In addition to this summary report, our Credentialing and Contract Administrative teams have information regarding the details of each

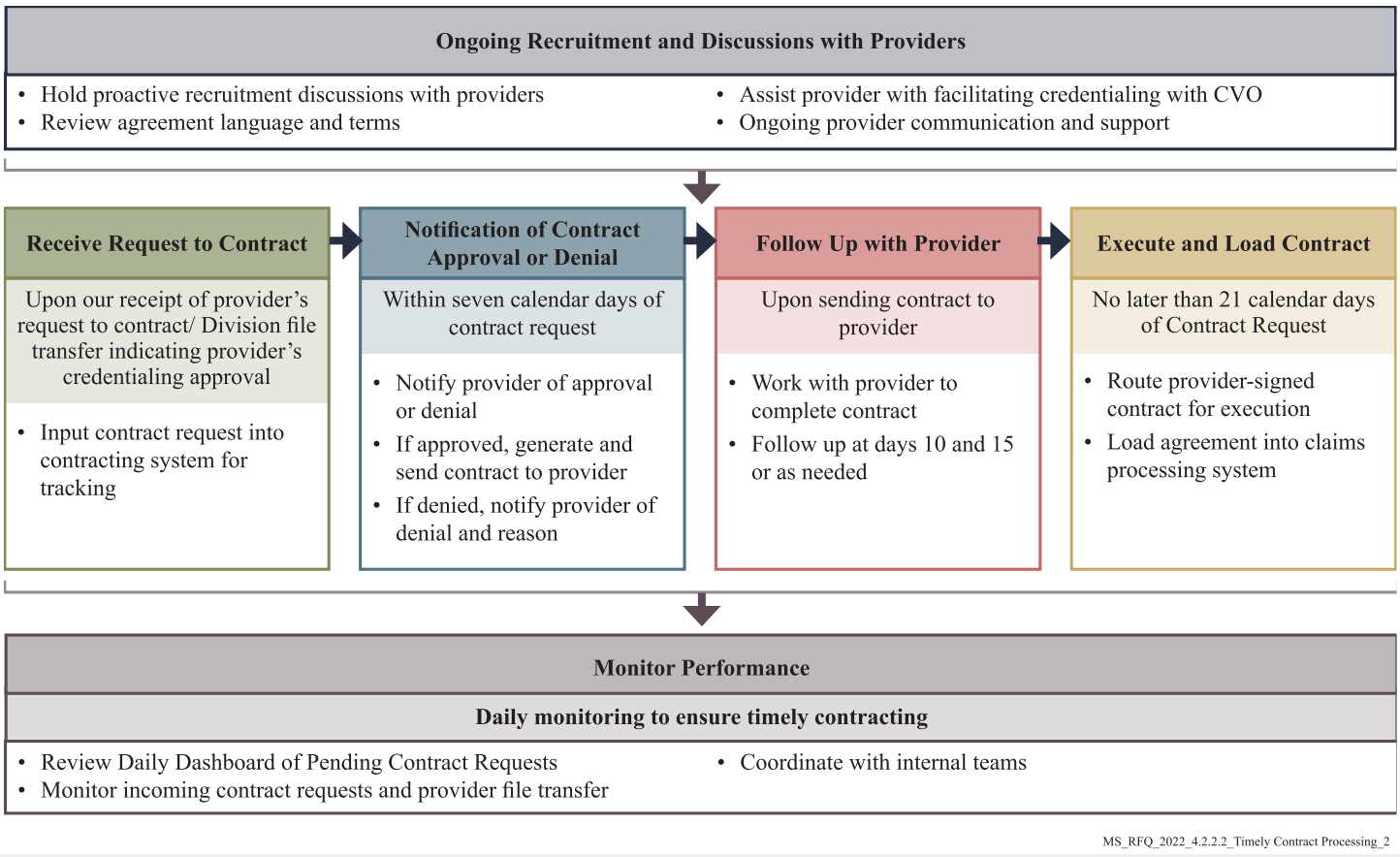
contract request. We share reports and status regarding our contract activities with our Quality Review Committee and Compliance Committee, which provides oversight and guidance regarding our contract process.

Real-time Provider Contracting Status

As part of the onboarding process, providers can easily check their contracting status on our provider portal. Providers can securely log into our "Check Enrollment Status" page to view a list of providers associated with a given national provider identifier (NPI), their status, and a copy of related documents.

Figure 4.2.2.2_B shows our contracting process, including timeframes for notifying providers of our contract decision and for loading contracts into our claims processing system. In most situations, before we receive a formal request to contract/notification from the state of the provider's credentialing approval via the provider file transfer, we will have already proactively held discussions with providers about joining our network. Although notification from the state starts the "formal" timeframe for notifying providers of our decision to contract, these discussions will have already been underway and providers will have already received a draft contract.

Figure 4.2.2.2_B: Process for Timely Contracting with Providers



4.2.2.2.A.5. Submit templates of the Offeror's standard Provider contracts.

We have included our standard provider contract template following Section 4.2.2.2.

4.2.2.2.A.6 Describe the Offeror's proposed policies and procedures for addressing the loss of a large Provider group or health system, including:
a. System used to identify and notify Members affected by Provider loss;

Our integrated service delivery model combined with our high-touch provider support and operational excellence makes losing a large provider group or health system highly unlikely. However, we have policies and procedures in place to quickly and efficiently mitigate these situations should they occur. We have a proactive system to prepare for and address loss of large provider groups or health systems. Our processes comply with all applicable law, including 42 C.F.R. § 455.416, and Appendix A, Section 6. If a large provider group or health system initiates termination,

we work with the Division to assess and resolve the impact on our MSCAN and CHIP members. If a provider terminates their contract with us, we notify the Division in writing within two business days after receiving notice of termination. If we are in a circumstance where we intend to terminate a provider, we notify the Division in writing at least 60 calendar days prior to the termination effective date. We provide all additional background information regarding the provider termination, including but not limited to a summary of the issues, reasons for the termination, and information on negotiations or outreach between us and the provider. If the Division requests additional information, we provide it within two business days of the request. We also submit a Provider Termination Work Plan within 10 business days of our notification to the Division of the termination and provide weekly status updates to the work plan.

Identifying and Notifying Members of Provider Loss

When we face circumstances that may result in losing a large provider group or health system, such as when we receive requests for renegotiation, we work collaboratively with the provider to arrive at a mutually agreed upon contract to prevent termination. In those instances where we have a termination, given the impact the loss of a large provider/health system can have, our process proactively prepares for termination in the event we are unable to reach agreement. We activate our internal provider termination team, consisting of staff from member services, provider network contracting, provider services, claims, utilization management (UM), care management, marketing, and communications teams to manage all aspects of the process. By the time we receive a termination notice, we have already initiated our policies and procedures to identify affected members, assess member needs and identify alternative providers, notify members and provide information to assist them in choosing alternative providers. Upon provider loss, members always have the option to select a new network primary care provider (PCP) of their choice. We perform and analyze members' health care needs and provider preferences, and use the information to inform and assist members in choosing network providers that meet their needs.

Identifying Affected Members: Within our claims systems, we identify affected members by generating reports of provider attribution and claims history, including at a minimum, hospital, ancillary, primary care, specialty, behavioral health, medications, and social support services. Through this process, we identify members most likely to be at highest risk of disruption, such as those with high frequency of provider visits or enrolled in care management. We also review affected members' profiles and provider preferences using a member 360 review, which includes demographic, cultural, and linguistic information, preferred language for communication, and insight regarding preferred methods of receiving communications (i.e., text, mail).

Identifying Alternative Providers: After considering the member's history and current service needs, including social determinants of health (SDOH), we identify available alternative providers located within the required time and distance standards that have characteristics similar to the preferences informed by the 360 review. We consider the group/health system's primary care and specialty capabilities in this analysis, and proactively contact providers to ensure ability to accept our affected members.

Notifying Members: We notify members of the provider loss through letters and phone calls. Our provider termination team obtains prior approval from the Division of our member notification letters and ensures the timely delivery of letters within the later of 30 calendar days prior to the termination effective date or within 15 calendar days of receipt of the termination notification. We enter the provider termination letter into our network system, which starts the member notification process.

The letter notifies members of the provider loss and their ability to select a new PCP of their choice. We share information with members to assist them in making an informed selection and provide a list of at least two alternative network patient-centered medical home (PCMH) certified PCPs that we identified using our analysis. Our letter also communicates that if the member does not select a new PCP by a specified date, we will auto assign one using the member's provider preferences from our member 360 profile and our PCP attribution algorithm. We send the letter through US mail based on the member's address on file. We add this letter to the member portal and send a text to the member notifying them of the letter in their member account.

If the member does not make an active selection by the date stated in the letter, of if we are unable to reach a member, we proceed with auto assignment based. We mail a new member identification (ID) card to the member, which we also make available through the member portal. We send the member a text notification that the new ID card is available to view and print through the member portal.

In addition to letters, we proactively contact all affected members, dedicating particular attention to members in care management. For members in care management, their established care manager contacts the member, coordinates all services, and manages the transition. For members not in care management, our member services team performs proactive outreach to further discuss members' preferences in a PCP and aid them in selecting the network PCP of their choice. We know that provider loss can have a disruptive impact on member care. We treat members with empathy, ensuring we consider all aspects of a member's health care, including SDOH, in providing assistance.

b. Automated systems and membership supports used to assist affected Members with Provider transitions;

Through our provider termination team, we proactively make all internal departments aware of potential loss of a large provider group/health system and status of negotiations well in advance of a formal notification of termination. Our provider network contracting team shares reports on active network negotiations with the provider termination team, and proactively inform care managers of potential terminations. We inform team members of official termination notices as soon as we receive them. As described previously, we use automated systems to identify members affected by provider loss, analyze their history of services and provider preferences, identify alternative providers available, generate member notification, and auto assign (if needed) to a new PCP. We use various systems and membership supports to assist members affected with provider transitions, such as:

Care Management and Member Services Teams: We provide personalized assistance and proactive notification to members in active care management, where our care manager leads transition of care and coordination between members and providers and provides support with scheduling appointments. For members not in care management, our member services team performs these services. Our care management and member services teams reach out to affected member in anticipation of the official termination notice and network loss.

Open Authorization and Claims Report: We run open authorization and claims reports to understand members' service needs and current treatment plans. While already known to the care manager for members in active care management, these reports reconfirm the information, and provide valuable information for members not in care management.

Continuity of Care: Our care management and member services teams work with UM to ensure all authorizations and supports are in place to facilitate continuity of care for members as they go through their treatment protocols, to continue for at least 90 days.

Scheduling: Our care management and member services teams provide membership support by helping members to reschedule upcoming appointments and routine screenings, and to schedule new patient and well-person visits with their new providers. We also address any specialty needs, and for members in care management, update their treatment plans. We continue to administer transportation for members to their appointments.

Community Based Organization Engagement: During these difficult and disruptive times, we continue to leverage social programs to support members. While this is part of our care management process on a continuous basis, we continue to connect members to social programs as necessary.

Systems Updates

We update our automated systems to reflect the terminated status of providers as of the termination date. These updates help ensure timely and accurate information for our members, providers, and internal teams, and ensure our ability to continue timely and efficient operations throughout and after the transition. System updates include:

- **Directory and Claims System:** We remove providers related to the terminated entity from both print and electronic versions of the provider directory.

- **Claims System:** We process any affiliated provider claims as out of network (OON) for dates of service after the termination effective date.
- **UM:** We reflect the terminated provider as OON, and our UM staff plan accordingly when authorizing care for dates of services after the termination effective date. UM also has visibility into the termination before the official termination effective date.
- **Care Management:** We update members' care plans and information regarding members' new interdisciplinary care team (ICT) and related providers in our care management system.

c. Systems and policies used to maintain continuity of care of Members experiencing Provider transition;

Our Continuity of Care policy delineates that we authorize members to continue an ongoing course of treatment, for up to 90 calendar days from notification, with their terminated provider (excluding those providers terminated with cause). We ensure we include all relevant services when providing for continuity of care, including but not limited to hospital, physicians, ancillary services, behavioral health, and prescriptions. For example, we perform medication reconciliation and ensure members receive ongoing prescriptions once they transition from their terminating provider to their new provider.

Our care managers are highly trained in supporting members through transition periods. They increase collaboration among all providers on a care team and ensure our members remain connected to high-quality care, including primary care providers, specialists, durable medical equipment vendors, and pharmacists. Care managers work with UM to ensure all authorizations and supports are in place to facilitate continuity of care for members as they go through their treatment protocols. We ensure continuity of care for at least the following instances:

- During the previous 12 months, the member was treated by the provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized
- An adult member with a previously scheduled appointment, with exception for a well adult visit
- Any eligible child with a previously scheduled appointment
- Any pregnant member – we allow all care to continue through delivery and postpartum period.

In addition, as part of continuity of care that each member's information is available for the next care provider, we ensure that newly assigned providers can easily access information regarding their new patients' diagnoses, visit history, dispensed medications, and other services. We assist with the transition of medical records from the terminating provider to the new provider in this effort. We also display members' details to their new providers in our provider portal.

d. Approach to cover membership needs with existing network resources following terminations.

We perform a network disruption analysis to identify potential gaps due to a large provider/health system loss, and implement the following approaches to ensure members receive care within our network:

- Ensure members under active care face no disruption by allowing members to continue care with their existing provider for up to 90 days.
- Maintain open authorizations that allow us to transition authorizations to another provider. We use the new provider identification process described previously, offering support through our care management and member services teams.
- Assess network adequacy, starting before the termination, to identify potential gaps and activate recruitment efforts to secure additional capacity. We perform routine GeoAccess analysis to help identify network gaps and continue weekly analysis through the transition period until we have resolved any network gaps. We overlay GeoAccess results with assessment of member needs through claims and member profile analysis, and promptly employ recruitment efforts to resolve network gaps. We update our recruitment work plan to guide our efforts.
- Leverage relationships with our other existing provider partners to encourage them to expand their capacity during these times of transition.

If we cannot cover needs with existing network resources, we ensure members receive access to care by providing authorization to OON providers and/or completing single case agreements with OON providers, providing transportation to a network provider outside of the geographic area, and offering use of telehealth to help bridge network gaps.

Loss of Large Provider or Health System Case Study

To illustrate our process the following case study follows our member, James, who lost his provider and how we, along with his care manager, Linda, helped him navigate the loss. In this example, we received a termination notice on June 30th from a large health system with which we have been in negotiations for the past six months. We proactively notified the Division of the renegotiation request in January. We also notified the Division of our receipt of the termination notification in writing on July 1. We submitted our Provider Termination Work Plan to the Division on July 7 and provided weekly updates thereafter. Table 4.2.2.2_C shows our detailed process to address the provider loss.

Table 4.2.2.2_C: Process to Address Provider Loss

Process	Description
Communication	We entered the termination letter into our network system on July 1, which starts the member notification process. The provider termination team ensures the timely delivery of member notifications by August 2.
Member Profile and Preferences	Our member 360 review shows James is African American, his most recent physician was also African American, and he prefers a male African American PCP. James' primary and preferred language for communication is English and his preferred methods of receiving communications are mail and text.
New Provider Identification	Our process identifies two other health systems that offer PCPs near James. Based on James' history and current service needs, we identify the health system that can best serve his health needs.
Member Notification	Care manager Linda proactively calls James on July 17 in anticipation of the network loss and notification letter to James. We informed Linda of the official termination, though she was aware of this possibility through prior communication and reports on active network negotiations. On August 2, we send a letter to James notifying him of the hospital and PCP loss and his ability to select a new PCP. To aid James, we provide a list of at least two alternative network PCMH certified PCPs. Our letter also communicates that if James does not select a new PCP by the date indicated, we will auto assign one to him using his provider preferences from our member 360 profile and our PCP attribution algorithm. We added the letter to the member portal and sent a text to James that he has a letter waiting for him in his account.
PCP Selection	James declines to make an active selection by the required date and we proceed with auto assignment to internal medicine physician Dr. R, MD, a PCMH certified PCP located 14.8 miles away from James' home. We mail new ID cards on August 15 and make them available through the member portal. James receives a text notification that his new ID cards are available for viewing and printing through the member portal
Care Management Coordination	Linda leads transition of care and coordination between James, providers and any supports he needs with scheduling appointments.
Open Authorization and Claims Report	On July 15, we run reports to understand James' service needs and current treatment plan. While already known to Linda, this reconfirms James' active course of radiation treatment for prostate cancer.
Continuity of Care	Linda works with UM to ensure all authorizations and supports are in place to facilitate continuity of care for James as he goes through his treatment protocol, which extends beyond the final in network date of September 1.
Scheduling	On August 16, Linda works with member services to help James reschedule his routine screening colonoscopy and schedule a new patient and well-person visit with Dr. R. Linda addresses any cardiology or gastroenterology needs and updates James' treatment plan. We previously confirmed that these services and providers are available at Baptist and continue to administer transportation needs. Linda continues to leverage any social programs to support James.
Systems Updates	As of September 1, we update our systems to remove all OCH providers from the provider directory, to show affiliated provider claims as OON in our claims system, and to reflect OCH as OON in our UM and care management systems. By September 1, Linda has already updated the care plan and information on James' new ICT and related providers.

4.2.2.2.A.7 Describe any Provider incentive programs the Offeror plans to implement to improve access and the quality of care.

As a CCO committed to change the trajectory of Mississippi's healthcare system our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing state resources.

We tailor our provider incentive programs to facilitate the achievement of the continuous quality improvement (CQI) initiatives outlined in the Division's Comprehensive Quality Strategy, including but not limited to maternal and infant health, chronic disease, behavioral health, health equity, and child and adolescent health. By design, our value-based purchasing program incentivizes providers to improve quality in order to receive value-based payment (VBP) and complies with all state and federal laws, including the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210. All providers have the opportunity to participate in a value-based program that aligns with their present capability and tolerance to take on risk. We provide the necessary supports to help them move along a continuum toward more advanced VBP models, including population-based payments, such as capitation, and full risk VBPs tied to the achievement of set quality goals.

- Inclusion of specific, measurable, achievable quality goals.
- Timeliness of incentive payment distribution
- Pay for performance and incentive payments that are separate from usual reimbursement.
- Incremental incentives aligned to tiered quality outcomes for multiple opportunities to earn incentive payments.
- Consideration of an administrative attributed member per member per month (PMPM) payment to facilitate dedicated staffing

Prioritizing Quality Improvement Incentives

Our VBP program is the engine that powers our provider incentives. We have a proven track record demonstrating our program's success in improving the health outcomes of our members. For example, some of the Healthcare Effectiveness Data Information Set (HEDIS®) measures where our performance meets or exceeds the 75th Percentile in our markets include Adult Access to Preventive/Ambulatory Health Services, Comprehensive Diabetes Control – Blood Pressure Control (<140/90), Comprehensive Diabetes Control – Retinal Eye Exam, Follow Up After Hospitalization for Mental Illness – 30 Days, and Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. We will commit to taking a leadership position and collaborating with other CCOs to focus on similar quality measures, and therefore increasing quality overall.

The design of our VBP continuum allows us to offer incentives to providers that match their level of experience and readiness. For example, we have options tailored to providers who have limited experience with VBP that are administratively easy, and we also have incentive structures to suit providers who are able to engage in more complex risk arrangements. We currently offer incentives for a variety of quality measures that align with the Division's Continuous Quality Improvement (CQI) goals. Our incentives span across all of the VBP programs on our Path to Value, affording providers engaged at any level on the continuum the opportunity to receive reimbursement for elevating care delivery and affecting improvement in member health outcomes. To incentivize participation in certain VBP arrangements, we plan to offer support for provider connection to a statewide HIE to equip the provider with better resource to manage patient care.

Path to Value

In addition to a foundation in behavioral economics, our approach to the design and implementation of value-based programs is a Path to Value based on the Healthcare Payment Learning and Action Network (HCP-LAN) Advanced Payment Model (APM) framework and links our providers to quality outcomes as a requirement for receiving financial incentives. This Path to Value elevates and supports providers along a stepped continuum and includes an array of models departing from the traditional fee-for-service (FFS) architecture and graduating in financial risk and reward toward the most complex integrated delivery system structure. Our comprehensive VBP program meets providers where they are, incentivizing them to improve the quality of care they provide to members, while reducing health care costs.

Incentive Programs

We understand value-based care is essential to facilitating CQI, and with the success of our VBP arrangements, we build networks effectively rooted in value-based care. We also understand that providers have varying levels of capabilities and experience with VBP, and we offer practice transformation consultation to walk alongside providers on the Path to Value to support the highest level of incentive payment achievement and improvement in member health outcomes.

Pay for Reporting (P4R)

Our Pay for Reporting (P4R) program is the first step on our Path to Value, providing incentives to primary care providers (PCPs) including Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and obstetricians and gynecologists (OBGYNs). **100% of our PCPs are eligible to participate in our P4R program.** Our model **prioritizes preventive care** and includes incentives for HEDIS® measures that directly correlate to the Division's quality priorities including, for example:

- Timeliness of prenatal care and postpartum care
- Controlling high blood pressure
- Comprehensive diabetes care HbA1c control
- Diabetic retinal exams
- Kidney function monitoring
- Medication reconciliation
- Breast cancer screening
- Colorectal screening
- Immunizations
- Adult ambulatory preventive care
- Annual well visits
- Well-child visits
- Pediatric body mass index
- Lead screening
- Screening for depression ages 12 years and older
- Developmental screening in the first three years of life

Our P4R program is administratively easy. We capture services related to the quality measures through the regular claims submission process and pay incentives to providers on a quarterly basis. Providers who earn P4R payments receive a separate payment either through EFT or paper check along with a letter indicating that the payment is for P4R performance activities. This payment process allows providers to easily identify and separate the P4R payment from their fee-for-service reimbursement. Providers also have access to VBP tools, including our reporting platform, and provider services staff to support engagement and success.

Social Determinants of Health (SDOH): We understand societal and environmental conditions such as food, housing, transportation, education, violence, social support, health behaviors and employment effectuate individual health outcomes more than traditional medical interventions. We seek to capture SDOH information with the help of our network providers who are on the front line of care with members. Our P4R program offers additional reimbursement to providers for reporting Z Codes on claims. This information augments our complex population profile for the purposes of developing, implementing, and refining interventions through care management activities.

Maternal and Infant Health: We recognize the criticality of ensuring pregnant members receive prenatal care as soon as possible. We offer a **Notice of Pregnancy** incentive payment for each notice of pregnancy form we receive. Receipt of notifications helps us to connect the member to the supports she needs to receive comprehensive, high-quality prenatal care as well as screen for and address any SDOH issues that may impact a healthy pregnancy and birth outcome.

Increasing Access to Care: We offer enhanced reimbursement through our telemedicine P4R program, which offers incentives to providers for conducting select HEDIS® measures and providing ADHD services through telehealth technology. By tying the provision of these services to HEDIS® measures, we are able to track improvements in quality and health outcomes.

Health Risk Screenings: Community Based Organizations (CBOs) play an essential role as central hubs for a variety of member services. We recognize their importance of affecting health outcomes and partner with and incentivize CBOs to complete health risk assessments as part of our P4R program.

Pay for Performance (P4P)

P4P is a pay for performance program addressing the complex needs of our members through a coordinated system of care and is the next step along the VBP scale. While eligible practices do not need to be National Committee for Quality Assurance (NCQA©) certified as a Patient-Centered Medical Home (PCMH), the P4P program supports the PCMH philosophy of a team-based approach to health care delivery.

The P4P Program compensates practices for obtaining maximized health outcomes through a coordinated system of care that includes comprehensive primary care, referral to specialty care, acute care, behavioral health integration and referral to community resources.

Our P4P Program uses the following payment model:

- Fee-for-service payments.
- Per-member-per-month Care Coordination Transformation (CCT) fee practice infrastructure payment to support transitioning from volume performance to quality-centric population health management.
- Quality incentives based on clinical outcomes measures. Providers are incentivized for each metric-related service for which they meet or exceed the established target.

Our P4P Program offers providers multi-level opportunities to earn incentive payments on quality measures. Quality measures are tied to one or more target achievement levels. With this tiered structure, providers have multiple opportunities to earn incentive payments – the higher the tier achieved, the higher the corresponding incentive payment. Timely and actionable reports are available to give providers regular insight into determining which care and referral decisions contribute to optimum results for quality, outcomes, and value.

Practice Transformation: We recognize practices often need significant capital to transform their services to participate in value-based care including our tier two P4P and tier three Shared Savings and Total Cost of Care (TCoC) programs. We offer financial support through prospective PMPM to help defray costs related to the adoption of the PCMH model and the associated NCQA accreditation. Providers can also use practice transformation funds for technology investments that allow for data sharing between us and the provider.

Patient-Centered Dental Medical Home: This P4P program is for general and pediatric dentists and combines partial capitation and incentive payments with higher reimbursement for preventive dental care tied to quality metrics. Additional non-monetary incentives associated with this program include recognition awards and eliminating prior authorization requirements for certain procedures.

Health Equity: We design payment incentives to reduce health disparities in quality of care, outcomes, and patient experiences and our health equity goals align to the Division's quality priorities, such as:

- **Access:** Increase the percentage of pregnant Black Mississippians seen for first trimester prenatal care.
- **Process:** Increase screening for Latina pregnant individuals for pregnancy related health conditions and risk levels.
- **Outcome:** Increase controlled HbA1c among pregnant individuals with diabetes.

Our interdisciplinary population health team uses data and tools to identify both populations (i.e., members with high-risk pregnancies, members with diabetes) and individuals with the highest risk for poor health outcomes. We use this data to establish regional **Health Equity Zones** and implement incentives for providers who are historically underfunded and who serve members with low incomes in areas of high social vulnerability.

Shared Savings

Our Shared Savings program offers providers an opportunity to earn financial incentives if they achieve an overall Medical Loss Ratio (MLR) reduction target (based on historical data) and meet quality metrics tied to provider performance. Shared Savings programs include upside only (share of savings achieved) or upside and downside risk (share of savings, penalties for exceeding MLR targets).

Community Mental Health Centers: We will build on our experience with complex populations in other markets by partnering with Community Mental Health Centers (CMHCs) to implement our Complex Health Serious Mental Illness (SMI) project starting in Region 6. Our integrated care coordination model offers concierge level service to providers in training, case support, prior authorization support, transition of care support and data sharing for individuals with SMI who have rising risk for comorbid physical health conditions. We incentivize CMHC providers through our quality improvement VBP program. The applicable VBP program from our Path to Value is determined through our assessment of the CMHC's capacity to engage.

Incentive to Reduce Administrative Tasks Related to Authorizations
We offer a program aimed at reducing administrative burden by allowing providers to bypass our standard outpatient prior authorization process for several services. Using our data analytics tools to review quality and performance measures we identify high-performing providers to qualify for this program.

Incentive Implementation and Provider Support
Supporting providers in delivering better patient care is a key tenant of our value-based care provider engagement philosophy. Our locally based, regionally assigned PRs not only address traditional provider concerns, such as those related to billing and claims, but quality as well, such as working with providers to implement interventions to address gaps in care. Frequent touchpoints and communications are the hallmark of our dynamic provider engagement process.

Provider feedback is critical to quality incentive program design and refinement. We engage providers through multiple channels including, for example, our Provider Advisory Council, provider satisfaction surveys, webinars, targeted outreach, our provider portal, and monthly joint operating committees. These avenues allow us to learn about issues affecting providers, identify challenges and barriers, problem solve, share information, and collaborate to improve care delivery through timely data sharing, provider supports, and emphasis on practice transformation. We continuously explore opportunities to develop new innovative VBP models and aligned provider tools that drive transformation and promote population health improvement.

Data Sharing and Reporting
A key component of successful VBP implementation is data sharing and reporting. We provide bidirectional data sharing and reporting to our providers to support driving population health improvement and earning the highest degree of VBP offered through our multiple provider incentive programs**. We contract with population health technology companies,** where we offer direct EHR data sharing with large health systems, FQHCs and RHCs. As part of our agreement, the population health company communicates directly with the provider's EHR vendor to tailor a solution for data sharing. Our integrated bidirectional platform for medical records and for delivering gaps in care reports every 24 hours. Data sent daily from us to the provider's office generates a monthly data extract for members assigned to the group but who have not received care. Our integrated bidirectional data connectivity platform is **already established,** and we will commit to making real-time data available to any other participants in the program so that we have a consistent framework among all CCOs. To implement this service, we will **collaborate with local health systems, associations, and providers.** For example, where possible, we work with local associations and their members to jointly define contract terms, and how-and-what data to send to the provider's EHR platform. Through this process, we develop a standardized data template using provider feedback, HEDIS® measures, outcomes goals, and address overall needs of the FQHCs. Building a standardized template based on the providers' suggestions enables each location to work together through the association to prioritize preventive care and share information electronically between us and the provider.

4.2.2.2.A.8 Explain the Offeror's proposed process to maintain the Offeror's Provider file with information about each Provider sufficient to support Provider payment including the ability to:

a. Issue IRS 1099 forms, b. Meet all federal and Division reporting requirements, and c. Cross-reference to state and federal identification numbers to identify and report excluded Providers.

We verify and certify to the Division that all network providers and any out-of-network (OON) providers, to whom we may refer members, are properly licensed in accordance with all applicable state and federal regulations. We maintain a comprehensive provider file in our claims processing system that allocates all necessary information to ensure accurate provider payments, including information regarding taxpayer identification number (TIN), National Provider Identifier (NPI), licensing, specialty details, and group or facility information. The provider file also includes information required in Appendix A, Section 6.5. We conduct reviews to ensure that providers excluded from Medicaid are also excluded from our provider network. We maintain all excluded providers (sanctioned providers) in a separate database and appropriately use while processing claims. Each month, we cross-reference our existing provider file with an external vendor to assess

issues including, but not limited to, state and federal sanctions, licensing issues, and malpractice claims. We notify the Division if we find a sanctioned provider is submitting claims.

Ensuring Provider Payment/Issuing IRS 1099 Forms
We employ an online bill payment portal to produce all provider and vendor 1099 forms. The online bill payment portal is diverse, allowing for ease of payment processing using the Electronic Funds Transfer (EFT) option, offering the flexibility of mailing paper checks if preferred as a method of payment, and creating Explanations of Payment (EOP) reports, should a provider request them.

The online bill payment portal's direct interface with our claims processing system ensures that our claims are accurate and paid to our providers in a timely manner. Our contract with the bill payment portal includes timely payment processing and financial accuracy through service level agreements. We also produce Health Insurance Portability and Accountability Act compliant 5010 national standard 835 files. We pay providers that are not enrolled for EFT by check and send a paper EOP to them. We ensure that any non-electronic payments are still reflected in any reports related to a provider payment.

Meeting Federal and Division Reporting Requirements
We use a supply chain management (SCM) platform to operate our financial business. Considered an industry standard in ensuring best practices and for meeting all federal and Division reporting requirements, SCM allows us LEAN methodology in planning, budgeting, forecasting, and consolidating capabilities. We store and process all financial data according to Generally Accepted Account Principles (GAAP) guidelines. Our Accounting teams keep a separate statutory ledger within this program that crosswalks changes between GAAP and the statutory basis statements issued to the state.

Cross-Referencing to State and Federal Identification Numbers
Federal and state provider agreements prohibit us from knowingly having relationships with a provider who is debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities. A *relationship* is defined as – a director, officer, or partner of our organization, a person with beneficial ownership of 5% or more of our plan, and a person with an employment, consulting, or other arrangement with our plan. To verify that we do not have relationships with prohibited affiliations, we check the System for Award Management-Excluded Parties List System (SAM-EPLS) and the Health and Human Services-Office of the Inspector General (HHS-OIG) websites.

The credentialing team certifies all providers when credentialed and recredentialed and performs cross-referencing on a minimum of a monthly basis. We also check providers against SAM-EPLS, HHS-OIG, National Practitioner Data Bank (NPDB), and state disciplinary action memos. We compare all delegated entities/vendors against both the SAM-EPLS and the HHS-OIG websites monthly. It is our policy to terminate the relationship immediately if we discover we have a relationship with a debarred individual or entity.

4.2.2.2.B. Provider Services Call Center

4.2.2.2.B.1. Describe the Offeror's Provider services call center operations including:

a. Hours of operation; b. Describe how the Offeror will ensure call center employees will have cultural competency; c. Specific standards for rates of response (e.g., live answer, incomplete calls, speed of answer, average length of call, abandonment rate, call monitoring requirements) and measures to ensure standards are met (the Division retains the right to approve all call center standards); d. Training program for call center employees including local and statewide cultural competency; and, e. A description of any plans to use electronic communication to respond to Provider inquiries.

We are **committed to changing the trajectory of Mississippi's healthcare system**. We will bring a new era of provider collaboration to Mississippi via **a transparent service delivery model which fully integrates with most Mississippi providers and offers real-time bidirectional data exchange**. We will ensure Mississippians can easily access their benefits, our next generation member engagement and education, and community-based coordinated care to help them lead healthier lives while we prudently manage State resources.

Our provider services staffing model has a dedicated, full-time manager to lead our team in Mississippi, including the oversight of the provider services call center. Part of our overarching provider services hiring

strategy is to ensure we attract diverse leadership and frontline workforce representative of the members and providers we serve. With a firm commitment to ensuring a positive experience for all providers, we will staff the provider services call center with highly qualified, well-trained employees. **Our ability to deliver call center operational excellence demonstrates we are a worry-free partner of the Division.** Our Mississippi-based provider call center staff members (who reside in the State and represent state demographics) will undergo State-specific training to ensure optimal support to the provider community. We pride ourselves on first-call resolution for our providers. Our automated call distribution system offers specialized, efficient call routing capabilities to connect providers directly to the appropriate department, significantly reducing the need for call transfers.

Hours of Operations

In accordance with Draft Contract, Section 6.9.1, the provider services call center hours of operation will be 7:30 a.m. to 5:30 p.m., Central Standard Time, including State holidays, with an after-hours provider voicemail option for providers who attempt to reach us outside of the stated business hours. We will provide a 24-hour utilization management line for any after-hours post-stabilization or emergency prior authorizations, ensuring providers in need of emergency assistance can access support 24 hours per day, seven days per week. To avoid any interruption or disruption of member care, we will respond to provider voicemails within one business day. **We offer an online chat option during regular business hours to support providers who prefer this option.** The provider services call center is separate and distinct from the member services call center. Our Interactive Voice Response (IVR) system, available in both English and Spanish, gives providers self-service options inclusive of checking status of claims and authorization information.

Using interactive call scripts (submitted to the Division for review and approval 60 calendar days prior to use), call center staff will assist providers with questions related to member eligibility status, prior authorization, and referral procedures, claims payment procedures, disputes, and grievances, and promoting the use of our web-based provider portal. We will use special scripts for emergency and unusual situations, as requested by the Division. We review all scripts annually to determine any necessary revisions. These call scripts educate providers on covered and non-covered medical services and benefit limitations, facilitate the transfer of member medical records among and between providers, and refer providers to our Fraud, Waste, and Abuse hotline. Call center staff members are also responsible for collaborating with utilization management and care management to coordinate the administration of out-of-network services.

Ensuring Call Center Employees Have Cultural Competency

We train, mentor, and monitor all employees, including call center staff, to interact with all members and providers in a culturally competent way that meets the social, racial, and linguistic needs of the community we serve. Call center staff undergo live and online training, as fully described following, to foster cultural humility and cultural competency, specific to local and Mississippi demographics. Provider services hires local leadership that stays in touch with the local and cultural needs of the community. They are engaged with community partners, providers, and local and state leadership to ensure they are in tune with the cultural needs of the local members. Our leadership meets regularly with local and state leadership to ensure appropriate actions and interventions are taking place that best support members' cultural and social needs. We ensure our call center employees have an in-depth understanding of our members using system alerts, team meetings, and individual one-to-one sessions to better serve our provider needs when they call.

Specific Standards for Rates of Response and Measures to Ensure Standards are Met

We are dedicated to exceeding the State's standards outlined in Draft Contract, Section 6.9.1.2. **Nationally, our provider services call centers consistently exceed contractual performance targets for average speed to answer, percent of calls answered by a live agent within 30 seconds, and call abandonment rate.** Call tracking statistics are run in real-time and reviewed in 30-minute increments to monitor performance and to adjust, as necessary, with service level performance reports provided to the State quarterly. Table 4.2.2.2_D includes a few examples of our performance from 2020 and 2021.

Table 4.2.2.2_D: Call Metric Performance

Performance Metric	Target	2020				2021			
		Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
Live Answer (Average Speed of Answer)	≤ 30 sec	17 sec	4 sec	9 sec	19 sec	15 sec	15 sec	14 sec	19 sec
Percent of calls answered within 120 seconds	≥ 80%	90.94%	91.84%	92.54%	91.32%	92.20%	92.44%	92.74%	93.17%
Incomplete Calls (Abandonment Rate)	≤ 5%	1.53%	0.30%	0.77%	1.83%	1.37%	1.79%	1.28%	1.59%
Average Call Length	N/A	7:30	8:04	7:17	8:37	8:38	8:39	8:48	9:34

Measures to Ensure Standards are Met

We will prioritize the achievement of call center sufficiency standards described in Draft Contract, Section 6.9.1.2 and any additional standards the Division develops. We take strategic measures to ensure standards are met. Our workforce management strategy includes: Demand Forecasting, Staffing Requirements, Recruiting/Logistic Support, Optimized Scheduling, Real-Time Management, and Performance Reporting. Our Workforce Management and Development team adjusts our plan to the changing needs of our provider community and to be responsive to those needs with no disruption to the provider. Our telephone and call routing system also enables a provider-friendly call back feature that, in the event of any spikes in volume, holds the providers' place in line and allows them to receive a call back.

There are numerous variables that impact staffing requirements, including volume, average length of call, membership, season, time of day, and planned events. Our delivery model includes forecasting, scheduling, hiring logistical support, and real-time management to ensure state standards are consistently exceeded. Workforce planning and monitoring tools provide reporting and analytics that deliver a transparent view of performance and insights to make the right decisions.

For quality assurance purposes, our call recording solution has a speech and data analytics component that allows us to record and analyze 100% of our calls. We maintain call recordings for three years, exceeding the 12-month requirement. The analytics allow us to specifically target calls for opportunities based on data attributes such as tone, word choice, volume, hold time, and length of call. We complete evaluations on 3% of calls attached to those targeted trends and themes. We fully cooperate with all reporting and auditing requirements with the Division, including the monthly and quarterly deliverable reports, and all requested recordings are available within five business days. Our monthly deliverable report includes call center staffing ratios and our recommendations to the Division regarding appropriate staffing based on call center sufficiency standards.

We review trends in calls each month compared to the previous six months through our call trend report to determine reoccurring issues among providers, conduct root cause analysis, and create resolutions to address the barriers. **Over the past two years, our proactive outreach, provider self-service tools and issue resolution have resulted in a 24% reduction in provider calls for assistance.** We will provide a monthly call trend report noting the most frequent categories of calls to the Division monthly. We will resolve issues presented to us by the Division within 10 business days of receipt from the Division.

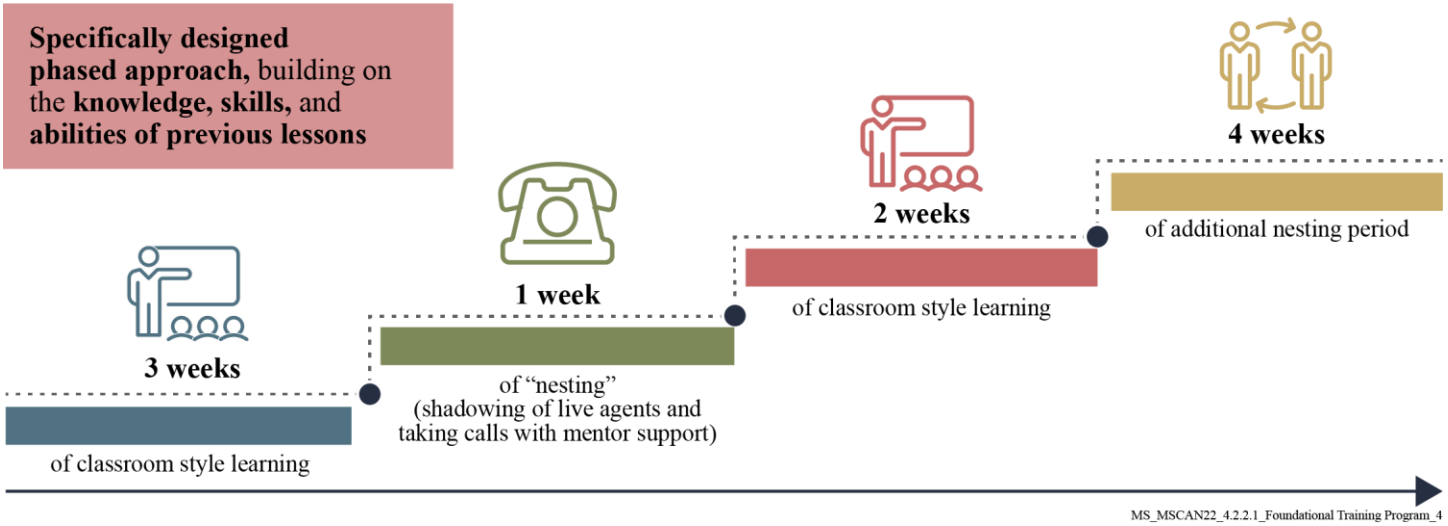
In compliance with Draft Contract, Section 6.9.1.2, we have a back-up system in the event of a power failure or outage to operate the call center for a minimum of eight hours at full capacity without interruption. We will notify the Division immediately if our phone system is on an alternative power source or is inoperative. We will submit our plan for outages to the Division for approval no less than 60 days prior to start date. This plan includes the details of our system, notification requirements, and manual back-up procedures.

Training Program for Call Center Employees Including Local and Statewide Cultural Competency

We recognize our provider services call center staff members require in-depth, quality training from the onset, followed by recurring training. In compliance with Draft Contract, Section 6.9.1.1 our new hire training program (Figure 4.2.2.2_C) offers a specially designed phased approach that builds upon the knowledge, skills, and abilities of previous lessons. Our 10-week training program includes three weeks of classroom-style

learning about our organization and the unique needs of our provider community, along with training on Medicaid, MSCAN, and Children's Health Insurance Program (CHIP), as required. We also provide ongoing training and updates to staff including "Late Breaking News" articles, provider bulletins, State Plan Amendments, CHIP State Health Plan Amendments, Administrative Code Filings, Provider Billing Handbook, and MSCAN and CHIP, and the number and positions of staff completing the trainings to the Division.

Figure 4.2.2.2_C: Provider Services Call Center New Hire Training Program
Using a phased approach to training, we drive superior service to our providers.



Knowing that things change often, we have established multiple ways to ensure our employees have the most current information to successfully service our providers. This includes:

- Real-time alerts to staff regarding changing procedures
- Targeted updates within team meetings and one-on-one coaching sessions
- Monthly and quarterly video-based micro learnings, work process reviews, and automated staff acknowledgement of information application
- Scheduled classroom training, where needed, to ensure adoption of new process and procedures

Local and Statewide Cultural Competency Training

Our leadership participates in an enterprise workgroup on cultural competency committed to advancing National Standards for Culturally & Linguistically Appropriate Services (CLAS). This high-level workgroup includes investing in employee education and training regarding social determinants of health (SDOH), health disparities, health inequities, and the importance of cultural competency. Our model includes educating and training governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. We address cultural, linguistic, and health literacy barriers proactively by requiring staff to attend cultural sensitivity training programs at hire and annually, at quarterly events, and as part of continued education and reinforcement programs. Curriculum includes:

- Health literacy, CLAS, commitment to health equity, culture, and diversity awareness
- Member health, safety, and welfare program
- Experiential poverty simulation which focuses on the challenges of living in poverty to provide employees with perspective on the social and economic barriers faced by our members
- Religion and culture and their influence on health care

All employees are required to take **Implicit Bias** and **Mitigating Bias** courses offered through a large state university. These courses were rolled out to the entire organization in 2021 and are assigned to all new hires for completion within their first 30 days. All employees have an annual training requirement related to Diversity, Equity, and Inclusion (DE&I) and cultural competency. This year, all employees are required to complete our

Complex Population course series which is designed to inform our staff on the changing needs of our members, and the providers that serve them. We refresh courses quarterly as nuances change for our members. How providers prioritize care is important to stay connected to their needs. The first three courses in this series were implemented in December while the next three will be assigned in second quarter. Other online DE&I courses available in our learning management system that could be assigned to any employee include:

- DE&I: Understand and Embrace Diversity
- DE&I: How to Create a Respectful Workplace
- DE&I: Fostering Inclusion in the Workplace
- DE&I: Unconscious Bias

Additionally, we will leverage Mississippi based, Alluvial Collective, to support a customized training curriculum that focuses on racial reconciliation. We have a shared desire to continually improve productive conversations about race and relationships.

Using Electronic Communication to Respond to Provider Inquiries

Our website serves as a central hub that houses pertinent provider information and communications. We post notice of changes to our operational processes and any new relevant information to inform both network and out-of-network providers. Notifications are also available on the provider website, where providers can retrieve and review communications at their convenience. We also offer several additional electronic modes of communication to providers, including:

IVR Self-service—Our best-in-class IVR system offers numerous options that enable providers to check the status of claims and authorizations, as well as to verify eligibility and benefits. For non-emergency or non-crisis issues, our IVR mailbox option enables callers to leave a detailed message to be returned the next business day. The voice mailbox provides clear instructions on how to leave a message and instructions regarding emergencies. **By incorporating feedback from our providers, we have continued to offer self-service enhancements resulting in 25% of all calls being fully resolved within our IVR.**

On-line Chat—We offer an online chat option during regular business hours to support providers that prefer an online option rather than a phone call.

Social Media Monitoring—We use social media to broadly promote messages related to Mississippi health equity, focus on the importance of quality, and reinforce important information around SDOH and the role we all play in contributing to member health and wellness. We monitor social platforms using social media moderation tools – and actively engage with providers if they choose to comment on our posts.

Secure Provider Portal—Our provider portal enables providers to easily access critical information. Providers can obtain documents, 24 hours per day, and execute online transactions. This portal serves as a key self-service tool for our providers and continues to redefine the ways in which our providers engage with us. The provider portal is a secure, encrypted online tool that enables quick access to information related to member care and enables providers to securely submit medical documentation for claims, disputes, and appeals up to 100MB in size. Providers can check the status of claims, authorizations, and credentialing, along with many other quick and helpful features that enable them to access the information they require including explanation of payment, authorization letters, and appeal letters.

Provider Mailbox—Providers who prefer to email us rather than use our provider services call center may do so by using a designated email address to respond to or resolve provider inquiries. We address provider inquiries submitted to us via our provider portal or directly emailed to us within two business days of receipt.

The provider services call center staff members responsible for responding to inquiries sent to our mailbox will have the autonomy and expertise to resolve issues on the spot. Further, our staff members responsible for jointly monitoring the mailbox are supported by our corporate teams. We set alerts for all email not addressed within 24 hours to quickly resolve identified issues and ensure exceptional support for our providers.

4.2.2.2.B.2 Describe how the Offeror will assess the quality and efficiency of the Call Center.

Our strategic performance achievement program rewards and incents our call center staff members and leadership to demonstrate behavioral competencies (*e.g., Personal Accountability; Training Achievement & Application)* and achieve Key Performance Indicators such as Provider Satisfaction, First Call Resolution and Interaction Quality Results. Our teams are empowered to resolve provider concerns immediately. We train our teams to adjust claims to allow for immediate resolution when appropriate. **All claim adjustments are audited, and teams are held accountable to achieve a minimum of 99.9% financial and 99% Procedural Accuracy related to claims resolution.**

When interacting with providers we want our staff members to focus on the quality of the conversation. We designed our interaction quality program to build a culture of coaching and continuous improvement at all levels including our call recording solution which has a speech and data analytics component that allows us to record and analyze 100% of our calls. The analytics allow us to specifically target calls for opportunities based on data attributes such as tone, word choice, volume, hold time, and length of call. We complete evaluations on 3% of calls attached to those targeted trends and themes. Performance dashboards allow us to celebrate success and target the largest area of opportunity for each staff member across all key metrics. We document personalized action plans and record them in our performance management system. We know providers need both a quality and efficient experience. In addition to our quality metrics, our dashboards include metrics such as average call length and hold time to allow us to provide additional coaching support to staff when individual performance for call length is +/- 5% of the team's average. **Over the past three years, we have seen a steady reduction in provider calls for assistance due to our high level of support and the availability of provider self-service tools.**

A brief post call survey is offered at the end of each call. Providers can rate staff on satisfaction and first call resolution, as well as leave recorded feedback for the staff member they worked with. **We maintain a national first call resolution rate of 92% and a satisfaction rate of 90%.**

We also use journey mapping as a routine part of our operations to analyze our processes and provider experiences for potential opportunities for improvement.

4.2.2.2.C. Provider Education and Communication

4.2.2.2.C.1 Describe how the Offeror will educate network PCPs/PCMHs about Care Management services, how to connect with Care Management, and how the Offeror will encourage PCPs/PCMHs to utilize Care Management. Include information about measurement of Care Management engagement of providers and how the Offeror will address providers who appear to be underutilizing the system.

We are a CCO committed to change the trajectory of Mississippi's healthcare system and bring a new era of provider collaboration to Mississippi. [redacted] Our overarching objective to provider education is to ensure **'success for every provider.'** We support PCP and PCMH success through education focused on integrated service delivery, care management services, and the value of these services to members. We accomplish this through new provider orientation, which is conducted within 30 days of the contract effective date, ongoing education, and technical assistance based on evidence-based adult learning principles tailored to meet providers' needs. Our approach for ongoing education and technical assistance includes personalized training provided on a quarterly, semi-annual, or annual basis depending on the size and needs of a provider's practice. We use multiple methods to deliver education, materials, and resources to providers including seminars/workshops, office visits by the assigned provider representative, Joint Operating Committee (JOC) meetings, and 24-hour access to recorded webinars and self-service training modules available via our website or our provider portal. Our training program complies with Appendix A, Section 6.9.3, Provider Education and Training and we will submit our comprehensive provider training manual and a prospective training plan no later than 60 days prior to the initial training for providers prior to implementation.

Educating Network PCPs/PCMHs about Care Management Services. Our new provider orientation includes information regarding integrated service delivery, care management principles, roles and responsibilities of the provider and our care managers, engagement expectations, and how to connect to care

management through our direct access referral process. In addition to new provider orientation, provider representatives visit with PCPs and PCMHs to promote the value of our care management program to members and answer questions about our services, including our fully integrated, transparent service delivery model of care (MOC). They also provide information about connecting to the health plan via the provider portal or by calling the provider services call center. MOC training reinforces the importance of the PCP/PCMH role in collaborating with the interdisciplinary care team (ICT), based on the needs of each member. We promptly address provider questions and concerns (including those of their staff) with follow-up meetings and check-ins to ensure long-term success.

Measuring Care Management Engagement of Providers and Addressing Underutilization. Within 6o days of award, we will deliver to the Division our plan to ensure PCP/PCMH's are interacting optimally with care management so that our members can achieve quality health outcomes. Our plan will include our methods for driving engagement, educating PCPs about care management, ways PCPs can interact with the care management system, ways to address health equity concerns, and best practices to ensure engagement. We will establish expectations for provider participation in care management and the ICT through our contracts, education, training, and technical assistance. Using a combination of predictive analytics, real-time bidirectional information sharing, and referrals, we identify and risk-stratify members who are eligible for case management. We will track engagement of all eligible members who enroll in case management by provider. This information will be available via real-time provider facing reports through the provider portal and shared with our PCMH providers regularly in JOC meetings. Members who do not engage will be reviewed with providers so they can assist with education and encourage members on the benefits of participating in care management. In high volume, under-resourced practices, we will embed care managers and work directly with the providers to promote appropriate utilization of care management services. Our community health workers (CHWs) will work with providers and local community-based organizations (CBOs) (e.g., food pantries, faith-based organizations) to conduct outreach to hard-to-reach members to engage them in care management.

4.2.2.2.C.2. Describe how the Offeror will educate network PCPs/PCMHs regarding how and when to refer a member for behavioral health/substance use disorder treatment, and how to collaborate with behavioral health/substance use disorder Providers and systems.

During initial provider orientation, we will introduce providers to our expectations regarding their roles as PCPs/PCMHs, including how and when to refer members for behavioral health (BH) and substance use disorder (SUD) treatment services and how to collaborate with other providers and systems of care. In addition to an introduction to the provider portal, PCPs/PCMHs will be educated on the availability of toolkits and clinical practice guidelines for opioids, depression and perinatal depression, autism, and attention deficit hyperactivity disorder (ADHD). With a keen understanding that many BH needs are undertreated, untreated, or simply undiagnosed, we will provide PCPs/PCMHs with targeted education and training opportunities on Screening, Brief Intervention, and Referral to Treatment (SBIRT) services and the availability and efficacy of screening tools such as the PHQ-9. We recognize providers may under-screen for BH and SUD if they feel there are no treatment options available. As part of our fully integrated service delivery model, our provider services, utilization management, and care management teams work in tandem to continuously share available treatment options and help close the referral loop when PCPs/PCMHs identify unmet BH needs. Providers can use a provider locator tool on our portal to assist with finding specialty BH providers, including community mental health centers, medication-assisted treatment, and outpatient SUD providers. Members can also self-refer for BH and SUD services. Self-referral services are explained through virtual and onsite new provider orientation sessions, the provider manual, information on the provider portal, online training webinars, provider newsletter, and quarterly Provider Advisory Committee (PAC) and JOC meetings. Members can also seek consultation from a BH/SUD provider on a real-time basis leveraging our telehealth vendor.

Collaborating with Behavioral Health/Substance Use Disorder Providers and Systems. We outline expectations for collaboration between PCPs/PCMHs and BH and SUD providers in our provider manual and trainings, highlighting the benefits of integrated care and encouraging network PCPs/PCMHs to collaborate with BH and SUD providers to sustain, strengthen, and spread recovery-oriented care models that meet the

needs of members. We commit that we will engage our providers and other stakeholders to build on the work of the Mississippi Department of Mental Health's interagency Integration Work Group and the vision established in the Roadmap for Integrated Care in Mississippi. Our provider services team will work closely with PCPs/PCMHs during on-site visits to help them build on their expertise and expand their capacity to support co-located and integrated services. We will routinely meet (e.g., webinars, forums, on-site visits, virtual visits) to build and foster new and existing relationships between mental health, substance use disorder, and physical health providers within and across each region. Recognizing the importance of collaborative care models, we will encourage our pediatric PCPs to enroll in the University of Mississippi Medical Center's Child Access to Mental Health and Psychiatry (CHAMP) program. We commit to providing a grant to expand access and support program sustainability. We will explore additional partnership opportunities to develop a similar collaborative care program for adults and welcome the opportunity to work with the Division to begin reimbursement for Psychiatric Collaborative Care Management codes (CPT codes 99492, 99493, 99494, and HCPCS codes G2214).

4.2.2.2.C.3. Describe how the Offeror will develop the Provider Manual, including brief descriptions of major sections.

Our comprehensive provider manual serves as an invaluable resource for clinical, operational, and administrative processes and information, as well as a reference guide in the administration of the State's program. We developed it with input from provider stakeholders, and it will conform to the Division's administrative and contractual requirements. This manual provides a wealth of information, including answers to common questions, policies, and procedures, claims submission guidance, and additional contact information. New provider orientation includes an in-depth review of the provider manual and the tools and resources available on our provider portal, which assists providers and their staff members in delivering effective and efficient member care. Providers can access the provider manual through the provider portal and our website and can request a printed copy.

Major Provider Manual Sections. In accordance with Appendix A, Section 6.9.2, a single provider manual incorporating requirements for both the MSCAN and CHIP populations will be developed and maintained for network providers. This manual will be available in electronic format, optimized to be easily searchable, on our website, the provider portal, and upon request in printed form. As required, we will submit the provider manual to the Division for approval 90 days prior to implementation and use. The provider manual includes the major sections detailed in Table 4.2.2.2_E with specific information separated by program.

Table 4.2.2.2_E: Provider Manual Major Sections

Major Section	Description
Our Organization	▪ Administrative structure ▪ Contact information (telephone number(s), email address(es), and website address)
Covered Benefits and Services	▪ MSCAN benefits and services ▪ CHIP benefits and services – Well-Baby and Well-Child Care services, including Immunizations – Provider responsibility to follow up with members who are not in compliance with Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule
PCP/PCMH Responsibilities	▪ Care Management System and protocols ▪ Role of a PCP (including the PCP's importance to the Care Management team) ▪ Role of the PCMH ▪ Covered Services, including excluded services, co-payments, and benefit limitations
Disputes, Grievances and Appeals	▪ Prior authorization review and reconsideration ▪ Grievance, Appeal, and State Administrative Fair Hearing information ▪ Filing provider disputes ▪ Member Grievance, Appeal, and State Fair Hearing procedures and timeframes
Medical Management/ Utilization Management	▪ A definition of "medically necessary" ▪ Emergency department utilization (appropriate and non-appropriate use of the emergency department) ▪ Prior authorization clinical and technical criteria guidelines

Major Section	Description
	▪ Prior authorization requirements ▪ Utilization management criteria and processes
Quality Management	▪ Provider performance expectations, including disclosure of quality management criteria and processes
EPSDT Requirements	▪ EPSDT screening requirements and EPSDT services ▪ Provider responsibility to follow up with members who are not in compliance with the EPSDT screening requirements and EPSDT services
Claims Submission and Processing	▪ Detailed billing instructions

4.2.2.2.C.4. Describe how the Offeror will develop Provider trainings and workshops, including brief descriptions of six (6) possible topics.

In addition to new provider orientation and ongoing education, we develop and offer numerous trainings and workshops. Provider feedback, community stakeholder feedback, and State-specific training requirements drive the selection of training and workshop topics. Training topics may also be selected based on identified program and system initiatives, performance improvement projects and identified system challenges. When we identify topics for development, our local subject matter experts work closely with our training development team to design the training, determine the most effective delivery modality (e.g., classroom training, webinar, large format), and develop a plan to roll out the training to providers. Six possible training topics are:

1. **Poverty Simulation.** This experience affords participants the opportunity to experience the social and economic challenges many of our members confront. Participants role-play the lives of low-income family members and have to obtain necessities and shelter on a limited budget. We have hosted several poverty experiences in other markets, allowing providers, community partners, and other stakeholders to experience the challenges faced daily by our members to meet their housing, clothing, employment, food, and childcare needs with limited resources. We have also conducted several poverty re-entry experiences to highlight the unique obstacles encountered by those leaving correctional facilities. The experience simulates the challenges faced by justice-involved individuals to meet their daily needs, while complying with their legal restrictions and requirements. Individuals share experiences at these events, adding to the authenticity of the simulation. Participants convey these events raise awareness of the challenges faced by our members, reduce implicit biases, build empathy, and foster equitable health care.
2. **Promoting Wellness.** We have provider training on strategies and tools to promote overall member health and wellness, including maternal and child health, diabetes, hypertension, and obesity. Through these trainings and seminars, we will educate providers on nationally accepted evidence-based preventive health guidelines for various illnesses and interventions. The guidelines are promoted to facilitate improved health care and appropriateness in the delivery of healthcare. These sessions also provide visibility and awareness to processes and education on working with members to enroll in disease management and wellness programs.
3. **Person Centered Care.** We will partner with the University of Southern Mississippi's Person-Centered Planning Facilitation Initiative (PCP-FI) and Alcorn State University, to deploy their training model to create and infuse strong person-centered planning for all Medicaid participants across the network. Person-centered care is a set of principles of service delivery that places members at the forefront of their treatment goals. This lends itself to a large-format conference/workshop, as well as ongoing training infused in our overall approach internally and with our providers.
4. **Social Determinants of Health (SDOH).** Our SDOH training module provides an overview of our program, which addresses the gap between health care and community support services necessary to address the impact of SDOH needs, including employment, education, food, housing, and social support systems. The training model offers targeted provider education and support aimed at ensuring they understand and address the social needs presented by members and their families. Training to submit SDOH referrals through the EHR will facilitate close loop referrals by leveraging the bidirectional real-time feeds with our integrated platform that connects to the CBO.

5. **Navigating the Value-based Purchasing (VBP) Continuum.** We recognize the importance of including the Division's quality strategy aims, goals, and objectives in the development of a uniformly applicable Mississippi Division of Medicaid VBP Work Plan. We offer provider training regarding our flexible and scalable enterprise-wide value-based programs to assist providers in using these strategies to improve health outcomes and clinical and financial performance. We will provide unparalleled access to real-time data through connection to a statewide HIE and interoperability with our providers' electronic health records (EHRs), resulting in improved health outcomes and decreased avoidable high-cost utilization. We will train providers on using of this tool and leveraging its data to improve member care and outcomes.
6. **Mental Health First Aid (MHFA).** MHFA is a national program that teaches providers and other interested members of the community on the skills needed to respond to the signs of mental health and substance use issues. These training events build our relationships with schools and the BH provider community and encourage agencies and their clinicians to contact us about patients who are transitioning to our health plan. Such training events may take the form of a large conference open to a broad variety of providers and other community members.

In addition to internally developed trainings and workshops, we will collaborate with other CCOs in planning and executing large format in-person conferences/workshops and webinars. We understand we are responsible for hosting and paying for six conferences throughout the year and an additional five webinars using non-duplicative material not otherwise covered in webinars. The development and delivery of these required trainings and webinars will comply with Appendix A, Section 6.9.3.2.

4.2.2.2.C.5. Describe how the Offeror will provide education to Providers concerning cultural competency, health equity, and implicit bias, and how the Offeror will ensure that Providers apply this training.

Our commitment to addressing racial, ethnic, and geographic disparities, as well as a variety of lived experiences is embedded in our corporate culture, including development of a culturally competent provider network. Our network development efforts emphasize meeting the cultural, racial, and linguistic needs of our members through provider recruitment and education. We analyze demographic and cultural information to continuously understand the social, racial, and linguistic needs of our members. Providers are required by contract to comply with all state and federal regulations, as well as the Culturally and Linguistically Appropriate Services (CLAS) standards established by the federal HHS Office of Minority Health. Providers are also required to attend training designed to increase cultural competence, promote health equity, and mitigate implicit bias; we provide initial education and training for providers no later than 30 days prior to implementation and re-training annually. Our cultural competency, health equity, and implicit bias trainings are available online and accessible at the convenience of the provider. During provider orientation, we share all links to the standards, with reminders to complete the trainings within a 30-day timeframe. The provider manual also contains a link to our training and events page where providers can access past trainings and sign up for future events. There are multiple sections within the provider manual reminding providers of their training responsibilities, along with options to receive training.

Monitoring Provider Application of Training. Established guidelines, described in our provider manual, require that services and care provided to our members demonstrate a high degree of cultural respect and psychological safety. Provider representatives address all questions and concerns from new providers and their staff, with routine follow-up meetings and check-ins. We track completion of required trainings within our provider relationship management (PRM) tool to ensure our providers are equipped to effectively address a variety of lived experiences, as well as the diverse racial, ethnic, and geographic characteristics of our members. Provider demonstration of cultural competence, health equity, and implicit bias mitigation is monitored through utilization management and care management evaluation of authorization requests (approvals and denials); member complaints, grievances, appeals; results from member satisfaction surveys; and clinical chart audits to ensure providers' application of trainings and their ability to meet linguistic and/or special needs.

4.2.2.2.C.6. Describe the Offeror's proposed approach to assess Provider satisfaction, including tools the Offeror plans to use, frequency of assessment, and responsible parties.

Our approach to assessing provider satisfaction directly aligns with the Quadruple Aim framework, of which the fourth pillar is provider satisfaction, and highlights provider satisfaction and experience as key factors in optimizing health outcomes for our members. In accordance with Appendix A, Section 8.7, we will submit to the Division a draft survey with questions and methodology for both the MSCAN and CHIP lines of business by March 1 for the current calendar year. We will distribute the uniform survey developed by the Division to identified providers annually. We submit survey results and associated action plans to the Division at least 90 calendar days following survey completion and no later than December 1. In collaboration with the Division, we assume responsibility for conducting all provider satisfaction surveys, compiling results, developing action plans, and filing all information with the Division within its specified timeframes. We incorporate all results into our quality management processes for resolution and continuous quality improvement. This information helps us identify areas with the strongest correlations to overall satisfaction, build and reinforce provider relationships, and reduce administrative burden.

We contract with an NCQA-accredited vendor to conduct the provider satisfaction survey by phone, seeking to achieve a statistically significant sample of all providers with up to three call attempts. Survey findings are shared broadly, with specific reporting to entities who play a direct role in enhancing the provider experience (e.g., utilization management, call center, claims, and provider services). Using this information, we develop and monitor action plans for continuous quality improvement. As an example, based upon feedback from a similar survey in another market, we identified an opportunity to enhance our provider portal, allowing providers to complete some tasks more efficiently. We made modifications to the functionality of the portal, soliciting additional provider feedback throughout the process, and created education for providers to highlight new capabilities to increase usage. Since that time, provider portal usage and satisfaction have both increased.

We also seek feedback from providers following every interaction to assess satisfaction. For example, the provider services call center uses a volunteer satisfaction survey at the end of each call for providers to rate their experience. These surveys roll up to a customer satisfaction survey percentage for call center staff. The scoring provides directional data on how call center staff members are performing when interacting with our providers. Additionally, we use a third-party vendor, along with the team lead, to ensure we complete a minimum of seven audits for each provider services call center staff monthly. Call center staff members have access to the results to help them organize a plan for growth and improvement. **Provider services call center call quality scores routinely exceed 90%.** Our 2020 Provider Satisfaction Survey results from other markets demonstrate the success of improving the provider experience, with **83% of providers responding they would recommend our plan to other physician practices.** Provider satisfaction also directly correlates with member choice of plans as providers are a main resource used by Medicaid recipients in selecting plans. In other markets representing 92% of our enrollment, **we are the number 1 selected plan among those who make an active selection.**

The Provider Portal team reviews multiple information sources to understand provider satisfaction and to collect feedback on future portal enhancements. Provider focus groups and training sessions, combined with survey feedback, information from customer care calls, and provider representative feedback drives the provider portal enhancement strategy. This feedback loop, incorporating satisfaction data, allows us to continuously exceed our providers' expectations and maintain our high provider satisfaction results.

4.2.2.2.C.7. Describe the Offeror's proposed approach to educating Providers concerning EPSDT services and Well-Baby and Well-Child Services, including but not limited to screening instruments, practices, and schedules; identification and referral of children with developmental delays; use of Care Management to facilitate care of children; and required documentation for reimbursement of EPSDT services.

Providers are initially educated at orientation regarding EPSDT, well-baby, and well-child services and during their annual orientation. We work with prenatal clinics and other providers to support and reinforce their efforts to ensure our members understand the importance of screenings/treatment and scheduling preventive visits for their infants and other children. Our approach to ensuring that providers are informed about EPSDT and well-

child activities include alerting providers when there are critical gaps in care, such as missed or unscheduled appointments, and letting providers know in advance which children are eligible for those services. Our EPSDT Tracker identifies gaps in care for our members and shares information with our providers on a real-time basis through the provider portal, including periodic and wellness screens and visits, in accordance with the Bright Futures EPSDT periodicity schedule; diagnostic and treatment services; immunization, lead testing, tuberculosis screenings, vision, hearing, and dental services; and missed periodic and well-child visits. Our EPSDT dashboard provides the provider with specific drill down capabilities that show EPSDT measures at the highest level, to age group at the next level, to individual provider performance at the lowest level. With this level of detail, provider representatives are able to meet with providers to educate them on very specific gaps in care, based on their individual dashboard, and assist them in identifying ways to close those gaps. Gaps are analyzed to assess potential missed opportunities. We send email alerts and monitor trends in utilization when practices have high numbers of members with gaps. Direct and targeted communication occurs with these providers in-person or via secure email. We customize ongoing technical assistance to meet the individual needs of the provider. For example, we provide interactive training on practice transformation when we identify a need, or a provider makes a request. We also offer technical assistance to providers who have a high encounter rejection rate as this potentially could negatively impact EPSDT rates. Performance on EPSDT service utilization is analyzed quarterly and annually to identify trends, gaps, opportunities for improvement, and potential interventions to drive optimal outcomes.

Additionally, we will partner with a Mississippi university to improve early childhood screening rates for the most vulnerable children in the state. Our partnership will focus on development and implementation of education materials and resources for providers and members that will be available on our provider and member portals, at community events and through our partners, including information about developmental disabilities, referral sources for assessments, and connection with advocacy groups.

Identification and Referral of Children with Developmental Delays. The most effective way to ensure children are screened for developmental delays is to meet them where they are. We will partner with Jackson State University to build EPSDT toolkits to train schools, Head Start centers, child development centers, and providers on the importance of EPSDT screenings. We will reimburse school nurses for screenings and partner with them to conduct screenings events during school break. Providers are educated on how to identify and refer children at risk for developmental disabilities, including referral mechanisms and available resources. We use claims data, diagnoses codes, and service utilization data to identify and refer at-risk members. Early identification affords the opportunity to educate providers regarding the needs of their members through one-on-one visits with our field based BH clinical team and BH provider representatives.

Using Care Management to Facilitate Care of Children. As previously noted, we conduct a comprehensive new provider orientation for all new providers within 30 days of their contract effectiveness date, along with ongoing education and outreach programs. We tailor education to the provider's preferences and needs, and it will include information on specific MSCAN and CHIP requirements, policies and procedures, and training and technical assistance on all specific administrative and clinical practices such as the roles and responsibilities of the care manager for children. Our provider representatives provide ongoing technical assistance to providers on all our services, including our MOC and connecting to care management for children.

Required Documentation for Reimbursement of EPSDT Services. Our EPSDT Quick Reference guide includes instruction on how to properly document and bill for EPSDT services, including clinical tools, clinical documentation requirements, and appropriate procedure codes and modifiers for each age range. We also offer a coding guide for HEDIS® measures, which we update at least annually, including EPSDT codes.

4.2.2.2.C.8. Describe the Offeror's proposed approach to educating Providers regarding the needs of Members with the following conditions or circumstances:
a. Perinatal; b. Behavioral Health; c. Substance Use Disorder; d. Chronic Conditions; and e. Foster Children.

Our comprehensive library of resource materials includes links to national standards for easy navigation so providers can easily obtain the latest information on perinatal, BH, SUD, chronic conditions, and foster children

needs. Providers can also view online educational videos and materials about our member portal, which contains information on immunizations, wellness, health literacy, and management of chronic conditions.

Educating Providers Regarding Members with Perinatal Needs. Infant mortality rates in Mississippi are the highest in the United States, driven by poor health status of the mother, tobacco use during pregnancy, high rates of preterm births, high rates of deliveries prior to 39 weeks, and sleep-related deaths. In more than half of the Mississippi counties, pregnant women must travel outside their county to see an obstetrician/gynecologist (OB/GYN) for prenatal care and delivery services. Studies show the rate of preterm birth as well as maternal mortality among Black mothers continues to be twice that of White women. Our perinatal and neonatal care management program goals are aligned with the Division's goal to reduce infant mortality as well as maternal mortality. Critical to our success in addressing disparities and improving the perinatal care of women is expanding access to high quality OB/GYN providers and assisting them in early identification of pregnant women to improve prenatal visits in the first trimester and promote engagement in care management of high-risk members. We provide culturally competent training to providers and their staff. We educate providers on evidence-based, nationally recognized clinical practice guidelines and best practice standards for medical care, preventive care, and BH care, both in person and via the provider portal. When appropriate, we educate providers on prescribing and enrollee utilization of 17-hydroxprogesterone to prevent premature births. We utilize our local CHW's to assist in educating providers on community resources and support opportunities for their members. We also educate and collaborate with providers on our initiatives and performance improvement projects targeted at improving care for members with perinatal needs. We promote the Pregnancy: Postpartum Care, American College of Obstetrics and Gynecology and Preconception and Prenatal Care: National Institutes of Health, Child and Human Development guidelines in our curriculum.

Educating Providers Regarding Members with Behavioral Health and Substance Use Disorder. We recognize the importance of promoting a recovery-oriented system of care for the treatment and support of members living with a diagnosis of BH and SUDs. We ensure our provider network is trained on the principles of recovery and overcoming stigma associated with BH and SUDs. We promote and offer educational opportunities for our providers on best practices and evidence-based interventions for treatment, including medication assisted treatment for opioid use disorders and alcohol use disorders; efficacy of long acting anti-psychotic injectables; and team based, recovery-oriented approaches such as assertive community treatment for our members with serious mental illness. Our foundational commitment to fully integrated, transparent care governs our approach to educating PCP/PCMHs regarding the needs of members with BH or SUD. We offer the educational resources necessary to promote excellence in BH and SUD service delivery, such as evidence-based screening tools; utilization of HBAI billing codes; identification of postpartum depression; opioid use, depression, postpartum depression, and ADHD tools; and more.

We support providers in building their capacity to offer BH screening, referral, and services through the provision of education, training, and incentives for BH conditions commonly identified in primary care settings, including sharing best practices toolkits and clinical practice guidelines. Access to BH and SUD services within primary care settings is expanded through provider training and billing guidance to screen for BH and SUD concerns and facilitate treatment. We ensure PCPs are equipped to screen for BH and SUDs, provide medication management services as appropriate, and refer for specialty BH care to meet the needs of the member. Our on-demand webinars provide education to PCPs on BH topics, including screening for BH/SUD conditions. We utilize our provider portal to offer providers access to a variety of assessment tools, access to member profiles that provide a comprehensive view of medical, BH/SUD and pharmacy utilization, and gaps in care.

Additionally, we will partner with NAMI to hold regional provider trainings for PCPs, BH specialists, CBOs, schools, and child welfare systems to promote a fully integrated, transparent, and competent system of support across the medical, behavioral, and social service eco-system. We place the voice of the member and family at the center of these trainings to humanize and destigmatize BH conditions and promote and recovery-oriented system of care for all Mississippians.

Educating Providers Regarding the Needs of Members with Chronic Conditions. We address chronic illnesses through our innovative disease management (DM) program, a component of our whole person population health management model. Our specialized care managers oversee the care of members enrolled in our DM program, providing the right individualized level of support based on the member's particular needs, strengths, and resources. Care managers coordinate with all treating providers to facilitate coordinated and integrated whole person treatment planning. Our provider-facing teams educate providers on our DM program and services to assist in managing chronic conditions. Training includes information regarding related HEDIS measures, with member materials designed to promote self-management of their chronic condition(s) and to optimize health outcomes. Condition-specific materials include preventive care reminders and community-based resources for self-management of chronic conditions. We partner with providers, including PCMH providers and specialty providers, to share data related to their members with chronic conditions, discuss trends and identify opportunities to improve outcomes for those members.

Educating Providers Regarding the Needs of Foster Children. Coordination across state programs and care continuums is integral to providing whole-person care for members with special health care needs, including members in foster care. We possess in-depth experience serving foster children in other Medicaid markets, including covering 47% of the Medicaid foster care population in a state with five operating plans. Whenever members in foster care are identified, we contact their respective providers to offer training, education, and ongoing support.

We have created the Institute for Relational Health, which aims to highlight the importance of positive relationships for our members and educate providers to make relational health a part of their practice. We are working to promote a widespread adoption of relational health practice, as it is a vital component of standard medical care. Through our contemplated partnership with Be Strong Families, a nationally recognized organization focused on innovative protective factors to promote family resiliency, we will collaborate to provide trainings and education that support more effective communication, stronger engagement with families, and promotion of the protective factors focused on strengthening and supporting families. We are integrating the HOPE (Health Outcomes for Positive Experience) framework throughout our policy and program development, which will affect the way we interact with members by creating a strength-based, child-centered, family-led process to better health. We will use the framework to educate and inform our providers on how to integrate it into their practice.

We created the Mississippi Racial Equity Collaborative to address health literacy and racial, ethnic, and geographic misconceptions to reduce removal and increase adoptions and relative placements. We will use our curriculum as a tool in educational offerings for our provider network and child welfare agencies. We will offer training provided through the Child and Family Health Training Institute, which was established to provide best-in-class training and technical assistance to the system of care supporting children and families involved with the child welfare system. The Training Institute brings together key stakeholders, including child welfare professionals; primary, secondary, and higher education communities; trusted advocacy groups; and leading providers who serve children and families. This training promotes emerging evidence-based practices and trauma-informed care and helps ensure lived experiences and cultural sensitivity are core tenets of those who serve this population and their unique needs. A full menu of culturally sensitive trainings, including trauma informed care, adverse childhood events and positive childhood experiences, advancing racial equity in child welfare, and the youth Mental Health First Aid program, will educate providers on the experiences of youth in foster care, the impact of adverse child experiences on life trajectory and health outcomes, and leading-edge youth and family engagement skills.

4.2.2.2.D. Collaboration with Providers

4.2.2.2.D.1. Describe how the Offeror will collaborate with PCPs/PCMHs regarding the care of Members with chronic illnesses, including but not limited to diabetes, asthma, and obesity.

We will change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which will bring a new era of provider collaboration to Mississippi. We collaborate with PCPs/PCMHs regarding the care of our members with chronic illnesses, including diabetes, asthma, and obesity, through a continuum of provider communication and engagement strategies. As a CCO, our **'success for every provider' philosophy** is grounded in collaborating with providers to ensure they receive the information, support, and services necessary to provide exceptional care to members with chronic illnesses, regardless of the sophistication of a provider's operations. We view our network providers as partners who bring vital knowledge to managing member care across Mississippi.

We continuously engage PCPs/PCMHs through our Provider Advisory Committee to ensure the methods we use to collaborate regarding members with chronic illnesses provide useful resources, along with prompt, meaningful, and accurate information. Providers engage in our Annual Quality Summit, a learning collaborative composed of plan leaders, other CCOs, CBOs, providers, and advocates, to identify barriers to care for members with chronic illnesses and to collaborate on treatment strategies. We also garner provider feedback during joint operating committee (for large providers) meetings to inform and implement best practice collaboration methods.

Education. Initial and ongoing provider education is paramount to collaborating with PCPs/PCMHs for members with chronic illnesses. Examples of provider education topics related to our care model for members with chronic illnesses include applying relevant clinical practice guidelines; locating early interventions and SDOH services; educating providers on value-added benefits and member incentives; identifying provider centers of excellence; using the provider portal and integrated clinical platform effectively; and accessing information available for consultation and use in caring for members with chronic illnesses. A full description of our provider education is presented in our response to Section 4.2.2.2 C.

Accessible and actionable information. Our clinical and provider-facing tools afford providers, PCPs, and PCMHs a wide array of information. Through our **provider portal**, providers can access evidence-based physical health clinical practice guidelines, which incorporate measurable objectives and instruction on the delivery of high-quality care for conditions, such as asthma, diabetes, obesity, as well as other chronic conditions, such as hypertension, chronic obstructive pulmonary disease, and sickle cell disease. They can also view clinical practice guidelines through a web-enabled transparency tool. With single sign-on access through our provider portal, users access our **integrated clinical platform** where they can view member care plans and authorizations. This enables real-time bidirectional communication between providers and care managers to support collaboration on member care. Our **provider performance platform** offers a single, easy-to-use, consolidated view of provider performance on key performance indicators (e.g., quality measures for chronic conditions), self-service tools for providers to monitor their performance, and real-time access to claims information to assist in tracking performance on cost of care metrics. We help providers monitor and improve performance on select adult and child quality measures related to the care of members with chronic illnesses. This approach promotes in-depth collaboration with providers to identify resources they can leverage to support members with chronic illnesses. As PCPs/PCMHs enhance their capacity for collaboration, we provide additional data and reports to support their practice-led population health and care management activities. Similarly, we give providers participating in value-based payment programs added communications on program goals.

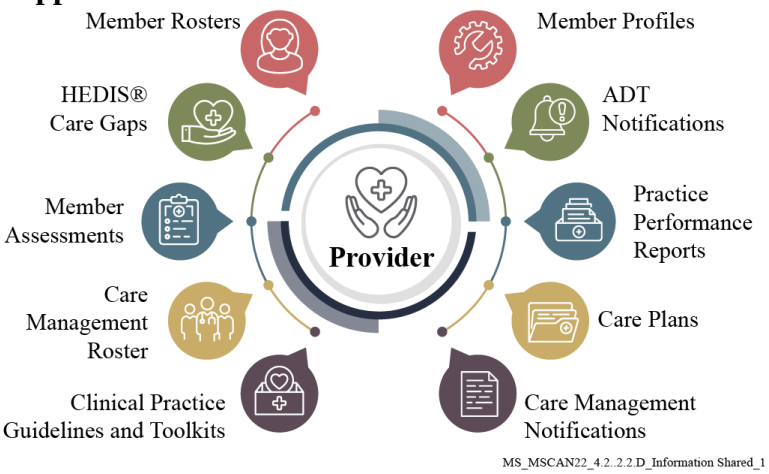
Integrated, real-time bidirectional data sharing. Our unparalleled access to real-time data through connection to a statewide HIE and interoperability with our PCP/PCMH providers' EHRs improves collaboration and coordination of care for members with chronic illnesses, resulting in improved health outcomes and decreased avoidable high-cost utilization. Because PCPs/PCMHs serve as partners in the management of care for members with chronic illnesses, effective bidirectional communication is critical to our collective success.

Care management collaboration. Our care managers build and foster trusting relationships with members and their PCPs/PCMHs, encouraging participation on the integrated care team (ICT) and development of individualized care plans (ICPs). We collaborate to implement our care model, identifying and addressing potential barriers faced by members by connecting them to appropriate resources, based upon their individual preferences. Care managers can schedule reminders within the integrated clinical platform and contact members prior to their scheduled appointments to confirm their attendance and arrange transportation, if needed, thus reducing no-shows and providers' administrative burden. Through our ICT and care planning process, we collaborate with PCPs/PCMHs to identify and address members' social determinants of health (SDOH).

Technology-enabled monitoring. We use technology to support continuous monitoring of members with acute chronic illnesses who require more consistent provider support. Our **remote patient monitoring (RPM) capabilities** make real-time feedback available to providers to support member care. For example, we offer RPM support, with continuous glucose monitoring of members with diabetes, specifically for Black members who reside in the Delta region, to address a key health disparity. Our specific approaches for chronic conditions that are priorities of the Division include the following.

Diabetes: PCPs/PCMHs receive specific information on members' gaps in diabetes care, including progress on relevant healthcare effectiveness data and information set (HEDIS®) measures, such as A1c testing, A1c in poor control, and A1c in control. Providers have access to a nutritionist/registered dietitian for members they identify with diabetes or weight management needs. During our virtual and on-site new provider orientation sessions conducted by our provider representatives, providers are informed on the availability of our services and diabetes self-referral options. We also provide information on self-referrals and provider referral mechanisms.

Figure 4.2.2.2_D: Information Shared with Providers to Support Care of Members with Chronic Illnesses



Obesity: We share data with PCPs/PCMHs, including obesity diagnoses, comorbidities, and relevant HEDIS measures, to identify and treat adults and children with obesity. Weight management programs are available to adults and children, and we assist PCPs/PCMHs with referrals. In addition, we partner with PCPs/PCMHs to develop tailored interventions in disparate communities, promote related health education programs, and to provide nutritional telehealth counseling. In another market, **these efforts resulted in a 26% increase in quality improvement for documented nutritional counseling**. Through our ICP development process, we identify and connect members to all underutilized evidence-based treatments that may benefit our members.

Asthma: We share useful asthma information with assigned PCPs/PCMHs, including diagnosis, medication adherence, percent untreated with asthma diagnosis, and member feedback, on our annual asthma program satisfaction survey. We work with providers to close gaps in care, including identifying members who are not using asthma-controller medications, red with Providers to Support Care of Members with Chronic Illnesses.

Sickle Cell Disease (SCD): As part of our care management solutions, members with SCD are automatically enrolled in our high-risk level of service, which drives collaboration with providers to manage members with the disease. We include SCD and SCD-pediatrics in our clinical practice guidelines, which we share with providers, along with support to deliver the identified evidence-based treatment.

As part of our population health strategy, our clinical, quality, network, operations, and analytics teams work in concert to deliver information to PCPs/PCMHs regarding members with chronic illnesses. Figure 4.2.2.2_D demonstrates the wide range of data our teams make available to providers so that we can collaborate in supporting care for members with chronic illnesses, leveraging real-time data exchange and interoperability capabilities whenever possible and via secure file transfer and other traditional methods (e.g., fax, mail, email), when necessary.

4.2.2.2.D.2. Describe how the Offeror will collaborate with PCPs/PCMHs to reduce pre-term births and improve perinatal care.

Together, the plan and our network of PCPs/PCMHs must collaborate to positively impact Mississippi's current rank of 50th for infant mortality (driven by pre-term births) in the nation and to improve perinatal care. We recognize that not all PCPs/PCMHs have the capacity to care for pregnant members with complex needs and have a full array of collaboration strategies to meet providers where they are. To collaborate with PCPs/PCMHs to reduce pre-term births and improve perinatal care, we:

- Train PCPs/PCMHs on evidence-based practices, relevant clinical practice guidelines, best practice standards for perinatal care, including use of 17P, birthing options, and postpartum contraception

Inform PCPs/PCMHs about their role in completing the Notification of Pregnancy form, the Perinatal High Risk Management/Infant Services System (PHRM/ISS), the national text4baby program available at no cost to all members, the Mississippi Tobacco Quitline, and other public resources

- Educate and collaborate with providers on our initiatives, including our:
  - Perinatal care performance improvement projects
  - Rental subsidy program for pregnant women
  - Perinatal telehealth program, including virtual lactation visits with a certified breastfeeding counselor and postpartum visits
- Conduct targeted outreach and education with perinatal providers at least quarterly, on topics such as updates to our perinatal programs and services, to foster innovative provider engagement and education strategies, and to provide actionable reporting to support providers to close gaps in care
- Provide PCPs/PCMHs with quick reference guides on screening, referring, and treating perinatal depression
- Advertise to our network PCPs/PCMHs to make sure they have comprehensive information about our pregnancy and high-risk obstetric (HROB) care management program and educate them on making direct referrals via email, telephone calls to our dedicated phone line, or through Notice of Pregnancy (NOP) forms, allowing our engagement of members into the HROB care management program to take place as early into the member's pregnancy as possible

Collaborating with Provider to Improve Birth Outcomes

Members in another market participating in our rental subsidy program had a 15% reduction in emergency hospital stays prior to delivery, a 60% reduction in NICU utilization, a 72% reduction in the NICU average duration of stay (8 days compared to 29 days), and reduced readmission rates.

The specialty HROB care manager collaborates with PCPs/PCMHs and PHRM/ISS agents, when applicable, to engage them in the ICT and in development of the ICP. For all members pregnant members, providers are able to submit their recommendations to the care manager on existing care plans through the integrated clinical platform. Care managers communicate with the member's PCP and obstetrician via telephone whenever they identify information regarding the member's pregnancy status, referrals, status of referrals, challenges with medications, or other red flags with communication about care plan updates at least quarterly. Providers can make or suggest changes to the care plan, and the assigned care manager introduces and implements these changes with the member on the next contact.

Additionally, our neonatal intensive care unit (NICU) program provides specialty inpatient and discharge supports for newborns and their families whenever newborns are admitted to a NICU, with real-time bidirectional data sharing and collaboration to ensure we receive and alert providers of inpatient admissions. Care managers contact PCPs/PCMHs not connected to our data-sharing platform to inform them of NICU admissions. Utilization management staff works in tandem with the hospital and the NICU case management team to ensure a safe transition to the community and connection to their PCP/PCMH. We support the pediatricians, PCPs, and PCMHs in scheduling appointments, as needed, in the first few months of the baby's life and educate parents/guardians on the importance of keeping appointments and complying with EPSDT screenings and vaccinations.

4.2.2.2.D.3. Describe any other conditions for which the Offeror anticipates collaboration with providers to develop improved care for Members.

We collaborate with providers, providing information on evidence-based practices, clinical practice guidelines, and national, regional, and local best practices standards for all conditions that result in stratification to medium or high risk categories (per Section 7.4.3.3.1 of Appendix A).

In addition to chronic illnesses, we prioritize collaboration with PCPs/PCMHs to improve dental care for members. We identify members with dental needs through algorithms utilizing member and claims data from our data warehouse. Care managers collaborate with PCPs/PCHMs to develop innovative interventions to improve dental care based upon the unique n system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, and operational excellence which brings a new era of provider collaboration to Mississippi. We ensure timely payment for all inpatient and outpatient emergency services in accordance with Appendix A, Sections 4.1.1, 4.2.1, and 42 C.F.R. § 438.114. We reimburse emergency services performed by out-of-network providers at the in-network rate. **Our ability to deliver in timely and accurate claims processing and payment demonstrates we are a worry-free partner of the Division.**

When we receive a claim for emergency services provided to members by non-participating providers, our claims processing platform bypasses the standard validation against the Division's master provider list. If the provider has not previously processed a claim with our plan, we send the claim to a special queue to have a non-participating record configured in the claims processing system. The turnaround time for this process is managed to no longer than three days from receipt of the claim. **From that point, 98% of the claims for non-participating providers are auto adjudicated and moved through payment processing within five calendar days.** We place outlier claims that require manual intervention into a dedicated queue for non-participating provider claims to ensure timely processing. Through this process, we adjudicate the remaining 2% of emergent services billed by non-participating within 21 days or less.

4.2.2.2.E. Provider Payment

4.2.2.2.E.1. Describe the Offeror's proposed process for ensuring that non-participating Providers who provide emergency services to Members are paid on a timely basis.

We ensure timely payment for all inpatient and outpatient emergency services in accordance with Appendix A, Sections 4.1.1, 4.2.1, and 42 C.F.R. § 438.114. We reimburse emergency services performed by out-of-network providers at the in-network rate. **Our ability to deliver in timely and accurate claims processing and payment demonstrates we are a worry-free partner of the Division.**

When we receive a claim for emergency services provided to members by non-participating providers, our claims processing platform bypasses the standard validation against the Division's master provider list. If the provider has not previously processed a claim with our plan, we send the claim to a special queue to have a non-participating record configured in the claims processing system. The turnaround time for this process is managed to no longer than three days from receipt of the claim. **From that point, 98% of the claims for non-participating providers are auto adjudicated and moved through payment processing within five calendar days.** We place outlier claims that require manual intervention into a dedicated queue for non-participating

provider claims to ensure timely processing. Through this process, we adjudicate the remaining 2% of emergent services billed by non-participating within 21 days or less.

4.2.2.2.E.2 Discuss the Offeror's willingness to pay claims with dates of services on and after the date of credentialing

Our process ensures payment of claims submitted for dates of service beginning when the provider is deemed credentialed on the daily file provided by the state. If a provider is credentialed (participating or non-participating) but is not yet loaded to our claims processing system, our pre-adjudication staging module pends the claim and a dedicated team builds the provider record within three days to ensure we pay the claim timely.

In accordance with Appendix A, Section 6.5, we notify providers regarding approval or denial of their request to contract with us within seven calendar days of the file interface exchange containing the provider's credentialing approval. We complete the contracting process and load the provider information into our claims processing system within 21 calendar days from the date of notification from the Division. Upon completion of the contracting process, we retroactively review claims submitted precontract and post credentialing to ensure accurate payment per the newly created contract.

4.2.2.2.E.3 To the extent that any subcontractor(s) will be processing and/or paying claims, include a systems diagram explaining this process, as well as an explanation of the Offeror's business relationship with any such subcontractor(s).

We have delegated arrangements with subcontractors who specialize in dental and vision claims processing to collectively provide accurate and timely claim outcomes. We apply the same rigorous oversight and accountability including performance penalties for noncompliance for our subcontractor's performance as we do to our medical claims to aggressively exceed claim processing turnaround times and accuracy requirements. We notify the Division of any changes to subcontracting arrangements for claims processing to obtain prior approval.

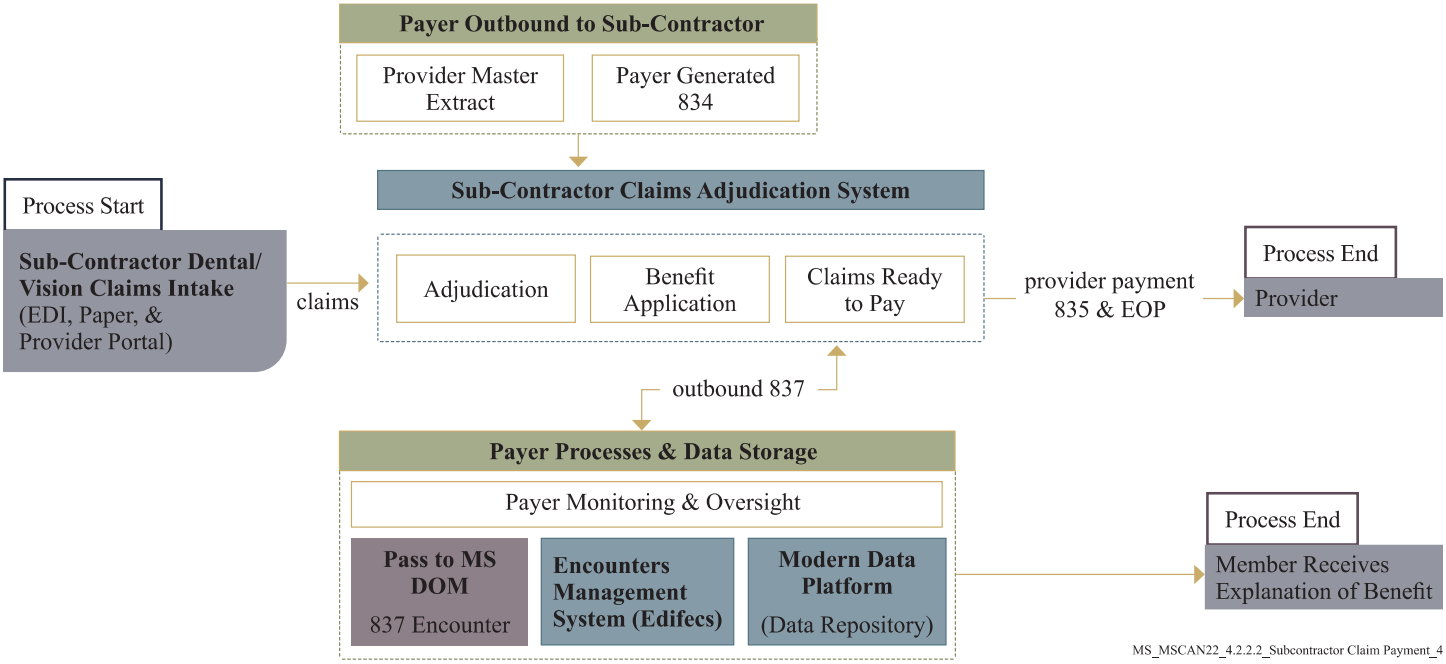
Dental and Vision Claims

Our fully delegated subcontractors specialize solely in vision or dental claim processing for adjudication and payment. Providers of dental or vision services submit claims directly to these vendors who manage the provider network and claim adjudication of these specialty claim types. These subcontractors remit payment and provider an explanation of payment (EOP) on our behalf. The subcontractor sends all final dental and vision claims to us for ingestion into our data platform where they are accessed for monitoring, inquiry, and production into a unified explanation of benefits (EOBs) and encounter files.

Our encounters operations team reviews regular reports from subcontractors. This dedicated team meets weekly to discuss submission issues, outstanding rejections, and to track performance ensuring compliance with the latest requirements and fiscal agents' encounter submission guidelines. Through this process, we manage the accuracy, timeliness, and completeness of the encounter data for oversight of these subcontracted services for utilization tracking and financial reporting. Figure 4.2.2.2_E depicts the claims processing and payment process for delegated subcontractors that provide specialty services for our vision and dental services.

Figure 4.2.2.2_E: Claims Processing and Payment Process for Subcontractors

We closely monitor every step of the process to ensure we make all payments in adherence with contract standards.



Explanation of the Business Relationship Between the Offeror and the Subcontractor

In Mississippi, we have delegated arrangements with subcontractors to process and/or pay for vision and dental claims. These agreements comply with the Division and requirements outlined in Appendix A. Since these entities are an extension of our own accountability, we closely monitor all activities with a multi-team approach. Our claims department and vendor oversight team closely monitor claims processing timeliness and accuracy with monthly Joint Operating Committees responsible for ensuring we met all service level agreements. The Joint Operating Committees also review any issues with member access to care and provider prior authorizations to identify continuous improvement opportunities. Our external review organization will also audit contract compliance to independently verify that performance meets and exceeds the Division's expectations.

4.2.2.2.F. Provider Grievances and Appeals

4.2.2.2.F.1. Describe the Offeror's proposed Provider Grievance and Appeal process specifically addressing:

a. Compliance with State requirements as described in Section 6.10, Provider Grievance, Appeal, and State Administrative Hearing Process of Appendix A, Draft Contract; b. Process for elevating Provider Grievances; and c. Process for identifying, tracking, and trending Grievances, using data to make program improvements, and sharing data with the Division.

Our process for administering Grievance and Appeals (G&A) is efficient, fair, and provider centric. Our G&A process is integrated into our health management platform, which is an innovative system that allows us to track, trend, and use data outcomes to make improvements and share information with the Division. On a daily basis, we regularly monitor status with real-time dashboards and data, allowing us to take prompt action to resolve providers' issues. We also track and trend data and use the results proactively to make improvements to overall processes, leading to a decrease in grievances and appeals and an increase in provider satisfaction.

Grievance & Appeals Stats

We average just under two provider grievances and appeals per thousand members per month for our Medicaid programs.

From January 1, 2019 through December 31, 2021, our provider appeals and grievances per 1,000 members dropped from 10.5 to less than 5 in another market.

We take a collaborative approach with providers to fairly and equitably resolve each grievance and appeal. Our steps include verifying timeliness of the request, acknowledging receipt, performing research, conducting

clinical review (as needed), and communicating with the provider and resolution. During this process, we ensure we have the appropriate documentation necessary to thoroughly review the case, and proactively reach out to providers to gather any additional documentation necessary to facilitate a complete and thorough review. By contacting and gathering all information up front, we can render a fair and equitable decision through an efficient and collaborative process.

We aim to resolve the concern during the first call, but if an issue requires further research in order to resolve, we forward the issue and keep the provider informed of our progress through resolution.

Table 4.2.2.2_E: 2021 Member/ Provider Grievances and Appeals for All Medicaid Programs

Description	Average Closure Time
Grievances	7 days
Clinical Appeals	18 days
Provider Claim Appeals	19 days
State Fair Hearings	12 days

Compliance with State Requirements

Our provider grievances and appeal processes are compliant with state requirements as described in Appendix A, Section 6.10, Provider Grievance, Appeal and State Administrative Fair Hearing Process, including definitions and timeframes, and aligns with the State's Quality Strategy with the modifications that are incorporated in Appendix A. Our approach to ensuring adequate oversight of provider grievances and appeals is drawn from our experience administering a well-established grievance system which includes a grievance process, an appeal process, and access to the State Administrative Hearing Process.

Our Policy Committee reviews and approves our grievance and appeal process continually to verify compliance with any updated State requirements, at a minimum, annually. We submit our policies and procedures to the Division for review, and obtain prior approval from the Division at least 60 days in advance if we make any modifications. After Division approval, we disseminate our policies and procedures to providers and subcontractors. Our provider manual includes information regarding how and when a provider (or their representative) can file a grievance or appeal and the resolution process. We also explain a provider's right to file a request for a State Administrative Hearing with the Division of Medicaid upon exhausting all of our appeal procedures. In addition to the provider manual, we inform providers of the grievance and appeal process through our secure provider portal, calls through the call center and provider representatives (PRs). At any point providers can call our provider services call center to ask questions about the process or inquire about the status of a case. As illustrated in Table 4.2.2.2_E, we have a well-established, grievance system that **exceeds performance requirements and timeframes for resolution.**

Provider Grievance Process

We define a grievance as any expression of dissatisfaction, regardless of whether identified by the provider as a "grievance" received by any employee orally or in writing about any matter or aspect of our organization or our operations, other than an Adverse Provider Determination (APD). A provider may opt of grievances in writing and provide an expected date of resolution within five calendar days of receipt of the grievance.

We resolve all grievances within 30 calendar days of the date wee frames up to 14 calendar days if resolution requires additional time. If we take an extension, we provide the provider with written notification that contains the specific reason for the delay.

Providers may submit a grievance through the provider services call center, provider portal, fax, mail or through communication with any of our staff. We maintain an electronic submission process through our portal as one avenue for providers to submit grievances. Through this process, providers also have real-time visibility into the status of each grievance and appeal.

The G&A coordinator contacts the provider via telephone to review the grievance and asks the provider questions to fully understand the nature of the grievance and the provider's circumstances. The G&A coordinator attempts to resolve the issue while on the call using the resources, they have available, such as standard operating procedures and access to the claims and clinical management systems. If the G&A

coordinator cannot resolve the issue during the call, they forward it to our issue resolution team to facilitate further research, inform the provider of this next step in the process, and let the provider know that we will contact them again within three business days. The issue resolution team triages the issue and works with the appropriate operations, utilization management or provider services team to perform root cause analysis and plan a solution for the provider. Through the process, we regularly update the provider on status and the target date of resolution.

If we are unable to reach the provider, the G&A coordinator makes a minimum of three additional phone contacts. If we do not reach the provider after three attempts, we send a written resolution letter to the provider within five business days that includes our contact information and next steps, such as filing an appeal. The G&A team also works with our PRs to inform them of submitted provider grievances. The G&A team and PRs discuss these situations during touch point meetings to ensure that the grievance/appeal has been resolved with no actions outstanding.

Process for Elevating Grievances

While grievances from providers are required to be resolved within 30 calendar days of their receipt, during the intake process of the grievance, we evaluate if the grievance is related to a member's health condition. If it does relate to a member's health condition, we collaborate with the provider to determine if it requires elevating to deliver a resolution more quickly. We establish the appropriate timeframe to resolve the grievance that aligns with the member's health condition and apply that timeframe as the resolution due date for the case.

Provider Appeals

We define an appeal as a request for us to review an APD we made related to a provider. The APD may include, but is not limited to, for cause termination or delay or non- payment for covered services. Providers can file an appeal with us within 30 calendar days of receiving our notice of an APD. We confirm receipt of appeals in writing and provide an expected date of resolution within 10 calendar days of receipt of the appeal. We resolve appeals within 30 calendar days of receipt of the appeal, or more expeditiously as required by the member's health condition requires additional time.

State Administrative Hearing

In the event a provider exhausts all of our appeal procedures and the appeal is not resolved wholly in favor of the provider, the provider may appeal the decision to the Division for a State Administrative Hearing within 30 calendar days of our final decision. In this instance, appropriate staff members who have firsthand knowledge of the provider's appeal are available to speak, provide relevant information on the case, and attend Administrative Hearings as scheduled. If a State Administrative Hearing results in reversal of our decision, we bear all costs associated with the hearing, including but not limited to medical appropriateness reviews by the Division's contracted Independent Physician Reviewers, hearing officer's fees, attorney's fees, and court reporter's fees.

Identifying and Tracking Grievances and Appeals

We capture G&A information in our integrated clinical platform, which enables our care managers, call center staff, and other CCO representatives to also have direct access into the G&A data. This allows staff to act on provider needs, escalate an issue, or conduct more analytical review during interactions with providers. The platform captures data such as the following, which we provide to the Division upon request:

- A general description of the reason for the appeal or grievance.
- The date of the resolution of the appeal or grievance.
- The resolution of the appeal or grievance.
- Information regarding the root cause analysis of the grievance or appeal
- The date the appeal or grievance was reviewed.
- The date the appeal or grievance was received.
- Information regarding the provider who submitted the grievance or appeal.

Our system tracks, monitors, and reports grievances and appeals, as well as generates daily reports, which we monitor to ensure timely and appropriate resolution. Throughout the day, the G&A team reviews the dashboard

reports, tracks time frames for filing, confirms receipt and resolves grievances to ensure compliance with Division standards.

Trending Grievances and Appeals

The G&A team monitors summary and trended data and submits quarterly reports to the Quality Management & Improvement Committee for review. We present monthly data and outcomes to the operations team senior leadership, develop quality improvement efforts based on the review of the data and trends, and use grievance and appeal reports to monitor quality of care issues, provider performance, access to care, improper billing, cleanliness of provider offices, and oversight of delegates. Our provider grievances and appeals per 1,000 members in other markets have **consistently trended down from 5.5 in January 2019, to just under two in December 2021, demonstrating the positive results of our approach.**

Making Program Improvements

We consider a responsive Grievance and Appeals process to be one that not only promptly identifies and resolves issues, but one that helps drive organization-wide improvements to the delivery of care. In doing so, our G&A team closely coordinates with our clinical operations team, which is comprised of utilization management (UM), quality, and care management experts that coordinate activities with other departments. The G&A team supports UM activities by monitoring requests and outcomes to inform UM changes. The UM team reviews grievances and appeals from providers who are having UM issues such as high denial rates.

Beyond solving an issue for a particular provider, the results of grievance information also present us with meaningful data we use to improve our overall operations. We gain valuable, immediate insight from grievance and appeal case information regarding the concerns of our providers. We empower our G&A staff to escalate system or benefit issues they identify while working a grievance or appeal. We submit issues to the appropriate supporting department to thoroughly investigate the root cause, determine a resolution, and implement a plan for remediation on a system-wide basis.

Through this process, we conduct ongoing review of issues presented by providers and make changes to policies and procedures. As we identify issues for remediation and a targeted date of resolution, we notify providers on the provider portal or through provider representative communication and reprocess all impacted claims.

[redacted] PROVIDER AGREEMENT
SIGNATURE PAGE

In consideration of the promises and representations stated, the Parties agree as set forth in this Agreement, the authorized representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The authorized representative further acknowledges and represents that he/she received and reviewed this Agreement in its entirety.

The authorized representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

The authorized representative for each Party executes this Agreement with the intent to bind the parties in accordance with this Agreement.

IN WITNESS WHEREOF, the Parties have executed and delivered this Agreement as of the last dated signature below ("Effective Date").

PROVIDER

on behalf of itself and its subsidiary
Federal Tax Identification Numbers:

Signature:_____

Name
(Printed):_____

Title
(Printed):_____

Date:_____

_____
Mailing Address – Official Correspondence

_____
IRS 1099 Address – If Different Than Mailing Address Address

Telephone Number:_____

Email Address: _____

[redacted]

on behalf of itself and its Affiliates

Signature:_____

Name
(Printed):_____

Title
(Printed):_____

Date:_____

_____
Mailing Address – Official Correspondence

_____
IRS 1099 Address – If Different Than Mailing Address

Telephone Number:_____

Email Address: _____

THIS AGREEMENT is made and entered into by and between [redacted], on behalf of itself and its Affiliates [redacted] and _____("**Provider**"). In consideration of the promises and mutual covenants set forth herein, the sufficiency of which is acknowledged by the Parties, the Parties agree as follows:

ARTICLE I
DEFINITIONS

The following terms, as used throughout the Agreement, its Exhibits, Appendices, Attachments and Addenda, shall have the meanings set forth below:

1.01 **"Affiliate"** means with respect to [redacted] any subsidiary, joint venture, or partner of [redacted] as well as any entity identified by [redacted] as an Affiliate, which is owned by [redacted] or under common control of [redacted] directly or indirectly, or any entity which is under common ownership, directly or indirectly, in whole or in part, with [redacted] With respect to Provider, "Affiliate" means any corporation, partnership or other legal entity directly owned or controlled by, which owns or controls, or that is under common ownership or control of Provider. [redacted] is an Affiliate.

1.02 "**Agreement**" means this agreement including all Exhibits, Appendices, Attachments, and Addenda, attached hereto.

1.03 **"Claim"** means an electronic claim form submitted by Provider to [redacted] unless another means of submission is expressly agreed to in writing by [redacted] or permitted by Law. Other requirements for submitting a Claim are contained in [redacted] Policies and Procedures.

1.04 **"Clean Claim"** means, unless otherwise defined by Law, a Claim for services provided to a Covered Person that is submitted pursuant to this Agreement, can be processed and determined without obtaining additional information from the Provider or from a third party, does not involve coordination of benefits, third party liability or subrogation, is not under review for Medical Necessity, under investigation for fraud, waste, or abuse, or contains any material defect or error that prevents timely adjudication.

1.05 "**Cost Share**" means an amount that a Covered Person is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty, or other Covered Person payment responsibility.

1.06 "**Covered Person**" means any individual, or eligible dependent of such individual, who is enrolled in a Health Benefit Plan and eligible to receive Covered Services.

1.07 "**Covered Services**" means Medically Necessary Health Services as determined by [redacted] in accordance with applicable Law and described in the applicable Health Benefit Plan.

1.08 "**Credentialing/Recredentialing or Credentialed/Recredentialed**" means [redacted] or its delegate's process of gathering, verifying, and evaluating information to determine whether applicable practitioners and facilities comply with [redacted] Network participation standards and/or NCQA standards.

1.09 "**Government Authority**" means any state, federal, local, territorial, regulatory, and/or other government entity that governs any of the services performed by either Party to this Agreement.

1.10 "**Health Benefit Plan(s)**" means any product or government program now or hereafter established, marketed, administered, sold or sponsored by [redacted] under which [redacted] is obligated to provide coverage of Covered Services to Covered Persons, as defined in [redacted] governing documents, including but not limited to a certificate of coverage, evidence of coverage, summary plan description, contract, or policy, whether in paper, electronic or other form means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

1.11 "**Health Services**" means those services or supplies that a health care provider is licensed, equipped, or otherwise approved to provide and which such provider provides to or arranges for individuals.

1.12 "**Law(s)**" means all applicable federal, state and local laws, statutes, regulations, decrees, ordinances, licensing requirements, standards of professional ethics and practice, treaties, instructions, writs, decisions, judgements, the decisions of any Government Authority, and the terms and conditions of any contract between [redacted] and any Governmental Authority. This includes, but is not limited to, any state or product specific regulatory language included in this Agreement.

1.13 "**Medically Necessary/Medical Necessity**" means the definition set forth in the Policies and Procedures and/or Product Specific Exhibit(s).

1.14 "**Network**" means a group of Participating Providers that support one or more Health Benefit Plan(s) in which Covered Persons are enrolled. Provider shall be eligible to participate in only those Networks designated in Product Specific Exhibit(s).

1.15 "**Network Notifications**" means the official means of communication regarding non-material changes related to Claims and/or reimbursement such as new coding edits, documentation requirements, accepted modifiers, and other billing issues.

1.16 "**Non-Covered Services**" means Health Services that are not Covered Services.

1.17 "**Overpayment**" means any funds that a Provider receives or retains of which the Provider is not entitled under the terms of this Agreement.

1.18 "**Participating Provider**" means a health care professional, facility, or other person or entity, including Provider, that has satisfied all applicable [redacted] credentialing Policies or Procedures or has otherwise been approved by [redacted] and has entered into an agreement with [redacted] participate in designated Networks..

1.19 "**Party or Parties**" means Provider or [redacted] as the case may be, each of which shall be individually referred to as a Party. Collectively, Provider and [redacted] shall be referred to as the Parties.

1.20 "**Policies and Procedures**" means the applicable provider manual and those policies, procedures, programs, protocols, and administrative procedures adopted by [redacted] to be used by Provider in providing services and doing business with [redacted] under this Agreement, including but not limited to [redacted] payment

policies, Credentialing/Recredentialing processes, utilization management, quality improvement, peer review, grievance process, and concurrent review.

1.21 "[redacted] **Provider Website**" means the online provider tool, including the provider portal that providers should access through [redacted] website, as well as those other portions of [redacted] website containing resources for Participating Providers.

1.22 "**Product Specific Exhibit(s)**" means those Exhibit(s), in Appendix C of this Agreement, that provide the additional terms and conditions applicable to a specific Health Benefit Plan and a corresponding state.

ARTICLE II
SERVICES/OBLIGATIONS

2.01 **Provision of Health Services.** Provider shall provide all Covered Services, and cause all employees, agents and subcontractors to provide all Covered Services, in accordance with this Agreement, applicable licensure and/or certification requirements, Laws, generally accepted standards of medical practice, and Policies and Procedures. Provider shall provide Covered Services to Covered Persons through the last day this Agreement is in effect, or such other date as set forth in this Agreement, or is required by Law, whichever is later. In providing Covered Services to Covered Persons during the term of this Agreement or following termination of this Agreement, Provider agrees to be bound by and to abide by the terms of this Agreement, and [redacted] requirements as set forth in Policies and Procedures. Provider is responsible to check for updates on [redacted] Provider Website including new or updated Network Notifications and comply with any changes outlined therein. With regard to the types of providers Credentialed by [redacted] or its delegate(s) as set forth in the Policies and Procedures, Provider will only allow Credentialed providers employed by Provider to serve Covered Persons.

2.02 **Licensure**. Provider represents that it and each of its employed providers or agents has a current, valid, and unrestricted license in the state in which it provides services to Covered Persons and that it, and they, are compliant with all applicable Laws. Provider also represents and warrants that it has the authority to conduct business in the state(s) in which it provides any services to Covered Persons.

2.03 **Government Programs Exclusion**. Provider represents that neither Provider nor any employee, agent or subcontractor of Provider is suspended and/or excluded from doing business with any Government Authority, state and/or federal government programs.

2.04 **Required Notices**. Provider shall make commercially reasonable effort to give notice to [redacted] five (5) business days of Provider's knowledge or when the Provider should have known, of any event that could be expected to impair the ability of Provider, or its agents providing services on its behalf, to comply with the obligations of this Agreement, including but not limited to any of the following: (a) an occurrence that causes any of the representations in this Agreement made by or on behalf of a Provider to be inaccurate, (b) Provider fails to maintain insurance as required by this Agreement, (c) Provider's license, certification or accreditation expires or is suspended, revoked, conditioned or otherwise restricted, (d) Provider is suspended, excluded, debarred, or sanctioned under a federal health care program, (e) a disciplinary action is initiated by a Governmental Authority against a Provider, (f) Provider's hospital privileges are suspended, limited, revoked or terminated, (g) Provider

is under investigation for fraud or a felony, and/or (h) Provider entered into a settlement related to any of the foregoing.

2.05 Policies and Procedures. Provider acknowledges its obligation to comply with all Policies and Procedures applicable to Health Services provided to Covered Person. [redacted] in its sole discretion, may make changes to Policies and Procedures as it deems may be required to administer Health Benefit Plans consistent with applicable Laws and subject to required approval from a Government Authority Except as prohibited by Law, [redacted] may communicate changes to Policies and Procedures by posting such changes on its [redacted] Provider Website. Provider is responsible for regularly monitoring [redacted] Provider Website to keep apprised of such changes. [redacted] shall make commercially reasonable efforts to provide thirty (30) days prior written notice of changes to Policy and Procedures which are expected to have a material impact on Provider's payments or obligations under this Agreement, unless a different notice period is required by Law. Where the change to a Policy and Procedure is a result is the result of a change in Law, Provider shall comply with any such change(s) prior to the effective date.

2.06 Accreditation Programs. Provider acknowledges that [redacted] and/or its Affiliates participate(s) in certain accreditation programs, such as the National Committee for Quality Assurance ("**NCQA**"), and Provider agrees to participate and assist [redacted] in Audits, programs, reviews and any other activity required for same.

2.07 Rights of Covered Persons. Neither Provider nor any employees, agents or subcontractors of Provider shall discriminate in violation of any Law in the treatment of Covered Persons or in the quality, quantity, or type of Health Services delivered to Covered Persons on the basis of race, gender, age, marital status, disability, color, national origin, ancestry, religion, sex, health status, sexual preference, Vietnam-era veteran's status or presence of handicap, source of payment, or need for Health Services. Provider will observe, protect, and promote the rights of Covered Persons as patients. Provider will comply with any Laws regarding the right of Covered Persons to make decisions regarding medical care. If [redacted] at any time, determines that a Covered Person's health or safety is in jeopardy by remaining with Provider, [redacted] shall arrange for immediate transfer of the Covered Person to another Participating Provider, as the case may be. Provider acknowledges that: (i) Covered Persons have a right to be treated with respect and recognition of their dignity and need for privacy; (ii) Covered Persons have a right to participate in decision-making regarding their treatment planning; and (iii) Covered Persons have a right to voice complaints or appeals about Provider or the care provided.

2.08 Provider Locations and Affiliates. Provider agrees to provide Covered Services only through those Affiliates, locations and providers listed on Appendix A of this Agreement, as updated via approved electronic notification. Provider shall immediately notify [redacted] in the event any of the information listed in Appendix A changes. The Parties agree that an Affiliate of Provider, new location or individual provider shall not be added to the definition of Provider under this Agreement or to this Agreement unless and until the Parties agree in writing that such Affiliate is bound to the terms of this Agreement.

2.09 Laboratory Certification. If Provider is a laboratory testing site or provides laboratory services to Covered Persons, Provider must maintain a Clinical Laboratory Improvement Amendment ("CLIA") Certificate of Waiver, Certificate of Accreditation, or a Certificate of Registration along with a CLIA identification number.

2.10 Credentialing/Recredentialing. Provider must meet all applicable Credentialing/Recredentialing requirements prior to the effective date of this Agreement. In the event Provider has not been credentialed prior to the Effective Date of this Agreement, this Agreement shall not take effect until Provider is credentialed.

Provider acknowledges that it has access to applicable Credentialing Policies and Procedures and agrees to comply with same. [redacted] shall have no obligation to pay providers that are not fully Credentialed for any services rendered prior to the completion of the Credentialing requirements. Provider acknowledges that [redacted] may delegate Credentialing/Recredentialing to another entity.

2.11 In-Network Referrals and Transfers. Provider shall use its best efforts to refer Covered Persons to Participating Providers within the Network.

2.12 Provider Insurance. Throughout the term of this Agreement, Provider shall maintain and provide proof of professional liability and comprehensive general and/or umbrella liability insurance acceptable to [redacted] and as required by Credentialing requirements, along with other insurance as necessary to protect Provider and its agents, officers, directors, trustees, members and employees acting within the scope of their duties against any Claim(s). Provider shall notify [redacted] not more than five (5) days after receipt of notice of any reduction, cancellation, or non-renewal of such coverage. Provider shall also give [redacted] prompt written notice of all complaints involving Covered Persons that are filed before any court or arbitration organization (such as AHLA or JAMS) alleging misconduct or unlawful discrimination on the part of Provider and/or any health professional employed by, agent of or independent contractor of Provider and which result in an adverse decision. [redacted] and Provider may satisfy this paragraph by self-insurance programs which are lawful in structure and amounts of retained limits.

2.13 [redacted]. [redacted] shall maintain insurance of the nature and in the amounts as may be required by Law.

2.14 Covered Person Identification. [redacted] shall ensure Covered Persons have a means of identifying themselves as a Covered Person by issuing a paper, plastic, electronic or other document to each Covered Person. The identification shall permit Provider to determine a Covered Person's participation in a Health Benefit Plan. The existence of such identification is not a guaranty of payment from [redacted] and the lack of identification does not mean the individual is not a Covered Person. Provider is required to confirm an individual's eligibility for Health Services prior to submitting a Claim to [redacted]

2.15 Grievance System. [redacted] shall maintain and administer a grievance system for Covered Persons. Provider agrees to cooperate with [redacted] in the resolution of complaints made by Covered Persons and comply with all final determinations made by [redacted] Complaints received by [redacted] concerning services rendered by Provider and/or its employees, agents, subcontractors will be resolved in accordance with the grievance procedure.

2.16 [redacted] Access to Covered Persons. When a Covered Person's medical condition permits Provider, to the extent applicable and allowed by Law, agrees to allow [redacted] or its representatives access to the Covered Person, or a person acting on behalf of the Covered Person, to discuss [redacted] benefits, discharge planning, follow-up care and other pertinent [redacted] processes or requirements.

2.17 Description of Covered Services. [redacted] shall make available a description of Covered Services through the [redacted] Provider Website, and/or other methods of communication as deemed appropriate by [redacted] or as required by Law.

2.18 Accessibility. Provider agrees to keep reasonable office hours or facility hours for Covered Persons in accordance with [redacted] Policies and Procedures or as required by Law. Provider agrees to provide Covered Persons with access to Covered Services without undue delay and as soon as necessary in consideration of the Covered Person's medical condition.

2.19 Quality Improvement and Utilization Management. Provider agrees to cooperate with, participate in, and comply with the requirements of [redacted] quality improvement and utilization management programs. Provider agrees that [redacted] may use Provider's performance data for [redacted] quality improvement activities. Upon reasonable notice and at reasonable hours, [redacted] or its agents may inspect Provider's premises and operations to ensure that such premises and operations are appropriate to meet Covered Persons' needs and to comply with quality assurance guidelines. Provider shall notify [redacted] five (5) days of the initiation of any complaint, inquiry, investigation, or review with or by any licensing or regulatory authority, peer review organization, Provider committee, or other committee, organization or body which reviews quality of medical care if such action involves or is related to a Covered Person. Further, Provider shall notify [redacted] within five (5) days after it has been determined that the basis for any such complaint, inquiry, investigation, or review is substantiated (an adverse outcome).

Provider will assist [redacted] in fulfilling [redacted] legal obligations with respect to the collection and reporting of data including, but not limited to, HEDIS and STARs requirements.

2.20 Referral Incentives/Kickbacks. Provider represents that Provider does not give, provide, condone, or receive any incentives or kickbacks, monetary or otherwise, in exchange for a referral of a Covered Person. Further, if a Claim is attributable to an incentive or kickback, such Claim shall not be paid, and if paid shall be considered an Overpayment due to [redacted]

ARTICLE III
CLAIMS AND PAYMENTS

3.01 Claims and Encounters. Provider shall submit Claims and accurate and complete encounter data to [redacted] for all Covered Services in accordance with Policies and Procedures and applicable Law. Upon [redacted] request, Provider will, at no cost to [redacted] supply [redacted] electronically an itemized bill and supporting medical records for Health Services rendered to Covered Persons.

3.02 Time to File and Payment of Claims. Provider shall submit Clean Claims within the time frames set forth on the applicable Policies and Procedures and Product Specific Exhibits, and [redacted] will adjudicate and pay those Clean Claims for Covered Services within the times frames provided in Policies and Procedures and Product Specific Exhibit(s),

3.03 Payment in Full.

(a) Provider agrees to accept as payment in full, in all circumstances, for Covered Services, the payment set forth in the Product Specific Exhibit(s) whether such payment is in the form of a Cost Share, a payment by [redacted] or payment by another source. In no event shall [redacted] be obligated to pay Provider any amounts in excess of the payment set forth in the Product Specific Exhibit(s) less any applicable Cost Shares or payments to Provider by another source including, but not limited to,

payments received in connection with coordination of benefits. Provider agrees to accept the payment set forth in the Product Specific Exhibit(s) as payment in full from [redacted] even if the Covered Person has not yet satisfied his or her Cost Shares.

(b) Provider shall bill and collect the Cost Shares owed by Covered Persons. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. Except as permitted by Law, Provider shall not bill or collect from Covered Persons payment of Covered Services in excess of Cost Share amounts provided in applicable Health Benefit Plan(s) including, but not limited to, in the event of insolvency of [redacted] breach of this Agreement, or denials or adjustments based on miscoding or other billing errors.

3.04 **Non-Covered Services**. [redacted] has no obligation to compensate Provider for Non-Covered Health Services. Provider agrees that in order to seek payment from a Covered Person for Health Services that are not Medically Necessary or experimental/investigative, Provider must, in advance of providing such Health Services, give the Covered Person written notice and the Covered Person must acknowledge, in writing, receipt of such notice that the Health Services that are not Medically Necessary, nor experimental/investigative are Non-Covered Services, and that the Covered Person will be responsible for payment of such Non-Covered Service. Such advanced written notice shall also include an estimated amount of the cost of the Non-Covered Services and contain all other information that is required by Policies and Procedures and Law. Provider may bill Covered Persons for such Non-Covered Services only in accordance with the provisions of this Agreement. Any payments made by [redacted] to Provider or representatives of Provider for Non-Covered Services may be recovered as Overpayments pursuant to the terms of this Agreement, Policies and Procedures, and Product Specific Exhibit(s), to the extent permitted by Law.

3.05 **Subrogation, Recovery, and Coordination of Benefits.** Provider agrees to cooperate with [redacted] and promptly provide information regarding subrogation, recovery, and coordination of benefits, as set forth in the Policies and Procedures and Product Specific Exhibit(s).

3.06 **Covered Person Held Harmless**. Provider agrees to hold all Covered Persons harmless in accordance with the Product Specific Exhibit(s) or as required by applicable Law.

3.07 **Pre-Determination of Coverage**. [redacted] shall provide a method for verifying whether a Health Service is a Covered Service pursuant to the terms of a Health Benefit Plan. Provider agrees to comply with any applicable precertification and/or prior-authorization requirements in the Policies and Procedures. Provider agrees that determinations or representations that an individual is a Covered Person that the services requested are Covered Services, or a determination of whether a Health Service is Medically Necessary is not a final determination of Claim payment, unless otherwise provided by Law. Payment of the Claim is subject to all the terms and conditions of the applicable Health Benefit Plan.

3.08 **Claim Denial Appeals**. Appeals of Claims denied by [redacted] be processed in accordance with the time frame and requirements of the applicable the Policies and Procedures and Product Specific Exhibit.

3.09 **Reviews and Audits**. The following provisions apply to reviews and Audits conducted by [redacted]

(a) [redacted] shall have the right to review Provider's Claims prior to payment for appropriateness in accordance with industry standard billing rules Policies and Procedures. Such standard billing rules

include, but are not limited to: (a) CPT and HCPCS coding; (b) UB manual and editor; (c) CMS rules, including bundling/unbundling rules and multiple procedure billing rules; (d) NCCI Edits; and (e) FDA definitions and determinations of designated implantable devices, implantable orthopedic devices, and specialty pharmacy and drugs. Such reviews are not considered audits.

(b) [redacted] shall have access to any of Provider's books, contracts, medical records, patient care documentation, payment and other financial data and records that pertain to any aspect of Health Services provided to Covered Persons for inspection and audit as may be reasonably required by [redacted] to satisfy the terms of this Agreement, Policies and Procedures, Health Benefit Plans or as required by Law. In lieu of on-site access and at [redacted] request, Provider shall submit requested records to [redacted] within thirty (30) days at no cost to [redacted] In addition, Provider shall make records available, at no cost, to [redacted] and/or state and federal authorities in connection with Covered Persons grievances, complaints, and appeals. Provider acknowledges that failure to submit records to [redacted] in connection with the review of a Claim may result in a denial of that Claim under review.

(c) Termination of this Agreement shall not terminate or otherwise limit [redacted] rights under this Section.

3.10 **Claim Adjustments**. Each Party shall inform the other within sixty (60) days after discovery of any Overpayment or any underpayment and both parties shall take prompt and effective measures to remedy such Overpayment or underpayment. A Party may recover an Overpayment or underpayment in accordance with this Agreement, Policies and Procedures and Law.

If [redacted] determines that an Overpayment has been made to Provider, [redacted] will notify Provider of such Overpayment and the Provider shall refund any amounts due within thirty (30) days. If Provider does not remit payment to [redacted] within thirty (30) days, [redacted] off-set such payment against future Claim payments owed to Provider by [redacted] to the extent permitted by applicable Law. If Provider disagrees with any determination by [redacted] that Provider has received an Overpayment, Provider shall have the right to appeal such determination as provided in Policies and Procedures; however, such appeal shall not suspend [redacted] right to recover the Overpayment during the appeals process, unless otherwise prohibited by Law.

3.11 **Never Event(s)**. "Never Event" means errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, as further defined by CMS or such other guidance issued by CMS. Notwithstanding any provision in this Agreement to the contrary, when any Never Event occurs with respect to a Covered Person, the Provider shall neither bill, nor seek to collect from, nor accept any payment from [redacted] or Covered Person for such events. If Provider receives any payment from [redacted] or Covered Person for a Never Event, it shall refund such payment to the person or entity making the payment within ten (10) business days of becoming aware of such receipt or [redacted] may offset amounts owed from future payments in accordance with Law. Further, Provider shall cooperate with [redacted] to the extent reasonable, in any [redacted] initiative designed to help analyze and/or reduce Never Events.

3.12 **False Claims**. Any falsification or concealment of material fact made by Provider when submitting Claims may be prosecuted under Law. Provider shall comply with all requirements of Section 6032 of the Deficit Reduction Act of 2005, as codified by Section 1902(a)(68) of the Social Security Act.

3.13 **Survival**. This entire Article shall survive even after termination of this Agreement and the "Covered Person Held Harmless" Section will supersede and oral or written contrary agreement.

ARTICLE IV
INFORMATION AND RECORDS

4.01 **Confidentiality**. Provider acknowledges and agrees that all information relating to [redacted] quality assurance, utilization management, risk management, Policies and Procedures, this Agreement, including rates of compensation payable under this Agreement and all other information related to [redacted] programs, Policies and Procedures, is confidential and proprietary information. Provider shall not disclose any such information to any person or entity without [redacted] express written consent or as required by Law. Notwithstanding the terms of this provision, Provider may disclose such information to its legal or business advisors as long as such legal or business advisors agree to keep such information confidential according to the terms of this Agreement. Provider shall immediately notify [redacted] in the event that Provider is required to disclose [redacted] confidential and proprietary information to a third party other than its legal or business advisors including, but not limited to, disclosure to a Government Authority or pursuant to a court order.

4.02 **Records**. [redacted] and Provider agree that clinical records of Covered Persons shall be regarded as confidential and both shall comply with all applicable Laws regarding such records. Provider shall be responsible for obtaining Covered Persons' consent for release of medical record information by Provider when such consent is required by Law. Provider shall:

(a) maintain and furnish such records and documents as may be required by regulators, CMS or their designees, or by Laws and [redacted] requirements. Provider shall cooperate with [redacted] to facilitate the information and record exchanges necessary for the payment of Claims, quality improvement program, Credentialing/Recredentialing, utilization management, peer review, transfer of records to providers, and other programs required for [redacted] administration of this Agreement;

(b) provide [redacted] or its designee with access during regular business hours and upon reasonable notice to specified clinical and medical records of all Covered Persons maintained by Provider. [redacted] shall have access to records for the period of at least ten (10) years following termination of this Agreement, from the date of completion of any audit or as long as required by Law, whichever is later;

(c) provide, at no cost, to [redacted] or its designee copies of such records as may be requested by [redacted] for purposes of any audit required by Law or accreditation organizations;

(d) place any and all advance directives in a prominent place within the Covered Person's medical record;

(e) provide Covered Persons with timely access to their own clinical records in accordance with Laws;

(f) share information about Covered Persons with other providers in a confidential manner, using adequate privacy and security mechanisms to send and receive Covered Persons' information, and in accordance with applicable Laws;

(g) in the event that a Covered Person is transferred to another provider, transmit copies of all records regarding such Covered Person to [redacted] or the provider assuming the responsibility for care of the

Covered Person, within ten (10) days of the request for records, and subject to obtaining necessary authorization for release of medical records as required by Law.

4.03 **Destruction of Information.** Should Provider receive from [redacted] misrouted information about an individual that Provider is not currently treating, Provider shall immediately destroy any misrouted information, safeguard the information for as long as it is retained, or immediately contact [redacted] to report receipt of such misrouted information.

4.04 **Access to Data**. Provider and [redacted] represent that in conducting their operations, they shall each collect, share, and review certain quality and clinical data as permitted by Law. Where available, the Parties will work together in good faith to share such data with one another through health information exchanges ("HIEs") (when applicable) in furtherance of treatment purposes, payment purposes, or health care operations as defined in HIPAA (45 CFR 164.501) or as revised. In the absence of an option to share clinical data via HIEs, direct electronic medical record system (or equivalent) will suffice. Within three (3) months of the Effective Date, the Parties shall use their best efforts to initiate and implement a process whereby Provider and [redacted] will share clinical data through the methods described above, with such process developed in accordance with Law.

4.05 **Use of the Name**. Provider agrees that Provider's name, office locations, office telephone numbers, addresses, specialties, board certifications, hospital affiliations, and other demographic information may be included on [redacted] Provider Website in [redacted] provider directories or such other written or electronic literature distributed to existing or potential Covered Persons or Participating Providers. Provider's use of [redacted] name shall only be used upon prior written approval or as the Parties may agree; provided, however, that Provider may use [redacted] name to advise the public that Provider is a Participating Provider.

ARTICLE V
RELATIONSHIP OF PARTIES

5.01 **Independent Contractor**. This Agreement is not intended to create, nor shall it be construed to create any relationship between [redacted] and Provider other than that of independent entities contracting for the purpose of effecting provisions of this Agreement. Neither Party, nor any of their representatives shall be construed to be the agent, employer, employee, partner, member of joint venture, or representative of the other.

5.02 **Medical Independence**. Nothing in this Agreement, including Provider's participation in the quality improvement program and utilization management process shall be construed to interfere with or in any way affect Provider's obligation to exercise independent medical judgment in rendering Health Services to Covered Persons. Provider understands and agrees that payments made to Provider by [redacted] under the terms of this Agreement are not in any way intended as an inducement to reduce or limit Provider's provision of Health Services to any Covered Person. [redacted] agrees not to prevent Provider and its employees and agents from discussing all treatment options with Covered Persons. [redacted] will not penalize Provider for good faith reporting to state or federal regulators regarding any practice that jeopardizes patient health or welfare.

5.03 **Physicians, Agents, Employees, and Equipment**. At Provider's sole expense, Provider may employ, subcontract, and use agents and employees that are necessary to provide Covered Services to Covered Persons. Provider shall not employ or contract with any individuals who have been debarred or excluded by any state or federal agency. [redacted] may not control, direct, or supervise Provider's employees, agents and subcontractors in the provision of Covered Services, but Provider shall ensure that all applicable individuals undergo

Credentialing/Recredentialing and oversight under applicable standards, and services provided by them shall comport with [redacted] Policies and Procedures.

ARTICLE VI
TERM AND TERMINATION

6.01 **Term of the Agreement.** This Agreement shall begin on the Effective Date and continue for one (1) year and thereafter will automatically renew for successive one (1) year terms unless written notice of termination is provided by a Party in accordance with this section.

6.02 **Termination.** Unless otherwise set forth in a Product Specific Exhibit, this Agreement may be terminated as follows:

6.03 **Termination Without Cause**. Either Party may terminate this Agreement or any Appendix or Exhibit hereto within at least one hundred and eighty (180) days' written notice to the other party, unless a longer notice period is otherwise required by the terms of a Product Specific Exhibit or Law.

6.04 **Termination for Breach of Agreement - Option to Cure Breach.** In the event a Party fails to comply with any material term of this Agreement, the other party may notify the breaching party of its breach in writing detailing the nature of the issue(s) giving rise to the breach. The breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within the cure period, the non-breaching party may terminate this agreement, which termination shall be no earlier than ninety (90) days from the date of the end of the cure period.

6.05 **Termination for Breach of Agreement - No Option to Cure Breach.** This Agreement and all Appendix(es) and Exhibit(s) shall terminate immediately upon the reasonable determination by [redacted] that any of the following have occurred:

(a) Provider is convicted of a felony;

(b) Provider has filed a petition for bankruptcy or liquidation or otherwise becomes insolvent;

(c) Provider's loss or suspension of license or is otherwise restricted from providing Covered Services;

(d) Provider's insurance coverage as required under the terms of this Agreement has lapsed;

(e) Provider has committed a fraud or material misstatement in materials submitted to [redacted] or government agency;

(f) Provider has placed the health of a Covered Person in jeopardy;

(g) Provider fails to maintain compliance with [redacted] applicable Credentialing/Recredentialing requirements or other [redacted] requirements for participation in a Network;

(h) Provider is ineligible or excluded from participating in a government sponsored Health Benefit Plan; or in the case of an employee or contractor of Provider, Provider fails to remove such individual from responsibilities related to this Agreement.

[redacted] may terminate an individual health care provider from providing Covered Services under this Agreement as specified by this Section.

6.06 **Insolvency or Cessation of Operations**. Provider agrees that, in the event of [redacted] insolvency or cessation of operations, Covered Services shall continue through the period of paid premium or discharge from an inpatient facility, whichever period is greater. If a Covered Person is hospitalized at time of insolvency or cessation of operations, Covered Services provided in an inpatient facility will continue until the services are no longer medically necessary.

6.07 **Continuation of Care.** Provider shall provide continuation of care health services requirements required by Policies and Procedures, Appendix(es), Product Specific Exhibit(s) or Law. Further, provisions included herein related to continuation of care shall survive termination of the Agreement and will supersede any written contrary agreement.

6.08 **Patient List.** Within 5 days of receiving notice of termination from [redacted] or providing notice of termination to [redacted] Provider shall provide a list of Provider's patients who are Covered Persons that will allow [redacted] to provide notice to Covered Persons as required by applicable law.

ARTICLE VII
INDEMNIFICATION AND LIMITATION OF LIABILITY

7.01 **Indemnification**. To the extent allowable under Mississippi law, [redacted] and Provider shall each indemnify, defend, and hold harmless the other Party and its directors, officers, employees, agents, Affiliates and subsidiaries, from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from (1) the indemnifying Party's violation of any Law or standard of care or (2) the indemnifying Party's performance or non-performance of any obligations under this Agreement. The obligation to provide indemnification under this Agreement shall be contingent upon the Party seeking indemnification providing the indemnifying Party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided, however, that the indemnifying Party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes fault or imposes any restrictions or obligations on an indemnified Party without that indemnified Party's prior written consent which shall not be unreasonably withheld, and cooperating with the indemnifying Party in connection with such defense and settlement.

7.02 **Limitation of Liability**. To the extent allowable under Mississippi law, in no event shall either Party be liable to the other Party for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portions of any multiplied damage award, or incidental, indirect, consequential, exemplary, special or punitive damages.

7.03 **Period of Limitations**. To the extent allowable under Mississippi law and unless otherwise provided for in this Agreement or required by Law, neither Party shall commence any action against the other to recover on any claim arising out of this Agreement or action in law or equity more than two (2) years after the event(s) which gave rise to such claim, unless compliance with this section would compel a Party to violate the terms of a Health Benefit Plan. Where Provider believes that [redacted] underpaid a Claim, the event giving rise is the date when [redacted] first denies the Claim or first pays less than the amount expected by Provider. Where [redacted] believes that it overpaid Provider, the event giving rise is the date when [redacted] provides notice to Provider of the Overpayment. The deadline for initiating an action shall not be tolled by the appeal process or any other administrative process. This two (2) year limitation does not apply to any claim related to fraud, waste, or abuse.

ARTICLE VIII
DISPUTE RESOLUTION AND GOVERNING LAW

8.01 **Dispute Resolution**. The Parties will use good faith efforts to resolve any issue, dispute or controversy arising out of or relating to this Agreement. Prior to electing the dispute resolution process contained in this Agreement, Provider must exhaust the applicable internal and external review or appeal process provided in Policies and Procedures, Product Specific Exhibit(s) and Law. Provider will provide [redacted] written notice of a dispute and within thirty (30) days of receipt of such notice, the representatives of both Parties will have a conference call or shall meet to exchange relevant information to attempt to resolve the dispute. The notice of the dispute must contain a detailed description of the amounts in dispute, and how those amounts have been calculated, and other information relevant to the dispute. If either Party intends to have an attorney attend a meeting or participate in a conference call, it will notify the other Party at least two (2) business days before the meeting to enable the other Party to also be accompanied by an attorney. All negotiations pursuant to this provision will be treated as compromise and settlement negotiations for purposes of evidentiary rules. If the Parties are not able to resolve the matter within sixty (60) days of the initial notice, each Party is free to pursue binding arbitration. The Parties, however, may agree to extend any deadline within this paragraph.

8.02 **Governing Law and Venue**. The Parties agree to the governing law and venue provisions set forth in the Product Specific Exhibit(s). The Parties agree that the Product Specific Exhibit(s) applicable to a Dispute shall be determined by the state in which the Health Benefit Plan at issue is offered, unless otherwise preempted by Law. In the event that more than one Product Specific Appendix applies, the Parties shall mutually decide upon the governing law and venue; provided, however, that if the Parties cannot agree upon such, governing law shall default to the State of Mississippi as governing law and venue shall default to [redacted], Mississippi as the sole, proper venue of any action or other proceeding between the Parties that arises out of or is in connection with any right, duty or obligation under this Agreement.

ARTICLE IX
MISCELLANEOUS TERMS

9.01 **Contracting Authority**. Provider represents and warrants that it has full legal authority to bind its employed physicians, practitioners and the Affiliates listed on Appendix A to the terms of this Agreement. [redacted] represents that it has full legal authority to bind its Affiliates to the terms of this Agreement.

9.02 **Change in Law**. Any change, including any addition and/or deletion, to any provision(s) of this Agreement, that is required by duly enacted Law shall be deemed to be part of this Agreement effective

immediately without further action required to be taken by either Party to amend this Agreement to effect such change or changes, for as long as such Law is in effect and applicable to the operation of this Agreement. However, in the case of a change in Law or guidance by CMS, the Parties shall deem the Agreement to be amended with such new or revised language or requirements.

9.03 **Compliance with Laws/Regulatory Requirements**. Provider shall perform its duties, and shall cause its employees, agents, and subcontractors to perform their duties, in compliance with all applicable Laws, rules, regulations, standards of professional ethics and practices, government directives, and contractual obligations of [redacted] Provider acknowledges, understands, and agrees that this Agreement and any subsequent amendments may be subject to review and approval by state and federal agencies with regulatory authority subject matter to which this Agreement may be subject. Any modifications of this Agreement required by such agencies or required by Law shall be incorporated herein as provided in the Amendment section.

9.04 **Assignment and Delegation**.

9.04.01 **By Provider**. Provider may not assign or transfer this Agreement to any person or entity without [redacted] prior written consent. Any attempted assignment, novation, or transfer without same shall be considered null and void. For the purposes of this provision, a change in control from a merger, stock transfer, consolidation, change in majority ownership or sale or transfer of a majority of stock ownership shall be considered an assignment, novation or transfer, even if it occurs through operation of law. Any attempted assignment in violation of this paragraph shall be void.

Provider may not delegate or subcontract its provider services or other contractual obligations under this Agreement without [redacted] prior written consent. Provider agrees that [redacted] or any applicable governmental authority shall have the right to suspend or terminate any delegation or subcontract where, in its sole discretion, it is determined that provider or the delegate or subcontractor has performed unsatisfactorily. Any subcontract or delegation must be in writing and oblige the subcontractor to abide by the terms of this Agreement and applicable Laws.

9.04.02 **By** [redacted] may not assign by operation of law or otherwise, delegate, transfer in whole or part, without the prior written consent of Provider, except that [redacted] retains the right to assign, by operation of law or otherwise, delegate or transfer in whole or part, this agreement to an Affiliate.

9.05 **Non-Exclusivity**. The Parties enter into this Agreement on a nonexclusive basis. [redacted] reserves the right to establish other networks or subnetworks for certain or all Health Services for one or more Health Benefit Plans, based on quality, cost, effectiveness or other criteria, which may involve differential Cost Shares or other Covered Person incentives. In such event, [redacted] agrees to provide Provider with written notice at least sixty (60) days in advance of implementation of such network or subnetwork.

9.06 **New Health Benefit Plan(s)**. Unless prohibited by Law, [redacted] reserves the right to determine, in compliance with applicable Laws, which new Health Benefit Plan(s) Provider shall participate in and does not guarantee Provider's participation in new Health Benefit Plan(s) that [redacted] may introduce. Notwithstanding, [redacted] represents that Provider shall have the ability to participate in new products, provided Provider meets all criteria and standards established and evaluated by [redacted]

9.07 **Entire Agreement**. This Agreement contain all the terms and conditions agreed upon by the Parties and supersedes all other agreements, express or implied, regarding the subject matter hereof. Any amendments hereto and the terms contained therein shall supersede those of other parts of this Agreement in the event of a conflict.

9.08 **Enforceability and Waiver**. The invalidity and non-enforceability of any term or provision of this Agreement shall in no way affect the validity of enforceability of any other term or provision. The waiver by either Party of a breach of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach thereof.

9.09 **Regulatory Approval**. Where regulatory approval is needed for the Agreement, and [redacted] has not received same, the Agreement is not effective until the Parties receive the required approval. In the event regulatory approval is not obtained, the Agreement is null and void.

9.10 **Notice**. All notices and other communications required to be given under this Agreement shall be in writing and either: (i) sent via e-mail with proof of receipt; (ii) via [redacted] provider portal; or (iii) deposited in first class United States mail, certified, with postage prepaid to the addressees set forth on the signature page of this Agreement; provided, however, that Provider shall also provide a copy of any notice sent pursuant to this Agreement to [redacted] Notices sent pursuant to this section shall be deemed given on the date received by the recipient. If a recipient rejects or refuses to accept notice given pursuant to this section, such notice shall be deemed received two (2) days after such notice was sent.

9.11 **Conflict Between Documents**. If there is any conflict between this Agreement and the Policies and Procedures, [redacted] Provider Website, or other manuals or documents, then this Agreement shall control.

9.12 **Amendment**.

9.12.01 **Non-Regulatory Amendments.** The Parties may amend this Agreement and/or any Product Specific Exhibit, or other attachment, at any time by mutual written amendment or as otherwise specified in a Product Specific Exhibit.

9.12.02 **Regulatory Amendments.** [redacted] may amend this Agreement and/or any Product Specific Appendix, or other attachment, unilaterally at any time, upon written notice to Provider where such amendment is required by Law. Any such amendment shall be effective on the date specified in the amendment or the date required by the applicable Law, whichever is earlier.

9.13 **Days.** Unless otherwise specified in a provision all date ranges in the Agreement are counted as calendar days.

9.14 **Counterparts.** This Agreement may be executed in counterparts and transmitted by mail, e-mail, or facsimile, and a scanned, electronic, or facsimile signature shall have the same force and effect as an original.

APPENDIX A
PROVIDER DIRECTORY APPENDIX

Hospital and Ancillary Providers

A. Legal Name(s) and Affiliates

B. Tax Identification Number

C. National Provider Identifier

D. Locations Affiliated with this Agreement – attach listing of all facilities affiliated with this Agreement. For Ancillary providers, provide the respective service area if providing home based services to Covered Persons.

Further, no locations associated with Provider shall be considered a Provider for the purposes of this Agreement until:

i. Provider submits a written request in accordance with the Policies and Procedures and [redacted] Policies and Procedures to add such location to this Agreement; and

ii. The location is Credentialed by [redacted]

Provider agrees that [redacted] has the right, in its sole discretion, and pursuant to its Policies and Procedures and applicable Laws, to determine whether a physician or healthcare professional may participate under this Agreement.

For Physicians Owned and/or Employed by Hospital

A. Legal Name(s) and Affiliates

B. Tax Identification Number

C. National Provider Identifier

D. Locations

E. Physicians Affiliated with this Agreement – attach listing of all physicians affiliated with this Agreement

No physician or healthcare professional associated with Provider shall be considered a Provider for the purposes of this Agreement until:

(i) Provider submits a written request in accordance with the Policies and Procedures to add such physician and/or healthcare professional to this Agreement; and

(ii) The physician and/or healthcare professional is Credentialed by [redacted]

Provider agrees that [redacted] has the right, in its sole discretion, and pursuant to its Policies and Procedures and applicable Laws, to determine whether a physician or healthcare professional may participate under this Agreement.

APPENDIX B
PROVIDER SERVICES

HOSPITAL

1. Definitions

a. "**Emergency Admission**" means an inpatient admission required to evaluate, treat, and stabilize an Emergency Medical Condition.

b. "**Emergency Medical Condition**" means as set forth in 42 U.S.C. §1395dd(e)(1), a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

c. "**Emergency Services**" means inpatient services, outpatient services or medical transportation services which are needed to evaluate, treat, or stabilize an Emergency Medical Condition.

d. **"Hospital"** means an institution that provides to inpatients diagnostic, medical, surgical, obstetrical, psychiatric, or rehabilitation care for a continuous period longer than twenty-four hours and which is classified as a "hospital" under applicable Laws.

2. General Terms

a. **Accreditation**. Provider shall, on the Effective Date and through the term of this Agreement, be accredited by The Joint Commission, the American Osteopathic Association, or another comparable accreditation organization acceptable to [redacted] Upon written request, Provider agrees to share accreditation survey findings with [redacted] and all documentation of correction of sustained contingencies.

b. **Chargemaster**. Provider shall provide [redacted] with a minimum of sixty (60) days prior written notice of any proposed increases to Hospital's Chargemaster ("**Increase Notice**"). [redacted] shall adjust any payment terms set forth in this Agreement which are impacted by Chargemaster changes in order to preserve the underlying financial agreement between the Parties.

c. **Provider's Referrals and Transfers to Participating Hospitals**. In the event a Covered Person requires Health Services that are not available at such Hospital, the Provider shall transfer Covered Person to another Participating Hospital after obtaining a written transfer order by the attending physician and prior authorization by [redacted] provided, however, that such prior authorization shall not be required in the event that the services necessitating transfer require an Emergency Admission by the receiving Participating Hospital. Provider agrees to notify [redacted] promptly, but in any event within twenty-four (24) hours or the next business day, whichever is sooner, of any such Emergency Admission transfer that did not receive a prior authorization by [redacted] (or its designee), even if [redacted] appears not to be the applicable payor.

d. **Prior Authorization**. Provider must obtain prior authorization from [redacted] before all inpatient admissions and services, except Emergency Admissions, and before furnishing any of the outpatient services specified in [redacted] Policies and Procedures or on the Provider Website which require prior authorization. If Provider fails to obtain prior authorization from [redacted] as required, then Provider shall not seek payment from [redacted] or Covered Persons and neither [redacted] nor any Covered Person, will be required to pay for such non-emergency admission or outpatient services.

e. **Emergency Services**. Provider shall provide or arrange for the provision of Emergency Services to Covered Persons seven (7) days per week, twenty-four (24) hours per day, three hundred sixty-five (365) days per year. Provider agrees to provide a copy of an emergency visit medical record regarding a Covered Person to the Covered Person's PCP within two (2) weeks of discharge. The Provider shall provide medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 U.S.C. §1395 dd(a)) and stabilize the Covered Person in all cases. Prior Authorization is not required for the provision of Emergency Services, for which the Provider will be paid according to the Attachments hereto. If the Covered Person requires non-Emergency Services that arise out of the screening assessment, Provider shall request and receive prior authorization, if required, for such non-Emergency Services prior to providing or arranging for the provision of such non-Emergency Services.

f. **Emergency Admissions**. Provider agrees to notify [redacted] promptly, but in any event within twenty-four (24) hours or the next business day, whichever is sooner, of any Emergency Admission and of any other admission that Provider did not receive a prior authorization for by [redacted] (or its designee). In the event Provider fails, to notify [redacted] of an admission, neither [redacted] nor any Covered Person will be required to pay for the services rendered prior to the time of [redacted] notification by Provider. Additionally, if [redacted] (or its designee) does not pre-authorize the services, any services provided by Provider shall also not be required to be paid by [redacted] or a Covered Person.

ANCILLARY PROVIDER

1. **Ancillary Providers** means an individual or entity that provides services, supplies or equipment (such as, but not limited to ambulatory surgery center, laboratory, home health care, hospice care, infusion therapy, durable medical equipment, dialysis or medical supplies).

PHYSICIAN AND HEALTHCARE PROFESSIONALS

1. **Primary Care Provider or PCP** means: (i) a physician with a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine who provides primary care services and who is a Participating Provider; (ii) a nurse practitioner, clinical nurse specialist, or physician assistant who provides primary care services; or (iii) any other individual or health care provider credentialed and contracted by [redacted] who contracts with [redacted] to provide or arrange for the provision of all primary care Covered Services to Covered Persons, to initiate and manage referrals, and to maintain the continuity of Covered Persons' care, as required by the applicable Law and this Agreement. [redacted] reserves the right to designate other specialties as PCPs when appropriate.

2. **Physician** means a person who has earned a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) degree and who is accepted as a practitioner of medicine under the laws of the state or province in which he or she practices.

3. **Accessibility**. Provider agrees to keep reasonable office hours or facility hours for Covered Persons for elective services and agrees to either be available for emergency needs or have a Participating Provider on call twenty-four (24) hours per day, seven (7) days per week. Provider shall provide coverage arrangements with providers who are Participating Providers in accordance with Policies and Procedures or as required by Law. Provider agrees to provide Covered Persons with access to Covered Services without undue delay and as soon as necessary in consideration of the Covered Person's medical condition.

APPENDIX C - PRODUCT SPECIFIC EXHIBIT(S)

EXHIBIT 1 – PROVISIONS APPLICABLE TO PROVIDER SERVICES RENDERED TO MISSISSIPPI MEDICAID MANAGED CARE COVERED PERSONS

This Product Specific Exhibit is expressly incorporated into this Agreement and is binding upon the Parties. The terms of the underlying Agreement apply to all services provided by Provider unless expressly addressed in this Medicaid Managed Care Product Specific Exhibit, in which case the terms of this Exhibit will supersede with respect to the line of business and/or product contained herein. In addition, the terms of this Exhibit shall be interpreted in a manner consistent with [redacted] Medicaid contract(s) with the State of Mississippi Division of Medicaid Office of the Governor ("**Medicaid Contract**").

ARTICLE I. GENERAL TERMS

1. **Definition(s).**
   - **a.** The **"Division"** means the State of Mississippi Division of Medicaid Office of the Governor.
   - **b.** The "**Department**" means the Mississippi Insurance Department.
2. **Covered Person Held Harmless**. If [redacted] fails to pay for a Covered Service(s), Provider shall not seek, pursue, or otherwise contact the applicable Covered Person requesting payment. Provider agrees that in no event, including but not limited to nonpayment by [redacted] or its agents, insolvency of [redacted] or its agents, or breach of this Agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person acting on behalf of the Covered Person for services provided pursuant to this agreement. This agreement does not prohibit Provider from collecting Cost Share amounts or fees for uncovered services delivered on a fee-for-service basis to Covered Persons. Nor does this agreement prohibit Provider and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as Provider has clearly informed the Covered Person that the service or services may not be Covered Services. Except as provided herein, this provision does not prohibit Provider from pursuing any available legal remedy.
3. **Termination of this Exhibit**: In addition to the termination requirements set forth in the Agreement, this Exhibit cannot extend beyond the terms of any contract(s) between [redacted] and the Division to service the Medicaid population.
   - **a.** In addition to the termination requirements set forth in the Agreement, this Exhibit cannot extend beyond the terms of any contract(s) between [redacted] and the State of Mississippi. Furthermore, this Agreement shall terminate immediately in the event Provider's license has been terminated. In the event of termination, Provider is obligated to submit all encounter claims for services rendered to Covered Persons while serving as a Participating Provider and provider or reference [redacted] technical specifications for the submission of such encounter data.
   - **b.** Where Provider is terminated, the reasons for a credentialing denial or termination shall be reviewed by [redacted] upon the request of Provider.

4. **Payment in Full**:

   (c) Provider agrees to accept as payment in full, in all circumstances, for Covered Services, the payment set forth in the Product Specific Exhibit(s) whether such payment is in the form of a Cost Share, a payment by [redacted] or payment by another source. In no event shall [redacted] be obligated to pay Provider any amounts in excess of the payment set forth in the Product Specific Exhibit(s) less any applicable Cost Shares or payments to Provider by another source including, but not limited to, payments received in connection with coordination of benefits. Provider agrees to accept the payment set forth in the Product Specific Exhibit(s) as payment in full from [redacted] even if the Covered Person has not yet satisfied his or her Cost Shares.

   (d) Provider shall bill and collect the Cost Shares owed by Covered Persons. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. Except as permitted by Law, Provider shall not bill or collect from Covered Persons payment of Covered Services in excess of Cost Share amounts provided in applicable Health Benefit Plan(s) including, but not limited to, in the event of insolvency of [redacted] breach of this Agreement, or denials or adjustments based on miscoding or other billing errors.

5. **Covered Person Held Harmless**: Provider agrees to hold all Covered Persons harmless in accordance with the Product Specific Exhibit(s) or as required by applicable Law. Provider agrees that in no event, including but not limited to nonpayment by [redacted] or its agents, insolvency of [redacted] or its agents, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person acting on behalf of the Covered Person for services provided pursuant to this agreement. This agreement does not prohibit Provider from collecting Cost Share amounts or fees for uncovered services delivered on a fee-for-service basis to Covered Persons. Nor does this agreement prohibit Provider and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as Provider has clearly informed the Covered Person that the service or services may not be Covered Services. Except as provided herein, this provision does not prohibit Provider from pursuing any available legal remedy.

6. **Compliance with State and Federal Law.** Provider agrees to comply with all applicable Federal and State Laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

7. **Conflict of Interest.** Provider agrees to comply with the conflict-of-interest safeguards described in 42 C.F.R. §438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent contractors. Sections 1128, 1156 and 1902(a)(68) of the Social Security Act.

8. **Time for Filing of Claims.** Provider must submit claims within 180 calendar days from the date of Services. Claims submitted within this timeframe, but denied by [redacted] may be resubmitted within 90 calendar days from the date of the denial.

9. **Governing Law and Venue**. The validity, enforceability and interpretation of this Agreement shall be governed by any applicable Laws. Madison County, Mississippi shall be the sole, proper venue of any legal action or arbitration to the extent allowable under Mississippi law and/or the regulations and contractual provisions prescribed by the Mississippi Division of Medicaid, proceeding or special proceeding between the Parties that arises out of or is in connection with any right, duty or obligation under this Agreement, and each Party agrees to submit to the jurisdiction of any court of Madison County, Mississippi in order to enforce any lawful arbitration decision issued by the American Arbitration Association and waives any objections based on forum non-convenience or to enforce any equitable remedies to protect a Party's intellectual property or confidential information.
10. **Approval.** Provider agrees that the Division and/or the Department has the right to approve this Agreement.
11. **Offshore Services**. Provider shall not perform Covered Services, or any other service under this Agreement, outside of the United States.
12. **Background Checks**. Provider represents and warrants that it and all of its Provider agents that perform services for Covered Persons have completed a criminal background check on such persons.

ARTICLE II. COMPENSATION RATES

For Medically Necessary Covered Services rendered to Covered Persons by Provider in accordance with the terms of this Agreement, Provider shall accept as payment in full the lesser of Provider's billed charges, or:

1. **Compensation Terms**
2. **Termination.** Should the Provider terminate the Agreement or this Exhibit, for any reason, the Provider will continue to provide Covered Services to Covered Persons assigned to Provider until the end of the applicable month in which the termination becomes effective.

ARTICLE III. REGULATORY LANGUAGE

1. **Transitional Care Plans.** Covered Persons that receive inpatient or psychiatric residential treatment facility Covered Services by Provider must be provided with a transitional care plan that includes outpatient follow-up and/or continuing treatment prior to their discharge.
2. **Medical Independence.** In addition, Agreement, Article V, "Medical Independence," [redacted] will not limit or prohibit Provider's ability to provide information regarding the nature of treatment options, risks of treatments, alternative treatments, or the availability of alternative therapies, consultation or tests that may be self-administered.

Where medically necessary, Provider will make referrals for social, vocational, education or other human services for Covered Persons.

3. Provider shall not be penalized or the Agreement or this Exhibit terminated by [redacted] because Provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or alternative treatments or Provider filing a complaint, grievance, or appeal on a Covered Person's behalf.

4. **Continuation of Covered Services**. Unless the Provider is terminated for cause, Provider must continue an ongoing course of treatment of a Covered Person for up to sixty (60) calendar days from the date the Covered Person is notified of the termination or pending termination, or for up to sixty (60) calendar days from the date of Provider termination, whichever is greater. A Covered Person is considered to be receiving an ongoing course of treatment from a Provider under the following circumstances:

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

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

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

   d. A Covered Person who is pregnant may continue to receive care from the Provider that is being terminated through the completion of the Covered Person's postpartum care. The transitional period may be extended by [redacted] if the extension is determined to be clinically appropriate.

5. **Insolvency or Cessation of Operations**. Provider agrees that, in the event of [redacted] insolvency or cessation of operations, Covered Services shall continue through the period of paid premium or discharge from an inpatient facility, whichever period is greater. If a Covered Person is hospitalized at the time of insolvency or cessation of operations, Covered Services provided in an inpatient facility will continue until the services are no longer medically necessary.

6. **Continuation of Care**. Provider shall provide continuation of care health services requirements required by Policies and Procedures, Appendix(es), Product Specific Exhibit(s) or Law. Further, provisions included herein related to continuation of care shall survive termination of the Agreement and will supersede any written contrary agreement.
   a. Within 5 days of receiving notice of termination from [redacted] or providing notice of termination to [redacted] Provider shall provide a list of Provider's patients who are Covered Persons that will allow [redacted] to provide notice to Covered Persons as required by applicable law.

7. **Medical Independence**. Nothing in this Agreement, including Provider's participation in the quality improvement program and utilization management process shall be construed to interfere with or in any way affect Provider's obligation to exercise independent medical judgment in rendering Health Services to Covered Persons. Provider understands and agrees that payments made to Provider by [redacted] under the terms of this Agreement are not in any way intended as an inducement to reduce or limit Provider's provision of Health Services to any Covered Person. [redacted] agrees not to prevent Provider and its employees and agents from discussing all treatment options with Covered Persons. [redacted] will not penalize Provider for good faith reporting to state or federal regulators regarding any practice that jeopardizes patient health or welfare.

8. **Compliance with the Medicaid Contract(s).** Provider agrees to incorporate all applicable terms set forth in the Medicaid Contract and to abide by same. This includes any incorporated documents to those Medicaid Contracts and all applicable state and federal law, as amended.

[END OF RESPONSE]

4.2.2.3 CARE MANAGEMENT

Our integrated care management (ICM) system empowers Mississippians to recognize their strengths throughout the care planning process with the goal of fully managing their own health and wellness whenever possible. Our system, accredited by the National Committee for Quality Assurance (NCQA), supports a comprehensive data-driven approach to identify the specialized needs of communities and the medical, behavioral, and social needs of our members across the state with care management services and supports provided by Mississippi-based care managers. **Our mission of making a lasting difference in our members' lives by improving their health and well-being is supported by our next generation member engagement and education programs.**

Integrated care management is a foundational component of our population health management strategy, which is aligned with industry best practices and complies with all Mississippi and federal regulatory requirements. We know that social determinants of health (SDOH) are key drivers of health care access, utilization, and outcomes. Our ICM system holistically addresses MSCAN and CHIP members' physical, behavioral, and social needs. Our ICM team ensures MSCAN and CHIP members' cultural, linguistic, spiritual preferences and health literacy are respected and incorporated to drive optimal health outcomes. We use data from a variety of internal sources and publicly available health data, including SDOH and health equity data, to inform program design, member identification, and individualized interventions. This data informs our 360-degree view of the MSCAN and CHIP member, their needs, and their care plans to assure better health outcomes**. Our unparalleled access to real-time data through connection to a statewide health information exchange (HIE) and bidirectional interoperability with provider EHRs improves coordination of care, resulting in improved health outcomes and decreased avoidable high-cost utilization.** This data will be leveraged by our care managers and provider network for immediate engagement and interventions. Supported by our best-in-class integrated care management platform, our local, knowledgeable Mississippi-based care management teams focus on cultivating relationships with our members and providers to fully address the needs of our members. Our team consists of registered nurses, licensed practical nurses, social workers, paramedics, and/or allied health professionals.

Our demonstrated record of accomplishments and successful outcomes in addressing social needs differentiates us from other offerors, and our aligned payor-provider model further supports this integration. We target health equity factors that create barriers to health and well-being as the catalyst to seek solutions addressing member needs such as food, transportation, housing, jobs, education, social connectedness, and access to care. As an example of our success in targeting social needs, 42% of members participating in our employment support programs attained full- or part-time employment with a 65% retention rate in their new jobs. Many of our programs use non-Medicaid funding and demonstrate our commitment to responsible stewardship of Mississippi taxpayer funding. **Our ultimate goal is to empower Mississippians to become more self-reliant, health literate, economically self-sufficient, and reduce the number of individuals requiring MSCAN and CHIP services.**

4.2.2.3.A Care Management Proposal

The ICM system is overseen by our Mississippi medical director and is monitored by the utilization management/care management committee, which reports to the quality management improvement committee, ensuring accountability for all care management activities. Our ICM system adheres to NCQA standards and practices and complies with all federal and state requirements outlined in Appendix A, Section 7. **Our ICM program consistently scores 100% in meeting all care management standards in our NCQA surveys**. Our ICM System Plan, which we will submit for approval to the state within 60 days after award of a contract, is adaptable to align with the Mississippi Division of Medicaid (the Division) evolving priorities. The plan includes but is not limited to:

- Screening/assessment tools, stratification methodology, reassessment frequency
- Member-centered care plans/services by risk levels

- Member-selected interdisciplinary care teams (ICTs) to develop and track person-centered care plans
- Integration with primary care providers (PCPs) and patient-centered medical homes (PCMHs)
- Closed-loop clinical and social services referrals and warm handoff protocols to connect members to providers, state programs, and community-based organizations (CBOs)
- Transitions of care and hospital discharge follow-up
- Reduction of preventable hospitalizations, readmissions, and emergency department (ED) utilization
- Identification of roles, reporting structures, training, and experience requirements of care management team members; stratification of caseload ratios
- Annual care management program evaluation with continuous improvement processes
- Appropriate Division-required reporting (partnership and referral reports, etc.)

Using our extensive experience delivering high quality, culturally appropriate care to Medicaid recipients, our ICM system promotes evidence-based health education, prevention, disease management, continuity of care, transition of care, and discharge planning. Leveraging our committed and fully integrated provider network, our system promotes real-time access and delivery of health care and services and coordination of care, including physical, behavioral, and substance use disorder (SUD) services. We utilize data, a health equity perspective, and community connections to drive outcomes and quality care customized to the needs of our Mississippi members and the priorities of the Division.

4.2.2.3.A.1 Describe the Offeror's overview of its proposed Care Management Strategy, including the process and criteria used for Care Management for the Members. Include relevant Performance Measures that will be used to assess the achievement of quality outcomes obtained through the Offeror's process. Address the following issues in the response:

Our care management strategies are member-focused, culturally specific, and goal-oriented to ensure each member receives timely and cost-effective services appropriate to their risk level and individualized needs.

Process and Criteria for Care Management: Our care management approach is grounded in population health principles acknowledging the impact of health inequity and unmet social needs. Any member can access care management at any time in their healthcare journey. Integrating requirements of Appendix A, including all mandatory assignments, we have outlined our criteria for care management in Table 4.2.2.3_A.

Table 4.2.2.3_A: Criteria for Care Management Risk Leveling

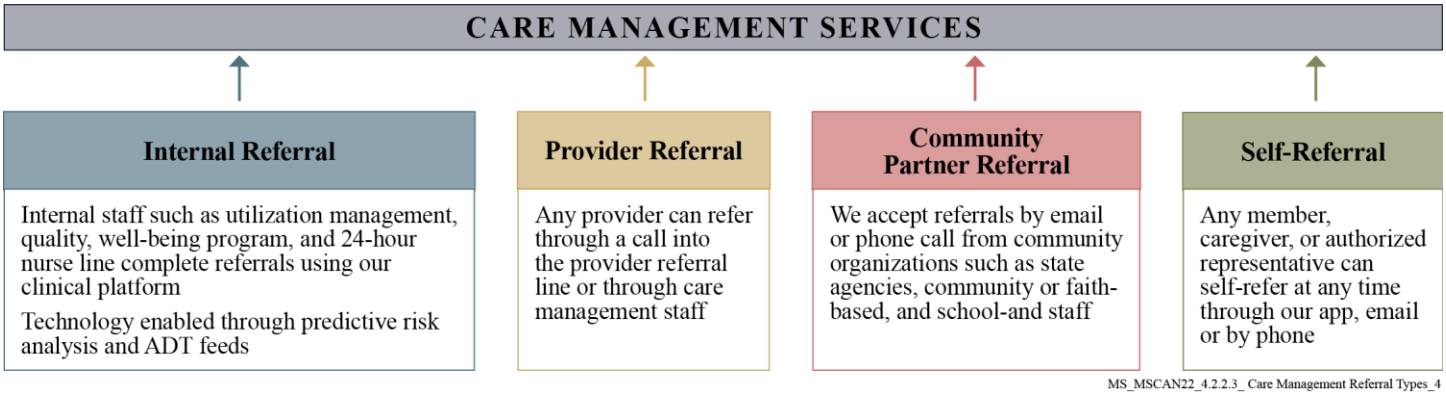
High Risk		Medium Risk	Low Risk
Intensive	**Complex**		
▪ 4+ acute stays in 6 months ▪ 4+ ED visits in 6 months	▪ 2+ acute stays/ED visits in 6 months	▪ 1 acute stay in 6 months ▪ 2 ED visits in 6 months	▪ 1 ED visits in 6 months ▪ 1 acute stay in 6 months
▪ 4+ qualifying diagnoses ▪ 3+ SDOH triggers ▪ Identified high-risk zip code ▪ Multi-system youth ▪ CAGE-AID score 2+ ▪ Industry standard tool score >1611	▪ 4+ qualifying diagnoses ▪ 3 + SDOH triggers ▪ Identified high-risk zip code ▪ Multi-system youth ▪ CAGE-AID score 2+ ▪ Industry standard tool score 929-1610	▪ 1+ qualifying diagnoses ▪ 1-3 SDOH triggers ▪ Identified medium-risk zip code ▪ CAGE-AID score 2+ ▪ Industry standard tool score 631-928	▪ 1-2 qualifying diagnoses ▪ 1-2 SDOH triggers ▪ Industry standard tool score < 630
▪ PHQ9 score 20-27 ▪ CANS for children score 3	▪ PHQ9 score 15-20 ▪ CANS for children score 3	▪ PHQ9 score 10-14 ▪ CANS for children score 2	▪ PHQ2 score < 3
▪ 4+ identified unmet needs ▪ 5+ pain rating with or without treatment	▪ 4+ identified unmet needs ▪ 5+ pain rating with or without treatment	▪ 3+ identified unmet needs ▪ 5+ pain rating with or without treatment	▪ 1-2 identified unmet needs ▪ < 5 pain rating without treatment

We use several processes to ensure we identify members in need of care management services. We complete the HRS with members upon enrollment, following significant change events, and annually thereafter to identify care management needs. We use predictive analytics of member chronic conditions, SDOH needs, pharmacy

and claims data, rising risk factors, and utilization patterns to proactively identify members who may need care management services. We will also connect members to care management through referrals, leveraging the deep community presence of our fully integrated provider and community partners. (Figure 4.2.2.3_A).

Figure 4.2.2.3_A: Referrals into Care Management Services

There are no wrong doors for members to engage in care management services.



Staffing to Meet Member Needs

To serve the diverse needs of our MSCAN and CHIP members, our member-centered ICM program is staffed by Mississippi-based ICM teams to address the specific needs of our members. We use geospatial intelligence and heat mapping to place regional ICM teams based on member population density and areas of high need. For example, in the Delta, more than 35% of babies are born to women under the age of 24, and preterm birth, low birth weight, and infant mortality are significantly higher compared to the rest of the State and the country.[1] The prevalence of preterm birth and infant morbidities drives placing a care management team including maternal high-risk specialist care managers in the region to ensure access to prenatal care and address SDOH, leading to healthy deliveries. Because our staff members live in the same communities as our members, they understand local healthcare/social landscapes and can readily link members to culturally and linguistically appropriate services. The teams coordinate with local resources to facilitate collaboration directly in the community, sometimes co-locating in care settings to increase member access to critical care management services. Our teams will take the lead or co-manage care (by member choice) and will work in partnership with hospitals, community mental health centers (CMHCs), CBOs, and faith-based organizations.

Our specialist care managers have extensive experience in complex care management preparing them to serve high-risk members (e.g., high-risk maternal/infant, NICU). Care managers facilitate transitions of care for their assigned members; those who do not have existing care management relationships, such as new members, work with our transition of care specialist care managers. Our intensive care managers provide support for certain high-risk populations (e.g., members with serious mental illness/substance use, individuals with intellectual and developmental disabilities who are waitlisted for waiver services, and children in foster care). They also focus on members who are at risk for short- and long-term placement in institutions and manage transitions from higher to lower levels of care by coordinating funded and unfunded services.

Partnering with Providers

We will be a collaborative partner to providers to ensure members receive care management services through:

- Facilitation of knowledge-driven care through bidirectional, real-time communication with providers
- Augmentation of provider capacity by delivering integrated care management services to address member unmet social and clinical needs, allowing providers to focus on providing high-quality medical and behavioral care; upon contract award, we will embed care managers in high-volume, under-resourced practices

[1]National Institute for Children's Health Quality, Mississippi Case Study_FINAL for WEB.pdf (nichq.org), accessed 2/9/2022

- Provider education about care management services and covered/non-covered benefits through the provider portal, care managers, and provider representatives; seamless referrals to care management through the provider portal and/or dedicated telephone line
- Provider participation in interdisciplinary care teams to develop and track member-driven care planning
- Provider-led meetings with PCMHs and other designated provider groups to discuss clinical issues, such as gaps in care and difficult to engage members

Performance Measures and Quality Outcomes for Care Management: Our care management team continuously monitors health outcomes and utilization to drive better care for the members they manage through in-person and telephonic contact, tracking and follow up of closed-loop referrals, and working with PCPs/PCMHs to identify and close gaps in care. Our care managers use data from the integrated clinical platform to close gaps in care and collaborate with providers to identify care gap opportunities. For example, we identify specific members who have not received recommended well-child screenings and work with both the member and the provider to complete those services. In addition, our operational excellence provides our care managers with real-time data (e.g., ED utilization, inpatient admissions/readmissions) to identify members for care management, reassessment, and/or assignment to different risk levels.

Care Management Results

We have seen notable outcomes in another market for Medicaid members engaged in 1:1 care management services.

- ED utilization decreased by 18.58%
- Inpatient hospitalization decreased by 8.32%
- Overall medical costs decreased 12.77%

We conduct an annual care management program evaluation to determine the overall effectiveness of our ICM system regarding key performance and metric outcomes using qualitative and quantitative data and will report our performance annually to the Division using the state's standard performance measures and targets. The evaluation also documents identified barriers to success of the ICM system, outlines improvements made during the year, and determines if updates or revisions are needed in processes and resources to address those opportunities for improvement. The evaluation documents key performance metrics shown in Table 4.2.2.3_B.

Table 4.2.2.3_B: Key Performance Metrics for Care Management

Key Performance Metric	Process
Case Review Quality Monitoring	Clinical process improvement, quality outcomes, adherence to clinical guideposts, and care management team initial and ongoing quality monitoring reviews to ensure all required activities and appropriate documentation is complete
Member Satisfaction	Care management member satisfaction survey administered by an outside vendor to gain information about member perceptions, expectations, and experiences
Health Outcomes & Utilization	Analysis of outcome/utilization measures for members in care management, including: Adult Access to Preventive Care, Annual Dental Visit, Childhood Immunization Status, Follow-Up after ED Visit, Lead Screening in Children, Postpartum Care, Prenatal Care, Well Child First 15 Months, Child and Adolescent Well Care, Follow-Up after BH Inpatient; other measures include engagement rates, resolution of SDOH needs (housing, food, member assistance fund) through closed-loop referrals, adherence to member contract schedules, foster care placements, ED utilization, inpatient admissions/readmissions, medication adherence, and medical costs
Grievances & Complaints	Monitoring and analysis of member complaints and grievances related to care management identify trends and/or issues indicating opportunities for improvement

a. The challenges unique to the MississippiCAN and CHIP populations that the Offeror perceives and will target in its Care Management approach;

Our care management strategies will break down barriers, enhance member health literacy and empowerment for self-management, and leverage our provider and community-based partners. Addressing root causes of health inequity, such as lack of access to care, unmet SDOH needs, and the broader impacts of poverty, is critical for all our Mississippi members, and even more so for specific target populations. We recognize these

needs are amplified in rural areas. While our care management strategies address all health-related challenges facing Mississippi members, we have selected a few significant challenges to demonstrate how we target solutions to drive improved health outcomes and decrease health care costs for Mississippi (Tables 4.2.2.3_C – 4.2.2.3_E).

Table 4.2.2.3_C: Maternal and Child Health (MCH)

MCH Challenges and Solutions	
Rationale	Infant mortality rates in Mississippi are the highest in the U.S., driven by the poor health status of the mother, tobacco use during pregnancy, high rates of early elective deliveries, high-risk births and pre-term births, and sleep-related infant deaths. In more than half of Mississippi counties, pregnant women must travel outside their county to see an OB/GYN for prenatal care and delivery services (Healthy People 2020 targets infant mortality rates of 6/1,000 births).
Care Management Solutions	**In addition to standard care management services including addressing SDOH for high-risk members (care planning, ICTs**,) our ICM team provides highly skilled maternal high-risk specialist care managers and enhanced monitoring and management through proven programs to reduce disparities. For example, our well-being program assists parents with employment, transportation, stable housing, and nutrition. These services are critical for members at increased risk of poor health or birth outcomes, especially Black members who are disproportionally affected by racial disparities: ▪ Identify pregnancies early through admissions, discharge, and transfer (ADT); predictive analytics; claims; provider network; and notification of pregnancy forms from providers ▪ Distribute free pregnancy tests to homeless, domestic violence, and trafficking shelters and connect women to prenatal services ▪ Identify members who are eligible and facilitate application the Mississippi Department of Health's Perinatal High-Risk Management/Infant Services System program to ensure our members receive these services; offer additional care management and coordinate with for members choose to participate in the program ▪ Invest in families/member-chosen support networks to provide culturally appropriate support to members and infants ▪ High touch care management focuses on education and involvement of member/families/support networks, connecting members to providers for prenatal care, in-home 17 P progesterone therapy, removing barriers for members to attend visits, providing education on prenatal care and infant care, including breastfeeding, safe sleeping, CPR, vaccination, and screening schedules (EPSDT); remote patient monitoring (RPM) for diabetes/pre-eclampsia/other conditions ▪ Mobile clinic providing prenatal, postpartum, and well-childcare to families in targeted areas with high infant mortality, low birthweight, and preterm births ▪ Mobile application customized to each member to track pregnancy milestones, learn about risk factors and relevant topics (e.g., preterm birth, breastfeeding, and nutrition), weekly notifications with tips and reminders, sign up for member incentives, creating appointment reminders, and selecting an OBGYN ▪ Smoking cessation, BH, and substance use resources ▪ Housing stability program with partners in Jackson and plans to expand throughout the state, provides housing to reduce infant mortality and prematurity, and improve maternal/infant health outcomes. Demonstrated results in another state include 60% fewer neonatal intensive care unit (NICU) admissions, 72% reduction in average NICU length of stay, and nearly 46% lower total per member per month (PMPM) spending compared to a control group ▪ Intensive, specialized inpatient, and discharge supports for newborns and their families when the newborn is admitted to NICU, including transportation for parents to visit the NICU and RPM when the baby comes home. Efforts in another state resulted in a less than 2% readmission rate for our NICU babies ▪ New parent welcome baskets delivered by community health workers (CHWs) to engage members/families/support networks in prenatal care, connect to educational resources and incentive programs supporting perinatal and infant well-care, and conduct home assessments to ensure infant readiness and safe sleep, access to a lactation consultant ▪ Education and resources on family planning, accessing counseling services, leveraging community- and faith-based resources to support members in family planning (e.g., preconception, the importance of prenatal visits, caring for an infant, breastfeeding) ▪ Two nurse-conducted postpartum in person visits for members identified at risk; provide members with safe beds and safe sleep and breastfeeding education; maternal/child-specific prenatal and postpartum telehealth visits with our nurse practitioners to support the member's OBGYN and pediatrician visits; on demand telehealth visits for BH; a digital platform to improve prenatal visits; access to prenatal vitamins, baby items, transportation, and childcare; and parent preparedness education

Table 4.2.2.3_D: Obesity

Obesity Challenges and Solutions	
Rationale	More than 30% of Mississippians are overweight; obesity prevalence among Black residents is 43.7% (with White residents at 31%).[2] Mississippi ranked second highest in the nation with 23.3% of children ages 10-17 diagnosed with obesity.[3]
Care Management Solutions	In addition to standard care management services (including addressing SDOH) for medium- or high-risk members (care planning, ICTs), we offer additional targeted interventions to address child and adult overweight and obesity to prevent the development of and support the treatment of chronic conditions such as diabetes, high blood pressure, and cardiovascular disease: ▪ Invest in families/member-chosen support networks to provide culturally appropriate support to members ▪ Support for diet and behavioral therapy to achieve and maintain healthy BMI in diabetic patients ▪ Consultations with our registered dietician and wearable devices to monitor exercise for members who complete the dietician-led program; incentives for completing 10,000 steps each day ▪ Weight management programs; dietician and pharmacist consultations; long-term weight management strategies and counseling; with Division approval, incentives toward the cost of community exercise programs, and weight management program enrollment for 12 weeks. ▪ Remote patient monitoring equipment based on disease condition for daily glucose monitoring, blood pressure, weights ▪ High-frequency counseling sessions focusing on dietary changes; "what's in my pantry" food planning; cooking classes; food shopping with members ▪ Consult with a clinical pharmacist, push notifications for medication refills ▪ Virtual, in-home, or office-based diabetes self-management education support and supplies, including group activities ▪ In-home screening based on disease condition: A1c, microalbumin for CKD monitoring

Table 4.2.2.3_E: Sickle Cell Disease

Sickle Cell Disease Challenges and Solutions	
Rationale	Mississippi has the highest Sickle Cell Disease (SCD) prevalence rate per 1,000 Medicaid beneficiaries (2.20) in the U.S. (national prevalence of 0.73 per 1,000 Medicaid beneficiaries). An estimated 3,500-4,000 individuals in the state live with SCD. [4]
Care Management Solutions	We will work with the Mississippi Department of Health and other state agencies to identify children who have been screened for SCD. We will automatically enroll all members with SCD into the high-risk level of service and provide intensive monitoring and care management services (including addressing SDOH) in addition to standard care management services, including: ▪ Access to specialists to manage SCD symptoms and access to BH specialists to help manage disease burden holistically ▪ Promotion of wellness behaviors to prevent infections, decrease triggering events and support healthy lifestyles (diet, hydration, avoiding extreme temperatures, exercise) ▪ Education on living with SCD (i.e., an overview of SCD, managing pain, children with SCD, and staying healthy with SCD); articles, videos, and online tools ▪ Clinical pharmacist outreach to providers for members not taking hydroxyurea to educate them on hydroxyurea and recommend they prescribe the medication for their patients; clinical pharmacist outreach to non-adherent members to provide education and resolve adherence barriers; access to penicillin for children up to age 5 to prevent infections; support children moving from childhood to living with SCD as an adult ▪ Connections of families to our well-being program to address SDOH (e.g., employment, housing, education) ▪ Smoking cessation resources, pain management navigation of resources and providers, and mental health resources (online, self-management, counseling, etc.) ▪ Support of prenatal care to identify SCD in unborn children through prenatal interventions and early childhood identification ▪ Referrals for stem cell transplant when indicated by the provider

b. How the Offeror plans to ensure that closed-loop referrals and warm handoffs are executed and sufficiently tracked, including details on the community-based referral platform it plans to use to monitor or close the loop on referrals and/or monitor community-based partnership development activities;

In keeping with our values of person-centered care, we train member-facing staff (including call center representatives, 24-hour nurse advice line, utilization management, and care management) to use warm handoffs supported by our integrated clinical platform. As an example, call center staff, member health assessors, and 24-

[2] Annual Mississippi Health Disparities and Inequities Report, Mississippi Department of Health, December 2018
[3] www.stateofchildhoodobesity.org, accessed 2/9/2022
[4] Data Highlight, Volume 16, Centers for Medicare and Medicaid Services Office of Minority Health, 2019

hour nurse advice line staff utilize warm handoffs to care managers, when indicated to engage members in care management. Our ICM team and well-being program staff makes direct referrals via warm handoffs to CBOs to connect members to needed services. We document referrals and warm handoffs in our integrated platform to ensure tracking and follow up, which alerts care managers to follow up with members to ensure the referrals were accessed. We identify the root causes for not accessing the referral and work with the member to overcome challenges and barriers (such as transportation). Further, we will support specific Mississippi CBOs to address critical needs for our members that we know will improve health outcomes, such as funding housing partners to get our members into safe, affordable housing and supporting food banks to ensure our members with diabetes have access to fresh produce. Our closed-loop referral and warm handoff protocols, processes, tracking, and reporting comply with all requirements outlined in Appendix A, Sections 7.8.4 and 7.4.1.

[redacted]

[redacted]

c. How the Offeror will ensure that Care Management is a tool to address health equity concerns;

Our goal is to make lasting differences in our members' lives by improving their health and well-being with health equity as our guiding principle. Our care management services address health equity concerns and challenges by removing barriers to health, such as housing instability, under/unemployment, stigma, or marginalization for being part of a minority group, having a disability, or living in a rural area with limited provider resources. We will identify health equity factors at the zip code level to understand challenges faced by our members within their communities and coordinate with local community partners to mitigate these issues. Of members engaged in care management with identified SDOH needs, we identified and addressed the following challenges: 50% needed utility assistance, 24% needed housing and home furnishings (e.g., cribs, beds); 15% needed maternal/child (e.g., breastfeeding supplies, diapers); and 11% needed clothing/shoes (e.g., amputee needs). We alleviate health inequity by advocating for our members and communities, facilitating access to care, and addressing individual member SDOH needs through a three-step process:

Data-Informed Approach: Care management strategies are supported by our population risk dashboard that filters member-level data by demographics, various health conditions, BH needs, and social risk factors to notify care managers and providers of the individual member and community needs. [redacted] We conduct a monthly risk stratification to identify members for care management, and we analyze and prioritize risk-stratified data to assess opportunities to improve health outcomes using a health equity lens. For example, through our real-time, bidirectional data we identify members who utilize the ED for ambulatory sensitive conditions and reach out to them to connect them to care management to address access issues driving ED utilization. Through this process, we identify target populations, align resources across the care continuum, and continually monitor the health status and needs of the population for any changes.

Community Barriers: Our regionally based Mississippi ICM teams serve members in their communities and address health disparities at the local level. Our community partner liaison leads efforts to develop asset maps of community resources including schools, health centers, grocery stores, food banks, transportation systems, housing resources, religious institutions, and employers for making closed-loop referrals for members to address SDOH needs. We will engage traditional and nontraditional providers, community and faith-based organizations, and other partners to target specific SDOH by establishing coordinated networks of community partners and enabling seamless referrals through an interoperable closed-loop referral platform. We will integrate with electronic health records (EHRs), HIEs, and other care management systems to screen for social needs, find community-based services, coordinate closed-loop referrals, and analyze outcomes and costs. This strategy extends to other providers and community partners having established relationships with members, such as pharmacies. We will conduct analyses of our membership to identify geographic service gaps across seven domains: food security; transportation availability; housing instability; social isolation; social vulnerability; neighborhood stress; and access to care information. After identifying these gaps, we will provide recommendations for interventions at both member and community levels.

By extending care into alternate settings through telehealth and enhancing the capacity of practices through supports, training, and value-based payments, we increase member access to PCPs/PCMHs and BH providers in communities with scarce provider resources. Access to care is a significant health equity issue, and we recruit and support providers to integrate telehealth services into their practices (especially those serving rural areas) and enhance their capacity through virtual learning collaboratives and our virtual psychiatric consultation service for PCPs. For network providers lacking technical telehealth capacity, we provide access to a telehealth platform to conduct telehealth visits with all their patients. Members can schedule these telehealth visits through our member portal. We build overall access by offering traditional plan-directed telehealth preventive, primary care, BH, and urgent care services to members through our nurse practitioner telehealth program and nationally recognized telehealth providers. We **document all telehealth services provided to members within our care management platform, send automated alerts to the provider, and make that information available to providers through our provider portal.**

Innovative Care Management Strategies: We integrate a health equity lens across our care management strategies to reduce health disparities, foster health equity, and give every member the opportunity to realize their life goals regardless of race, ethnicity, geography, socioeconomic status, or background. Table 4.2.2.3_F provides an overview of our care management strategies to address health equity by increasing access to care and empowering members to be more involved in their health.

Table 4.2.2.3_F: Innovative Care Management Strategies to Address Health Equity Issues

Facilitate Access to Care	
Alternative Care Settings & Telehealth	**Embedded Care Management Staff:** Nearly every county in Mississippi is facing significant shortages in primary care, BH, and dental providers, with Holmes, Claiborne, Bolivar, Jefferson counties having the highest Health Professional Shortage Area (HPSA) scores within the state. We will embed ICM staff in alternative and community-based settings such as provider practices, hospitals, CMHCs, and multispecialty clinics. **Home and Community Settings:** We will use alternative care settings to bring care directly to our members virtually or in-person. Our nurse practitioners will provide in-home assessments and close gaps in care working with the member's provider. We will explore opportunities to partner with community providers and organizations to connect members with services and offer health exams and screenings by our nurse practitioners. We will provide mobile clinics for services in underserved areas, retinal eye examinations at kiosks in Walmart, and collaborate with schools to connect with school-based health center electronic medical records and fund telehealth equipment in schools. **Telehealth:** We will provide a telehealth platform to non-telehealth enabled practices (especially those in rural areas) for scheduled medical and non-urgent telehealth services; scheduled and on-demand nurse practitioner telehealth services; and on-demand telehealth services for urgent medical needs and non-urgent BH sessions through our telehealth vendors.
Identify and Address SDOH	
Housing and Food Insecurity	We will connect members to housing and food supports through referrals to community partners, and assist members in applying for low-income housing, SNAP, and other programs. We will help members pay for housing deposits, utilities, and other costs through our Member Assistance Fund.
Education and Employment	We will assist members and/or their parents/caregivers in attaining high school equivalency by paying for test preparation and completion. We help members/parents/caregivers look for jobs, build resumes, and prepare for interviews (including buying appropriate clothing if needed). We also provide transportation to and from interviews.
Transportation	In addition to covered transportation benefits, through our value-added services, we will provide transportation such as trips to the grocery store/food bank, job interviews, support group meetings, the NICU for parents to visit their babies, and baby fairs

d. Creative methods to engage difficult to reach populations or Members who are unresponsive to outreach efforts and/or participation in Care Management; and,

We are equipped to engage difficult to reach populations and understand the value of being nimble and persistent in our efforts to reach this population. We make three telephonic outreach attempts at different days and times, mail one letter, and send multiple emails and text messages within the first 30 days of enrollment. Additional outreach and engagement strategies to engage members after 30 days include:

Community-Based ICM staff: As our frontline resources, CHWs have knowledge of the communities in which they work and strong relationships with CBOs to assist in locating and engaging our difficult to reach members. As part of our regional ICM approach, we determine which community- and faith-based organizations have the most interaction with our MSCAN and CHIP members in each region and place staff on site to build rapport and conduct initial screenings and in-depth assessments with our members. CHWs build trust with MSCAN and CHIP members who may be anxious or hesitant to engage in medical or BH care in community settings. We strategically place CHWs, care managers, and transition support staff in high-volume hospitals to facilitate rapid engagement when these MSCAN and CHIP members present to the ED or are admitted for an inpatient stay.

Committed Provider Network: We leverage all sources of data, including real-time actionable data from statewide HIEs, our return mail processes, pharmacy data, and social media to identify MSCAN and CHIP members who are unresponsive to outreach efforts. We generate reports of MSCAN and CHIP members who we have been unable to contact for our CHWs to share with key hospitals, CBO, pharmacy, and providers to find these MSCAN and CHIP members as they seek services in the community (ensuring compliance with HIPAA). Flags in our provider portal alert providers to MSCAN and CHIP members who have been difficult to reach so providers can alert us when the member presents for care at their facility. Through value-based agreements and using real-time bidirectional data exchange, we leverage our providers' trusted relationships with MSCAN and CHIP members to engage difficult to reach members by providing information on gaps in care for specific members through the provider portal or provider-preferred communication.

[redacted]

Partnerships with Mississippi Food Banks

We will partner with the Mississippi Food Network and other food banks to reach out to our members using their services to complete the HRS, identify gaps in care, and connect to other vital services. Preliminary data analysis of our program in another market reveals nearly 30% of food bank clients were our members and nearly 70% of those members had gaps in care that we were able to address through their engagement in care management.

e. The Care Management services the Offeror expects to provide by risk level (e.g., low, medium, high).

Our care management services, shown in Table 4.2.2.3_G, comply with and exceed requirements in Appendix A, Section 7 (model contract specific requirements italicized).

Table 4.2.2.3_G: Care Management Services by Risk Level Assignment

Care Management Services	Low	Medium	High
Care Management			
Health risk screening (all), comprehensive risk assessment (when indicated); monitor conditions, behaviors, risk factors, and unmet needs to trigger reassessment and additional interventions.	x	x	x
Access to our member services call center, 24-hour nurse advice line (with direct 24-hour access to care managers), 24-hr BH/SUD line; *inform members about the availability of services and access to those services.*	x	x	x
Assignment to an ICM team with minimum annual contact for low-risk (telephone); minimum monthly contact for medium-risk and high-risk (in person and/or telephone), and minimum bi-weekly contact for intensive high-risk members (at least one in person, other by telephone).	x	x	x
Person-centered care plans created with members and their ICM teams for all medium- and high-risk members; care plans for *low-risk members at their request.	x*	x	x
Care coordination/assistance accessing PCP/PCMH, inpatient, BH, SUD, preventive, specialty care; identify providers for members; assist with scheduling when necessary; assure baseline and periodic medical evaluations by PCP/PCMH; inform members of gaps in care.	x	x	x
Coordination with other health/social programs (e.g., MSDH PHRM/ISS, IDEA, WIC, Head Start, school health, medical/legal partnerships, and programs for children with special needs).	x	x	x
Clincial pharmacist collaboration for medication review, medication adherence, drug-drug interactions, polypharmacy, medication therapy risks.	x	x	x
Monitor/follow-up with members and providers through mailings, newsletters, calls, and/or face-to-face meetings.	*x*	*x*	*x*
Respond to member clinical care inquiries to promote member self-direction and involvement.	x	x	x
Transitions of Care			
Evaluate medical, BH, and SDOH needs of members in outpatient and/or home settings to facilitate appropriate care and services.	x	x	x
Timely and safe transitions of care, including *discharge planning and inpatient/PRTF follow-up care coordination; ensure continuity of care.*	x	x	x
Providers			
Educate provider office staff on symptoms of exacerbations, member communication; develop speaking points for members and providers on emergency appointment triggers, crisis resources REVIEW LANGUAGE.	*x*	*x*	*x*
Coordinate care with providers to optimize PH/ BH management (i.e., preventive screenings; closing gaps in care), and education on appropriate use of primary care and ED services; *support providers in utilizing medication adherence best*	x	x	x

Care Management Services	Low	Medium	High
practices (engage high performing providers to educate lower-performing providers); identify providers with special accommodations for complex populations; and member care plans available in provider and portals.			
Social Determinants of Health			
Closed-loop referrals and/or warm handoffs to community and faith-based organizations and other resources to address unmet social needs; *follow-up on referrals within 30 days with member and CBO; and assist the member in overcoming barriers to utilizing services.*	x	x	x
Develop, plan, assist members with information about CBOs, free care initiatives, and support groups.	x	x	x
Disease Management			
Condition-specific health coaches and evidence-based educational interactive online tools and printed materials (at 3rd-grade reading level and compliant with national clinical care guidelines) for health education and self-management addressing the member's main health concern, coaching, interventions to reduce risk and empower members and referrals for community-based self management programs.	x	x	x
Consultation with a registered dietician to improve health literacy and support self-management by providing education on nutrition, relationship with food, and exercise/meaningful movement.	x	x	x
Clinical pharmacist consultations with members and interdisciplinary team on medication adherence and to address barriers (focus on managing blood pressure, screenings for DRE, kidney function, cholesterol).		x	x
Provide information and make closed-loop referrals to community resources (e.g., certified diabetes educators, exercise/nutritional support; CBOs/faith-based).	*x*	*x*	*x*
Complex Care Management			
In-home visits for complex needs or concern for member/family safety; CHW video conference care managers while in the home to review medications; complete safety assessment; and member and family education.		x	x
Care plans with member and interdisciplinary care team (PCP/PCMH, providers, pharmacy, care managers, and CHWs); identify and address gaps, establish member-centered opportunities, goals, and interventions; care plan available to providers in our provider portal and members in the member portal.		x	x
Educate staff about barriers members might face in making and keeping appointments.	*x*	*x*	*x*
Utilize tools to monitor conditions, behaviors, risk factors, unmet needs.	*x*	*x*	*x*
Behavioral Health			
Predictive analytics to identify high-risk/rising risk members for targeted interventions.	x	x	x
Facilitate group visits to encourage self-management of medical, SUD, BH diagnoses (e.g., pregnancy, diabetes, tobacco use).		x	x
Referrals to 24-hour BH/SUD support line.	x	x	x
Community-based peer support services for children with SED.		x	x
Safety plans for at-risk children with SED and children in foster care, access to parent focus groups and training.		x	x
Complete referrals to medication assisted treatment (MAT), SUD home model with peer supports in targeted geographic areas where there are MAT prescribing access issues, and clinical pharmacist consults.		x	x
Establish member SUD, depression, other BH conditions relapse prevention plans with members and PCPs/PCMHs, CHMCs/private mental health centers (e.g., care planning, education, clinic visits, follow-up calls).		*x*	*x*

Care management works with our UM team, clinical pharmacists, and designated medical directors in weekly huddles to assess, identify, and establish solutions for high-risk MSCAN and CHIP members identified through predictive modeling and/or other triggers. We follow up with PCPs/PCMHs, other providers, and members to collaborate on proposed solutions. We provide additional services for identified high-risk populations, as shown in Table 4.2.2.3_H.

Table 4.2.2.3_H: Additional Care Management Services for Identified High-Risk Populations

Population	Care Management Services
Members who are Pregnant	▪ Pregnancy screener to evaluate clinical status and appropriateness of high-touch outreach; additional assessments and clinical judgment to identify social and BH needs, and early signs of complication in pregnancy ▪ Person-centered care plan addressing prenatal/postpartum needs, such as healthy eating and vitamins, breastfeeding, smoking or tobacco cessation, depression, abstinence from drugs and/or alcohol, and adherence to pre-and post-natal appointments ▪ Coordination with PCMHs, CMHCs, other BH providers, hospital discharge planners, and pediatric providers for infants ▪ On-demand telehealth platform and digital support; group prenatal and postpartum sessions; RPM for diabetes/preeclampsia ▪ Education on EPSDT services, safe sleep, and CPR training; postpartum telehealth services for mental health and lactation counseling, infant urgent care, the transition from OBGYN to PCP/pediatrician, and care for newborn conditions that can be safely managed at home
Members with Diabetes	▪ Diabetes assessment and person-centered plan with goals and interventions for diabetes self-management education, medication adherence, A1c/daily blood glucose goals, retinal eye exams, foot exams, and healthy diet and activity ▪ Hand-delivered A1c home testing kits; RPM for daily blood glucose monitoring ▪ Dietician consult ▪ Enhanced dental benefits for members with chronic conditions, including diabetes ▪ If approved by the Division, funding toward cost of community exercise activities, weight management plan fees
Members with Asthma	▪ Person-centered asthma action plan shared with member's PCP and member-identified ICT ▪ Clinical pharmacist consult; referral to a specialist (pulmonologist/allergist) if needed ▪ Well-being team to help members find safe and affordable housing to mitigate asthma symptoms ▪ Hypoallergenic bedding for children with asthma who are enrolled with care management
Members with Cardiovascular Disease	▪ Clinical pharmacist and dietician consults ▪ RPM for blood pressure checks and daily weights as indicated ▪ If approved by the Division, funding toward the cost of community exercise activities
Members with Chronic Kidney Disease	▪ Support self-management and medication adherence; disease management interventions for underlying chronic conditions contributing to CKD ▪ Early interventions for members in early stages of CKD identified through analytics to slow or stop the progression of CKD through home kits to assess microalbuminuria ▪ Assist with referrals to nephrologist, clinical pharmacist and dietician consults ▪ RPM for daily weights, glucose monitoring, blood pressure
Members having Persistent and/or Preventable Readmissions	▪ Coordinated discharge planning with facility providers and all providers for comprehensive discharge orders and follow-up, and CBOs addressing SDOH needs; assess functional/cognitive needs, SDOH for post discharge/advanced care planning ▪ Individualized outreach to ensure follow-up care is scheduled and received ▪ Targeted health literacy and member education programs to address underlying acute or chronic conditions ▪ Coordination with CMHCs, PCP/PCMHs, and other BH providers
Members with Serious and Persistent Behavioral Health Conditions	▪ Condition-specific comprehensive assessments and person-centered care plans; monitor/intervene in crisis situations and suicidal ideology; education to improve health literacy and support self-management ▪ Coordination with CMHCs and other BH providers, assist members in scheduling follow-up appointments with providers after inpatient admissions, coordinate discharge planning with facility staff ▪ On-line BH tool for additional assistance on the management of BH conditions and life stressors triggering BH symptoms ▪ CHWs, peer/family supports, licensed clinicians/embedded clinical/coordination staff in community settings such as provider agencies, hospitals, CMHCs/PCPs/PCMHs
Members with Substance Use Disorder	▪ Assess to identify history and current substances of abuse, level of abuse, presence of withdrawal symptoms, treatment history, and exploration of member motivation to change and current co-morbid conditions ▪ Harm reduction and person-centered care planning processes; care management for members in inpatient SUD programs ▪ Medication review, educate the member/family/caregivers on the use of Naloxone (and assist with obtaining Naloxone) and our prescription drug disposal program for proper disposal of medications to reduce overdose, abuse, and poisoning ▪ Peer support specialist engagement; SUD home, when appropriate ▪ 24-hour BH/SUD line and other recovery resources, including help finding providers and scheduling appointments ▪ Coordination with CMHCs/PCPs/PCMHs, other BH providers
Infants and Toddlers at Risk for	▪ Ensure members identified at risk are screened by providers ▪ Refer parents to providers, create individualized family care plans, help them advocate on behalf of their child, and coordinate services (e.g., vision, hearing, physical/occupational therapy)

Population	Care Management Services
Developmental Disability	▪ Support parents and families to navigate across multiple health care settings, education on developmental disabilities, referral sources for assessments, and connection with advocacy groups ▪ Help parents and families to recognize development delays and access immediate referrals to First Steps Early Intervention Program and/or the Children and Youth with Special Health Care Needs (CYSHCN) Services Program
Members with Serious SDOH Challenges	▪ Assessment of member SDOH needs through PRAPARE tool and document results in our clinical platform ▪ We will work closely with members to address serious SDOH challenges, such as homelessness and food insecurity, collaborating with community partners and providers to ensure members needs are met and all referrals will be closely monitored through our closed-loop referral system ▪ Referral to our coaches to help members develop essential life skills, find employment, manage their finances, and resolve other barriers, such as legal issues

4.2.2.3.B Stratification and Assignment

Our approach to risk stratification and member assignment in our integrated care management (ICM) system is based on a combination of quantitative and qualitative data (from the Division and other sources), strong data analytics, comprehensive screening of a member's risks and needs, and information from providers and community-based organizations, often in real-time. Our stratification and assignment methods are aligned to our commitment to change the trajectory of Mississippi's healthcare system using a fully integrated, transparent service delivery model with real-time bidirectional data exchanges, next generation member engagement, and education, community-based coordinated care, and operational excellence. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources. Our technical platforms integrate data as it is received on new MSCAN and CHIP members and updated monthly thereafter for existing members to ensure there are no delays in our stratification and assignment processes and engage MSCAN and CHIP members in care management, so their needs are met.

4.2.2.3.B.1 Describe the Offeror's proposed initial Health Risk Screening (HRS) for new Members, including questions, methods of seeking answers, and how answers will be used for stratification of Members based on acuity levels and Care Management.

Upon award, using our HRS tool submitted to the state within 90 days of contract award for review and approval, our member health assessment team will reach out to every member to complete the health risk screening (HRS) within the requirements and specific timeframes outlined in Appendix A, Section 7.4.3.1. This facilitates stratifying members based on acuity levels and links their answers to appropriate interventions, including the completion of comprehensive assessments. **With the Division's approval, we will commit to leading an effort with all CCOs to develop a standard HRS addressing physical, behavioral, SDOH, and health equity needs. We will fund dedicated resources (e.g., embedded HRS specialists, kiosks, scannable QR codes using smartphones) to complete the HRS on site for all individuals seeking Medicaid coverage and/or recertification.**

Proposed HRS questions: Our HRS tool documents cultural and linguistic preferences, self-assessment of overall health, and diagnoses and treatment of chronic medical and behavioral conditions, including medications. We document MSCAN and CHIP members' use of community resources to clarify their SDOH needs and ask about their emergency department (ED), urgent care, hospital, and primary care utilization. Questions address physical health (PH) and behavioral health (BH) status, utilization, pain, alcohol, drug, and tobacco use, and whether an advanced directive is in place. All staff who interact with MSCAN and CHIP members have access to HRS results documented in our integrated clinical platform. See Appendix 4.2.2.3.B.1.

Methods for seeking answers: As with all types of outreach to MSCAN and CHIP members, we follow the principle of meeting the member where they are and communicating in their desired modality. We utilize a variety of engagement strategies for completing the HRS, including in person at the member's home/community location, stations in Walmart and other stores, telephonic outreach, mailed welcome kits, email, and our secure member portal and mobile app. We use artificial intelligence-enabled text campaigns in a mobile-friendly format to complete the survey anytime from anywhere on the member's mobile device. **Using a similar text campaign in another market, we improved member engagement by 70%. We have also used text and email campaigns to deliver videos containing a**

QR code to link directly to the HRS for real-time completion and found members who clicked on the link to these videos were 2 ½ times more likely to take action. When we receive an incomplete HRS through the mail, email, or text we reach out to the member utilizing motivational interviewing and speed of trust techniques to ensure completion by phone or in person. Upon award, with Division approval we will provide financial incentives to members who complete the HRS.

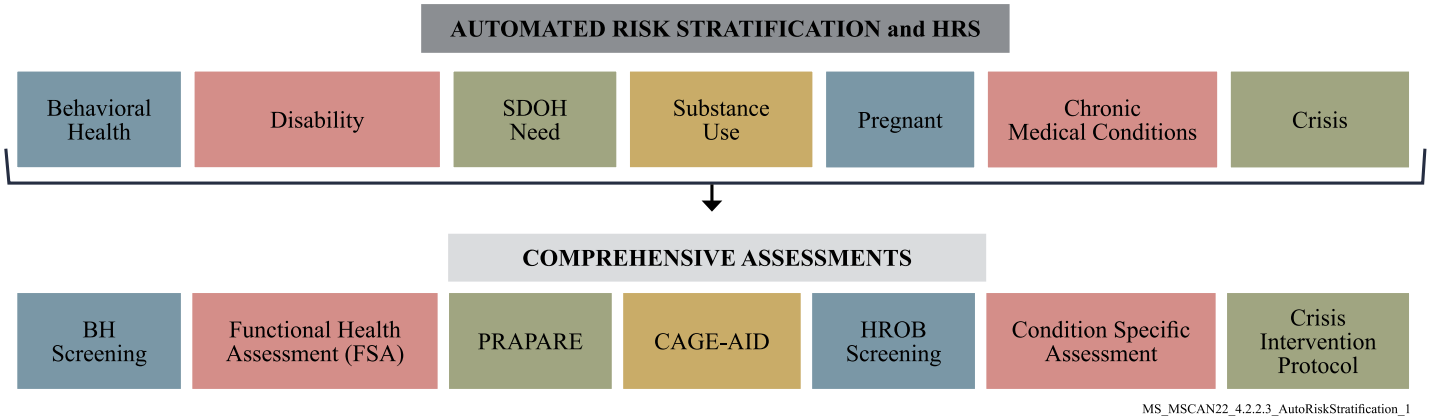
Our experience demonstrates one of the most successful methods of HRS completion is through direct, personal calls made by our internal non-clinical member health assessors who are part of the ICM team. Our member health assessors document all outreach attempts and initiate contact at various times during the day/week, including evenings and weekends. Our member health assessors can connect MSCAN and CHIP members via warm handoffs to care managers or community health workers (CHWs) who can address member needs in real-time. For new MSCAN and CHIP members, we proactively reach out to them every week until the member completes the HRS through the 30th day of enrollment. We make three telephonic outreach attempts at different days and times, mail one letter, send multiple emails and text messages within the first 30 days of enrollment. After 30 days, we continue weekly outreach for 90 days, while monitoring within our integrated care management platform for changes in status to collaborate with providers to assist with engaging members. Beyond our multimodal approaches to connecting with MSCAN and CHIP members for the initial HRS, we have strategies in place to engage hard to reach MSCAN and CHIP members. Our committed provider PCPs/PCMHs can assist our MSCAN and CHIP members with HRS completion. We also determine which CBOs have the most interaction with our MSCAN and CHIP members in each region and place staff on site to conduct initial screenings and in-depth assessments with our members. We will engage with CBOs and key providers in Mississippi to discuss partnership opportunities to capture and share health and social risk screenings. In other markets, **these strategies have yielded over a 60% active HRS completion.**

Using HRS answers to stratify members: Our HRS allows us to quickly identify the needs of members and expedite enrollment into the most appropriate population health/care management program. Following our data analytics and initial HRS, we preliminarily assign MSCAN and CHIP members to one of three risk categories (low, medium, high) to inform interventions and next steps. We stratify MSCAN and CHIP members identified as having one of the following conditions or circumstances into the high risk level: pregnancy; diabetes; asthma; cardiovascular and/or chronic kidney disease; persistent and/or preventable inpatient readmissions; serious and persistent BH conditions; substance use disorder (SUD); and serious social determinants of health (SDOH) challenges as determined in Appendix A. High-risk also includes foster care children, infants/toddlers with an established risk for developmental delays, MSCAN and CHIP members with high dollar costs or potentially high dollar costs, (e.g., sickle cell disease), and members being discharged from an acute inpatient psychiatric stay or psychiatric residential treatment facility (PRTF).

4.2.2.3.B.2 Describe the Offeror's proposed method(s) for the Comprehensive Health Assessment (CHA) of Members requiring a CHA after the initial Health Risk Screening, including questions, methods for seeking answers, and how answers will be used for stratification of members based on acuity levels and Care Management

When a member's HRS triggers the need for additional assessments, we complete a qualitative and quantitative in person or telephonic comprehensive health assessment (CHA) within 30 calendar days to appropriately stratify members (Figure 4.2.2.3_B).

Figure 4.2.2.3_B: Comprehensive Health Assessment Triggers and Follow-Up Assessment Tools
We assign members to the appropriate level of services by drilling down into specific member needs.



Proposed CHA tools/topics of questions: The CHA identifies physical, behavioral, social, and psychological needs, including barriers to care through a variety of specialized evidence-based assessment tools. We use the CHA to determine adherence to prescribed periodicity schedules for well-care and age-related environmental and social needs and learning needs. The CHA identifies the severity of conditions through specialty assessments, evaluates co-morbidities, and documents member demographic information, current providers, and treatment plans. Our CHA process considers every facet affecting a member's health and well-being and integrates information collected through claims, authorizations, clinical and nonclinical staff notes, provider (e.g., PCP, BH, and specialists) information, and observations of the member's representatives. Our integrated clinical platform uses branching logic in CHA protocols to include additional tools, such as condition specific elements, PRAPARE (SDOH assessment), and BH assessments such as the PHQ9 (Patient Health Questionnaire 9). Our comprehensive assessment process includes these domains:

- Demographics
- Self-reported health
- Cultural and linguistic needs
- Relevant PH and BH history/current status/chronic conditions
- Medications
- Cognitive/functional status
- Needed benefits and community resources
- Pain
- SDOH
- Life planning (advance directives)
- Caregiver support
- Assessment of barrier

Methods for seeking answers: Our CHA process begins with reviewing the member's status before outreach for further assessment, including looking at the member's industry standard tool scores, HRS, diagnoses and prescriptions, and relevant State data to determine which assessment tools are best suited to the member's needs. The review process prepares ICM staff to target assessment questions based on their findings. Preparation includes a review of medication adherence, utilization, and potential clinical or social needs and speeds the assessment process for member convenience (i.e., conserving member telephone minutes). We outreach to parents/caregivers/guardians to conduct CHAs for minors to review elements specific to infants, children, and adolescents via telephone, on site in community locations, email, or mail to schedule the CHA. Our care managers or other licensed professionals (including BH qualified assessors) engage MSCAN and CHIP members/caregivers in completing the CHA in person or via telephone using motivational interviewing techniques and trauma-informed care principles. Once the CHA is completed with the member/caregiver, our care managers document the formal assessment summary in our integrated clinical platform to inform stratification and leveling. We share assessment findings with the member's PCP/PCMH and BH providers via the provider portal.

Using CHA answers to stratify members: Our care managers apply care management criteria (outlined in 4.2.2.3.A) and clinical judgment using results from the comprehensive health assessments to update risk level

assignments appropriately to reflect any change or clarification in health status, needs, or a significant health care event to inform interventions and care plans with our MSCAN and CHIP members.

4.2.2.3.B.3 Describe the Offeror's proposed method(s) for a reassessment of Members during the life of their enrollment with the Offeror to accurately assess that Members are assigned to the correct acuity level. In addition to an overview of the proposed method(s), the Offeror should include how often Members are reassessed; whether a reassessment is ad hoc, systematic, or both; and why the Offeror would utilize this timeframe for reassessment.

We have standard protocols in place to assess, plan, implement, reassess, and evaluate a member's health status and needs to ensure they are assigned to the correct risk and acuity levels. Care managers complete reassessments and review acuity and risk levels. If the member does not require ongoing care management interventions at a higher level of service, we recommend leveling down to a lower level of service and monitoring claims, utilization, and other member data to ensure continued assignment at the correct level of services.

Reassessment cadence: Depending on the risk level, we conduct a comprehensive review of the member's health and care coordination needs by telephone or in person as needed and no less often than annually to align with care plan updates. For MSCAN and CHIP members stratified as a medium- and high-risk, our ICM staff use clinical judgment to assess member needs in every engagement. For all MSCAN and CHIP members, including those at low risk, a change in health status triggers the need for a comprehensive assessment conducted as soon as possible. When a member's circumstances change (e.g., hospitalization, change in functional status, new diagnoses, and/or SDOH challenges), care managers perform a reassessment. We continually monitor MSCAN and CHIP members for significant change events through utilization data mining for rising risk, significant health care events, care manager contact, and member/caregiver or provider requests and reassign the member to the appropriate level of services as needed.

Ad hoc and systematic reassessments: We proactively address the most pressing needs of our MSCAN and CHIP members through our population health dashboard, which is used by ICM teams to identify high-risk members to prioritize for outreach and targeted engagement strategies. As an example, we can filter the MSCAN and CHIP membership to identify and locate pregnant members by age, ethnicity, and/or BH/SUD diagnoses and target outreach and education to these members on topics such as breastfeeding, safe sleep, smoking cessation, and prenatal and postpartum visits to improve maternal health and birth outcomes. Our ICM team members interpret population health dashboards (described in Section 4.2.2.3.A) using their clinical expertise and provide additional data during the reassessment process. Circumstances that trigger reassessment include a change in the member's health status; inpatient hospitalization or transition from one setting to another (e.g., hospital to home); changes in living arrangements; and member/caregiver reports of pain, trouble sleeping, oral health, anxiety/depression, or reduced mobility. Reassessments may also be triggered by our risk analytics using real-time data from authorizations, ADT data from health information exchanges (HIEs), laboratory results data when available, pharmacy data, and targeted protocols to identify changes and evolving risk profiles of our members.

Timeframe rationale: We have developed reassessment cadence and protocols based on our extensive experience managing care for at-risk populations. Our member-driven guidelines for reassessment are intentionally flexible to address our MSCAN and CHIP members' changing needs and circumstances in a timely manner. At a minimum, we perform an annual reassessment for all MSCAN and CHIP members and reassessment following any significant change event. In addition, upon contact award, on a continual basis, our care managers utilize clinical judgment, real-time bidirectional data from HIEs and EHRs, automated clinical triggers using our care management criteria, input from MSCAN and CHIP members/caregivers/providers, and our monthly analysis of predictive risk to determine the need for ad hoc reassessments.

4.2.2.3.B.4 Describe any other methods the Offeror uses to identify Member acuity levels for assignment and Care Management, including the use of software or other tools.

To stratify and assign MSCAN and CHIP members to the appropriate risk level, we start with the industry standard tool score, followed by information gathered through the HRS and CHA. This stratification aids in the

prioritization of MSCAN and CHIP members for outreach and further assessments at a cadence that meets or exceeds contractual requirements. We use this information (based on member identified needs) to assign each member into one of three risk categories (low, medium, and high) to provide the appropriate level of care management services in compliance with requirements in Appendix, Section 7.4.3. and to prioritize members identified with specific conditions and/or excessive costs identified in Appendix A, Section 7.4.3.3.

Industry Standard Tool: Our initial risk stratification process augments the industry standard tool scores with other nationally recognized inputs and our predictive models. On a monthly basis, the industry standard tool calculates a member risk score based on demographics, medical claims, and pharmacy claims.

Integrated Clinical Platform: Our web based, integrated clinical platform serves as the central repository for all care management activities and member data. Care managers identify significant changes in health status via automated alerts from the platform based on utilization data, ED visits, inpatient admissions, or provider or member/caregiver referral(s) and updates the member's care plan.

Provider Data: We will utilize statewide HIE information from hospitals, BH hospitals, CMHCs, and accountable care organizations (covering 95% of discharges and providing other patient data on SDOH, care gaps, medication adherence) to inform member acuity levels. We will utilize electronic medical records (EHRs) from 75% of the state's federally qualified health centers (FQHCs), and our clinical platform can integrate with other providers' EHRs to access provider assessments of member needs and health status.

Predictive Modeling: We will use predictive models to proactively identify MSCAN and CHIP members with changing needs or circumstances that could necessitate re-stratification into a higher risk-based care management level:

- Identification/stratification of high-risk pregnancies
- Member specific SDOH indices
- COVID-19 composite risk scoring
- Prediction of unusually long inpatient stays
- Identification of MSCAN and CHIP members at risk for homelessness
- Prediction of member sentiment/satisfaction to mitigate disenrollment
- Disease/comorbidity identification/risk stratification
- Prediction of admissions/readmissions
- Prediction of preventable ED utilization

4.2.2.3.B.5 Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other non-medical risk factors into the HRS and CHA.

We build SDOH, health equity evaluations, and non-medical risk factors into the HRS tool and CHA process to ensure we can identify and address each member's needs holistically. Our HRS includes questions to identify member SDOH needs, health equity concerns, and other nonmedical risk factors, and our CHA process employs tools to deeply evaluate their impact on member health and well-being. We also collect information about factors commonly associated with health equity, such as locality, race, ethnicity, language, gender identity, and sexual orientation that contribute to barriers to care. As an example of how we integrate health equity into the assessments, when we ask the member the HRS question about needing help with accessing community resources and we find out the member has trouble accessing healthy food, we can assist them in signing up for SNAP and WIC, identify local food banks, and provide transportation for food shopping. While not exhaustive, the following HRS questions and CHA processes illustrate the ways we integrate SDOH, health equity, and other nonmedical risk factors into member health assessments. The HRS and CHA are included as Appendices 4.2.2.3.B.1 and 4.2.2.3.B.2 to this response.

Examples of Health Risk Screening SDOH/Non-Medical Risk Questions:

- What language do you want to use? (Arabic, Creole, English, French, Mandarin, Russian, Somali, Spanish, Vietnamese, Sign Language, other)

- What is your living situation right now? (Homeless, living with other family, living with a spouse, living with others unrelated, living in a group home, living in a shelter, living in an assisted living facility, living in an out-of-state facility, living in a nursing facility)
- Do you need help accessing community resources? (Meals on wheels, food bank, food stamps, WIC, free clothing store, SSI, Disability, legal services/adult probation, support groups, transportation, counseling services, housing, utility services, none, other)
- Do you need help with any of these activities? (Finding and accessing help, driving or arranging travel, preparing meals, shopping, doing housework, remembering to take your medicine as scheduled, getting the medicine your provider prescribes, handling finances, none, other)

Examples of Comprehensive Health Assessment Tools Evaluating SDOH/Nonmedical Risk:

- Review of closed loop referrals for social services to inform the comprehensive assessment of member needs.
- We complete the PRAPARE assessment, a nationally recognized standardized tool for assessing SDOH needs when a member's answers on the HRS indicate SDOH needs. Questions include:
  - Personal characteristics (race, ethnicity, military service, language)
  - Family and home (number of people in household, housing situation, concern of losing housing, address)
  - Money and resources (education, current work, health insurance, total household income, access to resources such as food, utilities, transportation)
  - Social and emotional health (social contacts, stress level)

4.2.2.3.C Care Management Services

4.2.2.3.C.1 Describe the Offeror's proposed policies, procedures, and processes to conduct outreach to ensure that Members receive all recommended preventive and medically necessary follow-up treatment and medications. Describe how the Offeror's will notify Members and/or Providers when follow-up is due. Address the following issues in the response:

In compliance with Appendix A, Section 7.5, our member outreach and education processes enhance member health literacy, address health equity factors, and empower members to make sound health decisions by offering the support, technology, and resources needed to engage in preventive services, access follow-up treatment, and ensure medications are prescribed and properly taken. In the coming contract, we propose to bring the **real-time bidirectional data exchange capabilities to Mississippi Coordinated Access Network (MSCAN) and Children's Health Insurance Program (CHIP) through our health information exchange (HIE) connection** to hospitals, community mental health centers (CMHCs), patient centered medical homes (PCMHs), federally qualified health center (FQHCs), and rural health centers (RHCs). All member-facing staff will have access to a 360-degree member view including this real-time data through our integrated clinical platform, maximizing opportunities to remind members of the importance of preventive and follow-up treatment during every member encounter. We will work through an innovative collaboration to encourage all CCOs to replicate our level of connectivity to better serve Mississippians.

Promoting Preventive Services, Follow-Up Treatment, and Medications

Supported by thoughtful policies, procedures, and processes, we use multiple avenues for member outreach to promote preventive and follow-up treatment and medications, including printed materials, texts, social media, mobile applications and web-based tools, targeted multi-modal health literacy campaigns, and personal health coaching. Our approaches are tailored to meet the needs of the member, including preferred language, limited English proficiency, reading (3rd grade level), health literacy, and method of communication. We use personalized intelligence-enabled text messages to provide information that is relevant to the member at that point in time, such as reminders for refilling medications, vaccinations, screenings, and making appointments for well visits. For example, in another market we deployed targeted text and personal outreach campaign aimed at increasing COVID vaccination, we initiated behavior change among 107,000 members who began the program classified as "unsure" [about getting vaccinated] to "ready" [to get vaccinated] by the end of the program.

As part of our fully integrated service delivery model, we will engage members at key access points in the community, such as Walmart and Dollar General stores, health fairs, and community events. Our regionally based ICM staff work alongside local community advocates, support agencies, health departments other governmental agencies, and public health associations who know our communities well to develop trusted community-relevant programs. We leverage our certified diabetes educators, certified asthma educators, and certified case managers for presentations and classes in community settings. In the coming contract, we will work with the Division to develop and implement focused statewide health literacy campaigns to ensure Mississippi state priorities inform all outreach and education efforts, including benchmarks in the Division's 5-Year Strategic Plan for Fiscal Years 2023-2027.

Care Management Results

Through care management strategies, including outreach and education, utilized in another market, we improved follow up after mental health discharge from the 66th percentile to the 90th percentile for 30-day follow-up. For 7-day follow-up we increased from the 66th percentile to the 75th percentile.

In addition to generalized outreach, engagement, and education strategies, we use rigorous outreach algorithms in the population health dashboard, health risk screening (HRS) and comprehensive health assessment (CHA) data, eligibility files, and other supplemental data to identify members/families who would benefit from additional outreach. For example, as part of our fully integrated service delivery model, our pharmacy clinicians reach out to members identified as not following medication therapies to understand and mitigate barriers to obtaining and taking medications, such as lack of transportation or not understanding when and how to take medication properly for maximum benefit.

Notifying Members when Follow-Up is Due

All member-facing staff (including care management and member services teams) have access to a real-time 360-degree member view in our integrated clinical platform which includes care gap alerts. When they engage with a member on a call or in person, they remind the member to schedule an appointment or conduct a warm handoff to our nurse practitioners to advise, connect the member back to their PCP/PCMH, and assist with scheduling appointments through direct visibility into provider schedules to close gaps in cares identified in the clinical platform. Our member portal also alerts and reminds members when appointments, tests, and screenings are due and provides links to schedule appointments. We have dedicated community health workers (CHWs) who reach out to members with an inpatient behavioral health (BH) admission to ensure seven- and 30-day follow-up appointments are scheduled, remind them a day or two prior to the appointment, and confirm attendance at the appointment. If the member misses an appointment, we find out the reason and connect them to resources to address the root cause (i.e., lack of transportation or childcare).

We notify members and their parents/caregivers when follow-up care is due for early and periodic screening, diagnostic and treatment (EPSDT) screenings, well-child visits, prenatal and postnatal visits, chronic condition screenings, post-discharge from inpatient appointments, and critical preventive and follow-up care. In the coming contract we will monitor real-time admissions, discharge, and transfer (ADT) information; HRS and community health assessments; member care plans; and claims data to identify when members are due for services and provide personalized outreach through a variety of means (e.g., letters, texts, telephone calls, member portal, home visits) focusing on direct in person communication whenever possible. For example, in another market, we personally deliver welcome baby baskets (diapers, education on parenting, value-added benefits, mom/baby incentives, care management/well-being services) to pregnant members. We link them to a free mobile application for weekly text messages about prenatal, postpartum, and infant care up to the baby's first birthday, and our nurse practitioners follow up with members to make sure they make and keep prenatal appointments.

Notifying Providers when Follow-Up is Due

Our transparent service delivery model will be fully integrated with the majority of Mississippi providers through real-time bidirectional data exchange. We notify our providers of gaps in care for members on their panel through our secure provider portal, which provides member history, including care plan, diagnoses, telehealth visits, and inpatient, outpatient, and emergency department (ED) utilization. Our provider

representatives meet with providers to share gaps in care and identify ways to close those gaps, and our care managers contact providers to discuss specific member needs. We monitor utilization trends, send email alerts, and reach out to practices with high numbers of members with gaps in care in person, telephonically, or through secure email.

a. Facilitation and monitoring of Member compliance with treatment plans.

We monitor compliance with treatment plans for all members regardless of risk level to ensure they access preventive and medically necessary follow-up treatment and medications through continuous automated claim and clinical review. Our care managers conduct regular and timely outreach (triggered by significant change events) based on member preference, risk stratification level, and outreach protocols (medium risk - minimum monthly contact; high risk - minimum bi-weekly contact; low risk - as triggered). They engage their assigned members telephonically or through in-home visits to review the member's care plan, treatment, adherence, and monitor and update goals. Using motivational interviewing and culturally appropriate communication, care managers help members identify and address persistent barriers that may negatively impact treatment plan goals/outcomes. **Our robust care management efforts to assure treatment plan adherence in another market achieved a 22% increase in A1c control and a 25% increase in A1c testing for diabetic members**.

We leverage relationships with our providers to identify and close gaps in care and treatment plans. We monitor claims data for appointments, screenings/testing, and medication adherence (e.g., pharmacy claims to monitor timely refills) to verify members access services in their treatment plans and reach out to members to uncover and address root causes for non-adherence. Care managers collaborate with the member to conduct a brief SDOH screen (PRAPARE) initially and update care plans as needed to document and address, new, or emergent social needs. As necessary and appropriate, care managers conduct person-centered supplemental screenings or assessments (e.g., PHQ-9, CAGE-AID) with members to gain deeper insight into the member's conditions and circumstances. We document results in our clinical platform, coordinate with the member and providers to update associated treatment plans, and monitor member outcomes on an ongoing basis. We organize internal huddles of our medical and BH directors, clinical pharmacists, and UM staff to ensure a comprehensive, coordinated approach to facilitating and monitoring member compliance with treatment plans. For members who have not engaged in care management, we work directly with providers to facilitate monitoring of compliance with treatment plans.

b. Partnerships of community-based partnerships and other state agencies; and

Community-Based Partnerships: We will have strong relationships with and will invest in CBOs, faith-based organizations, local health care providers, and other community partners to broaden member outreach and health literacy offerings. We will leverage the expertise of our community partners to reach and engage members and support existing community programs rather than launching new initiatives to avoid duplicating efforts and/or confusing our shared audience. As we identify opportunities to collaborate on programs, we will prioritize program development to address those topics with our CBO and provider partners. We will also invest in community organizations to enhance their ability to provide services to our members. For example, we will partner with North Mississippi Health Services to offer several educational programs, including series on diabetes prevention, nutrition, and pregnancy/childbirth to support health literacy and education in that region.

In the coming contract, we will work closely with the **MS Urban League** to link members to physical and behavioral health care, childcare, housing, and basic needs, and we will embed telehealth resources in their locations to increase member access to services. We will partner with **Life Help** and other CMHCs for community-based care management for members with BH needs throughout the state, and we will partner with the **Hattiesburg Diabetes Clinic** to create a Diabetes Center of Excellence, participate in collaborative best practice training, and refer members into their services. [redacted] We will provide physical and BH telehealth services in **Head Start** locations and engage members enrolled in their programs to conduct HRS,

SDOH, and health screenings (and referrals/connections to member benefits and programs). We will establish formal contracts with local providers and CBOs to outline care management partnership expectations including data sharing/protection, collaborative health literacy and disease prevention initiatives, coordinating service delivery with PCPs/PCMHs, documenting member outcomes, and making/tracking closed-loop referrals. We will report partnerships to the Division in compliance with requirements in Appendix A, Section 7.2.

State Agencies: We will work collaboratively with all State agencies serving MSCAN and CHIP members, including but not limited to the Department of Health and the Office of Preventive Health; the Department of Child Protection Services; Department of Rehabilitation Services; Department of Mental Health; Department of Employment Security; Department of Agriculture; Supplemental Nutrition Assistance (SNAP) and Women, Infants, and Children (WIC) programs; and programs for special health care needs, such as the Title V Maternal and Child Health Program, to ensure our members are aware of and connected to recommended preventive and medically necessary treatment provided by the State. We will follow up with our members and the organizations to which they were referred within 30 days to address any barriers in accessing services.

c. Coordination with other Providers.

As key participants in member-directed interdisciplinary care teams (ICTs), and as part of our fully integrated service delivery model, our ICM staff coordinate and collaborate with providers serving our members to ensure members receive all recommended preventive and medically necessary follow-up treatment and medications. This includes the member's PCP/PCMH, as well as specialists, BH practitioners, hospital staff, and CBOs (including schools and faith-based organizations) engaged in the members' care. ICTs can also include community pharmacies, dental and vision providers, and non-network and non-Medicaid providers. In the new contract period, with the Division's permission, we will explore opportunities to engage community pharmacies for enhanced pharmacy services using our bidirectional data exchange capabilities for clinical interventions and outcomes (e.g., completing an A1c in the pharmacy to close a gap in care).

We contractually require our network providers to participate in our quality improvement and utilization management programs, and we provide individual provider dashboards through our portal as a mechanism to track their progress in key performance metrics, including preventive and follow-up care. We coordinate care (including follow-up visits and preventive care visits) with providers in the following ways:

- Shared care plan development and maintenance to ensure providers are aware of member services/referrals
- Care gap and telehealth visit alerts and real-time ADT notifications to trigger provider outreach to members to schedule follow-up care
- Comprehensive list of filled medications to make providers aware of all prescribed medications
- Collaborative discharge planning for follow-up care orders from facility-based providers and completed by the member's providers
- Utilization management supports (coordinating referrals and authorizations/closing referral loops) to ensure members receive necessary care

Respecting member preferences, our care managers secure member informed consent to share data across providers as necessary and appropriate. While we respect any member's decision not to share their data, we provide member education on the importance of data sharing for coordinating integrated care across different providers and care settings. With member consent, we offer providers limited, role-based access to the member's health record through our provider portal. For providers with limited information technology systems or who otherwise cannot access the portal, we share data via HIPAA-compliant communication channels (e.g., secure phone, fax, email, and mail). When the member is engaged with state, county, provider, or community care management, our procedures clearly delineate roles/responsibilities to foster collaboration. With the member's permission, we include external care management providers in ICTs, and our staff participate in externally led care conferences when invited. Our care managers advocate on behalf of the member to ensure their voice is heard. Our primary goal is to ensure our members receive seamless, fully coordinated, and unduplicated support and services. We retain responsibility and accountability for member care and outcomes.

4.2.2.3.C.2 For Members with special needs, describe how the Offeror will ensure coordination of care across the care continuum and with state agencies. Describe how the Offeror will assist Members with special needs in identifying and gaining access to community resources that may provide services not covered.

In the coming contract, we commit to using our fully integrated, person-centered ICM model to build, strengthen, and sustain partnerships across provider and community settings to support established relationships and systems of care to benefit all Mississippians with special health care needs. We will provide intensive case management delivered by experienced care managers for complex populations, especially children and youth at risk for short- and long-term institutionalization, who are experts in coordinating care with state agencies and across the care continuum. We will incorporate person-centered thinking and community-based interventions while coordinating funded and unfunded services (including services not covered by MSCAN and CHIP benefits). In addition to the Division, we will work closely and convene quarterly meetings with Mississippi state agencies such as the Department of Rehabilitation Services, Department of Human Services, Department of Child Protection Services, Department of Health, and the Department of Mental Health to ensure coordination of care and an understanding of services across agencies. Building relationships with state agencies will break down gaps in care and provide for better coordination. We will lead or co-manage multi-system case conferences to create person-centered care plans which are shared through our electronic portal. Our ICM system supports seamless coordination across state programs and care continuums to provide comprehensive care for child and youth members with special health care and related needs who have chronic physical, developmental, BH, or emotional conditions of a type or amount beyond that generally required by children.

Demonstrated Leadership Serving Complex Populations

We have rich experience serving members with special needs and demonstrated leadership in serving complex populations. We are the preferred managed care organization for another state's foster care agencies and were selected to administer the state's home and community-based waiver from birth to age 59 and specialized recovery program. To enhance our capacity in serving complex populations, we acquired a respected organization that provides clinical staffing and quality improvement for over 100,000 individuals with complex/special needs across multiple states and government agencies. Our Mississippi members will directly benefit from the established enterprise-level programmatic supports/resources for members with complex needs of all ages, especially vulnerable children and youth.

Ensuring Coordination of Care for Members with Special Needs

We identify all members with special health care needs as high-risk and provide intensive care management. We offer well-being coaching services to the member/parents/caregivers for as long as the member is enrolled with us to mitigate SDOH needs, such as stable housing and education/employment supports. While care management needs may vary over time, our assigned intensive care manager regularly engages with the member/family/caregivers to foster trusting, sustainable relationships. We ensure seamless coordination of care by convening a family-centered ICT based on member choice (including participants from other agencies in the system of care) and creating a care plan addressing the holistic array of services and supports (both funded and unfunded) for the member, their family, providers, and state agencies. We provide in-home respite care for parents and caregivers of youth diagnosed with a serious emotional disturbance and caregiver supports for members who are in foster care or engaged with the child welfare system (living in a kinship home). Our care manager facilitates communication and collaboration among all service providers, state agencies, and member-identified supports, **using relational health principles to empower members to develop safe, stable, and nurturing relationships, which support members in achieving their health goals**.

In the coming contract, our care management teams will recognize and address the needs of members with special needs through their training in trauma-informed care, relational health, and mental health first aid. We will offer similar trainings for network providers, specifically targeting pediatricians/family practice providers to identify and appropriately care for members with adverse childhood experiences (ACEs) or histories of trauma. We will educate new parents/families on developmental milestones and the importance of early recognition of delays and inform them of early intervention programs for eligible infants and toddlers who may have a developmental delay or disability likely to result in a developmental delay if early intervention services

are not provided. We will also refer members to a Children and Youth with Special Health Care Needs (CYSHCN) program for eligible children and youth who have special health care needs requiring care coordination to navigate care systems, facilitate care needs, and advocate when appropriate. In addition, we will share data analytics managing the foster children population with the State to drive foster care programs based on diagnosis clusters, utilization patterns, and population attributes.

Strengthening Communication and Engagement with Service Providers and State Agencies: Upon award, and as part of our fully integrated service delivery model, we will formalize agreements with special need service providers and State agencies to outline ongoing communication and engagement activities designed to support coordinated care for members with special needs and strengthen engagement between providers and state agencies. We will embed designated care managers in child welfare agencies to provide immediate access and referrals and promote cross-system education and training. We will prioritize activities that allow CCOs, providers, and state staff to engage simultaneously (e.g., via multistakeholder workgroups). For example, in another Medicaid market, we assisted with foster placement for under resourced counties needing assistance and facilitated more than 70 successful placements. In the coming contract, with the Division's approval, we will work with other CCOs to align key strategic decisions to improve care for all vulnerable Mississippians. We will review these communication/engagement activities annually to identify opportunities for improvement and will make ongoing adjustments as necessary based on the feedback of all parties involved. Key provider/state agency communication and engagement channels will include, but are not limited to:

- Bidirectional data-sharing agreements accessible to all responsible parties through our designated portal, subject to HIPAA, 42 CFR Part 2, and associated State privacy laws
- Designated care management staff serving as state agency liaisons and regional provider representatives serving as single points of contact to identify and rapidly address operational barriers
- Participation, based on member preferences, of community-based case management providers, county agencies (for children in foster care), and state agency staff in our ICTs, such as case managers from providers of targeted case management services formerly covered through Mississippi Youth Programs Around the Clock or social workers representing the Department of Child Protection Services
- Designated staff liaisons with Mississippi Departments of Mental Health, Health, Child Protection Services, Human Services (including the Division of Youth Services), Education, Public Safety, Corrections, and Rehabilitation Services
- Intensive care managers will participate in external ICT meetings, case conferences, and workgroups, including the formation of new multi-stakeholder workgroups with representation from CCOs, members and their families, service providers, provider and consumer advocacy organizations, and state agencies

On award, to the extent allowed, we will provide support to strengthen and sustain activities of the MS Interagency Coordination Council for Children and Youth. We will endorse the Department of Mental Health and their partners' (e.g., Families as Allies) efforts in reviving Interagency Coordination Council for Children and Youth activities. While CCOs are not identified in statute as having representation on the council, we stand ready to partner with the State to systematically improve care and coordination for these vulnerable residents.

Helping Members Identify and Access Community Resources for Non-Covered Services

In addition to our value-added services described throughout this proposal, we will employ dedicated regionally based intensive care managers to establish and maintain relationships with community resources, including those organizations providing critical non-covered services to members with special health care needs. Our members, care managers, and providers can make referrals to community-based resources via our closed-loop referral system, and our care managers will ensure referrals are completed or identify other community resources as needed. [redacted] We will engage REM Mississippi and NAMI Mississippi to establish collaborative relationships and enhanced referral pathways to connect our members

with special needs to community-based resources and support services. We will also leverage the geographic overlap between our regionally based staff and the Mississippi Volunteer and Nonprofit Hub Network to identify and coordinate referrals with local community and faith-based service providers.

4.2.2.3.C.3 Describe the Offeror's proposed process to ensure appropriate communication with the Provider, follow-up communication with the Members' PCP/PCMH, and follow-up care for the Member. Address the following in the response:

Real-time bidirectional communication is critically important to our collective success in identifying and addressing members' physical/behavioral/and social care needs holistically, including required follow-up care. Within 60 days of contract award, we will deliver our COO/Provider communication strategy to the Division.

a. The Offeror's role and the PCP's/PCMH's role in this process.

Table 4.2.2.3_I describes communication roles of the CCO and our providers in ensuring effective communication to facilitate coordinated, high quality, and cost-effective care for our members.

Table 4.2.2.3_I: CCO and Provider Communication Roles to Ensure Appropriate Communication

CCO Roles	Provider Roles
Share timely, accurate, and actionable member and practice-level data in easily accessible secure formats	Review and utilize data provided by the CCO to inform care provided to members
Ensure each provider has an assigned provider relations representative who is qualified and available to assist providers with operational issues related to data sharing and data analysis	Engage with their assigned provider relations representative to resolve operational issues in a timely, efficient manner
Convene member-specific ICTs and facilitate provider participation, ensure care plans are available to providers and they are notified of changes to care plans/member acuity in a timely manner	Fully engage in care management and transition of care activities, including participation in ICTs to facilitate development of and changes to member care plans
Provide contact information to support PCP/PCMH engagement with other providers and CBOs	PCPs/PCMHs engage with other providers and CBOs to ensure member needs are addressed
Develop and administer value-based purchasing agreements with providers to adopt evidence-based practices and provide training for these practices	Engage in value-based purchasing agreements, participate in trainings, document outcomes required by VBP agreements
Help providers understand the benefits of data-sharing partnerships, facilitate meetings between providers and data partners, and use value-based payment arrangements to reward providers for utilizing interoperable data exchange (including closed-loop referrals)	Adopt interoperable systems to support bidirectional data sharing with the CCO and other providers (including documenting closed-loop referrals) and participate in value-based payment agreements for interoperable data exchange

Ensuring Appropriate Communication and Follow-Up Communication with PCPs/PCMHs: We will bring a new era of provider collaboration to Mississippi via a transparent service delivery model which fully integrates with most Mississippi providers and offers real-time bidirectional data exchange. Our multimodal provider communication strategy will facilitate meaningful engagement and data sharing regardless of the sophistication of a provider's data systems. While we are committed to meeting providers where they are in terms of interoperable data exchange, we will provide ongoing support to assist in the adoption and implementation of interoperable data systems throughout our network to ensure appropriate communication with member PCPs/PCMHs and follow-up care for our members. Upon award, we will embed care managers in high-volume under-resourced practices to facilitate coordination. We will ensure our providers have the information and data they need to deliver quality care through timely, accurate, and actionable member and practice-level data. We will connect to the statewide health information exchanges (HIEs) and electronic medical records of FQHCs, PCMHs, and hospitals for real-time bidirectional data exchange of clinical information and ADTs and support providers in connecting to statewide HIEs. Our real-time data will help providers transition from reactive care to proactive care. For example, we will include member HRS/CHA results, care management enrollment and disenrollment notifications, care management rosters, and member assessments and care plans in member records in our provider portal. This information supports PCPs/PCMHs

to fully participate in integrated care management efforts to facilitate coordinated, whole-person care across provider and care settings.

Communication for Follow-Up Care for our Members*:* Our ICM teams work closely with PCPs/PCMHs and other providers through member ICTs, case conferences, and one-to-one conversations centered around member care to ensure follow-up care for our members. Our care managers communicate directly with PCPs/PCMHs through the provider portal, mail, telephone, and/or visits with members (when requested by the member) to alert them of member needs, changes in circumstances and acuity, and care plan updates including recommendations from our clinical pharmacist on medication therapies. We share member information through the provider portal, including documentation of all referrals for specialty care, our well-being program, disease management programs, and SDOH referrals in the member's record. The provider sends information to care managers directly via the provider portal, mail, email, fax, or telephone when appropriate to provide updates to the member's care plan. We include PCPs/PCMHs in discharge planning during an inpatient stay to coordinate care across provider settings and ensure they are aware of follow-up care needs. We ensure PCPs/PCMHs are aware of follow-up with specialists through documentation in the provider portal. Likewise, we document all telehealth visits in the member's record and notify the PCP/PCMH of visits so they can follow up timely based on member condition or needs. Providers can make referrals to BH, specialty care management, transitions of care management, and general care management using our dedicated telephone referral line and/or provider portal. In the coming contract we will train providers on using the 2-1-1 system for community-based closed-loop referrals so they can offer additional non-medical resources to their patients. We will inform the provider of all member referrals so they can document those referrals in their own records and train providers on how to document those referrals back to us. We will document all member referrals, regardless of how they are generated, in the member's care plan, which is shared with providers via our provider portal.

b. Examples of information that the Offeror will provide to Providers;

Through our provider portal we share timely and actionable alerts/data to identify and address preventive care, care gaps, unmet social needs, and follow-up care for our members, as shown in Table 4.2.2.3_J.

Table 4.2.2.3_J: Information for Providers

Information Source	Description
Practice and Member-Level Population Health Reports	Member rosters and member profiles to allow providers to review and validate the full list of attributed members and share member-specific information, including risk scores, changes in acuity, and claims/utilization history
Care Alerts	HEDIS® care gaps, telehealth visits, and ADT notifications allow providers to monitor member care needs in real-time; connecting to the statewide HIEs, our providers gain access to real-time ADT alerts across payers, improving their ability to care for all Mississippians
Care Management Reports and Member Data	HRS/CHA results (including SDOH needs), care management enrollment and disenrollment notifications, care management rosters, and person-centered care plans allow providers to better participate in ICM efforts facilitating coordinated, whole-person care across provider and care settings
Practice Performance and Quality Reports	Aggregated practice-level data showing practice performance on HEDIS® benchmarks and other key performance indicators related to quality and value-based reimbursement to show practices how they have performed relative to their peers at both the regional and state levels and help providers understand where they need to improve
Clinical Practice Registry	On-demand information in the provider section of our website includes toolkits to access validated screening/assessment tools, clinical practice guidelines, and resources for BH conditions (e.g., attention-deficit hyperactivity disorder, depression, opioid/SUD, suicide); provider portal includes provider HEDIS measure performance to monitor quality and identify gaps in care, such as follow-up care

c. Interaction between Care Manager and Members, Members' PCP/PCMH, family, other physicians, and other relevant parties; and,

Care managers will partner with members at the high-risk level to convene an ICT, and at the request of the member, we form ICTs for members stratified at the low- and medium-risk levels. Our care managers work closely with the member/family/guardian/or authorized representative to develop an ICT that includes everyone important to the members' health and well-being, including the member's providers, our plan medical directors,

and our chief medical officer when needed. By jointly developing a person-centered care plan that integrates provider treatment plans and member-identified goals, everyone on the ICT is better able to understand their role in supporting the member. At a minimum, the ICT includes the member (or guardian/authorized representative), the assigned care manager, and the member's PCP/PCMH and other treating providers, based on member needs and preferences. Members may choose to add other ICT members, including family and friends, life coaches, teachers, CBOs, faith-based organizations, state agency staff, and other community or provider care managers. Our commitment to member and family-centered care relies on open communication between all parties through multiple modalities, including in-person and virtual meetings, telephone, email, and secure web portals to discuss member needs and care plans. Members/guardians/authorized representatives, selected family members, or providers can contact a care manager at any time to discuss questions or concerns regarding the member or their care via email, our care management line, or the care manager's cell phone.

As members experience certain trigger events (e.g., hospitalization, change in acuity, moving into a higher risk level), care managers re-engage ICT members to re-evaluate and update the member's care plan as appropriate, including adding new individuals to the team (e.g., hospital discharge planner, hospital inpatient provider). All ICM staff can access the member's care plan on the clinical platform to triage or create notes for care manager follow up, and care plans are available to both members and providers through secure portals.

d. Transition planning for Members receiving Covered Services from Out-of-Network Providers at the time of Contract implementation.

Preserving the existing relationships our members have with their providers is a critical goal. Our proven transition policies and procedures (described in 4.2.2.3.D.3) assure new/transitioning members can access their existing out-of-network providers and medications without interruption, recognizing maintaining continuity of care leads to lower costs by reducing ED visits and duplicative treatment/services. In new member welcome calls, we take the time to explain member benefits, referrals, processes for working with out-of-network providers and assist them in selecting in-network providers when needed. Our claims system automatically honors claims for new members receiving services from out-of-network providers for the first 90 days after enrollment without prior authorization. We offer contracts to out-of-network providers currently serving our new members, and when we are unable to contract with a specific provider, we execute single case agreements to assure continuity of care while we work with the member to select an in-network provider.

e. The Offeror's Care Management processes and specific communication steps with hospital inpatient Providers to ensure post-discharge care is provided to Members. The Offeror's response should address review of potential Member inpatient readmission by diagnosis and the Offeror's plans for readmission reduction through coordination with hospital providers and other relevant parties.

Supported by the evidence-based Coleman transitions of care model[5], our discharge planning/communication with hospital inpatient providers focuses on ensuring post-discharge care (including medications) is provided in a coordinated manner. Upon notification of admission, either through a real-time ADT alert or direct notification from the facility, our care manager initiates engagement with hospital-based discharge planners and treating providers to ensure discharge orders include critical post-acute support for a safe transition. Our care managers contact members upon admission and/or no later than within 72 hours of their discharge to assist them with follow-up care. Throughout a member's stay, care managers closely communicate and collaborate with hospital staff to assist in the development and maintenance of a member-led individualized transition of care plan which reflects the member's discharge-related care needs and preferences. In the coming contract, we will utilize data to embed our care managers in high-volume hospitals to further assure accurate, timely communication.

We facilitate case conferences with inpatient/residential providers, outpatient providers, members, and their caregivers to fully address post-discharge needs and expectations. Upon award, we will engage institutional clinics, hospitals, and other inpatient facilities through regular and ongoing activities including joint operating committee meetings (for larger providers), regional provider forums, and learning collaboratives. We will use

[5] Coleman Transitions Intervention (Coleman Model), www.caretransitions.org

these opportunities to solicit feedback on improving discharge planning and transition activities while identifying and disseminating best practices and lessons learned. Care managers will document discharge planning activities in our integrated clinical platform and notify the hospital discharge planner of any appointments scheduled during the admission to ensure these are reflected in the facility-provided discharge plan. All providers involved in the member's care will be able to see the member's record in our provider portal, regardless of provider network status. As appropriate, we will re-engage hospital staff throughout the post-discharge process to address any related care gaps or needs the member may identify, including a warm transition back into the hospital if readmission becomes necessary. We will report readmission data to the Division as required by the MSCAN and CHIP reporting manuals. Further detail on discharge processes is in 4.2.2.3.D.2.

Review of Inpatient Readmission by Diagnosis
Using our integrated clinical platform, claims data, and real-time ADT data, we review all inpatient readmissions by diagnosis to tailor care management strategies and ensure appropriate follow-up care is provided. Our transitions report provides review of admissions by diagnosis and ranks each member's readmission risk into risk levels. The transition of care (TOC) report generated by our platform is available to the ICM team, who use the data to determine readmission risk and implement care management and disease management interventions to prevent unnecessary readmissions.

Reducing Readmissions through Coordination with Hospitals and Other Relevant Parties
We understand the importance of the Division's Quality Incentive Payment Program (QIPP) to both the Division and to hospitals and we align strategies to support hospitals in achieving their QIPP goals and objectives. We identify members with elevated risk of readmission through our readmission predictive risk modeling algorithm (run at admission and discharge) and integrate ICM staff clinical judgement to initiate more intensive discharge supports, such as BH/SUD/peer support services. We refer members not having an established care management relationship and at high-risk for readmission to the dedicated TOC team for management during the transition, assessment for ongoing needs, and referral to appropriate services/programs. We identify and address root causes that could lead to readmission (e.g., unfilled prescriptions, lack of transportation to follow-up appointments) and ensure needed transition supports are in place upon discharge (e.g., durable medical equipment, home health, transportation, medication, meals) to ensure safe transitions and reduce the likelihood of potentially preventable readmissions. We may also refer members with SDOH to our well-being program which connects members/parents/guardians to a dedicated certified life coach to overcome obstacles (e.g., housing or food insecurity) which may affect member stability and impede continued recovery and health.

We ensure the hospital provider has issued discharge orders for follow-up telehealth or in person visits with the member's PCP/PCMH, required labs/tests, appointments with specialist(s), and medication. Our team works with the hospital's discharge planner to establish discharge dates and review discharge instructions to ensure required authorizations are in place. When the member is discharged to another facility (e.g., rehabilitation or skilled nursing) our care manager collaborates with the hospital discharge team to secure appropriate placement and ensure implementation of the transition plan and discharge instructions. All discharge information, including follow-up care (e.g., medications, post stabilization treatment) is documented in the member's care plan and is shared with the PCP/PCMH and other providers via our provider portal.

4.2.2.3.D Transition of Care

4.2.2.3.D.1 Describe the Offeror's overall approach to Transition of Care, including the process and criteria used for Transition of Care for Members. Include relevant Performance Measures that will be used to assess this process

We are a CCO committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model through real-time bidirectional data exchanges with providers, next generation member engagement and education, community-based coordinated care, and operational excellence. Our comprehensive transitional care management program efficiently manages transitions across the health care continuum, including transitions of care (TOC) from one care setting to another, discharge from inpatient

facilities, and continuity of care (COC) to ensure members can access their existing providers and treatment when/if they transfer into or between CCOs.

Process and Criteria for Transition of Care Services

Our approach (including processes for discharge from an inpatient facility) supports COC, minimizes complexity for the member by ensuring services and supports are in place for a successful transition, enhances member health literacy, and meets or exceeds all requirements in Appendix A, Section 7.8 and 42 C.F.R. § 438.62. Our approach for TOC between care settings is grounded by the evidence-based Coleman Model, which includes medication adherence, signs and symptoms of worsening conditions, follow up with PCPs/PCMHs, and the use of personal health records. We added two pillars, advance care planning and addressing functional needs and social determinants of health, to meet the unique needs of our members.

Our TOC system promotes timely, coordinated, and safe transitions between health care settings to help prevent preventable readmissions and emergency department (ED) visits, improve health outcomes, and satisfy QIPP goals. Mississippi Medicaid's QIPP, which emphasizes reduced readmissions, is vital to Mississippi's hospitals and is a cornerstone of the Division's quality strategy. We will proactively support our hospital partners in reducing readmissions by improving the transition of care for members, and by ensuring we will have a network of community providers who understand the importance of providing expedited care for those recently discharged from an inpatient setting. We understand the SDOH that impact the post-acute care recovery for the patient. We will embed dedicated care managers in high volume hospitals to improve the transition of care from the inpatient setting and will also assign care managers to work with hospitals identified by the Division for improvement under a QIPP corrective action plan. Transitions of care managers and member-assigned care managers facilitate seamless coordination through real-time bidirectional data communication and collaboration with physical and behavioral health (BH) care providers, and they ensure services are in place to meet member needs. We gain valuable insight into our TOC processes and protocols through our Provider Advisory Committee, which we use to minimize disruptions to care and ensure continuity of treatment for our members. Our fully integrated approach supports holistic and coordinated care across settings for all members following transition program protocols. For members with established care management relationships, their assigned care manager supports them during transitions, and TOC care managers support those members who are not currently engaged in care management (e.g., new members).

Identifying Members Needing Transition of Care Support

We use all available data, including health risk screenings (HRS); new member data from other CCOs or the Division; admissions, discharge, and transfer (ADT) notifications; and predictive analytics to quickly identify and address planned and unplanned TOC needs. We also utilize information from our members and/or caregivers, parents, or guardians; new member welcome calls and other inbound member services calls; provider referrals; and interactions with our care management staff and our school-based health administrator, to identify members in need of TOC services. Providers identify and refer patients who may benefit from care management interventions, and we provide a dedicated telephone referral line for providers to refer patients into care management and/or TOC services.

In keeping with our “no wrong door” policy for care management referrals, we will work closely with the Division and other state and local agencies, faith-based organizations, community-based organizations (CBOs), and providers to solicit input into our TOC care management strategies and to refer members into TOC services. We will conduct warm handoffs whenever possible (e.g., three-way phone calls between the member, provider, and us) to facilitate referrals, such as connecting pregnant members with the Perinatal High-Risk Management/Infant Services System (PHRM/ISS) and linking members to organizations such as Delta Hands for Hope for food distribution. Our closed-loop referral system (described in detail in 4.2.2.3.A.1) connects the member directly with organizations to assist them, regardless of who made the referral or who is in receipt of the referral. Our integrated care management (ICM) team follows up with the member within 48 hours after the referral is made to determine the status of the referral (i.e., if the member has been in contact with the receiving organization, appropriate resources are available, or services have been received). When the member experiences

challenges using the referral, we help them resolve those issues. We ensure the member's providers are aware of referrals and services in place for their members through collaboration and information sharing through the provider portal. In the coming contract, we will create a Transition of Care Partnership and Referral Report detailing partner agencies and community agencies utilized in our TOC strategy for submission to the Division.

Transition of Care Processes
Regardless of the type of transition, we take the time necessary to ensure our members understand what to expect and focus on ensuring timely and safe transitions between care settings, including:

Assigned Care Managers: When members receiving care management services require TOC support, their assigned care manager collaborates with them and their interdisciplinary team (ICT) to develop transition plans. If the transitioning member is not currently in care management, we assign a dedicated TOC care manager (nurse) to work with the member before, during, and after the transition. Our care managers ensure community supports (e.g., support groups, housing, and nutrition) are in place prior to discharge, and we coordinate with social supports, CBOs, medical, behavioral, and substance use disorder (SUD) providers to ensure they are prepared to support members through the transition.

We tailor our programmatic approach to address specialized needs, such as age, acuity, and admission types. All ICM care managers are qualified to act as the single point of contact for members through transitions. Prior to, during, and following transitions, we assess the member's short- and long-term goals, monitor continuity and quality of care, and track closed-loop referrals to ensure they have everything they need to be successful throughout the transition.

Working with Providers During Transitions: We educate providers on our TOC processes upon request and at least twice a year as well as making an on-demand training available through our provider portal. Information provided to providers during transitions includes a summary of the member's history, current medications, medical, behavioral, and social needs to ensure uninterrupted access to covered services and providers. Our care managers inform PCPs/PCMHs, BH providers, and specialists when their patients are in transition, and we engage providers in developing member-centered transitional care plans. We notify providers of members admitted to an inpatient facility in real-time through our bidirectional data feeds and no later than seven days post discharge.

Interdisciplinary Team Participation: Our high-touch model of care management supports members during transitions of care using specialized teams and protocols. Our utilization management and Mississippi-based care management teams work in tandem to support members, coordinate with providers, and effectively manage TOC by ensuring coordinated, clinically appropriate, and accessible services to achieve positive outcomes for our members. For members without an existing care manager relationship, we assign a TOC team member to outreach members who have been identified as needing TOC services as soon as possible and no later than 48 hours to ensure a seamless transition. If a member is engaged in our care management services, our clinical platform generates an alert to the member's care manager of potential TOC needs.

Preventing Avoidable Hospital Readmissions: Mississippi Medicaid's QIPP, which emphasizes reduced readmissions, is vital to Mississippi's hospitals and is a cornerstone of the Division's quality strategy. We will proactively support our hospital partners in reducing readmissions by improving the transition of care for their patients, our members, and by ensuring we will have a network of community providers who understand the importance of providing expedited care for those recently discharged from an inpatient setting. We understand the SDOH that impact the post-acute care recovery for the patient. We will embed dedicated care managers in high volume hospitals to improve the transition of care from the inpatient setting and will also assign care managers to work with hospitals identified by the Division for improvement under a QIPP corrective action plan. Interventions include:

- Reaching out to members for pre-service engagement before planned admissions to initiate discharge planning and mobilize the member's ICT to ensure a discharge plan is in place which identifies services, equipment, medications, and follow-up supports to reduce the risk of readmission
- Connecting to statewide HIEs for real-time ADT notifications upon admission to the hospital to identify and rapidly engage members and their PCPs/PCMHs
- Using locally embedded ICM staff members to conduct member engagement and outreach to hospitalized members prior to discharge (with facility consent) to identify and address readmission risks and reaching out to members who are not engaged in care management to connect them to TOC care managers
- Identifying members at high risk of readmission through our readmission risk algorithm at admission and discharge and ICM care manager clinical judgement; reaching out to members not engaged in care management to engage them
- Referring members with significant social needs to our well-being program, which connects members aged 16 and older and parents/guardians of minor children who are members to a dedicated coach to address immediate SDOH needs and help members overcome long-term obstacles to stable health such as education, employment, legal issues, and housing instability

Performance Measures to Assess Transition of Care Processes

We evaluate the ICM system to determine the effectiveness of our care management strategies, including TOC activities, as part of the annual QI program and evaluation. Our multi-departmental team, facilitated by our Mississippi medical director, serves as oversight for continuous assessment, monitoring, and improvement across clinical and non-clinical operations, including TOC. Key performance metrics are included in Table 4.2.2.3_K. When analysis indicates goals have not been met, initiatives and goals are re-evaluated for potential inclusion in the subsequent calendar year program as approved by the quality committee. We provide the health plan leadership a summary of the effectiveness review of performance targets identified by the Division and present findings to the Division annually.

Table 4.2.2.3_K: Performance Measures and Quality Outcomes for Transition of Care

Key Performance Metric	Process
Case Review Quality Monitoring	Staff members from the clinical process improvement, quality outcomes, and care management team teams conduct initial and ongoing quality monitoring reviews to ensure all required activities and appropriate documentation is complete
Member Satisfaction	CAHPS satisfaction surveys are administered by an outside vendor and supplemented by a member survey to gain information about member perceptions, expectations, and experiences
Health Outcomes & Utilization	Analysis of outcome/utilization measures for transition of care include Adult Access to Preventive/Ambulatory Health Services, Plan All-Case Readmissions, Postpartum Care, Follow-Up After Hospitalization for Mental Illness, Follow-Up After High-Intensity Care for SUD, provider follow-up within 30 days of discharge, and medication reconciliation within 30 days
Grievances & Complaints	Member grievances/complaints related to care management/TOC services are evaluated on an ongoing basis

4.2.2.3.D.2 Describe how the Offeror will provide Transition of Care to Members after discharge from an institutional clinic or inpatient facility, including:

Supported by evidence-based TOC processes, our discharge planning activities focus on scheduling outpatient follow-up, coordinating with hospital and facility discharge planners, notifying the member's PCP/PCMH and BH provider, supporting members in self-management of chronic diseases, conducting medication reconciliation, and collaborating with our UM staff to arrange home-based support, equipment, and services. Our regionally based ICM staff engages members, their families/caregivers, member providers, and facility-based staff to ensure member needs are identified and necessary follow-up care and services are arranged prior to discharge. The interventions are member-driven and based on member and caregiver needs and preferences.

Connecting to statewide HIEs ensures we have access to real-time ADT notifications for our members.

Upon admission to the hospital, we use this data to identify and rapidly engage members and their providers. Through our regional staffing model, locally embedded care management staff conduct member engagement and outreach to hospitalized members prior to discharge to identify and address readmission risks. We commit to facilitating network provider connection to HIEs to provide access to ADT alerts across their payer mixes and improve their capacity to coordinate care for all members.

Timely Contact: Upon notification of admission, the member's care manager reaches out to the member/family/caregiver within 48 hours to assess the member's current circumstances and arrange services, equipment, supplies, and supports necessary for a timely and safe discharge. This includes an assessment of the member's health literacy and a review of their linguistic and cultural needs and preferences. Based on the member's needs, preferences, and acuity, initial outreach may be telephonic, in-person, or through secure videoconferencing. Care managers also engage with member providers to acquire supplemental information on the member's condition and the events of their stay. We notify providers when the member is admitted to an inpatient facility in real-time (and no later than seven days) post discharge via telephone, data exchange, or provider portal. We coordinate interventions through the member's provider to ensure smooth, coordinated, and safe transitions in instances where the member chooses not to engage with our staff.

Member-Centered Transitional Care Planning: Our care managers work collaboratively with our members, family/caregivers, facility-based staff, and providers to develop individualized TOC plans to address post-discharge needs and preferences, and to update the member's current care plan in our integrated clinical platform. We share care plans with the member's providers through the provider portal and with members via the member portal.

Our TOC processes address the unique needs of members with special health care needs, including children who are at risk for out-of-home placement or involved with the Mississippi Department of Child Protection Services and members with serious unmanaged BH/substance use needs.

We train care management staff to identify signs of abuse or neglect and support coordinated transition planning for members with BH needs that cannot be adequately addressed in the hospital. In these instances, care managers coordinate with utilization management staff to facilitate referrals to clinically appropriate services based on evidence-based guidelines (e.g., American Society of Addiction Medicine criteria and Milliman Care Guidelines).

a. Scheduling outpatient follow-up and/or continuing treatment prior to discharge for Members receiving inpatient services;

We support members and their families/caregivers in scheduling all necessary follow-up and continuing treatments as part of our routine discharge planning for members receiving inpatient services. Coordination is performed by the member's assigned care manager or TOC care manager. During pre-discharge contact, we confirm the member's PCP/PCMH, BH providers, and any continuing treatment providers. Our care managers contact each provider, notify them of the member's admission and planned discharge, and facilitate scheduling of seven- and thirty-day follow-ups and continuing treatment appointments based on member availability and preferences. TOC staff coordinates with providers and utilization management staff to ensure all necessary prior authorizations are in place and approved prior to discharge. We make closed-loop referrals to providers and CBOs for follow-up care and ensure all referrals are documented in the member's care plan.

Community mental health centers (CHMCs) and PCPs/PCMHs (including federally qualified health centers and rural health centers) are eligible for an added financial incentive for completion of a timely follow-up visit after an inpatient hospitalization. We have demonstrated success using similar incentives in other markets where our 7-Day Follow-Up After Hospitalization for Mental Illness (HEDIS® FUH) rate of 53.75% scored in the 90th percentile for the 2020 measurement year.

Once appointments are confirmed, upcoming appointment information is added to the integrated clinical platform, and our care manager notifies the facility discharge planner to ensure these appointments are incorporated in the member's facility discharge plan. Our care managers confirm member attendance at all scheduled appointments and immediately engage the member to reschedule missed appointments. Members

who miss scheduled appointments receive more intensive engagement to gain understanding into why the member did not attend the appointment and rapidly address any barriers or needs (e.g., referrals to our transportation vendor).

Subject to any future changes to the Division's rules, our care managers will facilitate telehealth visits in the member's home or other provider sites (e.g., connecting to a remote specialist in their primary care provider's office). These visits preserve and enhance members' existing provider/practice relationships and offer viable alternatives to avoidable ED visits and potential readmission.

b. Coordinating with hospital discharge planners, PCPs/PCMHs, and Behavioral Health staff;

As part of routine discharge planning, our care managers engage with hospital discharge planners, PCPs/PCMHs, BH providers, and with the member's consent, any specialists and community-based service providers engaged in the members care and post-discharge recovery for fully integrated, transparent service delivery. When needed, we facilitate case conferences with inpatient/residential providers, outpatient providers, and member and caregivers to address all post-discharge needs and expectations.

Embedded Care Managers

We directly embed care managers in hospitals and practices we have identified as having high volume or located in areas of high need throughout our provider network to ensure meaningful collaboration and communication from admission through post-discharge follow-up.

Our care managers notify the member's PCP/PCMH and BH providers of member admission, planned discharge dates, and confirm when members have been successfully discharged. Prior to discharge, we engage with the member and providers to ensure all necessary follow-up and continuing treatment appointments have been scheduled and notify the facility discharge planner to add these arrangements to the facility's discharge plan. If member medical or SDOH needs change during the post-discharge period, we will assist the member in facilitating referrals to the appropriate provider(s) and community-based partners to rapidly close new or emerging care gaps. We follow up within 48 hours to ensure all services are in place for the member. All discharge planning records (including referrals) are available to providers and facility staff through our provider portal.

We will continuously engage institutional clinics, hospitals, and other inpatient facilities through regular and ongoing activities including the provider advisory committee, regional provider forums, and learning collaboratives to bring a new era of provider collaboration to Mississippi. We will use these opportunities to solicit feedback to improve discharge planning and TOC activities while identifying and disseminating best practices and lessons learned. Our providers will have assigned provider representatives who work with practices to identify and address operational issues and barriers, including those related to discharge planning and care transitions.

c. Arranging for the delivery of appropriate home-based support and services in a timely manner; and,

The availability of home-based support and services can make the difference between readmission and the member remaining safely at home. When possible, we reach out to members before planned admissions to better understand their living situations and determine if care can be safely rendered in the home. When medically necessary, we assist the member in arranging home health services, occupational or physical therapy, and other covered home-based services. We also identify and arrange durable medical equipment (DME) or home modifications the member may require before discharge.

For members discharging from a BH facility, we engage the local CHMC to determine whether the member qualifies for intensive community services that may include home-based services and supports. For adults living with serious and persistent mental illness, this will include programs of Assertive Community Treatment, Intensive Community Outreach and Recovery Teams, and Intensive Community Support Services. For children and youth in foster care, youth with serious emotional disturbance, or youth having juvenile-justice involvement,

this will include intensive targeted case management programs (e.g., High Fidelity Wraparound or Multisystemic Therapy), which have previously been provided through Mississippi Youth Programs Around the Clock.

Social Determinants of Health Screening

We proactively address non-medical needs by conducting a SDOH screening during the inpatient or institutional stay, and when we identify unmet non-medical needs pertaining to the member's home or living conditions, we connect the member to a local CBO to address the issue. For example, if a member expresses they will not have food when they get home and cannot afford groceries, we arrange local delivery from a food bank. Members participating in employment programs of our well-being program can also utilize our member assistance fund, an enhanced benefit providing financial support to address immediate member needs.

d. Implementing medication reconciliation in concert with the PCP/PCMH, Behavioral Health provider, and network pharmacist to assure continuation of needed therapy.

For fully integrated, transparent service delivery, we engage the member's PCP/PCMH, BH provider, hospital discharging clinician, and network pharmacist before discharge to assure appropriate post-discharge services are ordered. We post the member's medication list in the provider portal for their review to make sure medication lists are accurate, current, and reflect new medications are filled upon discharge. Based on established criteria (e.g., volume of prescriptions, medications barriers such as lack of transportation), the care manager sends a referral to our internal pharmacy team for clinical pharmacist review of the medication list and interactions. The pharmacist makes recommendations to the care manager on member education and reaches out to the provider or network pharmacy to address concerns. We ensure the member has filled all necessary medications and takes them as directed. As needed, the care manager conducts a conference call with the network pharmacist, the member/caregiver, and the prescribing provider to answer member questions or concerns. If the member is no longer using medications that could pose a risk to the member or family, we assist the member in obtaining an appropriate medication disposal packet through our free medication disposal program to discard them safely.

Timing of Discharge Planning Activities

Whenever possible, discharge planning begins before the member's admission to an inpatient facility through communication between the member and their care manager to determine needs and establish a plan for their safe return to home or the community. Upon admission, we work with the facility to ensure all resources are in place for a successful transition of care. Generally, discharge care management activities occur within the following time frames:

Pre-Discharge: We conduct initial outreach and collaborate with the member after admission to identify immediate care needs, including SDOH (e.g., transportation) and need for home-based supports (e.g., DME, supplies, home modifications). Our care managers coordinate with the member, utilization management, and facility-based discharge staff to develop an individualized TOC plan. We notify the member's providers of admission and anticipated discharge to schedule follow-up care, and our care manager conducts a medication review and reconciliation (supported by our clinical pharmacist when required). We discuss transition activities with the member/caregivers to make sure they understand the TOC plan and address any questions or concerns.

Two Days Post-Discharge: Our care manager confirms the discharge with the member's providers and ensures necessary and timely follow-up appointments are scheduled. We work with the member/caregivers to assess the member's post-discharge functioning, identify remaining care gaps and unmet needs, and confirm medications are filled and taken as prescribed. Our care manager reaches out to the member to answer any additional questions or concerns that may have emerged after their discharge. We educate members to identify signs and symptoms of condition exacerbation, when to seek care, and show them how to use their personal health record in the member portal when necessary. We engage member providers and CBOs to ensure progress on transitional care goals, and we update the member's TOC plan appropriately.

Seven Days after Previous Contact: We confirm attendance at seven-day follow up appointment(s) and work with the member to address any barriers to scheduling or attending appointments. To identify remaining care gaps and/or emerging needs, we talk with the member to identify changes in their functioning and provide

coaching supports to improve self-management skills as needed or requested by the member. We reconfirm the member has been able to fill all medications, is taking them as prescribed, and answer any questions or concerns. We also confirm the member has received all DME and home health services as ordered. When necessary, we update the member's TOC plan and make additional referrals to community-based supports.

Fourteen Days after Previous Contact: We engage the member to verify they attended additional follow-up appointments and ensure remaining appointments are scheduled. Respecting the member's needs and preferences, we may continue to provide coaching supports for self-management skills, connect them to disease management programs, and assess the member's functioning to identify changes, care gaps, and unmet needs. We confirm the member is taking medications as prescribed. We engage with the member's providers and community-based service providers as needed to ensure progress on TOC goals. Based on member wishes, we refer members with unmet care needs to care management services for ongoing engagement and support.

4.2.2.3.D.3 Describe the Offeror's proposed transition plan and policies for ensuring continuity of care for members who are currently receiving covered services from Non-Contracted Out-of-Network Providers at the time of Contract implementation.

We understand the importance of COC for our members and preserving existing relationships with their providers through the transition period is our number one goal. Our tried and tested policies and procedures for delivering fully integrated, transparent services, including automated and configured processes, assure that new members can access their existing out-of-network providers without interruption, minimizing administrative burden and disruption for out-of-network providers. **Our ability to deliver operational excellence demonstrates that we will be a worry-free partner of the Division and Medicaid providers through transitions of care.** We invite out-of-network providers to join our network whenever possible. Administrative processes supporting COC transitions include:

Sharing Information to Support COC: We send and receive information to support member care transitions, including prior authorizations, utilization data, care plans, and care management notes through secure flat file exchange with other CCOs and the Division as needed. Our automated systems accept information from the Mississippi pharmacy benefits administrator on prescriptions and medications, and we are equipped to receive fee-for-service claims and prior authorization data from the Division. We ensure member information is available to providers through our secure provider portal.

Honoring Previous Care Authorizations: For the first 90 days after enrollment, our claims system automatically honors claims for new members receiving services from out-of-network providers. For pregnant members who join our plan at any stage of pregnancy, we reimburse all providers treating chronic, acute, or BH conditions, regardless of network status, throughout the term of the pregnancy and postpartum follow-up to promote adherence to milestone appointments and treatment plans with their established providers. We use a weekly out-of-network claims pending report for all claims received for newly eligible members to ensure the member can continue receiving care from the provider, who does not need to refile or appeal any claim denials, and we waive prior authorizations for routine services. We contact out-of-network providers who are delivering services to new members and seek to initiate new contracts or single use agreements to avoid payment denials. When utilization management approves an authorization for an out-of-network provider, the approval letter contains standard language regarding payment. The provider has the option to contact us to negotiate a single-use agreement if they do not agree with the standard payment rate. Reviewing claims weekly ensures timely payment within the state's clean claims processing requirements of 21 days for electronic claims and 30 days for paper claims. Out-of-network provider utilization for Native American members is not subject to the 90-day limitation since they can utilize Indian Health Care Providers under this contract. When a provider is no longer available through our network, we allow members to access services from out-of-network providers for 60 days.

Contracting with Providers: We engage with a wide range of providers across the state to ensure our members have access to a comprehensive network of providers and specialists. We offer contracts to every available Medicaid provider, including out-of-state providers, in accordance with community referral patterns. Understandably, it may be a difficult change for some members to transition to a new provider. To assist those

members, we remain open to contracting with an unlimited number of hospitals, physicians, and most ancillary providers. If we are unable to contract with a specific provider, or in the case of a self-referral, we execute single use agreements. If, for any reason, including moral and religious objections, a provider is unable to offer care and no other in-network provider is available, we retain the ability to refer to a non-contracted provider.

Supporting Members during COC Transitions

Knowing that continuity leads to lower total cost of care by reducing avoidable or duplicative treatment and better health outcomes for our members, we make COC transitions as smooth and stress-free as possible. We support members in finding and connecting with PCPs/PCMHs. We provide real-time coordination and warm transfers to specialized care teams to prevent disruptions in care. Our regionally based ICM staff at provider locations and CBOs share information on our approach and address members questions, especially as it relates to preserving an existing PCP relationship.

4.2.2.3.E Staff

We are a CCO committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing state resources.

Our integrated care management (ICM) system functions are conducted by a broad contingent of skilled clinical and non-clinical staff led by highly qualified Mississippi-based care managers for the express purpose of helping our members achieve the highest level of health and wellness (see Table 4.2.2.3_L). Our ICM staffing plan complies with all requirements of Appendix A, Sections 1.13 and 7.3.

Table 4.2.2.3_L: Integrated Care Management System Staffing

Position	Role in Supporting ICM
Care Management Director	Oversee all care management functions by developing, implementing, and evaluating the care management system.
Care Managers	**Care Managers** support members with ongoing care management services, such as forming interdisciplinary care teams (ICTs), developing member care plans, providing disease management education and support, and monitoring activities for members at all ages and acuity levels as appropriate. Care managers retain members who change risk levels for continuity and include general care managers assigned to regional teams and specialist care managers working with specific populations. **Maternal High Risk Specialist Care Managers** screen members for high risk needs and support services at the level appropriate to the identified needs of pregnant members and infants. They collaborate with the Perinatal High-Risk Management/Infant Services System (PHRM/ISS) to identify members meeting program criteria and provide care management services coordinated with Division care managers to create care plans. **Transition of Care Specialist Care Managers** promote timely coordination of care and safe transitions for members experiencing inpatient hospitalization. They facilitate direct support to members and communication and collaboration with PCPs/PCMHs and community health providers (e.g., hospitals, home health care) for seamless coordination of care. **Behavioral Health Specialist Care Managers** are licensed BH clinicians who support members with complex behavioral health (BH) and substance use disorder (SUD) needs through the integration of physical and behavioral care. They collaborate with Community Mental Health Centers (CHMCs) and other BH providers. **NICU Specialist Care Managers** engage families to provide support for coordination of care and transitions of members into the neonatal intensive care unit (NICU). They coordinate with the PHRM/ISS and provide additional care management in coordination with Division care managers when members choose to participate in the program. **Native American Specialist Care Manager** will be trained in care management practices relevant to Mississippi Native American communities, including understanding specific barriers and challenges faced by these members. They will cultivate and relationships with Native American tribes and health care providers to promote CCO enrollment and services. **Foster Care Specialist Care Managers** will coordinate with the Mississippi Department of Child Protection Services, county child welfare agencies, and treatment facilities to support the needs of children and families in foster care or at risk of out-of-home placement. They will conduct care conferences for placement of children and facilitate transitions of care.

Position	Role in Supporting ICM
Community Health Workers	Extend care management services by identifying community resources and providers. They conduct face-to-face visits with members in their homes or communities to address health disparities and other barriers to care, with expertise in infant, pediatric, and adolescent health. They also identify and reach out to difficult-to-engage members in the community.
Member Health Assessors	Assess member needs through the health risk screening (HRS) and identify the most beneficial clinical programs. They also facilitate warm handoffs to care management.
Peer Support Specialists	Assist members by leveraging their own lived experience of SUD or BH conditions to assist members in their recovery journeys.
Community Justice Liaison	Engage juvenile and adult members prior to release from incarceration and during transition back to the community. They will coordinate with the Mississippi Department of Corrections and CBOs.
Nurse Line Representatives	Ensure availability of 24-hour medical and BH/SUD services and facilitate warm handoffs/referrals to care managers and crisis services via the nurse advice line.
Life Coaches (SDOH)	Provide one-on-one coaching for participants through our well-being program based on member needs; assist with applications for other benefits, such as SNAP; and connect members to housing, food, education, and other services through closed-loop referrals related to SDOH resources.
Other Positions Supporting Care Management Functions	**Medical Director** oversees clinical programs to ensure quality of programs/services available to members, including services provided to members with special needs. **Utilization Management Medical Director and Registered Nurses** ensure the highest quality clinical outcomes of utilization management (UM) and care management (CM) strategies to ensure use of medically necessary, cost-effective health care and resources, including transitions of care. **Behavioral Health Director** is a licensed adult and/or pediatric psychiatrists who provides clinical psychiatric oversight and subject matter expertise for the care of adult and pediatric members, including SUD. **Perinatal Health Director** is responsible for the development, implementation, and revision of the Perinatal Health policy through covered services to Members. **Population Health Director** is responsible to work directly with the Medical Director in the execution of the population health strategies in collaboration with population health corporate and market leadership. **Nurse Practitioners** provide telehealth services to members and connect members back to their PCPs. They also conduct outreach to members with identified gaps in care; **Neonatal Nurse Practitioner** supports the NICU team, hospital staff, and family members. **Clinical Pharmacists** collaborate with the clinical team to review member medication profiles, make recommendations to drive quality and cost-effective pharmaceutical care, and promote medication adherence. **Registered Dieticians** oversee nutritional-based programs such as diabetes counseling and weight management and assist members to make optimal decisions about their nutrition. They also collaborate with care managers. **School Based Administrator** develops relationships with school-based health centers, school nurses, and the School Nurse Association to ensure availability of quality preventive/primary care to school-aged members.

4.2.2.3.E.1 During the next contracting cycle, it is required that Care Managers be located in the state. Describe the Offeror's requirements for Care Managers, including but not limited to the following:

Upon award, our highly qualified care managers will be residents of Mississippi and have the skills/training to engage members of different acuity levels in compliance with Appendix A Section 7.

a. Education and training required for Care Managers

Education: Our care managers are nurses (RNs/LPNs), social workers, paramedics, or allied health professionals with appropriate education, training, licensure, and experience consistent with their care management responsibilities, including an associate's or bachelor's degree in a healthcare or social work-related field or equivalent years of relevant work experience. They have a minimum of three years' experience in a healthcare field (e.g., clinical, discharge planning, case management, and/or home/community health management).

Training: Our training team (including dedicated educators) develops curriculum with subject matter experts across our plan, including medical directors who review content and provide final approval prior to delivery. In the coming contract, we will use the evidence-based framework developed by the Learning Community for Person-Centered Practices (currently adopted by the Division) and embed Mississippi Person-Centered Practices

Facilitation Initiatives. With the approval of the Division, upon award we will partner with the University of Southern Mississippi's School of Social work to implement a comprehensive and localized approach to person-centered planning which is culturally competent and flexible across populations and systems to propel transformative change in the way we engage with members. We will also engage with local hospitals to provide a half-day training for regionally based care managers on local needs and resources. We provide access to annual training requirements on a rolling basis with follow-up testing to ensure staff members understand content. The care manager clinical training and auditing team requires all staff to sign off on their required training (Table 4.2.2.3_M), with a demonstration of skills and expertise, before release from orientation. Care managers complete initial training, ongoing, and annual competencies in care management requirements.

Table 4.2.2.3_M: Care Manager Clinical Training

Training Topics Requiring Sign Off	
Contact requirements including contact, cadence, and content. Engagement strategies, education, motivational interviewing, and member-centric interventions for all populations. ICT education, including provider contact and engagement for ICT meetings	Mandated reporting for abuse, neglect, and exploitation
Quality measures, NCQA HEDIS, best practices, clinical practice guidelines	Spiritual and cultural sensitivity, specific to Mississippi populations including Native American tribes, tribal organizations, or urban Indian organizations, and CLAS standards appropriate care
Health risk screening and comprehensive assessment completion, including evidence-based assessments such as PHQ9, PRAPARE, Edinburgh Postnatal Depression Scale, Child and Adolescent Needs, and others based on branching logic of screening	Identification of fraud, waste, and abuse
Risk stratification and clinical leveling criteria	Health Insurance Portability and Accountability Act requirements
Individualized, person-centered care plans including SMART goals and outcomes measurements	Clinical software platform and capabilities
Documentation protocols including those relevant to NCQA	Covered benefits and enhanced services training, including transportation, MSCAN and CHIP member incentives and programs, community-based resources and offerings, and extended continuity of care timeframe for new MSCAN and CHIP members.
BH training, including trauma informed care and Mental Health First Aid	Prior authorization process and internal hand-offs, including continuity of care, Coleman Model Transitions of Care
Social determinants of health	Behavioral health, maternal/pediatric, high-risk OB, NICU, EPSDT, developmental delays, emergency department diversion, transitions of care, discharge planning
Potential quality of care issues and incident management training	Advance directives
Person centered framework, process competency, and relational care	Center for Disease Control Health Equity training
Disease management focusing on diabetes, hypertension, sickle cell disease, asthma, and other regionally concentrated acute conditions	Closed-loop referrals and warm hand-offs to internal, community, and faith-based organizations

We track and maintain records of completion of all training through our award-winning learning management platform, which we audit on a quarterly basis. Upon completion of all training, staff members receive a core competency assessment to ensure they have successfully learned the material presented and are ready to interact with members. The threshold for competency is 95%. When we identify performance improvement opportunities through formal and self-auditing activities, the training team provides education to address the findings and ensure full core competency and compliance. Once staff members pass the core competency assessment, they are paired with a peer mentor to deepen the knowledge of role expectations of member interactions and documentation standards.

b. The Offeror's Care Manager hiring process, including how the Offeror plans to recruit and retain Care Managers

Upon award, we will continuously recruit care managers toward forecasted staffing needs with a focus on leveraging Mississippi local community resources and partnerships (see Table 4.2.2.3_N). We strive to ensure the racial and ethnic makeup of our care management staff mirrors the membership we serve. Due to today's distinct workforce challenges impacting the healthcare community, especially clinical staff, we will use our experienced staffing team in addition to staffing vendors and leverage relationships with schools, CBOs, job fair providers, and state-sponsored employee assistance programs. We will conduct informal informational sessions to engage community members interested available opportunities and maintain a pipeline of qualified candidates beyond immediate needs to ensure we accommodate future needs. We recruit with the future in mind and make significant investments in our team members to ensure their long-term growth and success.

Table 4.2.2.3_N: Mississippi Hiring Processes

Process	Description
Recruitment	▪ Social media and employment branding campaign to attract motivated, qualified applicants who share the vision and values of our team (e.g., Facebook, LinkedIn, website postings and job boards, local advertisements, local job fairs with immediate interviews, employee referrals, college recruiting, and community partnerships). ▪ Ensure a fully diverse slate of candidates by targeted sourcing to key minority and under-represented populations (including Native American representation). We utilize labor market data to target talent.
Retention	▪ Professional development through advanced, personalized learning and talent development programs providing business, leadership, and interpersonal skill development as well as job-specific skills training, and career advancement ladders. ▪ Licensure renewals, Certified Case Management certification, continuing education credits, and tuition reimbursement. ▪ Employee engagement surveys to identify department-specific trends/opportunities and follow up with leaders to address concerns; stay interviews to gain insight into how to retain employees while they are still employed. ▪ Seasoned leaders and peer-to-peer mentoring programs support employee growth and development. ▪ Connections with co-workers and the community through voluntary employee-led resource groups with monthly educational sessions, peer-to-peer engagement, and expanded company relationships, and paid volunteer time. ▪ Financial rewards/recognition of employees who go above and beyond to help one another and the organization.

c. How the Offeror will ensure that Care Managers are culturally competent and aware of implicit biases

We continuously provide diversity, equity, and inclusion (DEI) training to increase cultural awareness and sensitivity to foster diverse thinking and understanding of cultural norms in health. Expected competencies include working with members of different ages, religions, racial and cultural backgrounds, genders, income, disabilities, limited English proficiency, and diagnoses. Our corporate DEI director, with 18 years' experience in inclusion and diversity, learning and development, organizational leadership, and performance and improvement, organizes quarterly cultural competency programs on topics such as understanding/mitigating implicit bias and the history of racism in healthcare. We adhere to Culturally and Linguistically Appropriate Services (CLAS) standards established by the federal HHS Office of Minority Health. All employees, including care management team members, complete implicit bias and mitigating bias modules presented in partnership with a major university. All care managers complete an in-depth instructor-session on cultural competency as part of the care manager clinical training (shown in Table 4.2.2.3_M). Session topics include defining culture, influences on our identity, case scenario reviews, and bridging cultural differences. In the coming contract, our high-risk obstetrics and NICU care managers will also complete the March of Dimes Breaking through Bias in Maternity Care: Health Equity for Moms and Babies training. We provide a 2.5-hour poverty simulator training to develop empathy and better understanding of the impact of poverty on families/communities.

d. An overview of the Offeror's continuing education and training plan for its Care Managers

We support care managers by offering continuing and on-demand training, providing tuition reimbursement, continuing education credits, and assisting with the cost of licensure and care management certification. We provide tools to support ongoing skill development, such as clinical guideposts on prevalent medical and behavioral conditions and step-by-step guides on following care management workflows/documentation. Our quality team conducts monthly programmatic level audits to ensure contractual and NCQA adherence and

shares audit outcomes and feedback with care management leadership, training teams, and staff to identify areas for improvement and provide additional education and counseling as appropriate. We audit all staff (including call audits) monthly to ensure quality of coaching provided to members and individual staff adherence to contractual and NCQA requirements. Audit results are shared with team members to improve performance and to inform potential retraining opportunities.

e. Expected wages to be paid to Care Managers (hourly/salary and what amounts).

[redacted]

4.2.2.3.F Hypotheticals

4.2.2.3.F.1 Describe the Offeror's approach to providing Care Management in the following scenarios:

a. Member who had been stratified as low risk has had four (4) emergency department visits in the previous five (5) months.

Destiny is a 5-year-old child who is automatically referred to care management for outreach due to excessive visits to the emergency department (ED). Mary, a local and culturally competent pediatric care manager, with expertise and training in providing care management to children and their families, is assigned. This scenario, found in **Table 4.2.2.3_O,** illustrates the care management process of helping members become integrated with a health care team to improve outcomes.

Table 4.2.2.3_O: Destiny's Journey

Identification and Stratification	After two ED visits, Destiny is stratified as medium risk. On the third ED visit, our embedded care manager receives an alert that Destiny is at the ED for the third time in five months via our real-time, bidirectional data exchange system. The embedded care manager conducts an assessment in the ED. As part of our integrated service delivery model, the embedded care manager schedules Destiny for a visit with a primary care provider (PCP) to avoid additional ED visits. Destiny does not attend the scheduled appointment with the PCP. On Destiny's fourth visit to the ED, Destiny is identified and stratified as high-risk through our automated platform.
Outreach, Assessment, and Care Plan	Mary, the care manager, reviews all available information from Destiny's ED visits. She also contacts the hospital liaison who confirms that Destiny is frequently admitted for recurrent ear infections. Knowing this, Mary is prepared to make her first outreach to Destiny's parents. Using motivational interviewing to build trust and partnership, Mary completes the health risk screening (HRS), comprehensive health assessment (CHA), and individualized member-centric care plan with Destiny and her parents. Destiny's mother shares that she is concerned about missing work; as a result, she uses the emergency department (ED) when she can't get time off.
Care Plan Interventions Addressing Access	Together, Mary and Destiny's parents create the following **short-term goals**: ▪ Establish Destiny with a PCP of her parent's choice with **extended office hours** and facilitate scheduling of an appointment, as well as transportation to the visit ▪ Enhance parental support and education (the importance of establishing a PCP/PCMH, including alternative options to receiving outpatient care, such as our 24-hour nurse advice line, our nurse practitioner telehealth line, telehealth, and local urgent care centers within proximity to Destiny's home) ▪ Enhance parental knowledge of our additional services, including our member portal to access educational materials and receive EPSDT reminders, and our mobile app for medication refill alerts Together, Mary and Destiny's parents create the following **long-term goals**: ▪ Connect Destiny's parents to additional supports (parent support groups, childcare options, school-based clinics, transportation, etc.)
Provider Collaboration	Mary shares the care plan and assessments with Destiny's PCP using our provider portal and real-time bidirectional data exchange capabilities. Mary also provides her contact information to the PCP for any care coordination needs that may arise.
Ongoing Care Management	Mary provides Destiny's parents with information about our incentive programs that guide members on a health journey for EPSDT (childhood through young adulthood). Mary provides Destiny's parents with information about our value-added benefits including additional care giver support and children activity membership. Mary also connects Destiny's mother to a life coach for employment and transportation support. 
Member Success	Using our member tracker in our care management platform, Mary confirms that Destiny is seen by her new PCP, that she is current with age appropriate EPSDT services, and that there have been no further ED visits noted. Mary enrolls Destiny, with parental permission, in our children's wellness program.

b. Member with diabetes and attention deficit hyperactivity disorder has been identified as high risk, but the Care Manager has been unable to reach the Member by phone and face-to-face, and mail has been returned as undeliverable.

Peter is an 18-year-old member automatically referred to care management for outreach. Peter is assigned to George, an adult care manager with expertise supporting members with comorbid conditions. George has not been able to contact Peter to engage him in our care management program in past outreach attempts. This scenario in Table 4.2.2.3_P illustrates the importance of devising strategies to find and engage hard to reach members to improve health outcomes.

Table 4.2.2.3_P: Peter's Journey

Identification and stratification	Peter's diagnoses of diabetes and ADHD result in identification and stratification as high risk through our automated platform.
Outreach and Assessment	George, our care manager, has been unable to reach Peter by phone or face-to-face at his last known address, and his outreach letter has been returned as undeliverable. [redacted] George deploys Marie, a local community health worker (CHW) with an established relationship at the food bank. Marie works with the food bank to alert her when George shows up so that she can engage him face-to-face. On notification, Marie meets with Peter at the food bank. She explains the benefits of care management, helps him complete a health risk screen, and introduces him to George through video conference on her iPad. George and Peter complete the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) assessment to align Peter's needs with programs that will best serve him, and a comprehensive health assessment (CHA). Peter advises George and Marie that he is homeless and unemployed. Knowing this, Marie facilitates transportation to and placement at a local homeless shelter. She also provides Peter with a cell phone through a federal Lifeline program and establishes a follow up appointment for face-to-face engagement between Peter and George for the next day. She pre-programs important phone numbers in the phone for Peter, including care management, member services, Nurse Advice Line, and BH/SUD crisis line.
Addressing Access	George recognizes the necessity for Peter to be seen by his PCP and behavioral health (BH) clinician. He immediately schedules Peter's appointments with both providers. George educates Peter on the importance of glucose monitoring for his diabetes and facilitates immediate access to a glucose monitor and supplies through our remote patient monitoring (RPM) program, which he can access with his new phone. He also discusses coping strategies to better manage behavioral health symptoms. Our fully integrated service delivery platform provides George and Marie with a 360-degree member view to assure Peter receives the appropriate services and follows-up with care plan appointments.
Care Plan	Together, Peter and George create the following **short-term goals**: ▪ Secure immediate housing, food, and access to transportation services (office visits, pharmacy, etc.) for Peter ▪ Re-establish regular cadence for office visits with Peter's PCP and provide Peter with diabetes education (importance of "knowing your numbers"); assist Peter with nutritional support; ensure Peter has all diabetic supplies ▪ Establish Peter with a BH provider for both in-office and telehealth access Together, Peter and George create the following **long-term goals**: ▪ Peter will successfully self-manage his diabetes and adhere to his PCP follow ups ▪ Peter will adhere to his ADHD treatment plan and BH provider follow ups ▪ Peter will connect with a Life Coach for permanent housing options, employment support, and life skills
Provider Collaboration	George collaborates with the shelter care manager for immediate support and stable housing. George shares Peter's assessments, care plan, and RPM program information with the PCP and BH provider using our provider portal and real-time bidirectional data exchange capabilities.
Ongoing Care Management	George introduces Peter to our life coach who helps Peter find stable, low-income housing; create a resume; and prepare for his first job interview. George works with a local CBO that provides transitional housing to assist homeless youth so that Peter can transition to safe and stable housing. Using our value-added benefit member assistance fund and a donation from a community organization, Peter can purchase new clothing for his job interview. Peter receives ongoing BH treatment for his ADHD. With George's support, Peter is connected to local support groups, our mobile app platforms, information on member incentives, how to access the member portal, and how to connect with the 24-hour nurse advice line and the BH/SUD crisis support line. George enrolls Peter at his request in our diabetes disease management program.
Member Success	Peter is living in an apartment. He has obtained a new job and is attending a local support group for young adults with ADHD. Peter's diabetes is controlled; Peter attends routine visits with his PCP and BH specialist and adheres to his medications, which George confirms through our fully integrated clinical platform. Peter begins to work with Marie, our CHW, to transition off Medicaid.

c. The Offeror's Care Management System identifies that a fourteen (14) year old Member with behavioral health needs was admitted last night to a local inpatient facility after presenting with an asthma attack.

Brandi is a 14-year-old, recently admitted to the hospital, who automatically triggers for a referral for complex care management through our automated platform. She is assigned to Michelle, a local pediatric nurse care manager with behavioral case management experience, embedded at the hospital, with expertise in the management of children with comorbid conditions. This scenario in illustrated in Table 4.2.2.3_Q.

Table 4.2.2.3_Q: Brandi's Journey

Identification and stratification	Our real-time, bidirectional data exchange triggers Brandi's referral to high-risk care management due to her hospital admission and diagnosis of asthma.
Outreach/ Assessment/ Discharge Planning	Michelle, the care manager, engages Brandi's parents and hospital team within 24 hours of Brandi's admission to assess Brandi's current condition and assist with discharge planning. Using motivational interviewing skills to engage and build trust, Michelle completes works with Brandi and her parents to complete a HRS and CHA. Michelle also assesses Brandi's parents' understanding of asthma management, helps the family develop an asthma action plan, connects Brandi to a BH provider, and helps the family develop an individualized plan for Brandi's anxiety. Brandi's parents agree to care management and schedule a follow-up home visit within 48 hours of discharge from the hospital.
Care Plan	Together, Brandi, her parents, and Michelle create the following **short-term goals**: ▪ Brandi and her parents will have all medications and supplies (nebulizer, oxygen, etc.) on-hand at the time of discharge ▪ Brandi and her parents are aware of our preventive options 24-hour nurse advice line, nurse practitioner telehealth, and 24-hour BH/SUD crisis support line ▪ Brandi will be seen by her PCP within 48 hours of discharge from the ED and the asthma action plan will be finalized and subsequently shared with the school nurse or school office ▪ Brandi will be seen by her BH provider within one week of discharge Together, Brandi's parents and Michelle create the following **long-term goals**: ▪ As part of our transparent, fully integrated, whole person service delivery approach, Brandi and her parents will be connected to supports through community-based organizations ▪ Brandi and her parents will have access to our member portal, mobile application, and telehealth services that include BH providers ▪ Brandi will have access to our teen app to connect her to an online community that fosters resilience by giving teens a safe space to share their mental health stories and access mental health resources, and local teen support groups for anxiety
Provider Collaboration	Michelle coordinates follow-up care with Brandi's PCP and BH provider. She shares Brandi's care plan with both providers using our provider portal and real-time bidirectional data exchange capabilities.
Ongoing Care Management	Michelle reviews the asthma action plan; focusing on triggers and emergency medications to take during green and yellow levels to prevent full asthma exacerbation and possible hospital readmission with Brandi and her parents. She provides Brandi with a peak flow meter for RPM of her asthma by her PCP. Michelle also provides Brandi with access to our mobile app and asthma educational materials. Brandi chooses to see a female therapist while she is in school, and Michelle connects her to local peer support groups for extra support. Michelle reviews all benefits and available services and community programs with Brandi's parents and completes closed loop referrals for parental support groups. Michelle enrolls Brandi in our disease management program at her parents' request.
Member Success	Brandi is seen by her PCP within 48 hours of discharge and her BH provider within seven days of discharge. Brandi has frequent counseling sessions while in school and reports control of her anxiety with established healthy coping mechanisms. Brandi thrives in school and joins the volleyball team. Brandi, her parents, her PCP, and school nurse all have a copy of the asthma action plan and verbalize understanding. Brandi is provided hypoallergenic sheets (value-added benefit) to help with preventing an asthma exacerbation. Brandi has not had any further admissions for asthma or anxiety.

d. Member with behavioral health needs is taking multiple psychotropic medications and will be discharged from an acute psychiatric hospital and returning to his home next week.

Simon is a 40-year-old currently in an inpatient psychiatric hospital with a plan to return to his home next week. He is established with a care manager, Katie, and his journey is illustrated in Table 4.2.2.3_R.

Table 4.2.2.3_R: Simon's Journey

Identification and stratification	Our real-time, bidirectional data exchange triggers a notice to Simon's care manager, Katie, that he has been admitted inpatient to an acute psychiatric hospital.
Outreach/ Assessment/ Discharge Planning	Katie, the care manager, outreaches to the hospital within 24 hours of Simon's admission to understand Simon's current condition, treatment plan, and hospital discharge plan. Katie learns that Simon's stay is attributable to not taking his medications properly, even though he had picked up his medicines on their refill date. Simon says that the medicine made him feel tired all the time and he stopped taking them so he could have more energy. Katie collaborates with the hospital discharge planner as the single point of contact for Simon and his care team. Katie attends hospital rounds with the discharge team to begin collaboration and discharge preparation. She meets with Simon and the integrated care management (ICT) team to create an individualized, person-centered service plan.
Care Plan	Together, Simon and Katie create the following **short-term goals**: ▪ Simon will be safely discharged home ▪ Simon's psychiatrist at the hospital adjusts his medications to alleviate the lethargy but emphasizes that he must take the medicine as prescribed ▪ Simon will have all medications on-hand at the time of discharge ▪ Simon is aware of our preventive options (24-hour nurse advice line, nurse practitioner telehealth, and 24-hour BH/SUD crisis support line) ▪ Simon will be seen by his behavioral health provider within one week of discharge Together, Simon and Katie create these **long-term goals**: ▪ Simon will successfully manage his BH condition ▪ Simon will have support from his family and friends ▪ Simon will be connected to additional community supports and services
Provider Collaboration	With Simon's permission, Katie shares his completed assessments and updated care plan with his PCP and BH provider using our provider portal and real-time bidirectional data exchange capabilities. Katie coordinates BH services using varied methods (telehealth, community-based services, mobile app). Katie collaborates with a clinical pharmacist to educate Simon on the importance of medication adherence and addressing medication-related questions.
Ongoing Care Management	Katie visits Simon within 48 hours of his discharge. She provides education on the importance of follow up appointments and medication adherence to prevent readmission. Katie explains our preventive services, such as 24-hour nurse advice line, nurse practitioner telehealth, and 24-hour BH/SUD crisis support line. Katie contacts Simon after his seven-day provider follow-up and addresses concerns and questions. Katie connects Simon to local support groups and partners with local CHWs for targeted BH community supports. With permission from Simon, Katie engages Simon's parents in discussions to ensure adequate social supports and medication adherence. Katie contacts Simon the after his 30-day provider follow-up, ensuring there are no questions or concerns. As per Simon's request, Katie enrolls Simon in our BH wellness program.
Member Success	Simon is receiving BH services and is adhering to his BH medications as prescribed. The new medications have made him less lethargic, and he has more energy to exercise. As a result, he has lost 10 pounds and feels much better. He has no further inpatient admissions. Simon returns to work. He frequently attends a local support group.

e. Hospital staff are resistant to having you assist with coordinating discharge and Transition of Care activities for a member.

Angela is a 15-year-old who triggers for care management due to her inpatient hospitalization for sickle cell pain crisis. Angela's established care manager is Rita. Angela's journey is illustrated in Table 4.2.2.3_S.

Table 4.2.2.3_S: Angela's Journey

Identification and stratification	Rita, Angela's existing high risk care manager, receives an alert through our real-time bidirectional data exchange that Angela has been admitted to the hospital.
Outreach/ Assessment/ Discharge Planning	Rita attempts to engage Angela, her parents, and the hospital discharge planner face-to-face in the hospital, but is unsuccessful. She engages Angela's mother via telephone and uses motivational interviewing skills to empower Angela's mother to drive discharge planning decisions. Prior to discharge, Rita again attempts to reach the hospital to coordinate discharge planning but is unsuccessful. Rita facilitates all post-discharge follow-up services, including medications and follow up appointments. She collaborates with our utilization management team to expedite prior authorizations for discharge services.
Care Plan	Together, Angela's parents and Rita create the following **short-term goals**: ▪ Angela will be safely discharged home ▪ Angela's pain will be managed with oral medication ▪ Angela will have transportation to and from appointments

	▪ Angela and her parents will use preventive options including our 24-hour nurse advice line, nurse practitioner telehealth, and our 24-hour BH/SUD crisis support line Together, Angela's mother and Rita create the following **long-term goals**: ▪ Angela and her parents will successfully manage her disease ▪ Angela will be followed by a comprehensive care team to oversee the many aspects of her sickle cell disease
Provider Collaboration	Rita shares the updated care plan with Angela's providers using our provider portal and real-time bidirectional data exchange capabilities. She works with providers to arrange for all medications, services, and supports.
Provider Partnership	After Angela is discharged with services in place, Rita continues her outreach to the discharge planning team to provide education about our role in care management during transitions of care and how we can support our hospital partners. As part of our fully integrated, whole person service delivery approach, she collaborates with our utilization management and provider relations teams to discuss the potential need for a designated care manager at the hospital to reduce readmissions which impact the hospital's payments under the QIPP. Our CCO leadership team collaborates with our provider relations to engage hospital leadership in discussions about transitions of care support and the benefits of a partnership with a designated onsite. After demonstrating how our participation in discharge planning helps the hospital, the hospital agreed to embed our care manager in the hospital.

Health Risk Assessment

1. What language do you want to use?	☐Arabic ☐Creole ☐English ☐Spanish ☐French ☐Mandarin ☐Russian ☐Somali ☐Sign Language ☐Other
2. How do you feel about <your> <your child's> health and well-being right now?	☐Great ☐Very Good ☐Good ☐Fair ☐Poor ☐Not Sure
3. What worries you the most about <your> <your child's> health?	
4. <Do you> <Does your child> have any of these health conditions? Select all that apply.	☐Asthma ☐Behavioral Health – Bipolar Disorder ☐Behavioral Health – Depression ☐Behavioral Health – Psychotic Disorders such as Schizophrenia ☐Behavioral Health – Substance Use Disorders ☐Cancer – being actively treated ☐Congestive Heart Failure ☐Chronic Obstructive Pulmonary Disease/ COPD and if yes, is the member on oxygen ☐yes or ☐no ☐ Diabetes ☐End Stage Renal Disease/ESRD ☐Heart Failure, HIV/AIDS ☐High Blood Pressure/Hypertension ☐Intellectual/Developmental Disabilities ☐Liver Disease ☐Pregnancy ☐None ☐Other
5. What is <your> <your child's> weight?	
6. What is <your> <your child's> height?	

7. How often do you <see your doctor> <take your child to their pediatrician> for things like annual exams, immunizations, hearing and vision tests, and dental exams?	{Based on response, recommend at least annual checkup and offer to schedule appointment. Ask about current immunization status. For children: if no doctor appointment completed in the previous 12 months, refer to CM for comprehensive assessment and offer to schedule appointment}
8. How many times <have you> <has your child> visited the emergency room in the past six months?	☐0 times ☐1-2 times ☐3 or more times ☐Unsure
9. <Have you> <Has your child> visited the urgent care in the past six months?	☐0 times ☐1-2 times ☐3 or more times ☐Unsure
10. How many times <have you> <has your child> stayed overnight in the hospital in the past six months?	☐0 times ☐1-2 times ☐3 or more times ☐Unsure
11. <Do you> <Does your child> have any special needs we could help you with? If so, select all that apply.	☐Fear ☐Trouble reading ☐Not enough time ☐Eye problems ☐Cultural needs ☐Lack of support ☐Religious/spiritual needs
12. <Do you> <Does your child> need help with any of these activities? Select all that apply.	☐Bathing ☐Dressing ☐Grooming ☐Oral care ☐Eating ☐Using the bathroom, not able to control urine or stool ☐Moving around/walking, hearing/ communication/hearing aids ☐None ☐Other
13. <Do you> <Does your child> need help with any of these activities? Select all that apply.	☐Getting the help you need, driving or arranging travel ☐Making meals ☐Shopping ☐Doing housework ☐Remembering to take your medicine as prescribed ☐Getting the medicine your provider prescribes ☐Handling money ☐None ☐Other

14. <Do you> <Does your child> have pain?	☐Yes ☐No
15. On a scale of 1 to 10, 1 being no pain and 10 being very high pain level, how would <you> <your child> rate the pain?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
16. <Do you> <Does your child> get treatment for pain?	☐Yes ☐No
17. If you marked "Yes" in the last question, is the treatment helping the pain?	☐Yes ☐No
18. <Do you> <Does your child> take any medications?	☐Yes ☐No
19. If you marked "Yes" in the last question, Do you know what <your> <your child's> medications are for? Do you know why <you> <your child> are taking them?	☐Yes ☐No {ADHD/Diabetes/hypertension medication triggers comprehensive assessment}
20. <Do you> <Does your child> take your medications the way the doctor told you?	☐Yes ☐No
21. Do you worry about your memory?	☐Yes ☐No
22. Over the last 2 weeks, how often have you had little interest or pleasure in doing things?	☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

23. Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?	☐Not at all ☐Several days ☐More than half the days ☐Nearly every day {PHQ-2 (questions 20 and 21) positive response triggers comprehensive assessment and PHQ-9}
24. <Have you> <Has your child> ever thought about harming <yourself> <themself>?	☐Yes {If yes, assessor to trigger crisis intervention protocol} ☐No
25. If you marked "Yes" in the last question, do you have a plan to deal with these thoughts?	☐Yes ☐No
26. Have you ever used alcohol, drugs or tobacco in the past? Select what you've used in the past.	☐Alcohol ☐Drugs [Illicit] ☐Tobacco ☐None ☐No answer
27. Do you use alcohol, drugs or tobacco now? Select what you use now. {If yes, triggers comprehensive assessment}	☐Alcohol ☐Drugs [Illicit] ☐Tobacco ☐None ☐No answer
28. What is your living situation now?	☐Homeless ☐Living with other family ☐Living with spouse ☐Living with others unrelated ☐Living in a group home ☐Living in a shelter ☐Living in assisted living facility ☐Living in out-of-state facility ☐Living in a nursing facility ☐Member to document further details
29. Do you feel safe where you live?	☐Yes ☐No

30. Do you need help accessing community resources? Select all that apply.	☐Meals on Wheels ☐Food bank, food stamps ☐WIC ☐Free clothing store ☐SSI ☐Disability ☐Legal services/Adult probation	☐Support groups ☐Transportation ☐Counseling services ☐Housing ☐Utility services ☐None ☐Other
31. In the last 6 months have you worried about having enough money for food, medications, utilities or rent/house payment?	☐Yes ☐No {Yes triggers comprehensive assessment}	
32. An advance directive is a form that lets your loved ones know your health care choices if you are too sick to make them yourself. They will know just what types of treatment you want, how you wish to be cared for and who can make those decisions for you. Do you have a living will (a limited form of an advance directive) or advance directive in place? If not, can I send you information?	☐Living will in place ☐Advance directive in place ☐Neither a living will nor an advance directive in place – no information needed	☐Neither a living will nor an advance directive in place – would like further information

Comprehensive Health Assessment	
1. Compared to others <your age> <your child's age>, how would you rate <your> <your child's> health <and development>?	☐Excellent ☐Very Good ☐Fair ☐Poor ☐Unsure
2. What is your main health concern? What worries you the most?	CM to have member explain and help member make provider appointment to assess}
3. <Do you> <Does your child> have any vision problems? Do you wear glasses? Do you have a hard time reading??	☐ Yes {CM to have member explain and help member make provider appointment to assess} ☐ No
4. <Do you> <Does your child> have hearing problems? Do you wear hearing aids? Do you have trouble making sense of what people are telling you sometimes?	☐ Yes {CM to have member explain and help member make provider appointment to assess} ☐ No
5. <Do you> <Does your child> have any dental problems like trouble eating or pain in your teeth?	☐ Yes {CM to help member get connected to dental office and help make appointment} ☐ No
6. Are you able to access and make sense of information about your health needs so you can make the right health choices for yourself?	☐ Yes ☐ No Explain:
7.What health conditions do you have? check all that apply {For each of the conditions above that the member indicates having, the Care Manager will touch on any combination of these follow-up questions: 1. Does this condition affect your functioning? If yes, CM to have member explain. 2 Is your condition under control or getting worse? 3. Current treatment. 4. Past treatment. 5. Onset date of condition (month/year or range such as 1-2 years ago}.	☐Arthritis ☐Asthma ☐ADHD, Back Pain ☐Cancer ☐Congestive Health Failure ☐Cerebral Palsy ☐Chronic Obstructive Pulmonary Disease/COPD ☐Coronary Artery Disease/CAD ☐Cystic Fibrosis ☐Diabetes ☐End Stage Renal Disease/ESRD ☐Gastroesophageal Reflux Disease (GERD) ☐Heart Failure ☐HIV/AIDs ☐Hypertension, Hyperlipidemia ☐Liver Disease ☐Pregnancy ☐Pre-Diabetes, ☐Stroke or Transient Ischemic Attack/TIA ☐Spina Bifida ☐Sickle Cell Disease ☐Ulcer ☐Other
8. What is <your> <your child's> height and weight?	{Member to provide info, then CM to calculate BMI and follow BMI guideline}
9. Do you know your last blood pressure reading? {If member has high blood pressure}	☐Yes ☐No {Member to provide their last blood pressure reading}

10. Do you know your last hemoglobin A1c or average daily sugar? {If member has diabetes}	☐Yes ☐No {Member to provide their last hemoglobin A1c or average daily sugar}
11. Do you know your cholesterol numbers? {If member has high cholesterol}	☐Yes ☐No {Member to provide their cholesterol number}
12. Have <you> <your child> had any surgeries in the past?	☐Yes ☐No
13. Are you/is your child taking any medications?	{If yes, conduct medication review – when reviewing medications with member ask what each medication is for and how the member takes it to ensure appropriate use and understanding}

14. <Do you> <Does your child> need help with activities like…
How much help do you need with this activity?

☐Bathing
☐Lots of help ☐Some help ☐Little help

☐Dressing
☐Lots of help ☐Some help ☐Little help

☐Grooming
☐Lots of help ☐Some help ☐Little help

☐Oral care
☐Lots of help ☐Some help ☐Little help

☐Eating
☐Lots of help ☐Some help ☐Little help

☐Using the bathroom, Controlling urine or stool
☐Lots of help ☐Some help ☐Little help

☐Moving around/walking
☐Lots of help ☐Some help ☐Little help

☐Hearing/talking/hearing aids
☐Lots of help ☐Some help ☐Little help

☐None

☐Other
☐Lots of help ☐Some help ☐Little help

15. <Do you> <Does your child> have a caregiver who helps with these activities?	☐Yes ☐No, I don't need a caregiver ☐No, but I need a caregiver
{Only ask if "Yes" is answered in previous question} 16. Who gives you the care?	{Member to give CM an open answer}
{Only ask if "Yes" is answered in previous question} 17. Does <your> <your child's> caregiver have the tools they need to give you proper care?	☐Yes ☐No
{Only ask if "Yes" is answered in previous question} 18. Are you happy with the care, or do you need better care?	☐Yes, caregiver is meeting member's needs ☐No, caregiver is notmeeting member's needs {Through questions 3-6, CM will be able to determine action taken or develop plan to address this need.}
19. <Do you> <Does your child> exercise regularly?	{CM to assess whether the child involved in community and/or school activities based on natural conversation.}
20. <Do you> <Does your child> have pain?	☐Yes ☐No
21. On a scale of 1 to 10, how would you rate <your> <your child's> pain?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
22. <Do you> <Does your child> get treatment for pain?	☐Yes Is the treatment helping the pain? Tell us how. ☐No

23. Do you worry about your memory?	☐Yes ☐No
24. <Have you> <Has your child> ever thought about harming <yourself> <themself>?	☐Yes ☐No {If yes, CM to have member complete Functional Status Assessment (FSA) for cognitive function assessment Complete}

25. <Do you> <Does your child> have any of the following conditions?

☐Bipolar Disorder	☐Anxiety	☐Eating Disorder
☐Depression	☐Post Traumatic Stress Disorder/ PTSD	☐Intellectual/Developmental Disabilities
☐Psychotic Disorders [Schizophrenia, Schizoaffective, Delusional Disorders]	☐Autism	☐Other
☐Substance Use Disorders	☐Attention Deficit Hyperactivity Disorder/ADHD, Oppositional Defiant Disorder/ODD	

26. Over the last 2 weeks, how often have you had little interest or joy in doing things? {CM to mark one of these based on natural conversation}	☐Not at all ☐Several Days ☐More than half the days ☐Nearly every day
27. Over the last 2 weeks, how often have you been feeling down, depressed or hopeless? {CM to mark one of these based on natural conversation}	☐Not at all ☐Several Days ☐More than half the days ☐Nearly every day
28. Have you ever had thoughts about harming yourself?	☐Yes {If yes, CM to have member explain} ☐No
29. Do you have thoughts now about harming yourself? If so, do you have a plan?	☐Yes If yes, ☐No plan in place ☐Plan in place Explain: ☐No {If yes, activate crisis protocol}
30. Are there things in <your life> <your child's life> or environment that keep <you> <your child> from getting the best care?. This truly is an open-ended question for the CM to gauge environmental and personal factors that impact care. CM to check all that apply based on natural conversation and describe details in care notes}	☐Cultural Preference(s) ☐Fear, Low Literacy ☐Lack of Support Systems ☐Religious or Spiritual Needs, Time Constraints ☐Other; please describe.

31. Have you used alcohol, drugs and/or tobacco in the past?

☐Alcohol {CM to have member explain}	☐Tobacco {CM to have member explain}	☐Decline to answer
☐Drugs {CM to have member explain}	☐None	

32. Do you use alcohol, drugs and/or tobacco now?

☐Alcohol {CM to have member explain}	☐Tobacco {CM to have member explain}	☐Decline to answer
☐Drugs {CM to have member explain}	☐None	

{Only ask if "Yes" is answered in previous question} 33. How often do you <drink alcohol> <use tobacco> <use drugs>? Daily, weekly or monthly?	{Member to give CM an open answer. If member indicates usage of greater than 6 alcoholic beverages in a day/week, CM to administer the CAGE assessment.}

34. What is your living situation right now?
{CM to mark one of these based on natural conversation}

☐Homeless {CM to have member explain}	☐Lives with others unrelated, Lives in a group home	☐Lives in an assisted living facility	☐Lives in out of state facility
☐Lives Alone	☐Lives in a shelter	☐Lives in out of home placement,	☐Lives in a nursing facility
☐Lives with family			☐Other {CM to have member explain}
☐Lives with spouse			

35. Do you feel safe in your current living situation? {Member to give CM an open answer, based on which CM to mark the following}	☐Feels safe ☐Does not feel safe {CM to have member explain}

36. Do you need help with any social needs, like…
{CM to start listing out these different social needs and check all that apply}

☐Finding and getting access to help, driving or arranging travel	☐Remembering to take your medicine as scheduled	☐Handling money
☐Making meals	☐Getting the medicine your provider prescribes	☐None
☐Shopping		☐Other {CM to have member explain}
☐Doing housework		

37. How many meals <do you> <does your child> have per day?	{Member to give Care Manager (CM) an open answer}
38. Do you sometimes skip meals to pay for bills, medications or rent?	{Member to give Care Manager (CM) an open answer}
39. Can you describe a typical meal for <you> <your child>?	{Member to give Care Manager (CM) an open answer. Assess nutritional content and refer to dietitian for counseling as needed}

40. Are you using any community resources, like…

☐Meals on Wheels	☐SSI	☐Transportation	☐None
☐Food bank	☐Disability resources	☐Counseling services	☐Other, explain
☐SNAP	☐Legal services/Adult probation	☐Housing resources	
☐WIC		☐Utility services	
☐Free clothing store	☐Support groups	☐Community resources	

41. Are you using any community resources, like…

☐Community Mental Health	☐Wellness Organizations	☐Nutritional Support
☐Transportation	☐Palliative Care Programs	☐None

42. Would you like to start having access to any of the community resources I just listed out?
{CM to mark whichever of these resources the member expresses an interest in}

☐Community Mental Health	☐Wellness Organizations	☐Nutritional Support
☐Transportation	☐Palliative Care Programs	☐None

43. Did you know about some of the extra health and wellness benefits in <your> <your child's> plans, like... {CM to start listing out these different benefits and check all that apply}	☐Case Management ☐Nurse Advice Line ☐Mental Health, Pharmacy ☐BH/SUD line ☐Referral to Specialist ☐Smoking Cessation ☐Vision, Dental
44. Are you happy with these benefits? {CM to document resources provided in Care Plan and/or appointments}	☐Yes ☐No
45. What life planning documents do you have in place? {CM to check all that apply}	☐Living Will ☐Advanced Directive ☐Healthcare Power of Attorney ☐None - declines discussion ☐None – requests further information
{The following are more so requirements for the CM team to think about and comply with before the actual assessment and questioning takes place. These will NOT be administered as questions to the members and are not part of the assessment:}	
a. Has the member agreed to work with Case Management Program and has the next activity been scheduled per member's preference (Call, FTF, etc.) with agreement to date and time?	oYes oNo
b. Has the member been educated on then interdisciplinary care team process?	oYes, member agrees to schedule an ICT meeting oYes, member declines to schedule an ICT meeting oNo
c. Have the ICT members been identified?	{If yes, document in care team; or No – member refused to participate}
d. Has the member been offered a formal or informal ICT?	oYes, member agrees to schedule an ICT oYes, member declines to schedule an ICT at this time

[END OF RESPONSE]

4.2.2.4 QUALITY MANAGEMENT

4.2.2.4.A. Quality Management Program

4.2.2.4.1 Describe the Offeror's proposed quality management program, including:

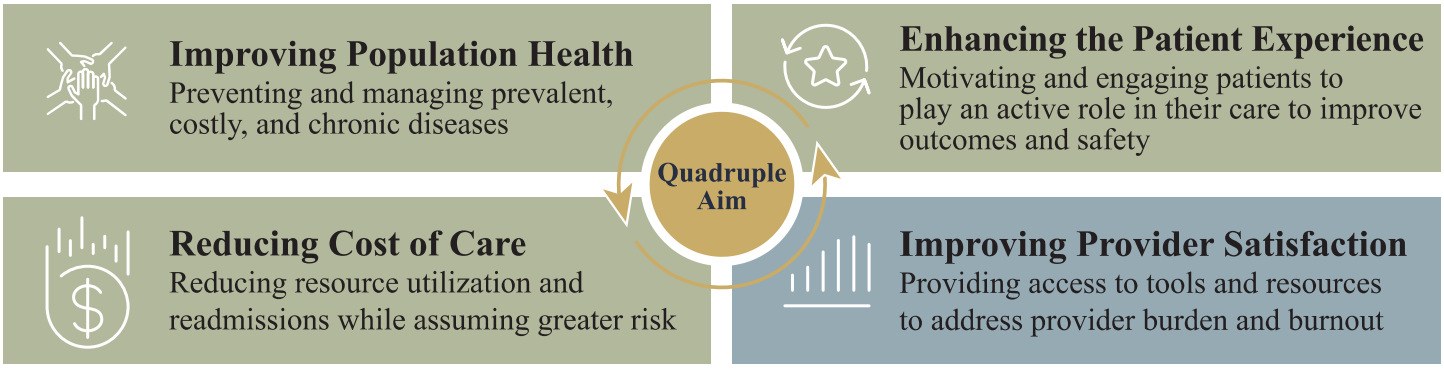
We are a coordinated care organization (CCO) committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing state resources. With a **superior model for accountable, data driven outcomes and quality care,** we harness the power of data to develop and implement initiatives and to drive improved outcomes across maternal health, chronic conditions, preventive care, child and adolescent health, and behavioral health areas of focus. We fully support the Division's goal to create an integrated primary care (IPC) value-based purchasing (VBP) model, and to transform delivery and payment systems through our VBP approach. Our quality management and improvement program (QMIP) and QMIP work plan meet all requirements of 42 CFR 438 Subpart E and National Committee for Quality Assurance (NCQA) standards. We understand and comply with the Appendix A, Section 8, Exhibits B and F, and the Division's 2021 comprehensive quality strategy.

Approach to Quality Management and Improvement Program

Building upon the Institute for Healthcare Improvement's (IHI's) Triple Aim, we have adopted a Quadruple Aim Framework as the foundation for our QMIP, as depicted in Figure 4.2.2.4_A., ensuring a comprehensive and effective QMIP necessary to successfully serve MSCAN and CHIP members and to align with the Division's priorities.

Figure 4.2.2.4_A: Our Quadruple Aim Framework

The Quadruple Aim guides the success of our quality design for the MSCAN and CHIP health system.



MS_MSCAN22_4.2.2.4_Quadruple Aim_2

Improving Population Health

Our quality team drives our population health strategy, using robust data analytics to establish baselines, measure performance, and identify opportunities for quality improvement. We initiate population health improvement programs using evidence-based medicine and practice guidelines. We focus on geographical disparities tied to race and ethnicity. Our population assessment process enables us to identify and target subpopulations with the greatest need, such as pregnant women, to focus on infant mortality and the wellness of growing children. By focusing on disease burden management from a regional and subpopulation perspective, our programs improve the management of chronic conditions, including cardiovascular disease, hypertension, and diabetes. Preventive care and related activities are also principal elements of our approach, using predictive modeling and additional tools to identify risk and connect members with risk reduction and treatment programs. We will also partner with providers and other community-based organizations (CBOs) to further address risk factors, such as physical activity, tobacco use, high blood pressure, and high cholesterol.

Enhancing the Member Experience

Our QMIP and population health program enhance members' participation in their own self-care, promote their ongoing engagement in their health care, remove barriers to improve health outcomes, and empower them to maintain and improve their individual health care. We ensure health equity is a vital component to enhancing our members' experience in our QMIP. We engage with members where they are to offer education to improve health outcomes, and we value member input and satisfaction with our services.

Member Engagement

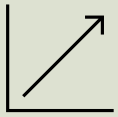
Our advanced analytics will enable us to understand patterns in member engagement and to design person-centered strategies, such as engagement through partnerships with CBOs. Member health literacy is critical to improve health outcomes, and we engage our members through health education programs and multiple member advisory groups that represent different geographies to address health literacy needs. Our member education will focus on their unique racial and ethnic needs, using population assessment, data analytics, input, and guidance from our regionally based integrated care management (ICM) team, and partnerships with CBOs. By coordinating with our other outreach and member engagement strategies, we ensure members participate in and benefit from our superior education program.

Member Incentives

With Division approval, we offer incentive programs to encourage member responsibility in keeping medical appointments and address barriers they may face when seeking health care services. We tailor member incentives to align with the Division's priorities, including well-child visits, dental care, immunizations, and attending timely provider follow-up visits. Our member portal provides access to incentives available so members can easily participate in the program.

Superior Education Program Provides Excellent Results

Across our markets, we successfully increased our Asthma Medication Ratio **from the NCQA 50th percentile (2019) to the 90th percentile (2020)** through targeted education about asthma prevention.



Member Satisfaction

We assess member satisfaction in numerous ways, and we use these opportunities to improve our plan operations and provider services for the highest member satisfaction. For example, we measure member satisfaction using Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. In accordance with NCQA accreditation standards, we measure member satisfaction in the full range of our operations, including the quality of clinical care; availability; and accessibility of health care practitioners and services; quality of preventive services; and other administrative and member services provided by us and our network providers. With experience in a similar Medicaid market, we achieved an estimated **consumer satisfaction rating of 4.0 Stars for surveys for the 2020 measurement period for patient experience,** aligning with the highest-performing coordinated care organizations (CCOs). We also achieved **a 5.0 Star rating for rating of specialist for adult members and a 5.0 rating for coordination of care for child members.** In our 2020 child survey for care coordination measures, we achieved statistically significant increases over baseline in key measures, including getting care quickly, coordination of care, and rating of personal doctor. Our established survey experience enables us to achieve high member satisfaction rates for our health plan and services for MSCAN and CHIP members.

To ensure we obtain trustworthy feedback from members, we use a variety of methods, such as surveyor quotas, member advisory committee feedback, member education, member services messaging, mailed reminder notices, phone reminders and provider outreach. Through these methods, we engage and gather input from members about their plan experience and satisfaction via additional surveys such as CAHPS, new member satisfaction, care and disease management satisfaction, behavioral health satisfaction, as well as private online communities, advisory councils, external qualitative research and focus groups.

Reducing Cost of Care

Our QMIP focuses on improving the quality of care, while reducing overall costs. This approach eliminates unnecessary or inappropriate care and enables us to identify any operational efficiencies necessary to enable the organization to streamline processes and ensure the prioritization of quality and value of services over the volume of services. Leveraging our experienced medical economics team, we review monthly cost and utilization trends to identify any variances to the budget or other key forecasts. We will maximize shared savings with the intent of creating funding streams that both incentivize and resource our provider partners to focus on and deliver high-quality primary and preventive health care.

Improving Provider Satisfaction

We will offer providers innovative tools, electronic health record (EHRs) and health information exchange (HIE) data exchanges, and provider profiling to measure performance with monthly reports and data on demand. Through our relationship with population health technology companies and the HIE, **we have bidirectional EHR connections with 81% of Mississippi FQHCs and hospitals**. As valued partners in caring for MSCAN and CHIP members, we also value provider participation in our program decisions and satisfaction. Our provider advisory committee (PAC) will include representatives across a range of provider types and meets regularly to inform our population health strategy, clinical policy development, network management approach, and VBP performance. We will share survey findings, with specific reporting to entities who play a direct role in enhancing the provider experience (such as utilization management, customer care, claims, and provider representatives). Using this information, we will develop and monitor action plans for continuous quality improvement. For example, based on feedback from a similar survey in another market, we identified an opportunity to enhance our provider portal, allowing providers to complete some tasks more efficiently.

We offer a VBP program designed to help providers identify where they are on the health care planning and learning action network (HCP LAN) continuum, determine their readiness to move along the continuum, and to support practice-level improvements necessary to achieve improved member health outcomes. Our local staffing model ensures our providers, particularly those who are ready to support the Division's transformation goals, have access to dedicated resources. Our model effectively engages all providers, including specialists, rural health providers, and hospitals, in care delivery and transitions. We offer practice transformation software and provide regionally based provider representatives to address any provider questions, concerns, and share performance data.

NCQA Accreditation

We have successfully obtained NCQA accreditation for all programs we administer and comply with the requirement for accreditation in Appendix A, Section 8.2. Our QMIP functions as part of our enhanced accountability approach to assure transparency and operational effectiveness to the Division. We will partner with the Division to improve quality services and member outcomes, leveraging our longstanding accreditation structure and continuous quality improvement processes. We have achieved excellent results from our population health and access to services, preventive screenings, prenatal and postpartum care, and chronic disease management quality success. **Our score of 100% on the NCQA quality standards and population health management standard** in another market underscores our adeptness in developing and implementing processes and procedures that support positive health outcomes, enhance the member experience, and ensure appropriate utilization of services and cost-effective care.

Along with achieving health plan accreditation, we will pursue NCQA's health equity accreditation. Health equity accreditation demonstrates our ability to improve health equity by reducing health care disparities among the Mississippi populations. Health plans going live after July 1, 2022, cannot achieve NCQA Distinction in Multicultural Health Care, as NCQA is retiring this distinction.

External Quality Review

We actively participate in external independent reviews of our performance related quality, timeliness, and access to covered health care services, in accordance with Appendix A, Section 8.3. External quality review (EQR) is an essential component of the state's annual quality strategy plan and ensures an ongoing state of

readiness. We maintain strong data repositories in adherence to HEDIS and other state reporting requirements. We maintain a formal process outlining the responsibilities of facilitating active participation in annual EQR activities and respond to all requests in the timeframe and format requested by the EQR organization. We attend audit meetings, review findings, communicate annual EQR recommendations, and will incorporate EQR findings into the annual MSCAN and CHIP QMIP work plan. For a similar program, we provided timely **responses to 100% of requests** made by the EQR organization. Upon receiving annual results, the quality management (QM) director shares findings with members of the Quality Management and Improvement Committee (QMIC) for input, to identify and prioritize immediate and long-term improvement strategies, and to make decisions to move forward with developing and implementing needed programs or initiatives.

a. The program's infrastructure, including coordination with subcontractors/corporate entities, if applicable;

Our joint development and operations committee (JDOC) relies upon the quality enterprise committee (QEC) to facilitate sharing of best practices for expediting improvements across the system. The QMIC and QEC share decisions, garner input from peers and others experienced in the quality initiatives and share results across markets and products to ensure the design and implementation of effective programs and best practices. The QEC ensures the quality of care provided to members consistently meets evidence-based care, service, and health, safety, and welfare standards, timely and consistently.

Our QMIC, which meets at least quarterly, represents the heart of our infrastructure, maintains a cross-functional representation of voting members, and oversees QMIP functions and related activities in compliance with state and federal regulations, and Appendix A, Section 8.13. Our Mississippi QMIC is co-chaired by our medical director and our QM director, with active participation from our behavioral health director. Our QMIC organizational structure requires subcommittees and workgroups supporting the QMIC and QMIP work plan, which report up to the QMIC on performance measures, operational activities, and outcome assessments to support QMIP goals and objectives.

We incorporate feedback received from our member advisory committee (MAC), CAHPS, and other member surveys. Providers and community providers have a voice on our QMIC through consistent involvement, reporting, and voting rights of provider-facing leadership, including managers of provider services, contracting, and our provider services call center. We monitor all vendors though our delegated vendor oversight (DVO) team. This team actively participates on our QMIC by providing routine reporting on vendor activities.

Internal Structure to Support the QMIC and the QMIP Work Plan

Our QMIC organizational structure requires subcommittees and workgroups supporting the QMIC and QMIP work plan, which report up to the QMIC on performance measures, operational activities, and outcome assessments to support QMIP goals and objectives and work plan for MSCAN and CHIP. The committees, subcommittees, and workgroups measure, monitor, and report quality of care outcomes and processes against accepted benchmarks to drive clinical quality and improvement and to provide a forum for review and discussion of clinical initiatives. Our staffing model allows for increased participation as needed for key performance indicators (KPIs) discussion. Our comprehensive QMIP work plan includes performance monitoring and quality improvement activities for all represented departments.

As part of our QMIP infrastructure, we include the committees, subcommittees, and workgroups as reflected in Table 4.2.2.4_A. Mississippi QMIP Committee Structure.

Table 4.2.2.4_A: Mississippi QMIP Committee Structure

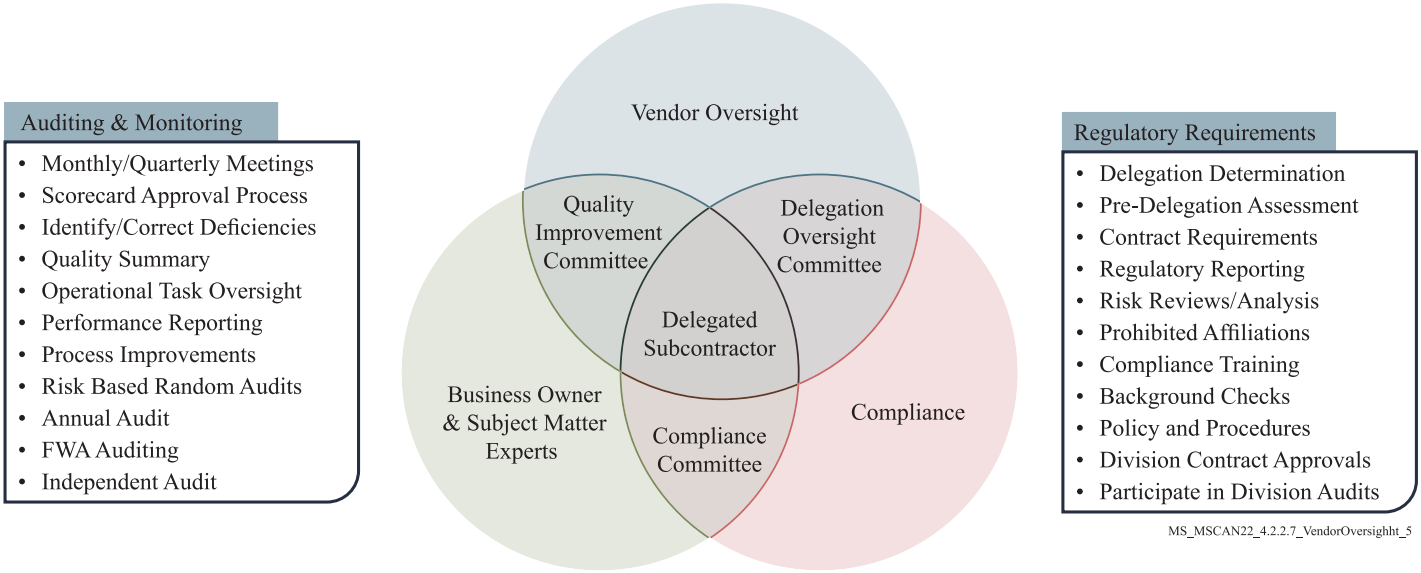
Committees, Subcommittees	Committee/Subcommittee Participants, Functions
Joint Development and Operating Committee	The JDOC oversees QM activities and performance data, identifies areas for improvement, and monitors quality improvement initiatives. The JDOC oversees policies and procedures designed to improve the overall quality and efficiency of the plan.
Board of Directors (BOD)	The BOD oversees development, implementation, and evaluation of the QMIP, including review and approval of the annual QMIP program description, work plan, and annual evaluation. The BOD also monitors program effectiveness.

Committees, Subcommittees	Committee/Subcommittee Participants, Functions
Member Advisory Committee (MAC)	These focus-group-style sessions focus on gaining granular feedback to support process improvements (clinical, health equity, etc.). We align member advisory committee membership within the region they are located which enables us to understand the disparities in each region and to appropriately administer sensitive interventions to assure outcomes optimization.
Utilization Management/Care Management Committee (UM/CM)	The UM/CM committee, led by our Mississippi medical director, reviews, and monitors clinical program considerations, relevant performance trends, and approves decisions related to the UM program and annual population health strategy.
Provider Advisory Committee (PAC)	Led by the Mississippi medical director, the PAC promotes discussion among practicing providers and dentists, throughout the state, with clinical staff, soliciting input and counsel regarding clinical policy and clinical operations decisions. Committee members provide the perspective of practitioners and providers to facilitate development of clinical policy changes and new program implementation.
Population Health Management Committee	Our population health management committee comprises two subcommittees: SDOH and health equity. These committees ensure SDOH and health equity challenges and projects receive focused attention. Our Mississippi medical director leads these committees to ensure all parts of our population health program are working in concert to achieve program goals. We include multiple health equity representatives to participate on this committee.
Special Populations Subcommittee	This subcommittee offers its recommendations on ways to provide person centered, community-based care management to individuals with special needs and to special populations with complex medical conditions, including individuals with physical disabilities, serious behavioral health needs, or individuals in foster care. We offer representation opportunities for members, family members, caregivers, guardians, providers, and community stakeholders on the subcommittee. To assure the equitable representation of plan members who identify as part of one or more of the target populations and choice for special members, 50% of the subcommittee's participants are members. We develop this subcommittee regionally to assure members can attend in person meetings close to their communities and offer virtual meetings both regionally and statewide. At least one plan member and one professional with expertise in the provision of evidence-based practices with one or more of the special populations' co-chair this subcommittee. Subcommittee co-chairs report directly to the BOD and share and disseminate findings and recommendations to both the MAC and the QMIC.

Subcontractor/Corporate Entity Coordination

Our Compliance Committee serves as the oversight body monitoring market performance and ensuring compliance with the requirements outlined in Appendix A. The Compliance Committee consists of key market leaders and the compliance officer and is responsible for the review of high-risk compliance items, including internal and external audit results, corrective action plans (CAPs), and material regulatory sanctions. The QMIC and the Delegation Oversight Committee support the Compliance Committee. These committees provide oversight of performance measures, performance improvement projects, evaluation of underutilization and overutilization, assessment of the quality and appropriateness of care, member experience with the health plan network, and grievances and appeals trends. The Compliance Committee is responsible for identifying, reporting, and remediating performance issues. Figure 4.2.2.4_B illustrates our subcontractor oversight infrastructure.

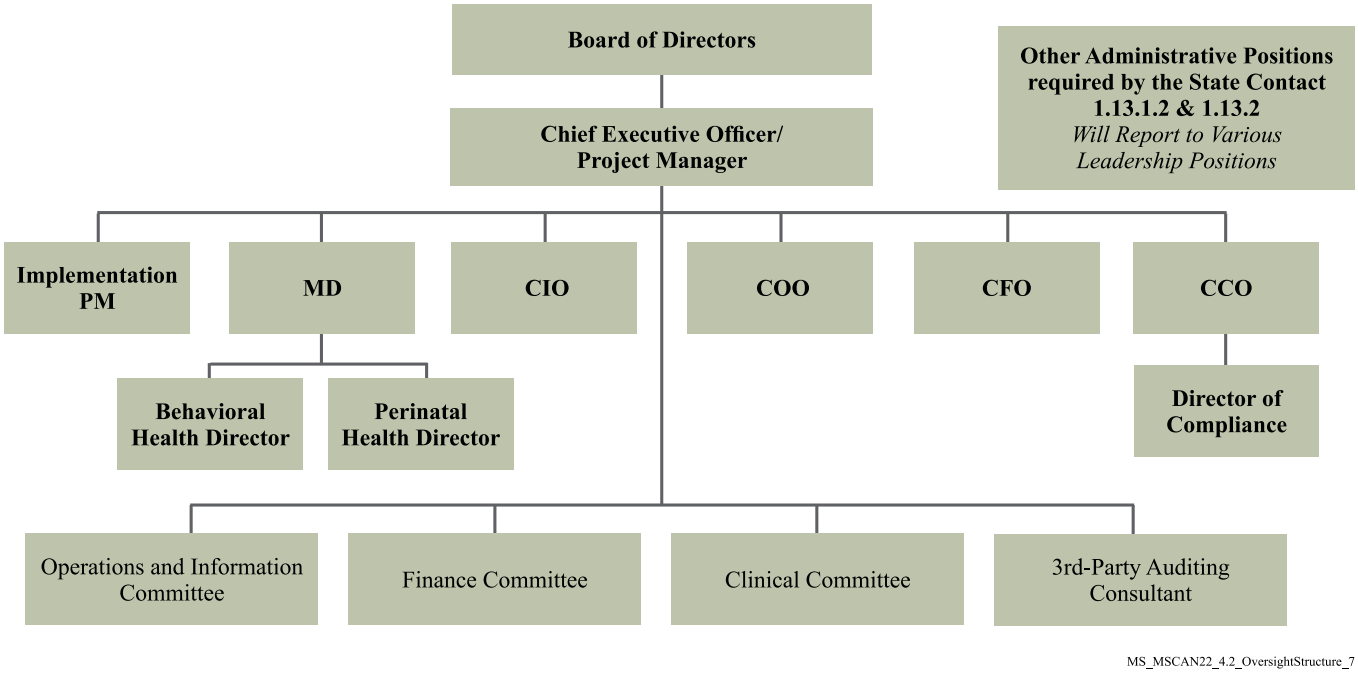
Figure 4.2.2.4_B: Organization Infrastructure
Our corporate infrastructure is designed to ensure our subcontractors perform beyond State expectations.



b. The program's lines of accountability;

Our Mississippi BOD oversees the development, implementation, and evaluation of the QMIP, including review and approval of the annual QMIP program description, work plan, and annual evaluation. The BOD monitors program effectiveness and ensures the QM department has sufficient resources with quality focus threaded across the organization. Our Mississippi medical director serves as the senior executive, representing quality management and improvement. The Mississippi medical director receives direction from the BOD regarding the QM program and share this information with the QMIC, in accordance with Appendix A, 8.1, 8.13, and Exhibit F QM B2 (refer to Figure 4.2.2.4_C).

Figure 4.2.2.4_C: Quality Management Oversight
The Mississippi medical director, in collaboration with the QM director, serves as the liaison directly accountable to the Division, the governing body, and the QMIC for all QM activities.



c. Process for selecting areas of focus;

Our approach to selecting areas of focus for our QM program aligns with the Division's priorities for the comprehensive quality strategy and EQR organization gap reports. Our activities focus on the evaluation of population analytics examined through a health equity lens, evidence-based performance measures and benchmarks to help us target the most impactful opportunities for improvement. These areas of focus support the goals of making care affordable, collaborating with communities to promote best practices of healthy living, promotion of effective prevention and treatment of chronic disease, making care safer by reducing harm caused in the delivery of care, strengthening in person and family engagement as partners in their care, and promoting effective communication and coordination of care across the health system. We leverage our data analysis and informatics from a range of reports, dashboards, and predictive models to address quality and target initiatives. Our population health strategy and ICM team members bring feedback from CBOs and providers to better understand available regional infrastructure and to develop community-specific initiatives to improve health outcomes and health equity.

Aligning with State Priorities

We ensure our QM activities align our efforts with the state's priorities for MSCAN and CHIP members, and ensure the strategic objectives of our quality work plan align with Mississippi's comprehensive quality strategy and the Division's strategic plan, as shown in Figure 4.2.2.4_D.

Figure 4.2.2.4_D: Alignment with the Division's Quality Goals

Aligning with the Division's quality goals ensures improved member access and health outcomes.

Our QM director leads these efforts, and our medical director oversees the process. We focus on child and adolescent health, chronic disease management, and health equity. We understand that maternal health and behavioral health are areas of focus for many programs. We also align our quality work plan to include quality initiatives to improve member health in these areas.

Child and Adolescent Health: Our quality, provider facing, ICM teams and health equity leadership teams work with school systems, CBOs, and other stakeholders to promote and improve access to well-child and adolescent care, including screenings, immunizations and early intervention programs prioritizing areas with greatest disparities in care and outcomes.

Chronic Disease Management: Our ICM and care management teams engage members in preventive services and wellness activities, such as diet and exercise, and reduce the onset of chronic conditions by increasing

access to adult preventive care, promoting healthy lifestyles, increasing tobacco cessation, and reducing the prevalence of obesity, especially in targeted areas of disparity.

Health Equity: Our rigorous approach to population management has a strong focus on health risk and disease burden, analyzed through the lens of health equity. We drill down population interventions to ensure that SDOH barriers are identified and mitigated using community-based and technologic innovations, including such benefits as providing transportation and internet services to increase member access to healthcare in rural areas. We utilize our closed loop process of evaluation to ensure that our strategies are effective.

Maternal Health: We promote and monitor effective maternal health programs to optimize pregnancy and postpartum care and timeliness of prenatal care by increasing maternity visits, health education and literacy, and reducing preterm births in the most vulnerable members.

Behavioral Health: Our person-centered approach integrates medical and behavioral health care and increases initiation of treatment for members with depression and other behavioral health conditions. We have developed a concierge care coordination model for children in foster care and individuals with serious mental illness and substance use disorders (SMI/SUD). We ensure members receive the appropriate follow-up care in their own environment when discharged from mental health facilities, and we have built a crisis response to reduce emergency visits and hospitalization.

NCQA Standards

Relying upon NCQA guideposts, baseline standards have been established for clinical and nonclinical operations throughout the organization, which enables us to identify key opportunities for improvement. These baseline standards incorporate HEDIS and EQRO results, member, and provider satisfaction outcomes, grievances and appeals, as well as disenrollment survey results.

Population Health

Our data driven process enables us to implement our population health strategic plan annually (and as indicated by population changes), aligning with Appendix A, Section 8.10. We conduct the baseline program annually, beginning with a detailed population assessment and data analysis to measure and compare the population across a range of key data points, including member demographics, disease burden, and other health care utilization metrics, in addition to alternative data sources. Our team of population health analysts, HEDIS® analysts, epidemiologists, and statisticians identify and evaluate statistical trends; monitor local conditions; identify targeted subgroups; and implement evidence-based interventions to drive improvement in health outcomes. Our comprehensive risk stratification segments target populations for development of interventions and to allocate resources. As we assess quality to refine areas of focus, we examine each population through the lens of health equity to identify the more vulnerable subpopulations, and those impacted by local community conditions and access to care SDOH factors and disease prevalence.

d. Process for using evidence-based practices;

We integrate evidence-based practices (EBPs) into our clinical and nonclinical quality operations, understanding that nationally recognized standards are key to ensuring continuous performance improvement. We review nationally and locally developed guidelines annually to assess currency with the scientific literature and national trends. If the scientific trends or literature changes prior to the annual review, we review and revise guidelines more frequently, as needed. To ensure consistency with evidence-based guidelines and industry best practices, we consult with our PAC. Pursuant to 42 CFR 438.210(b), the PAC reviews, make recommendations, and approves the clinical guidelines used to make medical necessity determinations, as required by the Division’s comprehensive quality strategy. Network providers review these guidelines at least annually.

Utilization Review: We have experience employing EBPs into our clinical operations and structure them to ensure an integrated, whole person approach to member care. Our NCQA accreditation and experience assures the use of nationally accepted and adopted evidence-based criteria developed by specialty organizations, national policy committees, and industry recognized review organizations, as well as application of state and

federal criteria or regulations to evaluate the necessity of medical services. Our process includes reviewing these criteria annually, as a minimum, to ensure they reflect current clinical principles, including our behavioral health and physical health clinical practice guidelines described in our response to 4.2.2.4.B.2, MCG Prior Authorization Care Guidelines of MSCAN and CHIP populations, 4.2.2.5A.1.e, and in accordance with the American Society of Addiction Medicine (ASAM) criteria and in compliance with Appendix A, Section 8.16. All UM staff undergo initial and ongoing training to interpret and apply UM criteria, practice guidelines, and other UM required activities. MCG clinical educators provide annual refresher trainings, as well. We ensure consistent and appropriate clinical determinations and documentation between UM staff, pharmacists, and provider reviewers through ongoing audits and inter-rater reliability (IRR) activities. Our QMIC maintains oversight responsibility for the UM program through the UM/Care Management subcommittee, which monitors outcomes against industry benchmarks and establishes goals and best practices.

Clinical Policies: Clinical policies are developed whenever evidence-based guidelines are unavailable, unclear, or inadequate to determine medical necessity. We develop these policies in accordance with state and federal regulations, based upon valid and reliable clinical evidence or consensus among clinical professionals, and in consideration of member needs. We have implemented clinical policies in other states, including gender affirmation, urine drug testing, and genetic testing policies. Further, we collaborate with local medical experts to update clinical policy. We also employ a formal committee to evaluate and address new developments in technology and new applications of existing technology for inclusion in our benefit plan to keep pace with changes and to ensure members have equitable access to safe and effective care. Our new medical technology subcommittee evaluates new or emerging technologies, products, or equipment innovations, which represent progressive developments for advancements within the medical field.

e. How the Offeror will comply with and support the Mississippi Managed Care Quality Strategy;

We share the Division’s aim of ensuring access to health care and achieving positive health outcomes for MSCAN and CHIP members, utilizing our continuous quality improvement methodologies, including the IHI and Six Sigma models. Key strategies and innovations that we will bring to Mississippi include:

- Superior provider partnerships that yield a seamless connection for real-time data exchange with 81% of hospital partners and FQHCs poised to maximize data exchange, accuracy, and timeliness, through an HIE in order to improve quality and further the QIPP goals to reduce potentially preventable readmissions and potentially preventable complications.
- Funding and a PMPM supported value-based gain share arrangement with at least the top 20 highest volume providers statewide, allowing alignment and support for achievement of PCMH recognition, facilitating practice transformation and improving member engagement, quality of care and health outcomes.
- Use of artificial intelligence (AI) and machine learning (ML) to analyze real-time public information from member behavior patterns. We use these data to better understand member buying, eating, shopping patterns and preferences, and tailor communications and rewards programs to greatest effectiveness for behavior change.

We methodically address all elements of the 2021 Comprehensive Quality Strategy, and include:

- Preterm birth and maternal mortality; identify key drivers and development of action plans to address the increasing rates of poor maternal health outcomes for Black women and babies and working with the Mississippi State Department of Health and the Division on initiatives; by improving timeliness of prenatal care and health literacy programs focused on best pregnancy, postpartum and well-childcare.
- Chronic diseases, such as cardiovascular disease, diabetes, chronic obstructive pulmonary disease; we target care and disease management programs and education to facilitate provider and community collaboration to reduce modifiable risk factors.
- Behavioral health including schizophrenia and bipolar disorders; and to reduce hospitalizations by initiating antidepressant medications within 30 days of initial diagnosis and increasing continuation of antidepressant medication.

We focus on health equity for all quality and performance improvement initiatives and clinical programming, including implementing EQR recommendations and other innovative solutions. We also have the expertise and systems capabilities to comply with all regular and ad hoc reporting requirements defined in the quality strategy, and to report, meet, and demonstrate improvement in defined quality measures. We implement multiple strategies to provide support at the provider, member, and community levels, relying upon our comprehensive data analytics and informatics to design and implement these strategies.

Our Mississippi medical director, other executives (as defined by the Division), two network providers, and members serve on the Mississippi Coordinated Care Quality Workgroup (MCCQW), in accordance with Appendix A, Section 8.1. Our quality managers, health services managers, and other staff (as directed by the Division) also participate in the state's MCCQW. The MCCQW provides an opportunity to collaborate with the Division, other CCOs, and the EQRO on the optimal way to support Mississippi's comprehensive quality strategy.

f. Use of data to design, implement and evaluate the effectiveness of the program;

We use data from a range of reports, dashboards, and predictive models to address quality, and develop targeted initiatives to support health equity, improve care quality, and address health disparities. Teams dedicated to data analytics across the organization support these efforts as detailed in our response to 4.2.2.4.C.1.

Data to Design QMIP

Our enterprise data platform consolidates data from multiple systems and external sources to provide a concise, accurate, and complete data repository to meet all information needs. Our QM department uses available data sources, including external benchmarks from quality compass and internal data captured via our monthly, quarterly, and annual regulatory submissions, to track and trend performance measures across key indicators, further informing and refining program design. Our business intelligence platforms enable report and dashboard development, using data within the enterprise data platform to inform quality improvement activities.

Our PAC also plays a key role in informing program design, soliciting input and counsel regarding our clinical policy and clinical operations decisions. The PAC is composed of providers with diverse backgrounds and specialties to provide valuable input and feedback related to our QM activities. For example, in other state programs, we use provider feedback to inform the design of our VBP model from our PAC, in coordination with feedback from other provider associations and individual offices.

Integrating Data

We integrate data accessible from providers, including claims and data shared via the health information exchange (HIE), and data from pharmacy claims; correctional facility management systems; community-based organization-led assessments; health risk assessments; and other data driven attributes, to obtain a full view of our population's needs. This data combined with our data visualization platforms and HEDIS® analytics software tools create monthly dashboards, with the ability to provide more detail on demographics. Using this integrated data, we identify racial and ethnic disparities; geographic regions with access issues; outlying providers; overutilization of emergency department (ED) for nonemergent conditions; excessive cost; and program participation process data. Our data driven decisions enable us to successfully implement clinical studies, internal quality improvement activities, and interventions for special needs populations. We rely on the HEDIS dashboard to measure performance in real-time utilizing the bidirectional data exchanges. Then we work with providers to target performance improvements.

Using Data to Implement our QMIP

Our QMIP and supporting systems provide for system data collection of performance and member outcomes. Using existing tools, such as our behavioral health peer report, we provide to our provider network and other out-of-network providers the interpretation and dissemination of performance and outcome data, as appropriate. We confirm that our encounter data is sufficient to identify each practitioner providing services to members.

Data for QMIP Evaluation of Effectiveness

Our QM department utilizes available data sources, including data captured via our monthly, quarterly, and annual regulatory submissions to track and trend performance across key indicators. Our directors of quality improvement and HEDIS® operations work in concert to ensure timely and valid QM report submissions and to ensure adherence to any new reporting requirements communicated by the Division or CMS. Our quality programs are rigorously evaluated on an annual basis and ongoing. Our QMIC serves as our oversight for continuous assessment, monitoring, and improvement across clinical and nonclinical operations. During quarterly meetings, business owners provide status updates on KPIs. The committee also reviews regulatory reports and other operational and program data. The committee is also responsible for the internal audit in compliance with Appendix A, Section 8.18. In addition to our QMIC, we facilitate subcommittees and workgroups, with cross functional participation to ensure adequate planning and implementation of improvement strategies, and a keen focus on improving health outcomes. Further, we analyze and benchmark the program's overall performance to goals and population needs annually and through a health equity lens, to determine overall effectiveness of the structure and interventions to address member needs and achieve health outcomes. Then we use this annual evaluation to align recommendations and program goals for the next annual cycle.

g. Assurance of separation of responsibilities between utilization management and quality assurance staff;

Within our organizational structure, UM and quality assurance activities operate distinctly. Each department and its staff have separate responsibilities and reporting structures, with independent lines of accountability. Our director of QM reports to the associate vice president of enterprise market quality, and our UM staff report to the Mississippi medical director. Recognizing that ensuring quality is an enterprise-wide function, our quality staff serve in a supporting role by providing oversight of the UM program through our QMIC. The UM/CM committee reports up through the QMIC. Periodically throughout the year, the UM/CM committee reviews outcome metrics, policy changes, and other program modifications pertaining to the program, and then reports through the QMIC.

h. How the Offeror will address health access and equity in its QM program

Removing barriers to improve health equity and to address SDOH is of paramount importance. Our methodology to address and correct health equity in treatment across races and ethnic groups in Mississippi has been informed by the experience, data, and expertise gained from addressing health equity in multiple markets. We leverage this experience, coupled with sophisticated population data analysis, to identify disparities in health outcomes and access to care based upon geographic location, race, ethnicity, income level, age, gender, language barriers, and physical disabilities. This methodology shapes initiatives aimed at correcting disparities in treatment across these factors, improving health outcomes, and working to achieve health equity.

Addressing health access and equity are central to our QMIP and our annual QMIP work plan, which includes a written description of the QMIP and its plan to address health access and equity specific to CHIP. This is also reflected as a recurring theme through our PIPs. We will have a MAC located within the rural and metropolitan areas of Mississippi to develop targeted strategies that will improve health outcomes, based on removing identified barriers related to health equity.

Addressing Access to Health Resources

We offer to the Division a strong, local understanding of the needs of MSCAN and CHIP members and the sophisticated processes necessary to effectively engage stakeholders in addressing health equity. We prioritize identifying and addressing social factors to optimize health care access, utilization, and outcomes. We distinguish ourselves from traditional managed care through our record of accomplishments and results in integrating social needs and other nonclinical factors into every interaction with our members during care coordination. Our mission is to make a lasting difference in our members' lives by improving their health and well-being. Our commitment to establish programs targeting social factors that cause barriers to health and well-being is the catalyst used to seek solutions that address member needs, such as nutrition; transportation; housing; jobs; education; financial literacy; social connectedness; behavioral health; and access to care.

We hire our ICM team members from communities that represent the patient demographics and based within the markets to serve members in their communities and to address member health disparities at a local level. Along with input from our MAC, our ICM enables enable us to tailor our approach to Mississippi at the state, regional, and local levels. As a result, our local ICM staff apply the IHI model to address the unique disparities in access to care, addressing health equity concerns and outcomes across each of the communities we serve.

Our team uses the asset-based community development (ABCD) model to build relationships with key stakeholders in each neighborhood or community we serve. This evidence-based strategy identifies and expands on existing, but often unrecognized assets, such as:

- The skills of residents
- The power of local associations
- The resources of public, private, and nonprofit institutions
- The physical infrastructure and space in a community
- The economic resources and potential of local places
- The local history and culture of a neighborhood

In alignment with our QM strategy to improve health outcomes, we will engage CBOs and other partners to target individual SDOH and health equity by establishing coordinated networks of community partners and by enabling seamless referrals through an interoperable referral platform. We integrate with EHRs, a HIE, and other care management systems to screen for social needs, find community services, coordinate referrals, and analyze outcomes and cost. As part of these partnerships, we will conduct analyses of our membership to identify geographic service gaps across seven domains: food security; transportation availability; housing instability; social isolation; social vulnerability; neighborhood stress; and access to care information. Following identification of these gaps, we provide recommendations for interventions at both a member and community level.

Community Needs Assessments

We conduct ongoing community health needs assessments (CHNAs) and conduct initiatives to address health disparities at the local level, building upon the information captured in CHNAs and experience in implementing a range of strategies to address disparities. We use an online mapping tool that geocodes over 95% of member encounters at hospitals. This includes demographics (e.g., age, gender, race, and ethnicity); payer type; admission type; health outcome data; and other data points. We can assess and identify where race or ethnicity affect health indicators. Health indicators include eight major categories: 1) chronic diseases; 2) infections; 3) accidents and injuries; 4) prenatal and perinatal conditions; 5) mental health; 6) substance abuse; 7) oral health; and 8) the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs). Our data informs us of where the disparities exist and overlays rich social determinant information, which enables us to deduce the root cause of the disparities.

Identifying Racial and Ethnic Disparities to Address Access to Health

Our localized approach leverages the resources of Mississippi providers and community partnerships to promote best practices of healthy living and health equity. In Mississippi, Black people comprise the largest minority group, representing 38% of the population. The next largest minority group is Latinx people, representing approximately 3% of the population. Racial and ethnic minority populations, along with the rural and urban poor in Mississippi have borne a disproportionate burden of disease and illness. Our Mississippi population assessment shows that 28% of Mississippi children are living in poverty, higher than the national average of 18%. Rates for children living in poverty differ among racial and ethnic groups, ranging from 14% for Asian/Pacific Islander children, to 46% for Black children. Within Mississippi counties, rates of children living in poverty also vary among racial and ethnic groups. Health outcomes vary significantly across the state; counties in the northwest region of Mississippi are minority dominated and experience poorer outcomes.

The Center for Disease Control and Prevention (CDC) 2021 Mississippi Health Outcome Ranks by County shows the bottom ranked counties are in the Delta region. There are still huge disparities in disease burden among low-income communities and communities of color. For example, this report shows Black and American Indian residents in Mississippi have a significantly higher rate of avoidable heart disease and stroke deaths than all other groups within the state, far exceeding the national average, as well. The state highlights this disparity

in the comprehensive quality strategy, stating that chronic diseases are among the most common health problems in Mississippi, thus prioritizing the need to promote the most effective prevention and treatment practices for the leading causes of mortality, beginning with cardiovascular disease. The CDC 2021 shows Mississippi obesity rates are higher than the national average.

In addition, the Mississippi State Department of Health's Maternal and Child Health 2020 Needs Assessment studied disparities across subgroups within the state. Findings revealed that individuals of color face various barriers to access and those may contribute to the state's high infant mortality rate. Addressing inequitable access to care, particularly due to race, is key to reducing the infant mortality rate.

More than three percent of Mississippi's residents are Latinx. The state's Needs Assessment found that Spanish-speaking residents have language related barriers to care, including inaccurate translation of paperwork and poor quality of interpretation. Spanish speaking women may not have access to mental health providers, particularly in rural areas, due to the language barrier. This results in a lack of or inadequate access to comprehensive mental health services, such as prevention, crisis care, and postpartum.

Individuals who experience the condition of poverty experience unfair differences across the spectrum, including access to care; air and water quality; availability of healthy foods; community safety; educational support; employment opportunities; housing opportunities; income; and quality of care.

Annual Population Health Analysis

We bring demonstrated excellence in population health management, scoring **100% on both NCQA population health management standards and NCQA quality standards.** In alignment with our population health management model, our population risk dashboard is to identify target populations and subpopulations, including by race and ethnicity, for interventions. The dashboard stratifies member populations with special needs, risks, and health considerations, such as geographic access to care, chronic conditions, or health disparities representing rising risk, high utilization of services, and other barriers to care, such as SDOH and maternity care deserts. The dashboard also integrates predictive models, including those that identify high-risk pregnant members, those at highest risk of adverse COVID-19 outcomes, and members at risk of homelessness.

An example of informing outreach and resource allocation using these data and other inputs is our COVID outreach campaign in another market. Following analysis of the data from initial outreach efforts, we were able to view vaccine hesitancy at the zip code level and then work to focus on areas with both low vaccine rates and low vaccine hesitancy.

The integrated data provided by the dashboard facilitates our population health strategy by enabling leadership to map members by location, identify disparities and gaps in care, and drive design decisions for targeted interventions to address them. Consistent with our population health management model, we intervene at multiple levels of influence including the member, provider/system, community, and policy levels, with the goal of encouraging and optimizing the ability of our members to adopt healthy lifestyle behaviors. We perform risk stratification monthly to identify members with special health care needs for care management. We analyze and prioritize risk-stratified data to assess opportunities to improve health outcomes using a health equity lens. Through this process, we identify target populations, align resources across the care continuum, and continually monitor the health status and needs of the population for any changes.

Capturing and Incorporating SDOH Risk

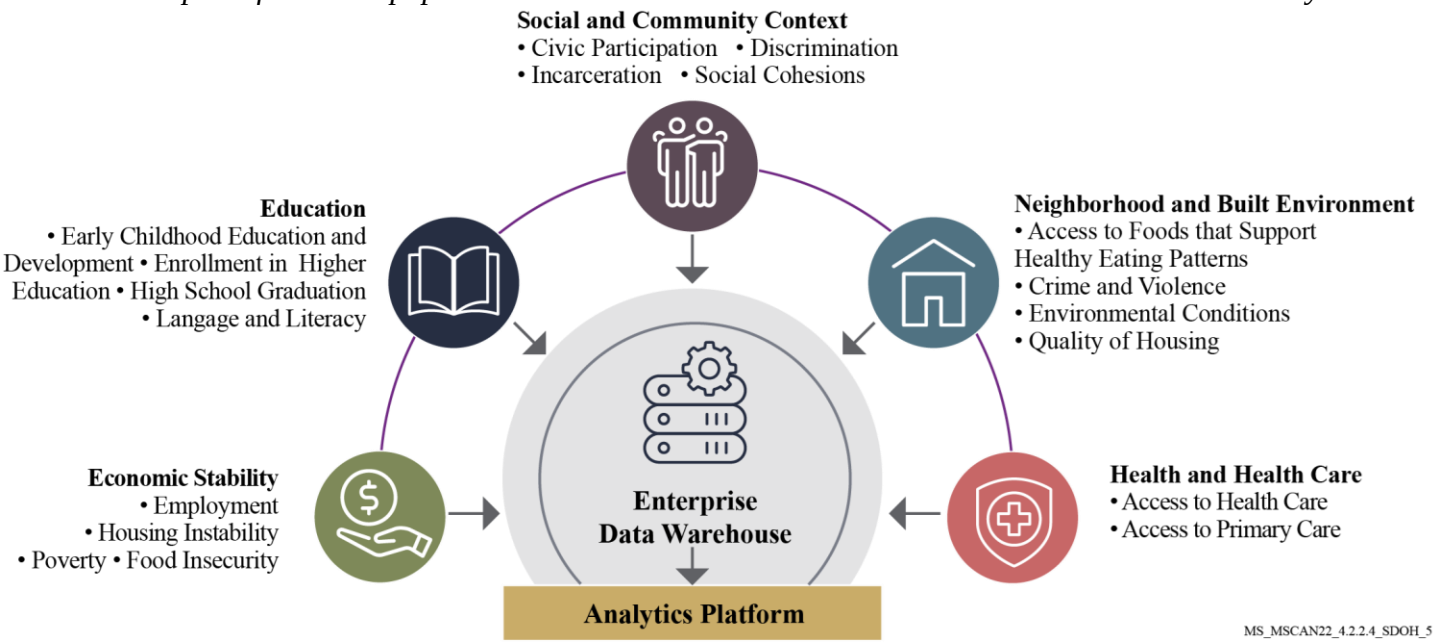
SDOH are key drivers of health care access, utilization, and outcomes. As a result, SDOH requires full integration into the treatment of members' physical and behavioral health. We integrate these nonclinical aspects into every member interaction. Our population health analytics team monitors various sources of data from our enterprise data warehouse, including claims and z-codes, member assessments, and member health risk assessments. These data points capture SDOH risk, which we can then juxtapose against health outcomes and member demographics (e.g., race and ethnicity). We prioritize identifying and addressing social factors to optimize health care access, utilization, and outcomes. **Our record of accomplishments and results in**

integrating social needs and other nonclinical factors into every interaction with members during care coordination distinguishes us from traditional managed care.

We have developed a collection of proprietary SDOH indices to refine and simplify the application of these factors in identifying at risk members and populations. The platform captures SDOH data (Figure 4.2.2.4_E) and assigns a high, medium, or low index value to individual members. The platform assigns the index value for five domains: 1) Economic Stability; 2) Education; 3) Community; 4) Environment; and 5) Health Care. Then the platform combines these index values with other member level attributes to provide a more complete view of member and population characteristics.

Figure 4.2.2.4_E: Social Determinants of Health Data Input

SDOH data input informs our population health initiatives to ensure members receive the services they need.



Addressing Health Equity

Improving health equity foundational to our approach to improving health for our members, delivering inclusive programs to improve access to health care services, and improving public health infrastructure. We honor, respect, and embrace the opportunity to reduce or eliminate inequities our members face, while encouraging and supporting the highest level of success and independence possible, and address health equity, as outlined in Appendix A, Section 10.9.

Leveraging our ICM, we will expand training opportunities to increase the capabilities of our internal staff and community partners to advocate for our members, meet our members where they are by exploring alternative care settings, and applying our successes in other state programs to develop targeted initiatives to address existing disparities in Mississippi. We are eager to work with the Mississippi State Department of Health's recently relaunched Health Equity Initiative and to support its strategic vision to improve the health of all Mississippians. We participated in the inaugural Mississippi health disparities conference and look forward to continuing discussions on the ways in which we can support and promote these transformative efforts.

Our approach to ensuring health equity includes incorporating a root cause analysis to better understand the factors and circumstances contributing to the inequities in health outcomes. Our regionally based ICM team enables us to partner with local organizations to better understand health disparities in their communities and to better equip us to identify the changes necessary to address them. **Our approach will leverage the resources of Mississippi providers and community partnerships to promote best practices of healthy living and health equity.**

Regional and Local Focus

A focus area identified by the state's latest quality strategy is community engagement. We share the state's view that fostering relationships with the organizations that service and work with communities affected by disparities is critical to improving health outcomes among the most vulnerable and disadvantaged populations. We will develop strategic partnerships with key community organizations across the state, including the Urban League and the Southern Rural Black Women's Initiative. Our regionally based ICM will enable us to tailor our approach to Mississippi at the state, regional, and local levels. Our ICM will ensure a local presence to help us better understand regional barriers necessary to achieve goals and tailor partnerships, programs, and community engagement to resolve for those barriers. A local team dedicated to each region staffs that ICM team. They use the population health dashboard to review information specific to their region, using data to support tailored interventions and initiatives. The dashboard provides KPIs, including performance on HEDIS® measures based upon race and ethnicity of their assigned members.

Training

To help our CBOs and faith-based partners support our members in their communities, we will partner with University of Mississippi Medical Center's (UMMC) community health advocate (CHA) training program to ensure multiple members are trained as CHA Trainers from each ICM team. This allows our staff to train faith-based and community groups as health screeners, with instruction in the detection of obesity, high blood pressure and diabetes, as well as training on how to locate community and regional resources for care. This enables staff from organizations within our members' communities to address health needs with our members in the communities where they live, collaborating with individuals they trust.

Alternative Care Settings

Every county in the state is facing significant health professional shortages in primary care, behavioral health, and dental providers, with Holmes, Claiborne, Bolivar, Jefferson counties indicating the highest health professional shortage area (HPSA) scores within the state. We develop protocols for providing population health management services in alternative and community-based settings to remove barriers to improved health outcomes. We use alternative care settings, including the member's home, to bring care to them. Our providers have implemented targeted telehealth initiatives to serve their members, including remote monitoring and e-visits. St. Dominic's Health System is using a mobile screening bus throughout Central Mississippi to better engage children and seniors in screening activities.

We will also explore opportunities to partner with community providers and organizations to connect members with services. For example, in another market, we identified a food bank, where our members accounted for 60% of the foot traffic and where 70% of those members had outstanding care gaps. We worked with the food bank to engage members, including placing nurse practitioners on-site to conduct health exams and screenings.

Telehealth Solutions

Building upon Mississippi telehealth successes, we support the most efficient use of telehealth for our members and providers and enhance access to health care services for all members, particularly those living in rural areas of the state. Our direct experience providing telehealth services in Mississippi and other markets informs our comprehensive telehealth policies, procedures, and processes.

We encourage members to use telehealth to mitigate access to care barriers, such as lack of transportation or childcare, limited availability of providers, or the need for care outside of practice hours, by educating them on the availability of telehealth as a viable care alternative, making scheduling of telehealth appointments easy, and mitigating issues of limited Internet-connected devices and broadband/Internet access.

Our internal staff and contracted telehealth vendor providers cover preventive health; well-care; urgent care; behavioral health; maternal health; and chronic and/or complex conditions for our members, preventing the need for unnecessary hospital readmissions and ED visits. We direct members to telehealth resources only after primary care routes are exhausted, and we encourage members to seek telehealth services from our network providers, particularly PCPs/PCMHs, to maintain continuity of care and treatment.

Targeted Initiatives

Our approach to developing and implementing evidence-based strategies to address health equity enables us to leverage our initiatives in other states to develop tailored and targeted initiatives to work toward health equity in Mississippi. We commit to pursuing opportunities to address less traditional categories of health inequality as well, including digital equity and transportation.

We leverage our ABCD model to build relationships with key stakeholders and utilize existing, but often unrecognized, assets. For example, in another market, we identified a lack of digital equity as a barrier to achieving optimal health outcomes. We worked with one of the counties, the local telephone company, and a housing management company to offer Smart Wi-Fi Network and Chromebooks to residents in 900 housing units.

Our community services programs are another way in which we work to address health equity. We personalize these programs to each member's needs and provide connections to transportation; childcare; education; training; job placement; mentoring; and health care solutions that are appropriate for our members. Our population health analysis shows that 46% of Black children live in poverty; we recognize that initiatives that improve economic stability for adults also improve the economic stability and related factors for children.

According to the state's most recent health inequalities report, Black Mississippians have the highest infant mortality rate in the state, as well as the highest rates of teen pregnancy. We will collaborate with the Southern Rural Black Women's Initiative, which focuses on women's health, from prenatal care through adulthood. We will also work with the Urban League and Sisters in Birth Inc. to support maternal health initiatives in Jackson.

4.2.2.4.A.2 Provide models of the following documents: Annual Program Evaluation and Annual Program Description/Work Plan that meet the requirements of Section 8, QM, of Appendix A, Draft Contract (no more than 10 pages).

We provide models of the Annual Program Evaluation and Annual Program Description/Work Plan that meet the requirements in Appendix A, Section 8, as Appendices 4.2.2.4.A.2.a, 4.2.2.4.A.2.b, and 4.2.2.4.A.2.c, respectively.

4.2.2.4.B Clinical Guidelines and Compliance

We use nationally recognized and evidence-based clinical practice guidelines (e.g., Milliman Care Guidelines) for acute care and behavioral health services. We invite providers to review these guidelines annually through participation on our Provider Advisory and Utilization Management/Care Management Committees. We look forward to collaborating with the other care coordination organizations (CCOs) when reviewing and updating clinical practice guidelines and comply with Appendix A, Draft Contract, Section 8.15.

4.2.2.4.B.1 Describe the Offeror's proposed process to notify Providers of new practice guidelines and to monitor implementation of those guidelines.

We follow an established process to notify providers of new practice guidelines and monitor implementation of those guidelines. We will continue to follow our process, amending as needed, to comply with Appendix A, Draft Contract, Section 8.15, and we will submit these guidelines to the Division for annual review.

Notifying Providers of New Practice Guidelines

Our provider services team educates providers on practice guidelines and utilization review criteria through onboarding orientation, annually, and via the provider manual, the secure provider portal, provider newsletters, and blast Notifications. When new guidelines are developed, we distribute a notification to all network providers 30-60 days prior to implementation. Our provider representatives also review new guidelines with providers during periodic office visits. We implement clinical practice guidelines that promote quality/cost effective care. These guidelines are also available to providers, on request. Providers will have access to our **Provider Innovation Collaborative** (PIC), which includes a hub of resources, training, and technical assistance that enable providers to operate as fully accountable, quality-driven, innovative care providers, adopt and scale evidence-based practices, and participate in value-based payment models, depending on the provider's unique strengths and needs. Finally, we will engage and collaborate with provider associations for education opportunities so their members remain informed.

Monitoring Provider Implementation of Guidelines

We monitor an extensive array of information, including provider adherence to medical care standards and practice guidelines to evaluate provider performance in areas, such as access to preventive care, utilization metrics, HEDIS® scores, cost-effectiveness of services (e.g., high-tech imaging), outcomes data, and member satisfaction with their providers. Provider representatives train providers on the use of the clinical practice registry within our provider portal, which displays the provider's member panel and any gaps in care, and past due or upcoming preventive care visits. In addition to the clinical practice registry report, provider services share gaps in care with attributed providers to ensure both the assigned provider and the attributed provider have the information necessary to proactively contact members and offer condition specific and preventive care services.

By contract, we require that contracted provider medical records include documentation of all medical services the member receives, in accordance with state and federal laws. Our Quality Management team assesses reports and processes to monitor provider adherence to clinical practice guidelines (CPGs), including, medical record audits, provider profiles, gaps in care reporting, and HEDIS® metrics, in addition to the annual review of the physical health CPGs. Our Quality Management team tracks and monitors adherence to published and accepted standards of clinical care through proactive and retrospective processes.

- Verification of provider's compliance with medical record standards and privacy practices
- Review of provider compliance with adopted clinical and preventive care guidelines
- The ability to track and trend individual and plan wide provider performance over time

4.2.2.4.B.2 Provide a list of the behavioral health/substance use disorder clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines

Our behavioral health (BH)/substance use disorder (SUD) clinical practice guidelines (CPGs) are devised from evidence-based, peer-reviewed sources, including professional associations, such as the American Psychiatric Association, Substance Abuse and Mental Health Services Association, American Academy of Child and Adolescent Psychiatry, Alzheimer's Association, and American Society of Addiction Medicine. These establish standards of practice to guide providers to deliver high-quality care for specific disease conditions, such as attention deficit hyperactivity disorder (ADHD), autism, dementia, and opioid use. Our quality management staff also use our BH/SUD CPGs to support providers' practice patterns and for quality audits to assure their members receive appropriate care. We prioritize these guidelines based upon analysis of the conditions experienced by our enrolled populations using our population health analytic data and in accordance with state or federal mandated topics.

Our enterprise quality improvement (EQI) coordinates the development, approval, and distribution of new and revised clinical practice and preventive health guidelines, in conjunction with our board-certified chief medical officers and provider advisory committees (PACs). We review guidelines at least every two years or as needed, and we update them when required. We will submit guidelines for annual review and approval by the Division by January 1 of each calendar year.

We also provide resources for providers on our portal that include screening tools (ACES, PHQ-9, PHQ-9A, and Depression Screening Tool: Pregnancy/Postpartum); BH/SUD toolkits, including an opioid toolkit that contains resources that support provider practices and encourage best practices in opioid use and pain management; as well as suicide prevention, depression/perinatal depression, ADHD, and SUD toolkits. We have a fully integrated, transparent service delivery model with the majority of providers using real-time bidirectional data exchanges with the goal of bringing a new era of provider collaboration to Mississippi. **Our structure will bring unmatched accountability to providing cost effective and safe care for Mississippians.**

Promoting and Monitoring Provider Adherence

Our provider representatives promote practice guidelines and utilization review criteria to providers through on-boarding, and annually thereafter; the provider manual; the provider portal; and through provider newsletters. When we develop new guidelines, we distribute a notification to all network providers 30-60 days prior to implementation. Our provider representatives also review new guidelines with providers during periodic office

visits. We provide CPGs that promote quality/cost effective care available to providers on request in accordance with Appendix A, Section 8.15. Providers also have access to our PIC, which includes a hub of resources, training, and technical assistance that enable providers to operate as fully accountable, quality-driven, innovative care providers, to adopt and scale evidence-based practices, and depending on the provider's unique strengths and needs, participate in value-based payment models. We offer providers updates on their performance by providing monthly provider profiles and data on demand. Provider representatives also share provider profile discoveries with providers to improve member health outcomes.

Monitoring Adherence

Our quality management team assesses reports and processes to monitor provider adherence to CPGs including, medical record audits, provider profile information, gaps in care reporting, and HEDIS® metrics. Our BH HEDIS® dashboard enables us to drill down into key subsets of data associated with CPG compliance. An example of this is assuring members with a BH diagnosis attend follow-up visits within a seven-day period when discharged from an emergency room. This information is transparently shared with our providers through our provider portal.

We monitor adherence to published and accepted standards of clinical care through proactive and retrospective processes. Retrospective reviews occur in follow-up to a member or staff report regarding quality of member care. We refer the matter to dedicated clinical quality staff who collaborate closely with the provider to review and investigate each case. When the team receives a referral, they request medical records from the provider and review it according to published CPGs and standards of care. If the provider meets the standards of care, the Registered Nurse (RN) clinical quality analyst documents and closes the case. If the provider does not meet the standards of care, the nurse clinical quality analyst forwards the case to the medical director for further review and follow-up through our professional peer review process.

Prior authorization reviews may identify situations where a provider may not be following appropriate CPGs. In this instance, we initiate peer to peer calls with providers over prior authorization denials to review these guidelines with providers and/or learn from providers so that we can add to or adjust our CPG set. If the provider does not meet standards of care and CPGs after peer discussion, we prepare corrective action for performance improvement at the practice level that is driven by a quality workplan.

Similarly, we proactively use administrative data to identify claims indicating the potential of medical error. Under our Mississippi medical director leadership, we analyze these reports for iatrogenic or avoidable medical error, present them for PAC discussion and recommendation, and remediate as necessary in collaboration with providers and network health systems in alignment with our Health Safety Program plan and national patient safety goals. We will bring a new era of provider collaboration to Mississippi using our fully integrated, transparent service delivery model with real-time bidirectional data exchanges with providers.

Annually, our quality management team measures performance against important aspects of four CPGs which address a portion of the population reflecting a high volume or high-risk condition in compliance with Appendix A, Section 8.15. We will provide the Division the results of the study and summary of any corrective actions taken to ensure compliance with the guidelines.

4.2.2.4.B.3 Describe the Offeror's proposed process for compliance with the SUPPORT Act.

Since the passage of the SUPPORT Act, our pharmacy team has implemented a range of targeted prospective and retrospective drug utilization review programs to further reduce and prevent inappropriate and unnecessary utilization of opioids and antipsychotics. These programs include customized point-of-sale alerts, safety edits, and automated claims reviews specific to state-level limits for maximum daily morphine milligram equivalent dosages; concurrent opioid and benzodiazepine or antipsychotic use; and antipsychotic use for members aged 18 years and younger, specifically including those in foster care. Our tailored SUPPORT Act solutions will **empower Mississippi families to foster future success for their children by strengthening family engagement in care and improving health literacy**.

Understanding the pharmacy benefit will be controlled by the pharmacy benefit administrator (PBA), we commit to aligning our opioid-related drug utilization review programs with the Division's opioid initiative requirements and in compliance with Appendix A, Section 4.1.4.

We furnish SUPPORT Act letters to providers containing helpful information concerning antipsychotic regimens for children. We have also implemented successful initiatives resulting from our SUPPORT Act compliance programs:

Pharmacy Utilization Trends Analysis. Our pharmacy utilization trends analysis drives our initiatives to adhere to requirements of the SUPPORT Act. We will partner with providers to actively reduce the frequency of new opioid utilizers progressing to chronic use or escalating doses. We analyze members' morphine milligram equivalent (MME) dose and conduct outreach to prescribers who prescribed ≥ 60 days of opioid therapy at or above 90 MME/day. Our provider outreach improves understanding and awareness of opioid prescribing and risks associated with the use of high-dose opioids for identified members. In another market, we have experienced **more than a 30% reduction in MME for members eligible and included in our initiative**. We will offer an individualized provider Controlled Substance Report on our provider portal which demonstrates provider prescribing patterns including members at risk of high dosage or high duration of opioids, medications with contraindications, and areas for improved care coordination.

Behavioral Health Medication Monitoring. We conduct behavioral health medication monitoring for children who may be receiving behavioral health medication treatment regimens. Our pharmacy intervention center behavioral health pharmacist performs a comprehensive chart review for identified members and assesses the appropriateness of therapy, lab monitoring, and the need for any additional support services. The behavioral health pharmacist then reaches out to the provider and/or caregiver to further determine appropriateness of therapy and provides recommendations for therapy adjustments if deemed necessary. In 2021, there were more than 10,000 children enrolled in our SUPPORT Act program. We had successful discussions with 93% of the providers in another market requiring therapy appropriateness outreach. We integrate the SUPPORT Act program clinical review outcomes into our care management platform. This enables our care management team to see a person-centered view of each member in the program.

Medication Disposal Program: To reduce the amount of unused or unwanted medication available for misuse, abuse, or theft, we have enhanced our medication disposal program to include members who receive short term opioid supplies. Our pharmacist reaches out to members who are new to opioid therapy to educate them on the safe use, storage, and disposal of opioid pain medication. In addition, we have clinical guideposts for our member-facing staff that directs them on how to discuss the importance of medication disposal with members and how to facilitate delivery of medication disposal packet delivery to the members.

4.2.2.4.B.4 Provide a list of the physical health clinical guidelines that the Offeror intends to promote and discuss how the Offeror will monitor Provider adherence to these guidelines.

Our evidence-based physical health clinical practice guidelines (CPGs) direct providers in the delivery of high-quality care for specific disease conditions and preventive health, such as well-child screenings and immunizations. We adopt guidelines from evidence-based, peer-reviewed sources and include professional medical specialty associations (e.g., American Academy of Pediatrics, American College of Obstetrics and Gynecology, American Diabetes Association, and American Lung Association); and federally funded agencies (e.g., NIH and CDC and Prevention). Our quality management staff use our CPGs to support providers' practice patterns and for quality audits to assure their members receive appropriate care.

Our enterprise quality improvement (EQI) manages the development, approval, and distribution of new and/or revised CPGs and preventive health CPGs, in conjunction with our chief medical officers and the PAC. We prioritize these guidelines based upon analysis of the conditions experienced by our members using our population health analytic data, and according to state or federal mandated topics. These CPGs serve as the clinical basis for program development to address chronic health conditions, promote member self-management skills and disease prevention, and wellness initiatives.

Promotion and Monitoring Provider Adherence

We make physical health CPGs available to providers consistent with the requirements outlined in Appendix A, Section 8.15. Our provider services team educates providers on CPGs and utilization review criteria through provider orientation, and annual provider refresher training, and via the provider manual, the provider portal, and through provider newsletters. Whenever we develop new guidelines, we distribute a notification to all network providers 30 to 60 days prior to implementation. Our provider representatives review new guidelines with providers during routine office visits, and they are available to providers on request and in compliance with Appendix A, Section 8.15. Providers also have access to our **PIC**, which includes a hub of resources, training, and technical assistance that enable providers to adopt and scale evidence-based practices, and participate in value-based payment models, depending upon the provider's unique strengths.

We are committed to changing the trajectory of Mississippi's healthcare system and bringing a new era of provider collaboration via our fully integrated, transparent service delivery model with the majority of providers using real-time bidirectional data exchanges. We offer providers updates on their performance by providing monthly provider profiles and data on demand. Provider representatives or quality staff members review the profile with the provider to address any CPG performance concerns.

Monitoring Provider Adherence

We use the same process to monitor physical health CPGs, as with BH/SUD CPGs detailed in our response to 4.2.2.4.B.2. Our quality management team assesses reports and processes to monitor provider adherence to CPGs, including medical record audits, provider profiles, gaps in care reporting, and HEDIS® metrics, in addition to the annual review of the physical health CPGs. Our quality management team tracks and monitors adherence to published and accepted standards of clinical care through proactive and retrospective processes.

[redacted]

We follow up on member care using retrospective reviews or a staff report regarding quality of member care. We refer the matter to dedicated clinical quality analysts who investigate each case. Whenever a quality analyst nurse receives a referral, they request medical records from the provider and review them according to published CPGs and standards of care. If the provider meets the standards of care, the quality analyst nurse documents and closes the case. If the provider does not meet the standards of care, the quality analyst nurse sends the case to the medical director for our professional peer review process. Prior authorization reviews may identify situations where a provider may not be following appropriate CPGs. For this situation, we initiate peer-to-peer calls with providers regarding prior authorization denials. This discussion serves as an opportunity to review these CPGs with providers and learn from providers so that we can add to or adjust our clinical guideline portfolio. If the provider does not meet standards of care and CPGs following peer discussion, we prepare a corrective action for performance improvement.

Our quality management team measures performance based on NCQA benchmarks, peer provider groups located within similar locations, and trends noted throughout our monitoring. We will provide the Division the results of the study, along with a summary of any corrective actions taken, to ensure compliance with the guidelines.

4.2.2.4.B.5 Describe the Offeror's proposed policies, procedures, and processes to conduct Provider profiling to assess the quality of care delivered.

We are a coordinated care organization (CCO) committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi. A facet of our unparalleled delivery model is to employ policies, procedures, and proven processes to conduct provider profiling for assessing the quality of care delivered by providers, in compliance with Appendix A, Draft Contract, Section 8.4.1.

Our high-value, data-driven provider profiling processes and tools support our Quality Management Work Plan by identifying, tracking, and evaluating provider practice patterns' effects on specific health outcomes metrics for members in their care. Profiling also supports the identification and selection of providers for recruitment and assesses their readiness for participation in our value-based payment (VBP) programs, which by design drives improvements in population health quality and outcomes. Our Provider Services and Quality Management teams use this information to address outlier provider behavior and improve the quality of care delivered to members. **Our innovative programs and services are proven to consistently improve health outcomes. We have demonstrated improvement in focused quality measures through implementation of our value based contracting arrangements in other markets between 2018 and 2020. In ensuring timely prenatal care for newly pregnant members, our top 20 provider groups, across other markets, achieved an average improvement of 10.8% in the timeliness of prenatal care (TPC) HEDIS measure.**

Elements of our Provider Profiles

We will use provider profiling as an integral building block of our provider partnerships and component of our overall quality improvement and VBP strategies. Our provider profile reports use clinical and administrative data to calculate group cost and performance by disease category, compared to our baseline. We use quantitative and qualitative strategies to profile providers focused on measurable patterns of care, service delivery and cost, as well as analyses of the attributed member panel at the provider practice level.

Provider profiling includes evaluation of clinical and administrative practices that contribute to all aspects of health outcomes and member experience. We categorize provider performance by membership volume and variety of clinical, administrative, and service-based measures including HEDIS® quality measures, compliance with clinical practice guidelines, average risk score of attributed members, patient centered medical home (PCMH) member engagement, integrated care coordination, financial performance, and health information exchange (HIE) participation and interoperability programs.

We evaluate network providers according to the effectiveness and efficiency of care delivery to stratify high and low performers. Our analysis includes the assessment of key financial measures including total cost of care and medical cost ratio (MCR), as well as summary measures of clinical quality and safety, compliance to HEDIS® and clinical practice guidelines, enrollee experience and access/availability. We have profiling activities for obstetricians (notice of pregnancy, postpartum care), behavioral health (referral to a primary care provider), reduction of emergency department (ED) visits and follow-up on crisis interventions, gastroenterology (preventive care screening), and facilities (30 day all cause readmission, ED visits/1000).

Methodology for Determining Which and How Many Providers Will Be Profiled

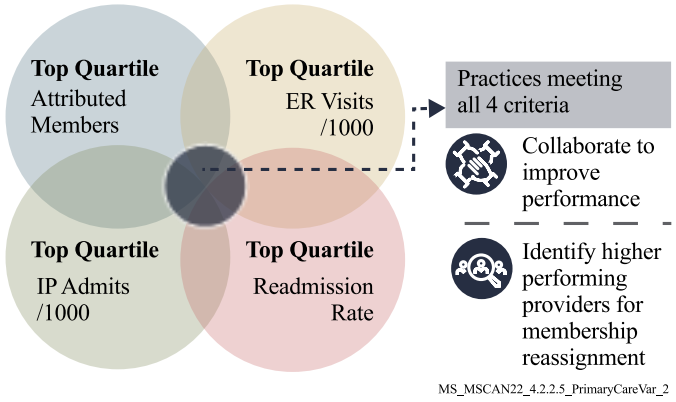
We will select Mississippi network providers to profile based on incoming data sources that are evaluated through our internal credentialing and peer review processes. This includes grievance and appeals data, quality of care reports and investigations, utilization management reports, and information from licensing and accreditation boards. Providers participating in our VBP program will receive profile reports, through our provider portal, on a quarterly basis. We base all VBP programs on quality parameters defined through our quality analytics efforts. We use a provider profiling methodology to analyze clinical and administrative data and determine the VBP program best suited for a provider. Driving provider adoption of VBP requires a clear understanding of what it takes for providers to succeed and a high level of provider engagement.

Data Driven Provider Profile

Our national provider analytics, quality and information technology teams are the information management engines that oversee the integration and aggregation of data from disparate internal and external sources, which results in the production of robust provider profiles, dashboards, and care gap reports. These comprehensive reporting tools are available to providers in real-time through our end-to-end provider performance improvement technology application and accessed on the secure provider portal. We share provider performance dashboards and care gap reports with providers during in-person visits with their local assigned provider representative.

Figure 4.2.2.4_G: Example of Primary Care Variation Analysis and Opportunities

Providers can compare their performance using this analysis.



Our end-to-end quality management platform, which incorporates Artificial Intelligence (AI)/Machine Learning (ML)-based advanced analytics, automated workflows, and coordinated approach protocols, complements, and elevates our efforts to drive equitable health care and reduce administrative burden on providers. The quality management platform works by unifying information from diverse systems for data driven decision making, helping quality teams implement multiple initiatives, streamline provider engagement, and enhance care outcomes. It includes an extensible library of 700+ pre-measures across financial, operational, cost, care quality, and value-based programs with powerful self-service capabilities.

Primary Care Variation Analysis

We offer providers a primary care variation analysis that provides statistically meaningful benchmarks to stratify the performance of provider practices across a variety of metrics. Our approach leverages industry standard risk and case mix adjustment methods, as well as stratification based upon social determinants of health (SDOH) indices.

Our benchmarks focus on quality measures, utilization, cost, and other value-based reimbursement goals. Custom provider profiles, comparative data visualizations, outlier analyses, and self-service solutions enable us to actively identify opportunities and manage providers against benchmarks to improve outcomes and value. For example, we create and run algorithms that cohort providers into peer group clusters and risk-adjust the

utilization, cost, and quality metrics to create a 360-view of a provider's performance against their peer group benchmark (Figure 4.2.2.4_G). Providers are then segmented into quartiles low-performing, average, and high-performing tiers for advanced analysis.

Supporting Providers Using Provider Profiles

Reliable, easy-to-access, shareable data is crucial to attaining improvements in quality through value-based contracting arrangements. We take pride in offering our providers real-time data at their fingertips when they need it. We are transparent, sharing our provider 360 reports, found on our provider portal, that contain up to date VBP earnings and performance data to provide valuable insights for practice transformation and earning opportunities.

Our clinical and quality teams collaborate and review reports on metrics to determine if there is evidence of inappropriate overutilization or under-utilization, and develop strategies, as appropriate. Our utilization data identifies areas of practice where providers can improve. Additionally, we use the data to facilitate provider education about their specific patterns of care. We also conduct practice and provider level profiling on administrative, risk, and key credentialing indicators. The purpose of this is to monitor provider practices to ensure network surveillance for contract compliance on required factors and reduce avoidable risk. Quality of care complaints and grievances are tracked, trended, and reported via the credentialing process. Data are aggregated to assess trends in health safety needs across the enterprise. Figure 4.2.2.4_H displays a model report used to communicate practice concerns and matters with credentialing impact.

Our quality team works in collaboration with provider representatives to regularly assess provider performance on key indicators. The teams routinely meet with providers to share practice-specific data and analytics, discuss improvement opportunities and interventions in alignment with the needs and capabilities of the practice. Additionally, our provider representatives educate providers and practice administrators on key topics such as coding guidelines to improve HEDIS compliance and how to use our support tools, such as the Clinical Practice Registry report (an online tool that will emphasize preventive care by identifying and prioritizing health care services and screenings for Mississippi members), which is available on our secure provider portal.

We also hold quarterly Joint Oversight Committee (JOC) meetings to review quality and financial progress. We focus on strategies to close care gaps and address operational concerns. Providers track performance through our provider profile or one of the dynamic, interactive tools available on our secure provider portal.

4.2.2.4.B.6 Describe methods the Offeror will use to ensure the quality of care delivered by Non-Contracted Providers.

Our goal is for all MSCAN and CHIP members to have access to quality services based on their health needs. Periodically, we need to facilitate access to a non-contracted provider, such as in underserved urban and rural areas. **Our innovative structure brings unmatched accountability to providing cost effective and safe care for Mississippians**. We verify the quality of care delivered by non-contracted providers through the same processes as contracted providers. Our utilization management (UM) staff first confirms the provider's eligibility to participate as a Mississippi Medicaid provider. They send an authorization letter with the authorization number to the provider that contains provider agreement language to comply with applicable federal and state law, our provider manual, policies, and procedures, and claims submission and appeal timeframes.

In addition, our provider services and compliance teams continually collaborate and review non-contracted provider claims submissions, non-contracted provider authorization requests, and any member grievances or complaints to identify potential quality of care concerns. A cross-functional team including representatives from the contracting, program integrity, legal, quality improvement, and medical services teams discusses non-contracted providers to determine if they pose regulatory, quality, member, or accreditation risks. During these reviews, participants discuss non-contracted provider documentation, including adverse action documents from professional licensing agencies, federal websites, and member complaints obtained from a self-service report in our data system. Determinations are made to continue monitoring a provider for further actions or pend for additional information/review at the next meeting or terminating the provider at the indicative level in our claims payment system with no further action required.

Ensuring Quality of Care Delivered by Non-Contracted Providers

We detect quality of care (QOC) concerns for services delivered by non-contracted providers using analysis of non-contracted provider claims submissions, authorization requests, case reports, and member grievances. We use a similar process monitoring QOC for non-contracted providers as we use for contracted providers (detailed in or responses to 4.2.2.4.B.2 and B.4). Our fully integrated, transparent service delivery model enables communication and collaboration with providers and non-contracted providers alike. If we detect a QOC concern, information is provided to the Quality Enterprise Committee (QEC). The QEC investigates all QOC concerns, which initiates contact with the provider to request medical records. Our QOC clinical quality nurse conducts case investigation through review of these records and other supporting materials to determine if the provider met the standard of care. If the case investigation identifies that care and treatment did not meet the standard of care, in accordance with established clinical practice guidelines, the case undergoes medical director evaluation and peer review, as warranted by the Mississippi Provider Advisory Committee (PAC).

The PAC peer review meeting is a protected environment where open discussion of the case occurs with interdisciplinary practitioner participants. If indicated, the PAC may recommend a performance improvement plan (PIP) or a corrective action plan (CAP). Peer oversight determines the closure of a PIP or CAP, and they continue to monitor the provider for at least two years to ensure delivery of quality care. The PAC routinely reports QOC events for non-contracted providers to the cross-functional workgroup. While the QEC follows the

same process for investigating QOC concerns from contracted and non-contracted providers, there are limitations in applying a PIP or CAP to non-contracted providers. If we receive the medical records, we conduct the investigation and track accessible data. We communicate the outcomes of our analysis to the contracting team in the event the provider wishes to join our network.

Single Case Agreements for Non-Contracted Providers
We offer contracts to every available Medicaid provider, including out-of-state providers who are part of the community referral patterns. We collaborate with non-contracted providers to execute a single case agreement (SCA), and during the SCA process, we encourage the non-contracted provider to review our model of care training available on our Mississippi provider-focused website.

Regardless of contract status, it is still necessary for these providers to have access to information about Mississippi-specific programs, policies, procedures, and our organization. A SCA ensures the provider understands payment for services rendered and the necessity for the provider to have a valid Mississippi Medicaid Identification Number on the date that services were performed. Non-contracted providers have limited access to the provider portal; however, they can view member eligibility and claims status information. Non-contracted providers can also view general operational information about policies, procedures, clinical guidelines, educational materials, newsletters, and other non-member information from the portal, as well as our provider-focused website.

4.2.2.4.B.7 Describe the Offeror's proposed policies and procedures for reducing Provider Preventable Conditions, including Never Events. Describe the Offeror's process for 42 C.F.R. § 438.3.

We use real-time and actionable data, utilization management, and care management oversight/feedback to identify hospital acquired condition (HAC) occurrences, their frequency, and hospital/facilities involved in each incident. We analyze incoming data, including claims from our provider and health system network; we identify, review, and mitigate situational risks in a timely way through corrective action or performance improvement steps to reduce future risks to members. Our medical directors who conduct utilization reviews are trained to look for provider preventable conditions (PPCs) and communicate those to the quality team for follow-up. We also collect other data including claims payments for HACs and Never Events with relation to PPCs. We will not reimburse providers for HAC conditions, in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines. PPCs will be measured under the Division's Quality Incentive Payment Program (QIPP). We will identify members at heightened risks for PPCs as well as root causes of PPCs and we will work with our hospital partners to reduce PPCs so that each hospital may satisfy its QIPP goals.

We bring unmatched accountability to providing cost effective and safe care for MSCAN and CHIP members. Our internal policies and procedures align with the science of member safety, National Patient Safety Indicators, and Just Culture integrated into surveillance monitoring. Our approach to the culture of safety is twofold. We have implemented health safety plans with measurable goals integrated to quality workplans in all markets. The approach to monitoring PPC's trends and remediations is in place, measurable, and reportable. The surveillance process provides a proactive way to monitor network provider practices and facilities. This process captures potential medical errors and member safety events from administrative and other incoming data sources, based upon coding criteria. Our safety events monitoring process includes review of real-time reporting of claims data.

Educating Providers
We educate providers on PPCs and HACs, including nonpayment of claims in a multitude of ways. Our provider contracts cite these requirements; we include information in the Provider Manual; we include updates in our provider newsletters; and we send notifications to providers about these policies and procedures. Providers have access to educational tools via our provider portal and website. In addition, our provider representative provides education and technical assistance to those providers who may have questions about these events and to ensure the delivery of quality services.

Addressing Potential Quality of Care Concerns

In our experience, Never Events, HACs, and PPCs may be indicators of quality-of-care concerns. We enable provider collaboration and communication with our fully integrated, transparent service delivery model via real-time bidirectional data exchanges to capture information including quality-of-care concerns. We route such concerns to our clinical quality team comprised of nurses, who initiate contact with the provider to obtain medical records in accordance with our policies and provider contracts. The clinical quality nurse conducts case investigation through review of these records and other supporting materials to determine if the standard of care is met. If the case investigation identifies that care and treatment did not meet the standard of care, in accordance with established clinical practice guidelines, the case undergoes medical director evaluation and peer review, as warranted by the Mississippi provider advisory committee (PAC).

The PAC peer review meeting is a protected environment where open discussion of the case occurs with interdisciplinary practitioner participants. If indicated, the PAC may recommend a performance improvement plan (PIP) or a corrective action plan (CAP). Peer oversight determines the closure of PIP/CAP, and we monitor the provider for at least two years to ensure providers continue to deliver quality of care. Our provider representative collaborates with the provider to deliver education and technical assistance and ensure the remediation of any quality-of-care concerns. In addition, the PAC routinely reports quality of care events to the Credentialing Committee. Depending upon the findings, the Credentialing Committee recommends provider termination and will collaborate with the state for further decision-making.

Precluding Payment to Providers

We employ policies and procedures to preclude payments or to reduce the reimbursement amounts for all claims that include PPCs, or where one of the reported conditions was not present on admission for an inpatient stay, in accordance with 42 CFR 434.6(a)(12), 42 CFR 438.3(g), 42 CFR 447.26, and CMS guidelines and protocols. This process complies with Appendix A, Section 9.2.6.2. Should we become aware that payment was issued for a Never Event, we promptly adjust those claims and recover the payments**.** Our reimbursement policy eliminates any confusion or conflicting information for the provider community. We will comply with any future additions to the list of non-reimbursable PPCs.

Our written provider contracts require that providers cannot bill or collect any payment for Never Events. We review these requirements with providers during new provider orientation to ensure clear understanding. We also provide continued education and awareness to providers on PPCs via our newsletters and provider forums. We use claims editing software that automatically identifies and denies these claims when received. If a provider receives any payment from us for such events, we require the provider to refund the payment within 10 business days of becoming aware of such receipt. If we can identify and isolate the portion of the claim which is related to the treatment of the HAC, then we reduce the reimbursement of the claim by the specific amount related to the HAC, which will follow the most recently published CMS guidelines at that time. We require providers to cooperate with us in any initiative designed to help analyze or reduce Never Events.

We also require all providers to agree and comply with reporting requirements in 42 CFR 447.26(d) as a condition of payment. We develop our policy on non-payment of certain Never Events in accordance with current Medicare National Coverage Determinations and Mississippi Medicaid Fee-for-Service (FFS) rules.

Reporting through Encounter Data to the Division

We configure benefits and our claims system to identify codes specific to PPC and Never Events. Our policy requires providers to report these types of events with a no-pay claim. We require providers to submit encounter data for us to meet all requirements outlined in Appendix A, Section 16.7.5. We will submit a report to the Division quarterly indicating whether any Never Events occurred during that quarter, in compliance with Appendix A, Section 9.2.6.2.

4.2.2.4.B.8 Describe how the Offeror will encourage Providers to use electronic health records and e-prescribing functions

We understand the vital role technology plays in effective health care management and actively promote the use of electronic health records (EHR), e-prescribing, and sharing of clinical information across health information exchanges (HIEs). We have experience in adoption, training, and use of EHRs, HIE, meaningful use (MU), and e-prescribing. We are committed to working collaboratively with the Division and its other vendors and will implement technological innovations and programs designed to enhance interoperability and data sharing, while ensuring ease of use and support to network providers to better serve members. Our far-reaching commitment includes collaboration with other organizations in the Mississippi health care community with the goal to improve health outcomes and quality of life for all Mississippi Medicaid populations.

Encouraging Providers to use Electronic Health Records

Advancing the ability of providers to communicate patient centered clinical and medical information rapidly, accurately, and efficiently to determine member health status, avoid harmful drug interactions, and direct appropriate care, includes making EHRs easily accessible to providers to monitor and document members' medical history. We require our contracted providers to maintain medical records for their patients, and we strongly encourage the use of EHRs as a pathway to implementing platforms designed to support interoperability in health information technology, as shown in Appendix A, Exhibit E, Section D.

Incenting Providers to Implement Electronic Health Records

Our Mississippi value-based payment (VBP) program and contracting standards encourage providers to utilize EHRs. Through our VBP provider evaluation readiness process, we assess provider EHR capabilities and together create a path to achieve efficient interoperability. The initial phase starts with basic medical record exchange, moves toward the exchange of supplemental EHR data feeds and files, and expands to leverage data exchange via HIE conduits with the goal of achieving full systems interoperability. Our locally based, regionally aligned provider representatives collaborate with providers either individually or through group events to support and encourage participation in programs, and progress along the continuum as provider comfort levels with taking on increasing risk evolve throughout their relationship with us.

We will collaborate with our providers to assess their capabilities and readiness for VBP in support of their full engagement in quality and total cost of care initiatives and programs. Incentives, such as consultative, monetary, or technology-based commitments are also utilized to encourage EHR utilization. For example, our provider services, quality, and clinical operational teams collaborate with our providers to understand their EHR implementation status and maturity in EHR use. **Our ability to deliver operational excellence demonstrates that we support providers and will be a worry-free partner of the Division**. Through this process, we offer opportunities to strengthen and maximize digital data transmission from practice sites to us. We achieve this through a joint work plan tailored to provider group preferences and readiness, including:

- Supported chart retrieval and digitization
- Bidirectional flat file feeds collecting key service and results data
- Access to existing EHRs for viewing download of clinical data and/or appointment availability
- Partnerships on integrated software solutions that map to provider EHR systems for data retrieval
- Alignment with and support for connectivity to health information exchange (HIE) initiatives, with the goal of real-time data interoperability to optimize health services and decision support at the point of care

For providers ready to transition to EHR use, we offer our care coordination transformation (CCT) incentive as part of our pay-for-performance value-based program. The CCT incentive is in the form of a per member per month (PMPM) payment used by providers to invest in practice infrastructure and technology to improve care. This funding helps practices build the necessary infrastructure for success by providing for staffing and/or technological resources that drive positive care outcomes.

Innovative Tools to Optimize Provider Data Sharing

We provide tools for providers to optimize data sharing during VBP implementation. Our practice transformation software provides a foundation for success by providing technological resources that drive positive outcomes on care. This software elevates the quality program influencing meaningful working relationships with practice physicians to track metrics (potentially avoidable, gaps in care, and utilization trends, and disease cohorts). **Our innovative programs and services are proven to consistently improve health outcomes. We have demonstrated improvement in focused quality measures through implementation of our value-based contracting arrangements between 2018 and 2020. Notably, ensuring timely prenatal care for pregnant members, our top twenty provider groups, across all markets, achieved an average improvement of 10.8%, across multiple markets, in the timeliness of prenatal care (TPC) HEDIS measure.**

We also contract with a centralized data reporting and analytics solution vendor to facilitate care transformation, drive quality improvement, aid in cost reduction, and simplify mandated reporting. The resulting quality reporting identifies gaps in care which assists in member scheduling. To implement this service in our markets, we work with local associations and federally qualified health centers (FQHCs) to jointly define contract terms, and how-and-what data to send to the provider's EHR platform. Through this process, we develop a standardized data template using provider feedback, HEDIS® measures, and the Division's quality goals to address overall FQHC needs.

We offer direct EHR data sharing through a population health technology company vendor. As part of our agreement, communication occurs directly with the provider's EHR vendor to tailor a solution for data sharing. We use this platform for bidirectional feeds; electronic medical records data from the EHR system to us and to deliver gaps in care including gaps closed at other provider locations from us as frequently as desired by both parties. When offering vendor integration to select health systems, we demonstrate the ability to connect with the hospital's provider EHR system by showing the number of sites and interfaces currently linked and demonstrating the platform's aggregation of medical records from the EHR and the direct record transmission to us. This data exchange not only allows us to share member information and gaps in care directly into the provider's EHR but also eliminates the administrative burden associated with chart review requests.

Our provider facing, regionally based provider services staff collaborate closely with providers to develop and enhance quality driven engagement by providing quality reporting and facilitating regularly scheduled meetings with providers. This is part of our fully integrated, transparent service delivery model that uses real-time bidirectional data exchanges to enable provider collaboration. Our provider services staff stand shoulder-to-shoulder with our providers to support them in their data integration and electronic transformation efforts.

Health Information Exchange

In addition to operating functional areas using our industry leading information system, providers will also have access to the statewide health information exchange from the implementation phase of the program. This innovative approach to provider data sharing was recently noted in the 2021 comprehensive quality strategy as being well positioned to positively impact health care outcomes by providing hospitals, providers, commercial insurers, and appropriate state agencies improved access to clinical data. The health information exchange receives daily admissions, discharge, and transfer (ADT) feeds with information across all areas of the state regarding member hospitalizations and emergency department (ED) visits and will also include clinical health records. This data creates alerts in our care management platform which our care managers use to identify members for outreach and to share information with outpatient providers.

With over 90% of hospitals and over 95% of hospital discharges in Mississippi expected to be fully connected by the end of 2022, as well as community mental health centers (CMHCs), RHCs and FQHCs coming online, we will continue to work with providers to adapt technology platforms and connect to the HIE for a gap free and streamlined HIE. We will also work with the hospitals and providers to use this resource and provide technical assistance as needed. The data will be actionable data, not simply resting data.

Encouraging Providers to use e-prescribing

We encourage e-prescribing as a solution to ensure appropriate prescribing habits, decrease point of service rejections, increase formulary alignment, promote member safety, minimize adverse drug incidents, and increase member and provider satisfaction. In addition, e-prescribing removes prescriber administrative burdens and decreases the possibility of drug misuse related to controlled substances or fraud.

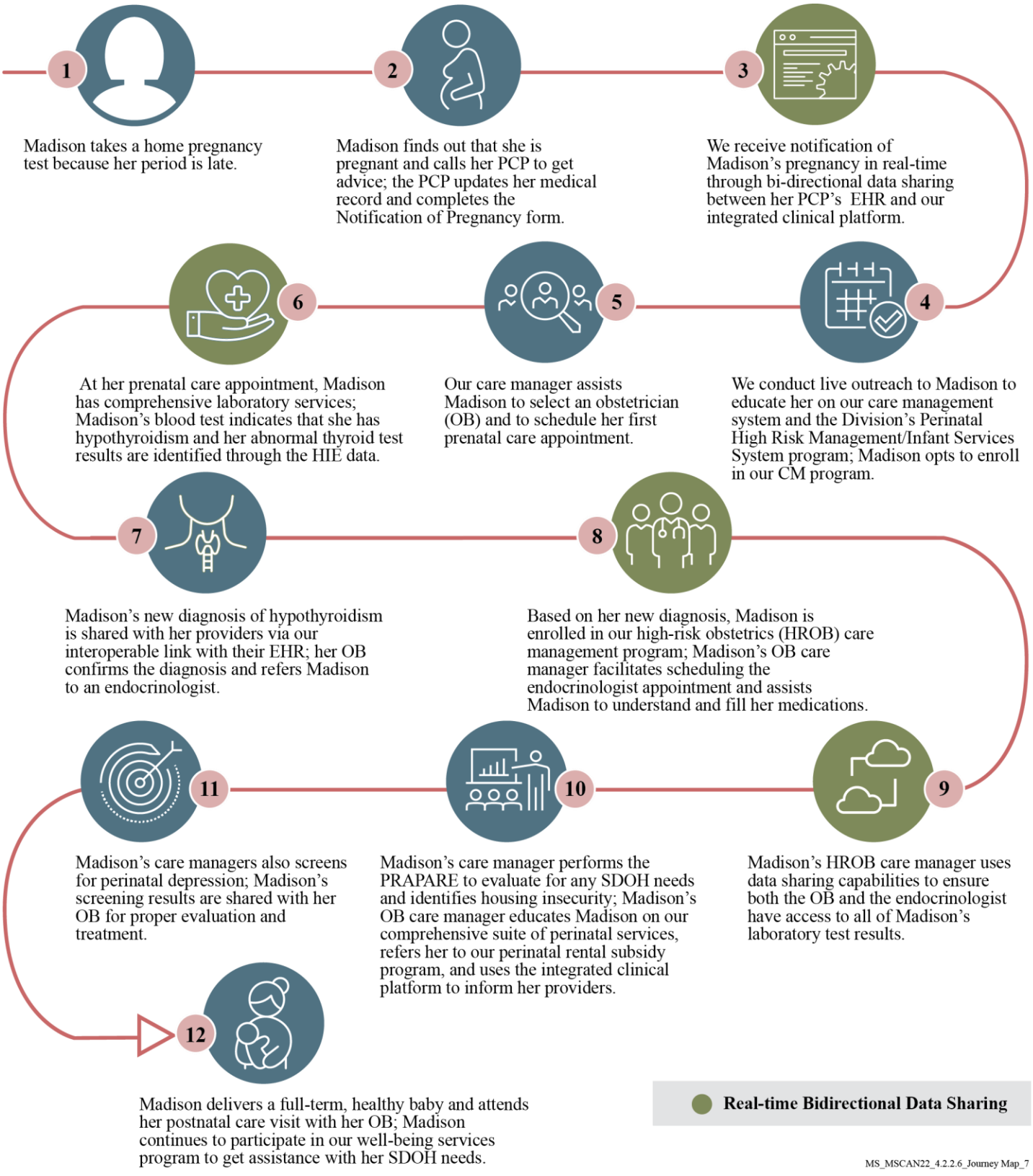
We will partner with the Mississippi Pharmacy Benefits Administrator (PBA) to administer an e-prescribing program to use clinical edits for medical necessity and help adjudicate claims at point of sale. Network pharmacies can send and receive secure prescription and member data while also receiving electronic prescriptions for controlled and noncontrolled substances. For example, in another market, we have proven a leader in physician EHR system connectivity and have made significant investments in the improvement and delivery of e-prescribing tools to benefit payers, prescribers, and members.

4.2.2.4.C Quality Measurement

We oversee quality driven services; including data collection and management for clinical studies, internal quality improvement activities, assessment of special needs populations, and other quality improvement activities requested by the Division. **Our innovative programs and services are proven to consistently improve health outcomes for the Division's priority areas**. Data capabilities drive our members' journeys as seamless experiences, demonstrated in Figure 4.2.2.4_I. Every aspect of our operations use reports, dashboards, and analytics to drive decisions, monitor and manage resources, and meet regulatory guidelines. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources and bring a new era of provider collaboration to Mississippi. We meet the requirements for data collection of performance and member outcomes as described in Appendix A, Section 8.4.

Figure 4.2.2.4_I: Interoperability Member Journey

We embrace interoperability as a means for improving member health outcomes



4.2.2.4.C.1 Describe the Offeror's data analytics and data informatics capabilities and how the Offeror will use those capabilities to drive performance improvement and quality management activities. Provide up to ten (10) pages as appendix to this response of excerpts from or full sample reports that the Offeror proposes to use for this Contract.

We use data from a range of reports, dashboards, and predictive models to address quality improvement and develop targeted initiatives to support health equity, improve care quality, and address health disparities. We have positioned our data analytics teams across the organization to support these efforts. The population health analytics team monitors comprehensive data sources from our enterprise data warehouse, including medical claims, pharmacy claims, ADT data, laboratory data, immunization data, SDOH data, member assessments, and health risk assessments. By combining this data with our business intelligence platform and Healthcare Effectiveness Data and Information Set (HEDIS®) analytics software tools, we create monthly dashboards to provide enhanced detail on demographics (e.g., race and ethnicity). Using this integrated data, we identify racial and ethnic disparities, geographic regions with access issues, outlying providers, overutilization of the emergency department (ED) for non-emergent conditions, excessive costs, and program participation process data. Our organization makes data-driven decisions to design and implement interventions for target populations. If requested by the Division, we will adapt our systems and processes to include any future quality improvement activities.

Expert Data Analytics Teams

Our dedicated enterprise analytics team provides expertise to both internal and external stakeholders. Our senior leadership analytics team has more than 70 years combined experience in healthcare analytics. Staff with deep expertise in their team's respective focus areas lead each of the teams described in Table 4.2.2.4_B. This depth of expertise is a differentiator and key strength of our data analytics capabilities. Our formal Data Governance Office ensures consistency of methods and data sources.

Table 4.2.2.4_B: Our Data Teams

Team	Key Functions
Population Analytics	▪ Profiling by disease, demographics, and socioeconomics with a focus on vulnerable populations ▪ Epidemiological analysis including complex populations (e.g., seriously mentally ill [SMI], substance use disorder [SUD], intellectual and developmental disabilities [IDD]) ▪ Geospatial reporting and analysis
Clinical Informatics	▪ Analysis of utilization management policy, activity, and outcomes ▪ Monitoring of care management enrollment, engagement, and caseloads ▪ Assessment of care management efficacy ▪ Analysis of utilization management/care management (UM/CM) system to ensure alignment of clinical workflows
Quality Analytics	▪ In-depth analysis of HEDIS®, STARS, and other quality metrics ▪ Monitor and trend performance measures ▪ Collect and report required HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS) submissions ▪ Lead and facilitate the annual HEDIS® Roadmap and Audit ▪ Maintain National Committee for Quality Assurance (NCQA) HEDIS® software
Provider and Network Analytics	▪ Hospital rate optimization ▪ Steerage analysis ▪ Primary care practice profiling and reimbursement modeling ▪ Provider settlement analysis
Predictive Analytics and Data Science	▪ Practical application of Artificial Intelligence and Machine Learning (AI/ML) ▪ Prediction of key opportunities to prioritize members for engagement ▪ Identification of claims payment anomalies and fraud, waste, and abuse (FWA) ▪ Assessment of member sentiment and impact on disenrollment
Regulatory Reporting	▪ Produce, validate, and maintain regulatory reports ▪ Report across all domains including care management, utilization management, grievance and appeals, encounters, claims, members, and providers ▪ Internally provide reporting around regulatory key performance indicators (KPIs) to drive continuous improvement
Medical Economics	▪ Review monthly cost and utilization trends, variance to budget/forecast ▪ Identify and quantify opportunities to improve quality and affordability of healthcare
Mississippi Market Finance Analytics	▪ Dedicated to understanding the specific nuances of Mississippi to lead the data analysis needed to support Division requests and initiatives

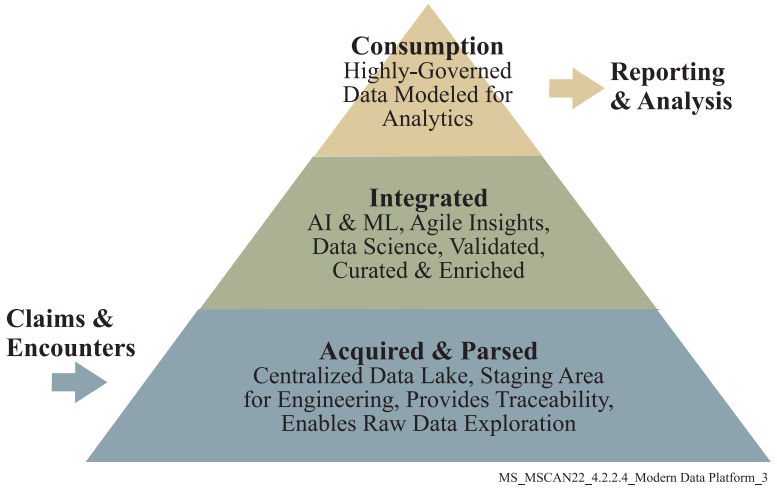
Modern Data Platform

Our data management platform will enable full compliance with all Mississippi reporting and regulatory requirements, robust and advanced data analytics, and a full integration with state systems. Our modern data platform (MDP) orchestrates and automates the lifecycle, copy management, compliance, and governance of data across infrastructures, application types, formats, containers, and locations, even software as a service (SaaS). The MDP uses business centric data structures as a core principle.

Our platform design allows flexibility for market and regulatory changes, and scaling to workload and volume of data automatically. Our MDP shown in Figure 4.2.2.4_J. is supported by our enterprise data warehouse (EDW), which consolidates data from multiple systems and external sources, to include claims and encounters data. This provides a concise, accurate, and complete data repository to meet all information needs, including both current and historical data.

Figure 4.2.2.4_J: Modern Data Platform

This platform provides flexibility for market and regulatory changes



Our cloud platform ensures scalability and performance using the most current technology available. Our industry-specific blueprint ensures the integration of all data and an organization-wide view of KPIs and other measures. We use a state-of-the-art security model to facilitate broad access to only the appropriate data. Our business intelligence platforms and reporting services intelligence platforms deliver critical operational and analytical dashboards and reports for our internal leadership.

Our tools, which are outlined in Table 4.2.2.4_C, integrate a wide range of alternative data sources. These data sources include more than 400 member-specific social determinants of health (SDOH) for the entire adult population, admissions, discharges, and transfer (ADT) messages from participating hospitals, electronic health records (EHR) data from participating physicians and practices, and State-provided data feeds. Each of these data sources makes up our fully integrated, transparent service delivery model.

Table 4.2.2.4_C: Data Analytics Tools

Tool	Key Functions
High-Risk Pregnancy Predictive Model	▪ Employs an algorithm to identify patterns in historical high-risk pregnancies ▪ Identifies clinical and social drivers to predict potential adverse outcomes ▪ Applies geospatial analytics to understand disparities in access to care ▪ Applies a severity value for each condition, creating patient cohorts ▪ Cohorts based on risk and condition characteristics
SDOH Indices	▪ Assigns an index value to members in each of five domains: economic stability, education, community, health care, and environment ▪ Integrates data to reflect overall SDOH risk rating ▪ Uses a combination of diagnoses from claims to identify medical and behavioral conditions ▪ Monthly predictive models to identify and target at-risk members
Homelessness Predictive Model	▪ Identifies members likely to experience homelessness ▪ Integrates data to reflect overall SDOH risk
Readmission Predictive Model	▪ 30-day readmission predictive analysis applied at admission or discharge ▪ Uses demographics, clinical factors, historical utilization data, SDOH ▪ Assigned risk score prioritizes clinical reviews and targeted interventions
ER Predictive Model	▪ Identifies members at future risk of emergency room visits for non-emergent diagnoses and services ▪ Leverages variables including utilization, comorbidities, SDOH, and engagement with care management programs

Tool	Key Functions
Member Engagement	▪ Use advanced analytics to understand patterns in member engagement ▪ Clusters members in various cohorts with similar behaviors to design person-centered engagement ▪ Algorithm flags and categorizes members, used to deploy staff to support gap closure in targeted populations
Rising Risk Model	▪ Identifies members who are not utilizing the healthcare system as much but are at higher risk to do so in the future ▪ Algorithm identifies rising risk for complex members to enable prior interventions
Inpatient Cost Projection Model	▪ Machine learning model to project medical cost related to inpatient stays ▪ Uses prior authorizations as a leading indicator to estimate cost per admit category ▪ Helps to inform enhancements to our transitions of care program and framework
Opioid Model	▪ Predicts members who are at the highest risk to go from acute to chronic usage of opioids ▪ Uses pharmacy claims, ED, inpatient and outpatient, SDOH, and health risk assessment (HRA) data ▪ Use information to proactively engage members in care management and services to prevent opioid addiction

Data Governance Model Ensures Data Accuracy

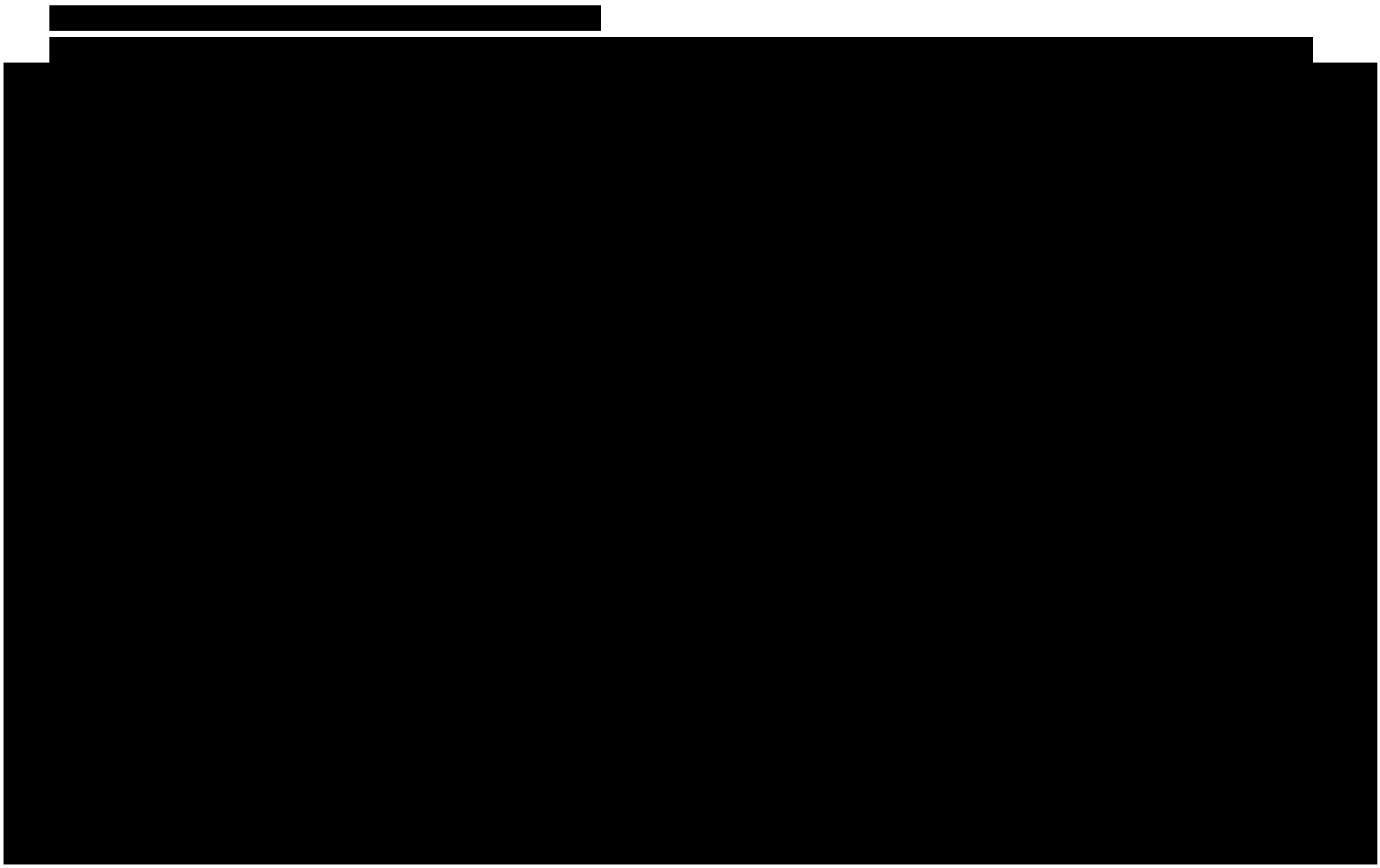
Our business driven data governance structure ensures trust, consistency in data use, and standardization of metrics and definitions. The Data Governance organization approves single source of truth, system of records, defines metadata and governs reports for enterprise consumption and regulatory submissions. Our Data Governance Office also establishes standard policies, procedures, and controls to ensure all internal and external parties have a clear understanding of their data use responsibilities. Data governance includes active participation of executive and senior leadership teams that conduct process reviews monthly as part of a comprehensive quality management program to review encounter data, reported measures, and implementation of quality improvement projects. During monthly Executive Steering Committee meetings and monthly Data Governance Council meetings, leaders review and discuss data and reports during cross-functional forums to decide how resources, initiatives, and priorities shift based on the needs of members at that point in time.

Data-Driven Performance Improvement and Quality Management Activities

Our extensive data analytics and informatics capabilities drive quality management and performance activities in Mississippi, allowing for initiative development that targets at-risk members, as well as identifies regions where targeted interventions provide value. For example, our innovative technology identifies members who are more likely to experience homelessness. The model relies on an extensive set of variables including historical medical and pharmacy utilization, demographics, various SDOH, current housing data, and historical address changes. At a community level, this tool identifies geographies with a high concentration of at-risk members for a more targeted deployment of programs and interventions to prevent homelessness.

Another key application of our data is our **Population Risk Dashboard** (Figure 4.2.2.4_K), which is instrumental in supporting initiatives to promote health equity and reduce health disparities. This dashboard integrates data sources, including a population health analytics software; claims and authorizations data; health needs assessment, other assessment data; and ADT data. The dashboard also integrates our predictive models that identify high-risk pregnant members and those at highest risk of adverse COVID-19 outcomes.

Using our fully integrated, transparent service delivery model with the majority of providers through real-time bidirectional data exchanges, we will integrate information from the industry standard health risk assessment tool, comprehensive assessments (including SDOH), any continuity of care information received from the member’s previous coordinated care organization (when appropriate), and member information from their providers to determine the member’s medical/behavioral status.



The integrated population health dashboard generates geospatial intelligence to geolocate members and can be filtered by demographics, condition, behavioral health (BH) needs, and social risks. This allows us to target interventions that are specific to local barriers our members may be experiencing. We have integrated the population health dashboard with our care management platform and other predictive analytics models to offer a **one-stop data solution** that every organizational functional area can use to identify gaps in care and the design interventions to address them. Our care management staff interpret the available data inclusive of predictive modeling to make the final determination of level of service for everyone who would benefit from care management services. The team can also use the dashboard to identify high-risk members to prioritize for outreach.

SDOH Data. We incorporate SDOH data into our predictive modeling engine and population health dashboard to identify patterns of health determinants, social determinants, inequities, and/or disparities within each population stream. Our algorithms enable us to assess concentration of need for more targeted deployment of programs and interventions aligning with community resources. Our SDOH assessment risk tools identify members' most common social risk domains, including housing, education, employment, social isolation, stress, and transportation. Table 4.2.2.4_D. shows the summary of our other innovative key dashboards.

Table 4.2.2.4_D: Summary of Key Dashboards

Dashboard	Performance Improvement and Quality Assurance Application
Rx Drug Profiles Dashboard	▪ Combines medical/pharmacy claims, member attributes, disease conditions, prescriber data ▪ Provides a comprehensive view of pharmacy trends and variations
COVID-19 Member Outreach Dashboard	▪ Uses 48 metrics including socio-demographics, utilization, and medical conditions ▪ Identifies highest risk members ▪ Assists clinical staff with outreach efforts

Driving Provider Performance. Our partnership with an end-to-end quality management platform vendor will drive quality improvement and boost network engagement across our populations. This platform is AI/ML-based advanced analytics, automated workflows, quality improvement consulting expertise, and coordinated approach protocols. It complements and elevates our efforts to drive equitable health care and reduce provider and Division administrative burden. The HEDIS Run Rate Dashboard, demonstrated in Figure 4.2.2.4_L, enables our quality team to drive interventions and initiatives to address provider performance. Using this platform, we have created a single, consolidated view of all programs for each provider that will help reduce costs while providing higher quality care to our members. By aggregating this information for our network providers, we reduce the time and effort to find and execute cost savings and quality improvement initiatives while increasing information sharing speed. **This dashboard drills down to additional tiers by specific measure, by provider groups like PCMH's, FQHC's, etc., down to individual provider performance within a group. This helps to track performance on a real-time basis by measure and drive improvements at the provider level if warranted.**

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Improvements based on HEDIS® data. We participate in HEDIS® data collection and reporting each year using the National Committee for Quality Assurance (NCQA) certified software. We collect, analyze, evaluate, and compare data to regional and national benchmarks. The results, comparison data, and quality team analysis, identifies opportunities for improvement. Assessing the quality and appropriateness of care provided to members under 21 years of age, by subgrouping the members by age groups from zero to 20 aligned with the

CMS 416 report, and aligning interventions targeted to the age groups has resulted in a high compliance rate with Early Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. For example, in another market, we developed incentives for members and providers for vaccinations and preventive health screenings based on HEDIS® vaccine rates for children, adolescent, adult, and pregnancy, annual flu rates, and COVID-19 vaccine completion rates.

Monitoring Performance. Our quality team conducts a monthly programmatic level audit to ensure contractual and NCQA adherence in care management practices and documentation. The quality team shares audit outcomes and feedback with care management leadership, training teams, and staff to identify areas for improvement and provide additional education and counseling. We audit all staff monthly to ensure individual adherence to contractual and NCQA requirements and share audit results with team members to improve performance and to inform potential retraining opportunities.

Preventive Health Screening Initiative

In another market, from HEDIS report year 2019 – 2021, a 61% improvement was noted in immunization rate for children aged 2 years old, despite COVID restrictions.

Our Quality Management and Improvement Committee (QMIC) facilitated by our Mississippi Medical Director, will oversee the continuous assessment, monitoring, and improvement across clinical and non-clinical operations. During quarterly meetings, business owners will provide status updates on KPIs. The QMIC will also review regulatory reports and other operational and program data to assess for care gaps and compliance with specific HEDIS measures.

In addition to the Quality Management department, report owners include regulatory compliance; member services, grievances and appeals; pharmacy; provider relations; credentialing; clinical operations; utilization management; behavioral health; maternal child health; care management; and transitions of care departments. All departments come prepared to review pertinent data for discussion of escalations and plans to resolve identified barriers. In addition to our QMIC, our quality team facilitates subcommittees and workgroups with cross-functional participation maintained to ensure adequate planning and implementation of improvement strategies, all of which focus on the program goal of improving health outcomes.

Quality Management Sample Reports

Examples of key reports that we will submit to the Division are in Table 4.2.2.4_E and can be found in Appendix 4.2.2.4.c.1-1 Sample Reports. We have an established process and the expertise to assure accuracy, completeness, and timely submission of each report which will be requested by the Division.

Table 4.2.2.4_E: Sample Quality Management Reports

HEDIS Performance Report	Performance Improvement Plans (PIP) – per desired methodology
Value Based Payment Workplan Measures	Clinical Practice Guidelines Compliance Report
HEDIS Final Audit Report (FAR)	QM Program Evaluation
CAHPS Survey Results	Maternity Admissions report (Draft Contract, Section 8.17)
Provider Satisfaction Survey Results	EPSDT – Form CMS 416 (Draft Contract, Section 8.20 and 8.21)

a. Describe the type of build necessary to create these types of reports.

We will create and submit all reports provided in Appendix 4.2.2.4.c.1-1 Sample Reports; emphasizing no additional system builds will be needed to meet the Division's reporting requirements, and we commit to accurate and complete data reporting. Our enterprise data platform consolidates data from multiple systems, as well as from external sources, to provide a concise, accurate, and complete data repository to meet all information needs. Our business intelligence platforms enable report and dashboard development using the data in the enterprise data platform, both for internal operational and analytical reporting and for regulatory and

compliance consumption. Constantly enhancing and modernizing our data management and reporting capabilities enables us to stay ahead of information needs, including investing in next-generation data platforms.

4.2.2.4.C.2 Describe any innovative approaches the Offeror plans to use to ensure that Quality Measurement is both accurate and evidence efficacy of programs.

Our innovative approaches include performance outcome rates, interoperability, member rewards and risk assessment, care gaps service and organization controls audits.

Accuracy - Performance Outcome Rates

We align with Center for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols and all volumes of NCQA's HEDIS® Technical Specifications for collecting and assuring accuracy, validity, and reliability of performance outcome rates. This process corresponds with the Mississippi Coordinated Care Performance Measures that are based on the HEDIS®, the state legislature, CMS Core sets, and other quality measurement organizations. We contract with a Certified HEDIS® Audit firm to analyze our HEDIS® rates. We will report audit results to NCQA and to the Division. We will report rates for all required performance measures to the Division for publication on the Division's website. **Our HEDIS® audit for a similar program received 100% compliance and we were recognized for our commendable practices.**

Best in Class Quality Analytics

Our innovative quality analytics includes a modern data platform to store all incoming data to authenticate accurate data aggregation. We achieve this by performing integration and regression testing, assessing volume, and validating data quality. Our vendor partnership will enable an end-to-end quality management, business intelligence and analytics platform. We have access to over 700 KPIs – the largest measure library in the industry.

To support accurate and complete performance measures, a dedicated team of HEDIS® analysts runs and review data quality reports within the software after each data refresh. We monitor measure rate, including numerators, denominators, and data quality trends. Our innovative platforms can create traceability across financial, contractual, operational, and regulatory domains and empower data analysts to easily generate audit reports to determine the accuracy and completeness of measure calculations.

Measures developed by our programmers involve the subversion (SVN) or global information tracker (GIT) source control management systems. Source control manages and tracks all code, which allows us to review the development and any changes performed along with requirements. We review and test all code before we generate a release. We copy our released source code to a data and records management company for backup and recovery purposes.

Accuracy – Interoperability

Our automated and exception-based process for normalizing data feeds supports quality measures, interoperability, and care programs. This process uses semantic and syntactic mappings conforming consolidated clinical document architecture (CCDA), nonstandard, and object specific data into a Summary Document Architecture (SDA) and established format. SDA is an InterSystems format used to represent patient data. By employing upfront automations and clinical reviews based on standards mapping using medical terminology for electronic health records such as (LOINC, UCUM, SNOMED, and HL7), we optimally influence the accuracy and usability of patient quality data.

Efficacy – Risk Assessment and Care Gaps

For our in-office assessment program, we provide a list of risk adjustment and care gaps for our members to their assigned primary care providers (PCPs) so they can be assessed during a PCP visit. Modalities include 1) E-data: if the provider group has a two-way connection with us, the risk adjustment and quality assurance gaps will be sent via the provider's EMR during the member's visit; 2) Practice Assist: this is a web-based portal the provider will go to get the open risk adjustment and quality assurance gaps; and 3) Paper: The final option is paper. The provider will receive a paper form with the risk adjustment and quality assurance gaps.

Regardless of the modality, we ask the provider to assess the conditions to determine if they are still present, document the assessment, and then send the medical record back for coding. We will collaborate with the provider to compare the claims from a visit to the medical record to ensure that all diagnoses found in the medical record were present on the claim; if not, our we will work with the provider to submit a corrected claim on their behalf after the provider has reviewed and approved it.

Efficacy - CMS Interoperability

We use real-time data from our innovative CMS interoperability effort to drive decisions for quality efficacy. A single event for an individual member triggers proactive actions across multiple departments that feed back into the individual's care plan. At every step in each member's journey, a diverse team of our experts actively assesses and triage care in a collaborative and holistic manner to address that member's specific healthcare need.

Efficacy – Member Rewards

We understand that our members may face barriers to seeking recommended services. Our member rewards programs encourage the appropriate use of health care services and engagement in healthy behaviors. We strategically offer innovative rewards across the care continuum, and this customized program guides members toward the person-centered care decisions. Supporting the appropriate use of health care services and fostering member responsibility, our member incentives increase adherence to keeping medical appointments and receiving care in the appropriate settings. Our diverse member rewards offerings will facilitate enhanced member engagement for statewide Mississippi-focused clinical conditions.

Annual Program Evaluation
MSCAN and Mississippi CHIP
Model Document

OVERVIEW

Our overview will include a description of completed and ongoing QM activities including a Care Management effectiveness evaluation. It will also contain trending measures to assess performance in quality for clinical care and quality of service to members. It will also contain an analysis, including a Cost-Effectiveness Analysis, of whether there have been demonstrated improvements in Members' health outcomes, the quality of clinical care, and quality of service to Members, with an explanation of methods and data used to conduct the analysis and access to raw data if requested by the Division

ACCREDITATION

MEMBERSHIP

I. Program Structure and Oversight

Committees, Resources and Staff
Data Sources
Scope of Previous Year QI Work Plan
QI Workgroups

II. Quality of Clinical Care for Members

HEDIS® Performance Measurement Year
Trended Data Results & Method of Collection
Analysis (includes cost-effective analysis)
Barriers
Opportunities
Planned Interventions

III. State Priorities

Performance Improvement Projects
Trended Data Results & Method of Collection
Analysis
Barriers
Opportunities

IV. Safety of Clinical Care

Health, Safety & Welfare Program

Quality of Care and Adverse Events

Continuity & Coordination of Medical and Specialty Care

Continuity & Coordination of Medical and Behavioral Healthcare

Safety of Clinical Care Planned Interventions

V. Quality of Service to Members

Customer Advocacy – Member Calls
Trended Data Results & Method of Collection
Analysis (includes cost-effective analysis)
Barriers
Opportunities
Planned Interventions

Consumer Assessment of HealthCare Providers and Services (CAHPS)
CAHPS Analysis

Additional Member Satisfaction Surveys
Supplemental satisfaction surveys (e.g., new member satisfaction, satisfaction with care management, satisfaction with behavioral health surveys, etc.).

Grievances & Appeals by Category
Trended Data Results & Method of Collection
Grievances & Appeals Analysis (includes cost-effective analysis)
Barriers
Opportunities
Planned Interventions

VI Network Management

Provider Satisfaction Survey Results
Trended Data Results & Method of Collection
Analysis
Barriers
Opportunities
Planned Interventions

Provider Access and Availability
Trended Data Results & Method of Collection
Analysis
Barriers
Opportunities
Planned Interventions

Credentialing

Credentialing Continuous Monitoring
Trended Data Results & Method of Collection
Analysis
Barriers
Opportunities
Planned Interventions

VII. Utilization Management

Trended Data Results & Method of Collection
Analysis
Barriers
Opportunities
Planned Interventions

VIII Pharmacy

Trended Data Results & Method of Collection
Analysis
Barriers
Opportunities
Planned Interventions

IX. Behavioral Healthcare

Trended Data Results & Method of Collection
Analysis
Barriers
Opportunities
Planned Interventions

IIX. Case Management

Trended Data Results & Method of Collection
Analysis
Barriers
Opportunities
Planned Interventions

X. Serving Diverse Members

Geographics (e.g. communities, rural/urban), Racial, and Ethnic Disparities

Language Preferences

Special Populations

Trended Data Results & Method of Collection
Analysis
Barriers
Opportunities
Planned Interventions

XI. Analysis and Evaluation of Overall Effectiveness

Overall effectiveness of the QM program (e.g., improved HEDIS® scores, improved State Custom Performance Measures

Annual Program Description

MSCAN and Mississippi CHIP

Model Document

Overview

Our plan is committed to providing the highest level of quality care and service to our members. A cornerstone of this commitment is the development of quality management and improvement programs that address the needs of specific MSCAN and Mississippi CHIP member populations and demonstrate improvement in health outcomes.

Our Mississippi Quality Management Improvement Program (QMIP) aligns with the Quadruple Aim, focusing on improving population health, enhancing the member experience, reducing the cost of care, and improving provider satisfaction. We also align our QMIP to the Division's Comprehensive Quality Strategy.

The purpose of the Mississippi QMIP is to ensure that we have the necessary infrastructure to:

- Coordinate care using evidence-based tools
- Improve member health and outcomes
- Promote quality care
- Ensure performance and efficiency on an ongoing basis
- Improve the quality, safety and equity of clinical care and services

The Quality Management Improvement Program encompasses both clinical and non-clinical services and is reviewed and revised as needed to remain responsive to:

- Member needs inclusive of health, safety, and welfare
- Provider feedback
- Evidence-based standards of care and best practices
- Regulatory and business needs.

SCOPE OF THE QM PROGRAM

The MSCAN and CHIP Quality Management Improvement Program governs the quality assessment and improvement activities for Mississippi under the leadership of the Mississippi Medical Director to ensure coordination and program implementation. Requirements of the QMIP include the development of realistic and measurable objectives developed via consensus with medical and quality improvement team members. The scope includes the ability to:

- Meet the quality requirements of the Centers for Medicare and Medicaid Services (CMS), State and/or Federal regulators, the Mississippi Quality Strategy Plan, and the Affordable Care Act (ACA), if applicable.
- Meet the quality requirements of the Division of Medicaid
- Monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members
- Incorporate an internal system for monitoring services, including:
    - Data collection and management for clinical studies
    - Internal quality improvement activities

  - Assessment of special needs populations
  - Other quality improvement activities requested by the Division
- Establish safe clinical practices throughout the network of practitioners and providers.
- Provide quality oversight of all clinical services.
- Comply with NCQA accreditation standards.
- Perform HEDIS® compliance audit and performance measurement.
- Conduct CAHPS Survey and performance measurement for MSCAN and CHIP.
- Monitor and evaluate member, practitioner, and provider satisfaction.
- Monitor over/underutilization, including documentation of activities to address concerns, state clinical priorities and EPSDT services.
- Review and assure appropriate resolution of all quality-of-care concerns, and clinical quality of care grievances.
- Develop organizational competency in quality methodologies, including use of the Plan Do Study Act (PDSA) rapid cycle improvement model.
- Ensure efforts to monitor and improve behavioral healthcare
- Ensure Programs are effectively serving members with culturally and linguistically diverse needs as well as and health equity.
- Ensure effective care for members with varying levels of health, safety, or welfare needs, including complex health issues.
- Data Availability to participate in performance and quality improvement projects, clinical studies, and External Quality Reviews.
- Develop and maintain an annual work plan specific to the MSCAN and CHIP Program.
- Assess specific population health characteristics and needs, including the social determinants of health.
- Assess the geographic availability and accessibility of primary and specialty care providers.
- Ensure adequate and appropriate written policies, procedures and resources are available to maintain the QMIP.
- Include an annual provider relations project.
- Participate in any state-sponsored prenatal care coordination programs.
- Develop and maintain a physician incentive program.
- Develop a member incentive program to encourage member responsibility for their healthcare and outcomes.
- Participate in clinical studies, as appropriate.
- Submit quality improvement data, status and results of performance improvement projects and information to complete the state’s Quality Strategy Plan for CMS.
- Maintain procedures for collecting and assuring accuracy, validity, and reliability of performance outcome rates consistent with protocols developed in the private/public sector.

Quality Improvement Organizational Structure, Responsibilities & Reporting Relationships

Quality Strategy and Improvement Process

Quality Management Improvement Program Components

Monitoring Clinical Quality & Safety

- Remedial action for deficiencies
- Issues requiring corrective action
- Monitoring and evaluating corrective actions to ensure that actions for improvement have been effective
- Obtaining provider feedback on remedial action for deficiencies, issuing corrective actions, and monitoring and evaluating corrective actions.

Population Health Management

- Assessing the quality and appropriateness of care furnished to members with special health care needs using health care professionals who are trained and qualified to assess and address special health care needs

Utilization Management
Pharmacy Program
Credentialing and Re-Credentialing
Delegation Oversight
Consumer Experience
Network Management
Incentive Program

Addressing Culturally & Linguistically Diverse Populations

Resources Dedicated to Quality Improvement

Health Information Systems

Member and Provider Communication and Education

COMMUNICATION ON QI PROGRAM WITH STAKEHOLDERS AND COMMUNITY PARTNERS

Confidentiality and Conflict of Interest
Reporting on Required Standards, such as Network Adequacy

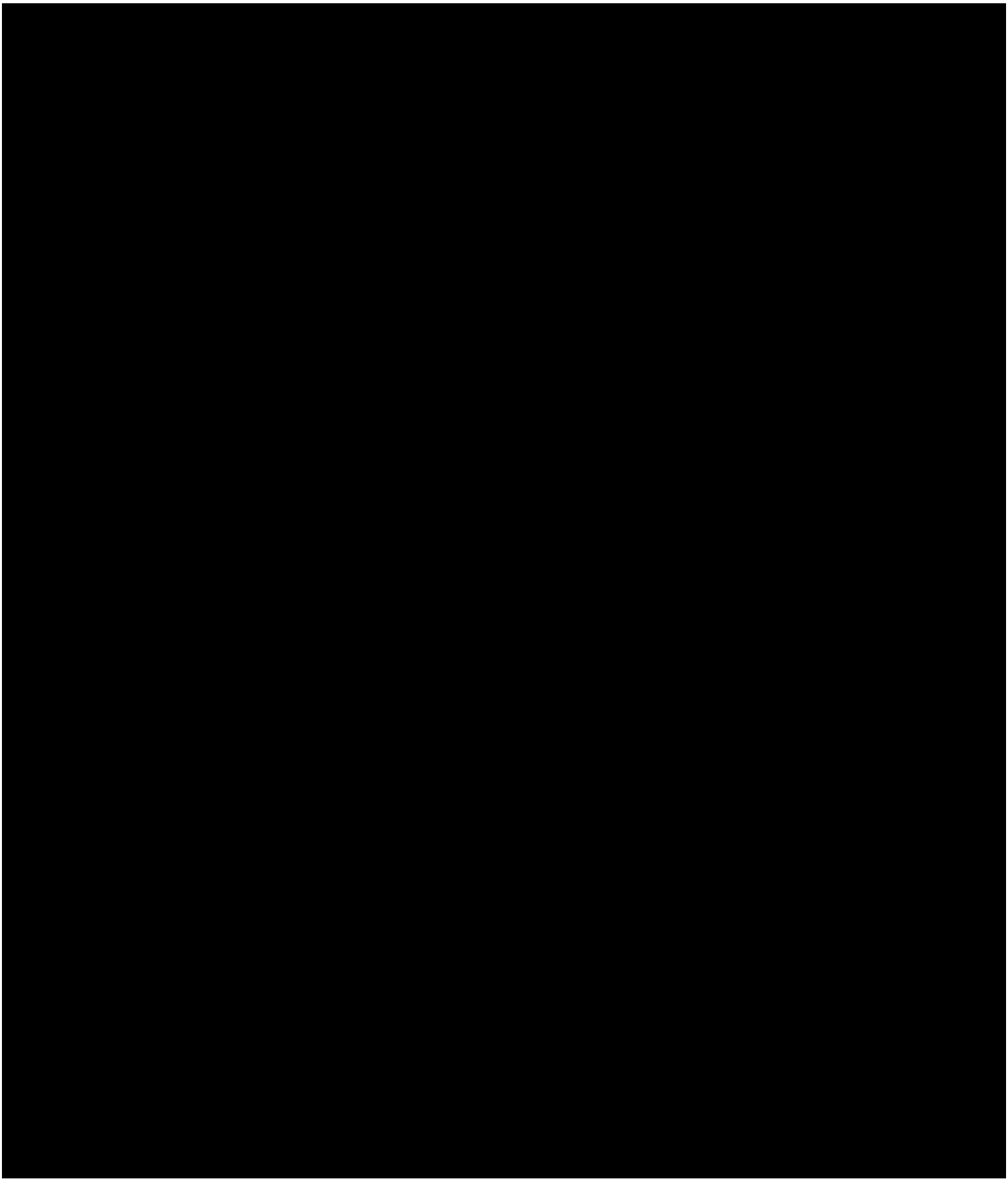
Quality Management Improvement Program Evaluation
On an annual basis, we will complete an evaluation of the Mississippi Quality Management Improvement Program. The QMIP Evaluation examines actual performance compared to goals, evaluates trends in the organization's performance, identifies barriers/challenges which made improvement difficult to attain, includes recommended interventions, and provides a summary of the effectiveness of the plan and activities. Where analysis indicates that objectives have not been met, activities and goals are re-evaluated for potential inclusion in the subsequent calendar year program. The Mississippi Quality Management Committee approves the annual QMIP Evaluation.

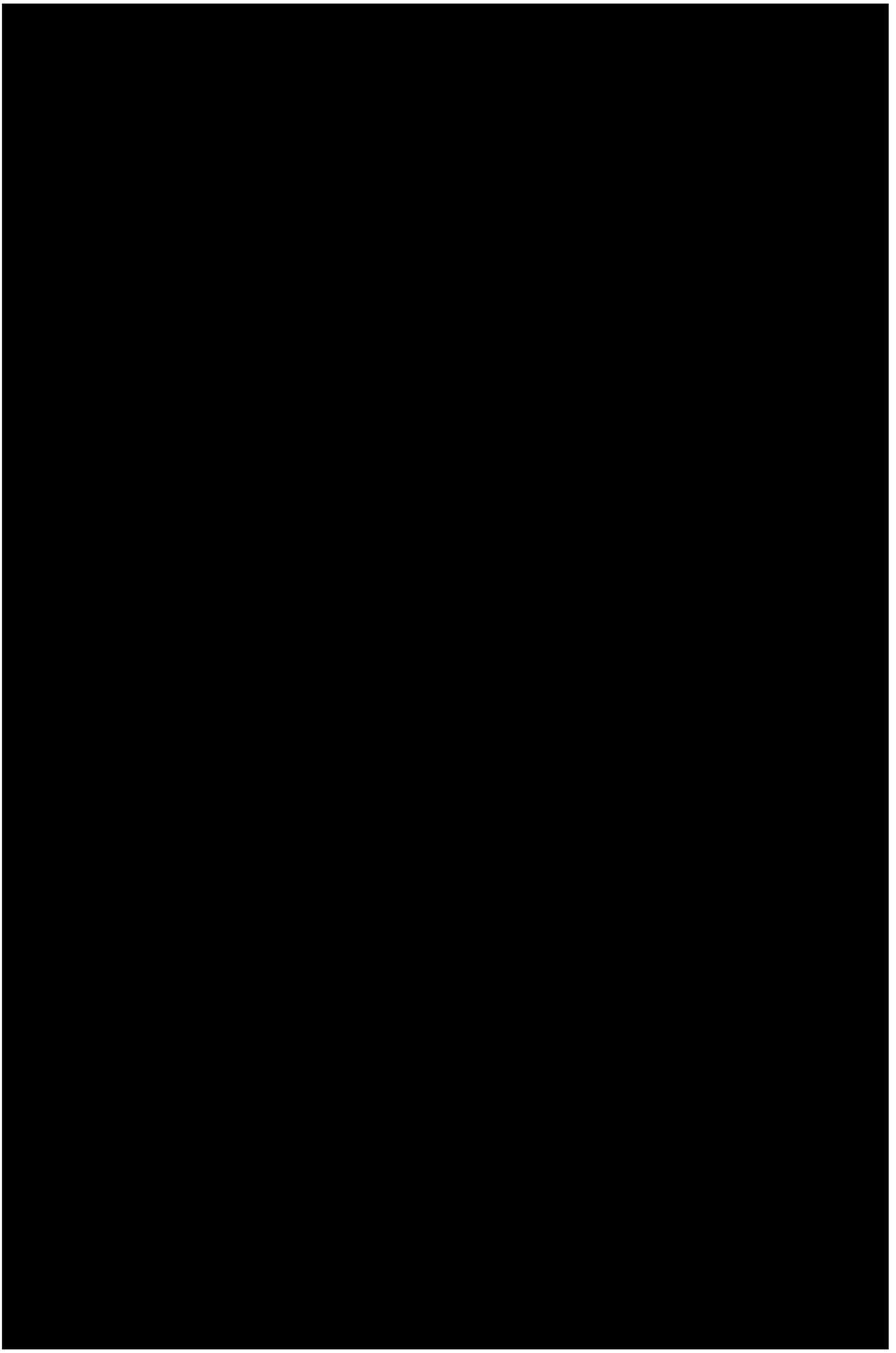
Annual Program Description Work Plan
MSCAN and Mississippi CHIP
Model Document

1.0 Quality Improvement Plan					
Planned Activities	Responsible Person	Objectives & Improvement Actions	Goal	Evaluation & Reporting of Findings	Data Collection & Analysis
1.1 Quality Management and Improvement Description Annual Updates	Mississippi Medical Director	Annual review and approval of the program description to ensure program activities align with state, federal and compliance requirements	Annual Document Review and Approval	Annually	Completed Approved
Planned Activities to be determined					
2.0 Ancillary Programs and Work Plans					
Planned Activities	Responsible Person	Objectives & Improvement Actions	Goal	Evaluation & Reporting of Findings	Data Collection & Analysis
2.1 Utilization Management (UM)Program Description Annual Updates	Utilization Management Coordinator/ Director	Annual review of UM program description to ensure UM decisions in a fair and impartial and consistent manner and according to state requirements	Annual Review and Approval by UMC	Upon Request	Completed Approved
Planned Activities to be determined					
3.0 MSCAN and CHIP Improvement Projects (QIPS, PIPS and Monitoring of Previously Identified Issues)					
Planned Activities	Responsible Person	Objectives & Improvement Actions	Goal	Evaluation & Reporting of Findings	Data Collection & Analysis
3.1 Improve Health Risk Assessment completion rates within 90 days of enrollment	Quality Management Director	Implement innovative and effective strategies to improve HRA completion rates to ensure screening for member Resource: 1) Use of Kiosk	Use of Kiosk > 10% HRA Locate completion rate > 45%	Quarterly	Goal status

		2) HRA Locate Strategies			
Number of activities will be determined					
4.0 Quality of Clinical Care					
Planned Activities	Responsible Person	Objectives & Improvement Actions	Goal	Evaluation & Reporting of Findings	Data Collection & Analysis
4.1 Conduct Annual Population Assessment	Quality Management Director	1) Annual population health analysis according to internal policies and procedures to determine programs, staffing ratios, services, and resource needs. 2) Identify opportunities for the improvement and align performance goals and need for additional clinical practice guidelines	Annual Review and Approval	Second Quarter	Completed
The number of activities is to be determined					
5.0 Member Experience					
Planned Activities	Responsible Person	Objectives & Improvement Actions	Goal	Evaluation & Reporting of Findings	Data Collection & Analysis
5.1 Monitor Member Call Center Statistics	Manager, Member Advocacy Member	1) Timely access to knowledgeable customer service staff 2) Ensure compliance to state contract standards	Draft Contract, Sec. 5.1.6 Call Center Sufficiency Standards	Quarterly	Goals met
Activities to be determined					
6.0 Safety of Clinical Care					
Planned Activities	Responsible Person	Objectives & Improvement Actions	Goal	Evaluation & Reporting of Findings	Data Collection & Analysis

6.1 Monitor Over/ Underutilization	Mississippi Medical Director	1) Monitor for over and underutilization for inpatient admissions, ED use, outpatient services mental health and substance use treatment services in comparison to national utilization benchmarks 2) Identify opportunities for improvement	QC Benchmark 50th percentile	2nd and 3rd quarter	Completed
Planned Activities to be determined					
7.0 Network Management and Health Partnerships					
Planned Activities	Responsible Person	Objectives & Improvement Actions	Goal	Evaluation & Reporting of Findings	Data Collection & Analysis
7.1 Monitor Credentialing and Recredentialing Process	Provider Services	1) Timely implementation of credentialing from date of receipt to deemed complete date 2) Timely recredentialing process	100% Initial Credentialing TAT < 25 days 15 day stretch goal 100% Recredentialing every 36 months	Quarterly	Credentialing: Goal Met Recredentialing: Goal Met
Planned Activities to be determined					
8.0 Regulatory, Accreditation and Delegation Oversight					
8.1 NCQA Accreditation	Accreditation Manager	Monitor to ensure ongoing compliance to NCQA standards and guidelines	Meet NCQA Health Plan Accreditation requirements for Survey	Monthly	Completed Maintained timeline and communications with business owners
Planned Activities to be determined					





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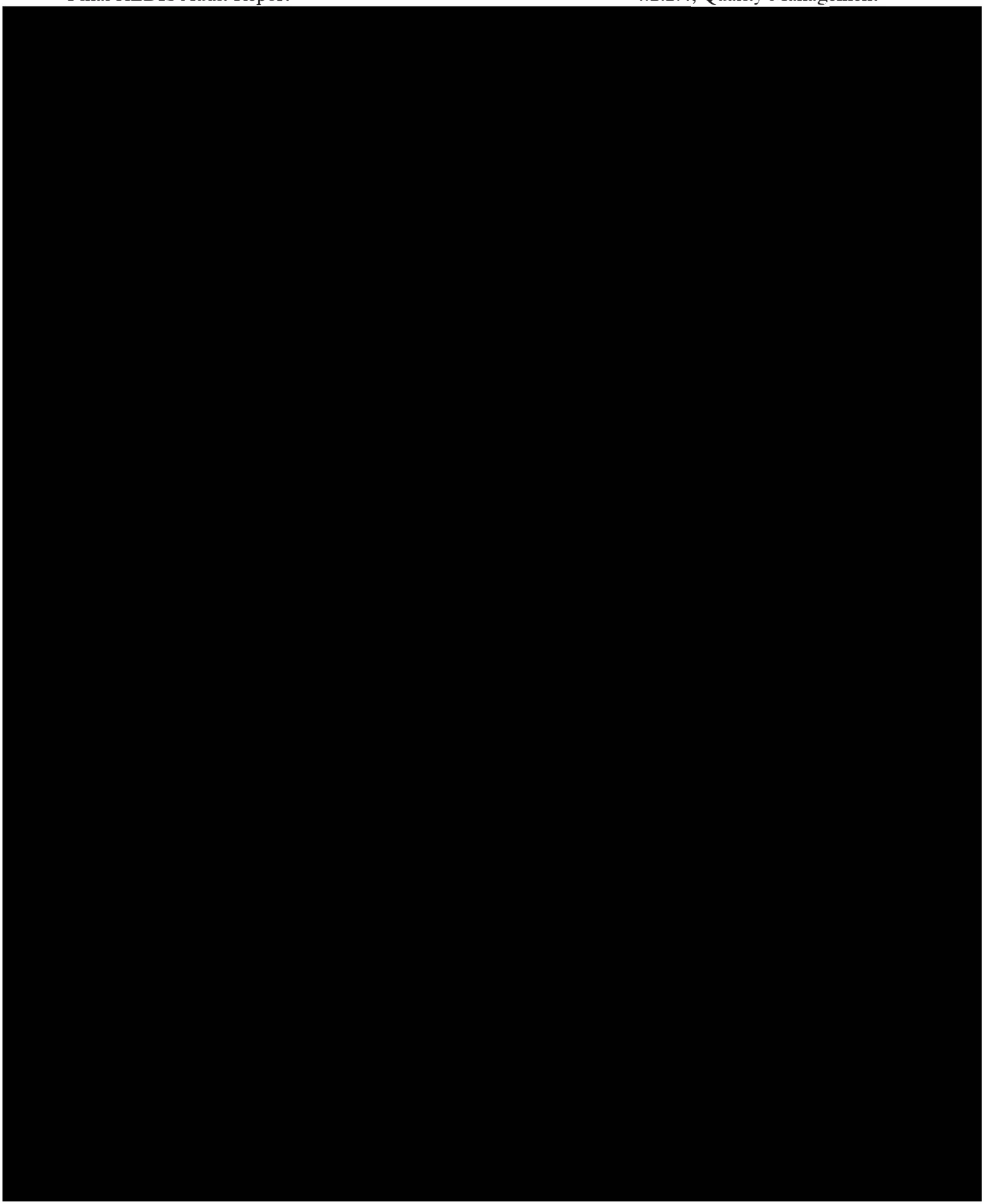
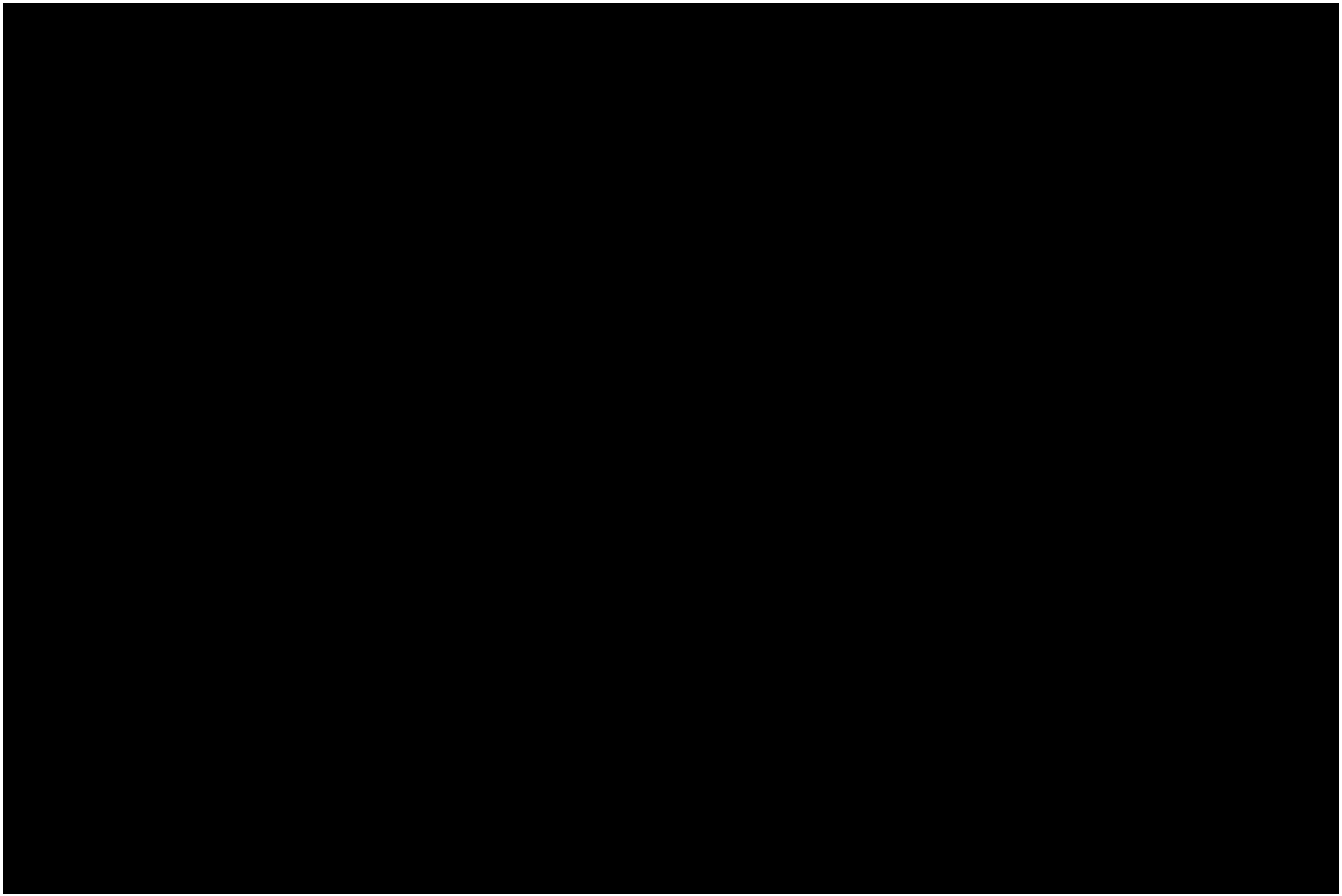
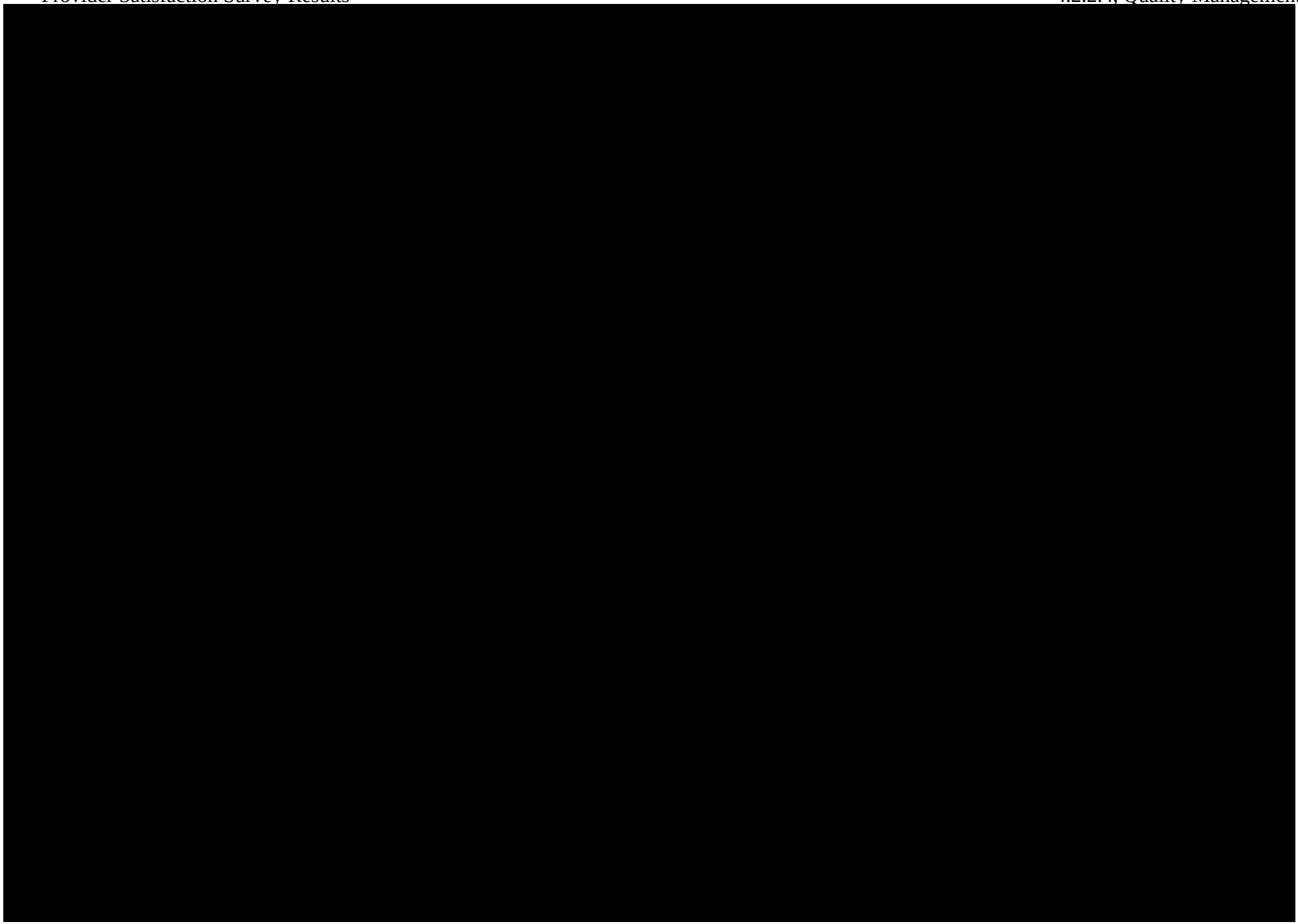
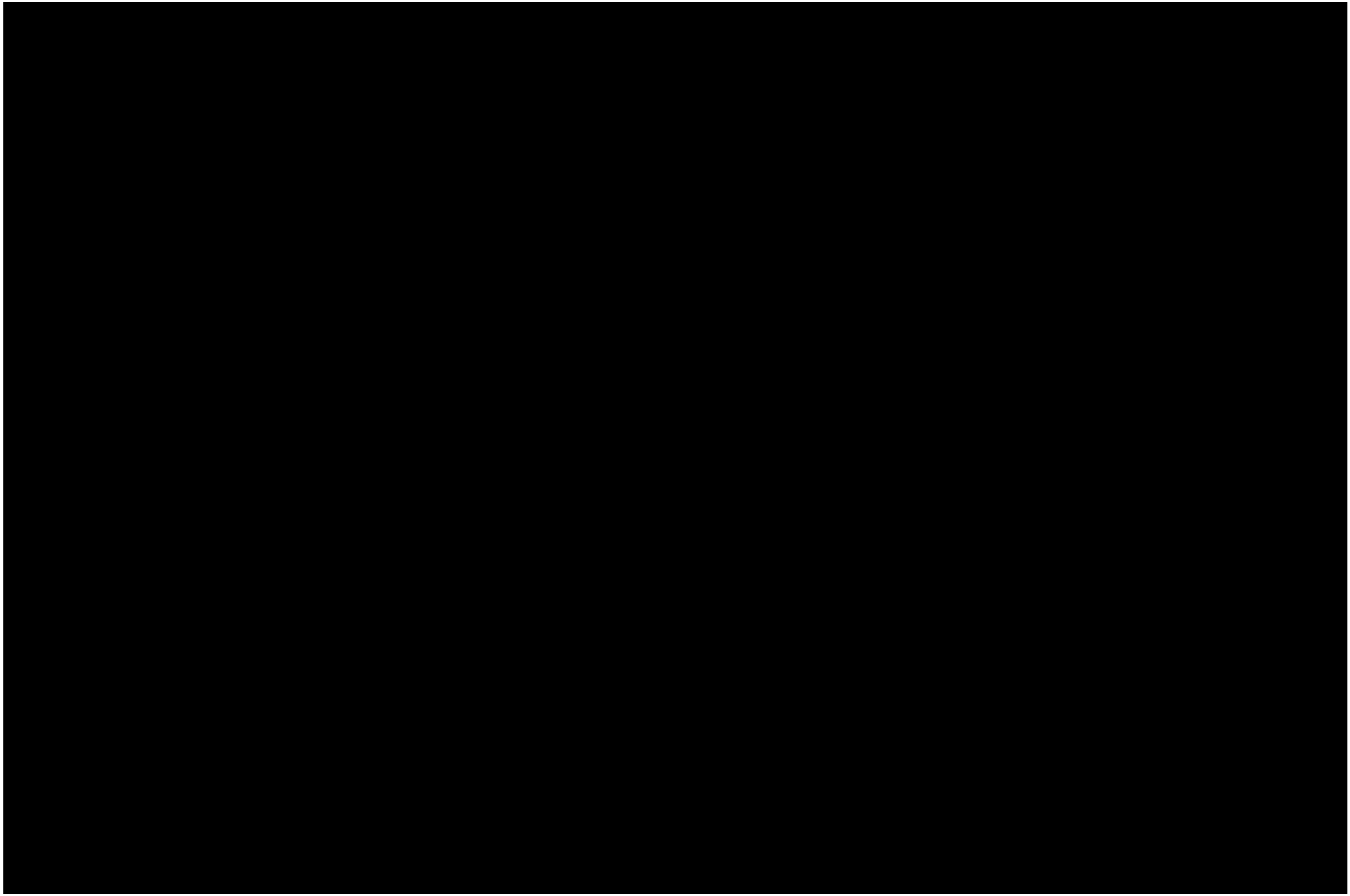
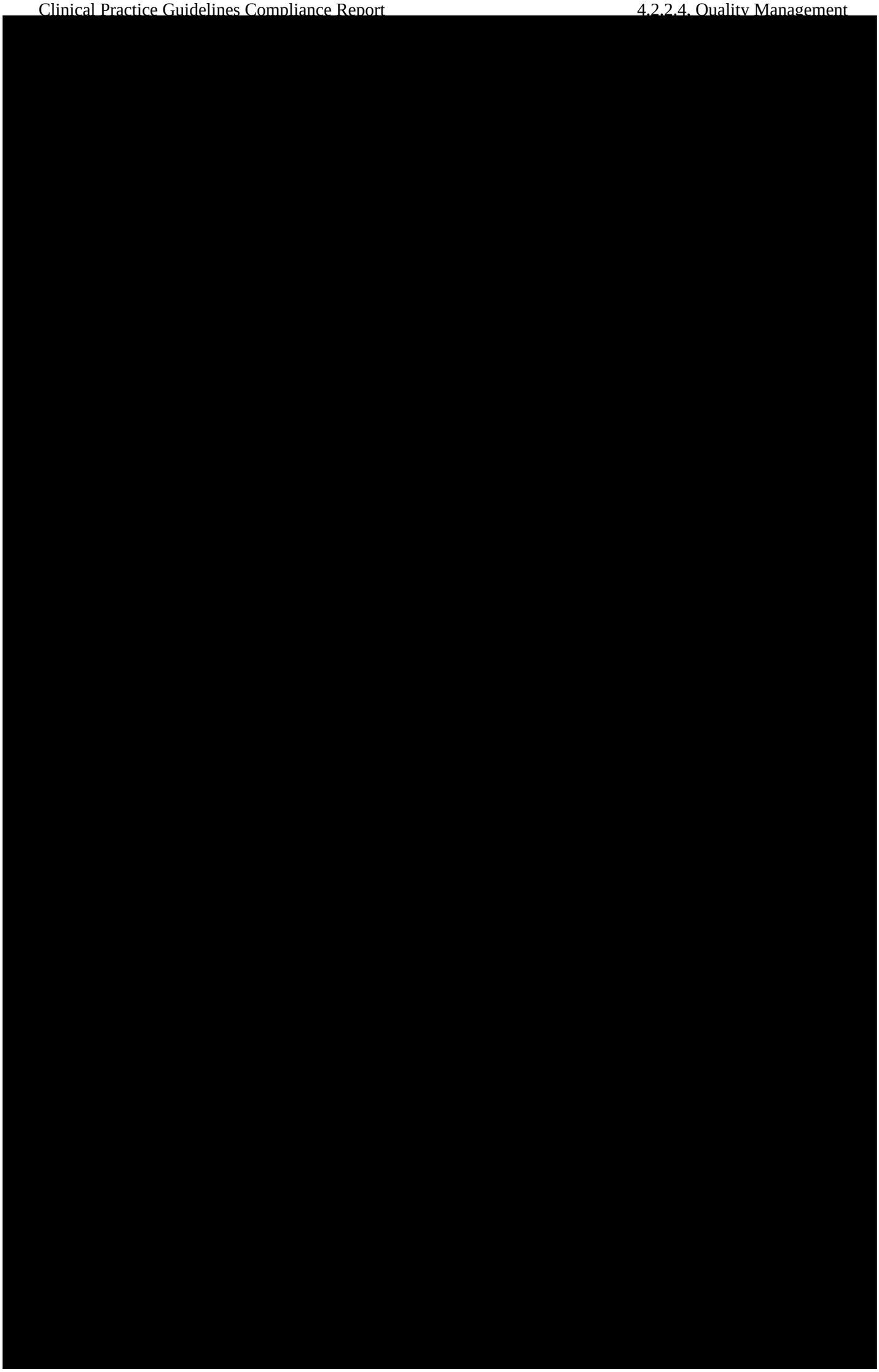
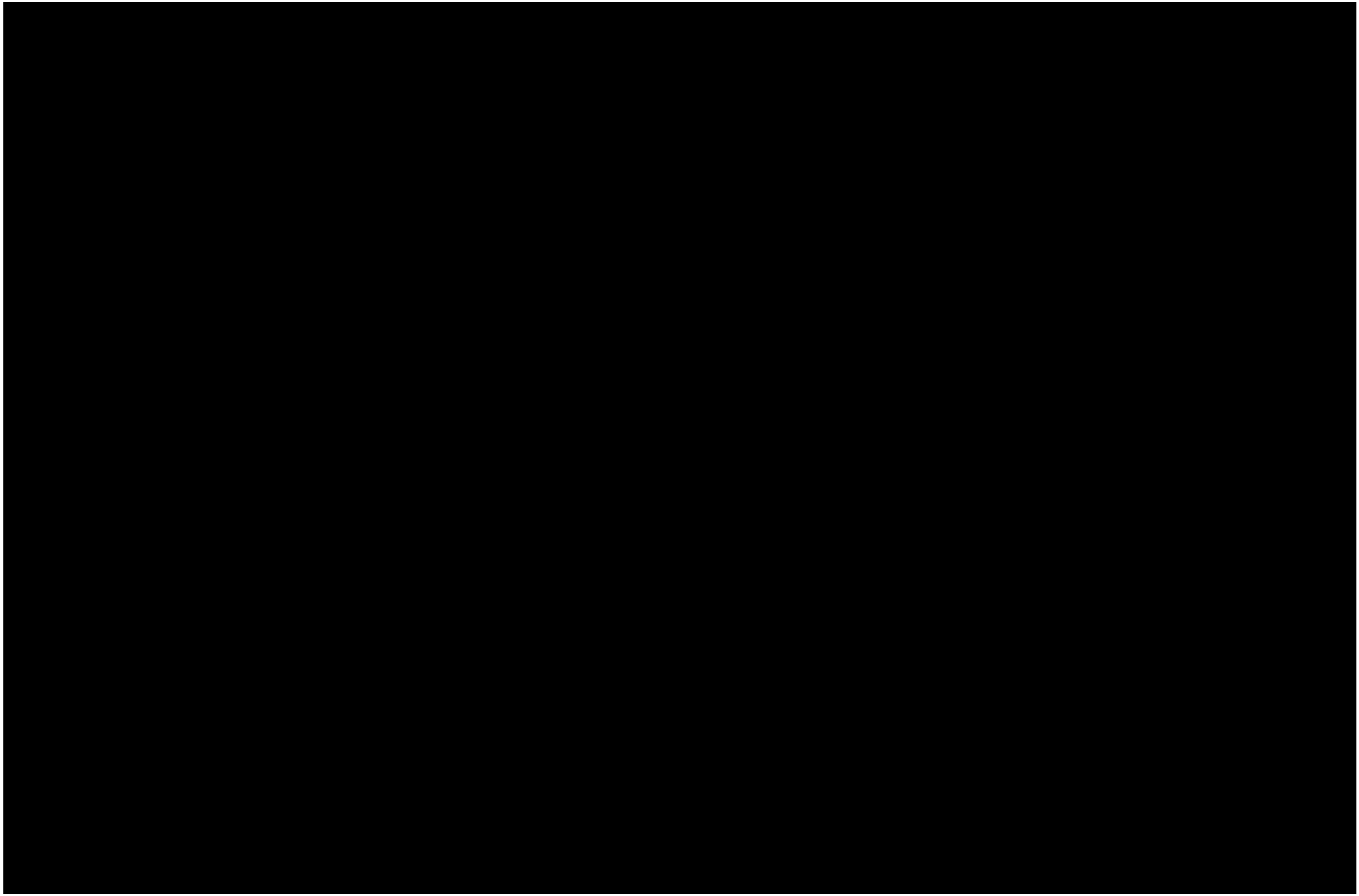


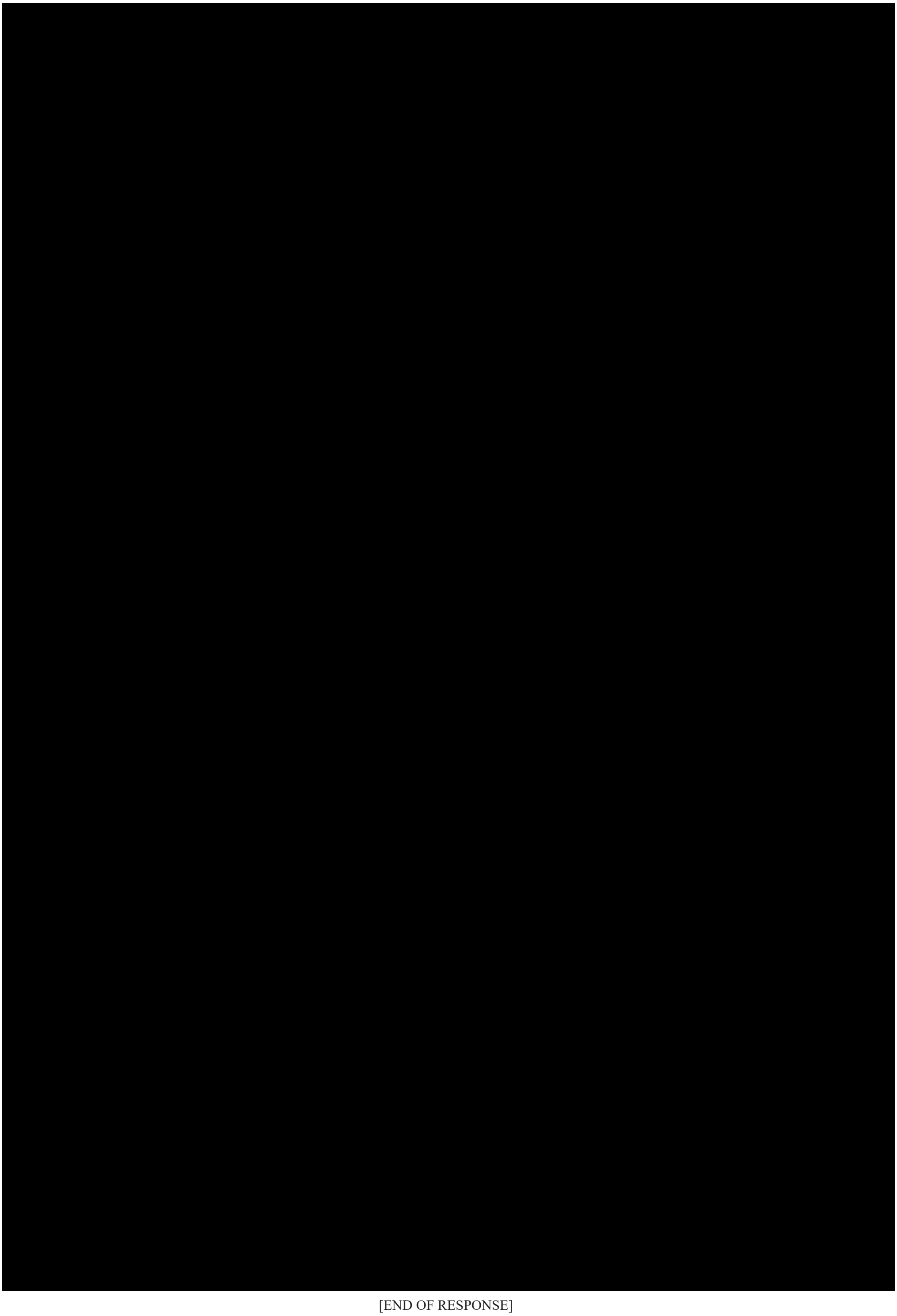












[END OF RESPONSE]

4.2.2.5 UTILIZATION MANAGEMENT

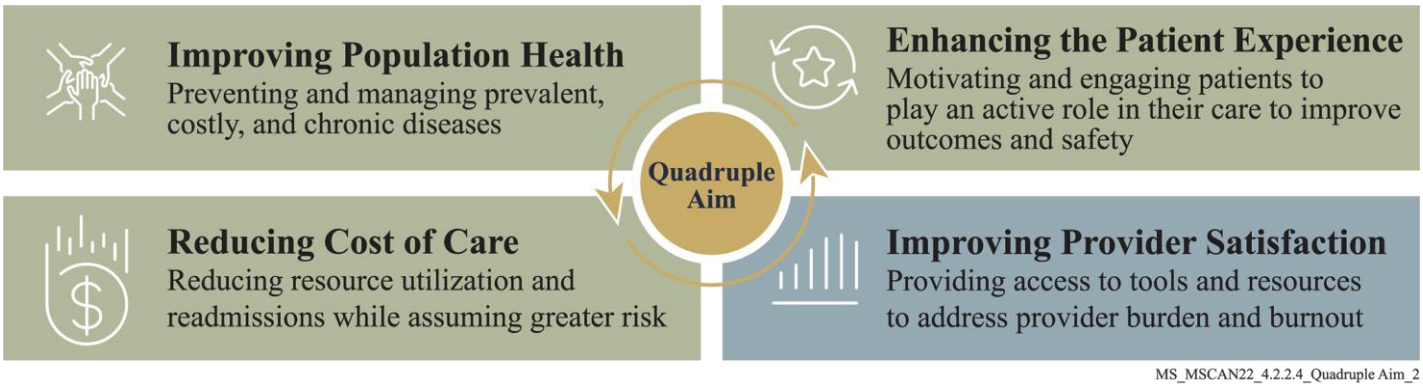
4.2.2.5 A. Utilization Management Approach

4.2.2.5.A.1 Describe the Offeror's proposed approach to utilization management, including:

Our utilization management (UM) approach aligns with the **Quadruple Aim framework** (Figure 4.2.2.5_A) highlighting provider satisfaction and experience as key factors in optimizing health outcomes for our members. In addition to provider satisfaction, we focus our quality improvement efforts on population health, enhancing the member experience, and reducing the cost of care. We will engage Mississippi providers in a fully integrated service delivery model, incenting providers to ensure Mississippians access their benefits so they can live healthier lives and serving as a transparent and effective steward of taxpayer dollars.

Figure 4.2.2.5_A: Our Quadruple Aim Framework

The Quadruple Aim framework guides our utilization management approach.



Accredited by the National Committee for Quality Assurance (NCQA), our program focuses on members receiving cost-effective, evidence-based, medically necessary covered services that optimize health outcomes. We support transparent decision-making, with both member and provider engagement in the authorization process.

Our Collaborative UM Approach Is Person Centered to Enhance the Member Experience

We use a population health approach to improve patient outcomes and decrease costs, including aggregation of patient data across multiple health information technology (IT) platforms, analysis of the data compiled into a single, actionable patient record, and identified actions through which providers can improve both clinical and financial outcomes.

Our integrated UM and CM teams collaborate with providers and members, using real-time and bidirectional data, along with our innovative tools, to facilitate early identification of member needs. Our **unparalleled access to real-time data through connection to a statewide HIE** and interoperability with our providers' electronic health record (EHR) systems improves utilization management, resulting in improved health outcomes and decreased avoidable high-cost utilization. This approach supports seamless access to medically necessary care.

We will monitor, evaluate, and take effective action to identify, and address, needed improvements in the quality of care delivered to members in the MSCAN and CHIP, following all provisions in Appendix A. Our UM staff collaborate with quality management teams to close member gaps in care, including preventive services and care management teams to address social determinants of health (SDOH) and improve member health outcomes. We achieve UM objectives, including member empowerment and member and provider satisfaction, with the program. **Our collaborative partnerships, innovations, and programs will expand access to care and improve member health outcomes.**

Access to Innovative Tools and Resources to Improve Provider Satisfaction

We acknowledge the essential role providers serve in caring for our members. We support the intentional and impactful care our providers continue to deliver to our members by reducing the administrative touch typically experienced by clinicians. We use innovative technology to empower providers with the tools they need to

make decisions at the point of service; this includes tools to expedite reviews and remove administrative burdens. Providers can access our authorization platform using the web-based provider portal as indicated in Appendix A, Section 4.3.1.9. This platform integrates directly with the provider's EHR system enabling a real-time authorization decision. In addition, our automated authorization technology provides authorization for inpatient and select outpatient services. This bidirectional tool facilitates real-time decisions at the point of care, reducing provider administrative burden. Our providers are empowered to access utilization review criteria, directly on our provider portal, increasing transparency in decision-making for covered services. **Our innovative programs and services are proven to consistently improve health outcomes.** In other Medicaid markets, our 7-day and 30-day all-cause readmissions rates are better than the national average of 13.7%: with one market 4.1%; another at, 7.6 %, and a third at 11.0%.

We value the insight from our provider network and take pride in the transparent relationships we have established. Our sophisticated analytics are available to our providers, through monthly reports and data on-demand, highlighting their performance. We hold quarterly joint operating committees with high volume providers where we discuss trends in over and underutilization. The joint operating committee meetings include our medical director and representatives from our UM, quality management (QM), care management (CM), and behavioral health (BH) teams to ensure alignment and process improvement across all functional areas to improve member outcomes and increase member and provider satisfaction.

We are a coordinated care organization (CCO) committed to changing the trajectory of Mississippi's healthcare system and bringing transformative provider collaboration to Mississippi via **our transparent service delivery model which is fully integrated with most of its providers through real-time bidirectional data exchange**. Our mission is to ensure Mississippians can easily access their benefits through efficient utilization management processes to help them lead healthier lives while we prudently manage State resources.

As demonstrated throughout our response to 4.2.2.5, our UM program meets requirements detailed in Appendix A, Section 8.16 and 4.3.

a. A description of the utilization management program;

Our UM program is an evidence-based model that ensures members receive high quality, cost-effective medical and behavioral health care, and services across the care continuum to optimize their health outcomes. The UM model design complies with all accreditations, regulatory, and contractual requirements, meets fiduciary responsibilities, and facilitates robust communication and partnership with providers and community-based organizations/communities. The integration of the UM program with our comprehensive population health strategy serves to provide an unparalleled data-driven and proactive approach to delivering holistic person-centered care.

The UM program and the work plan are the basis of development for all policies and procedures. They are reviewed, updated, and evaluated annually and adhere to all regulatory, contractual, and accreditation standards and are consistent with the requirements of 42.C.F.R Part 456, 42 C.F.R. Section 438.210 and with Miss. Code Ann. Section 41-83-1 et seq. The UM program includes the appropriate cultural, linguistic, and literacy provisions to address the needs and preferences of Mississippi members through core competency training of staff and providers and offer materials in alternate formats when needs are identified or requested. We provide interpreters or bilingual staff to all members as needed. We bring unmatched accountability to providing cost effective and safe care for Mississippians.

We will submit our UM program description to the Division for review and approval by January 1 of each year. This program contains all 15 components identified in Appendix A, Section 8.16.

The main goals of the UM program include:

- Promoting, monitoring, and evaluating the delivery of high quality, cost-effective care and services
- Identifying alternatives to health care resources when needed such as community-based and government programs and coordinating with local and state agencies
- Analyzing data including reports and surveys to identify opportunities for improvement across the program
- Rendering timely medically necessary UM decisions by consistent application of evidence-based criteria and availability of resources and benefits to improve member outcomes
- Monitoring and improving provider and member satisfaction
- Providing education to providers and members to achieve optimal health outcomes

Structure and Accountability

Our UM program structure will be comprised of a multidisciplinary team of Mississippi-licensed physicians, pharmacists, registered nurses (RNs), BH professionals, licensed practical nurses (LPNs), allied health professionals, and non-clinical support staff. All UM staff receive training at hire and on an ongoing basis on MSCAN and CHIP, trauma-informed care, and social determinants of health (SDOH), in addition to their job specific training to interpret and apply the UM criteria, practice guidelines, and other UM required activities.

Our expert staff, who are MCG certified (certified users of nationally recognized evidence-based criteria), represent both physical and behavioral health specialties. These highly trained Mississippi licensed clinicians administer exceptional UM expertise by consistently applying nationally accepted guidelines for all UM decisions, including authorizations, prior authorizations, and retrospective prepayment reviews within the state mandated turnaround times. They conduct timely reviews of all requests, from providers or members, to determine if the covered services are appropriate and accessible and achieve positive member outcomes. Any requests that are not approved by these qualified health professionals will be referred to our Mississippi licensed medical, behavioral, and/or dental directors.

This UM structure has resulted in our exceptional member satisfaction with UM activities, evident through the results of our Consumer Assessment of Healthcare and Provider Systems (CAHPS) 2020 survey that demonstrated excellent results for ease of accessing care timely.

UM Program Enhances Member Experience

- In another market, 95.7% of adult members were satisfied with obtaining care as soon as needed.
- 91.5% of adult members were satisfied with obtaining care quickly.

Our dedicated full-time Mississippi UM coordinator directs the activities of the UM department; this includes review of staff performance regarding prior authorization (PA); medical necessity determinations; concurrent review; retrospective review; appropriate utilization of health care services; continuity of care; care coordination; and other clinical and medical management programs.

Our Mississippi medical director is a board-certified physician who will have oversight of all clinical programs. We also employ a BH medical director who will oversee BH utilization management. This cross functional oversight of all programs ensures alignment and adherence to our population health model. These medical professionals will also oversee the development of all clinical policies that are governed through the UM/CM committee.

The UM program leadership monitors services provided to members through providers and ancillary quality programs with outcomes that they report to the UM/CM committee, and quality management and improvement committee (QMIC). The Medical Director will conduct an annual evaluation of all aspects of the program including structure, policies and procedures, and sources used to determine medical necessity. Evaluation also includes how UM assesses member and practitioner satisfaction with its process for determining coverage and satisfaction with service.

Process Standardization for Optimal Decision-Making

Our UM review process is rooted in evidence-based practice to ensure appropriate application of medical necessity criteria and utilization review that complies with Appendix A, Section 4.3.1.1. On receipt of a request

for a specific service, we verify member eligibility, plan benefits, and PA requirements to confirm whether the request should be forwarded for a medical necessity review. Our UM staff determine whether a covered benefit or service is medically necessary, based upon an individualized assessment of the member's medical and BH needs, using a hierarchy of guidelines and valid and reliable clinical evidence and/or consensus among medical professionals. UM staff follow the hierarchy of federal and state mandates, as follows:

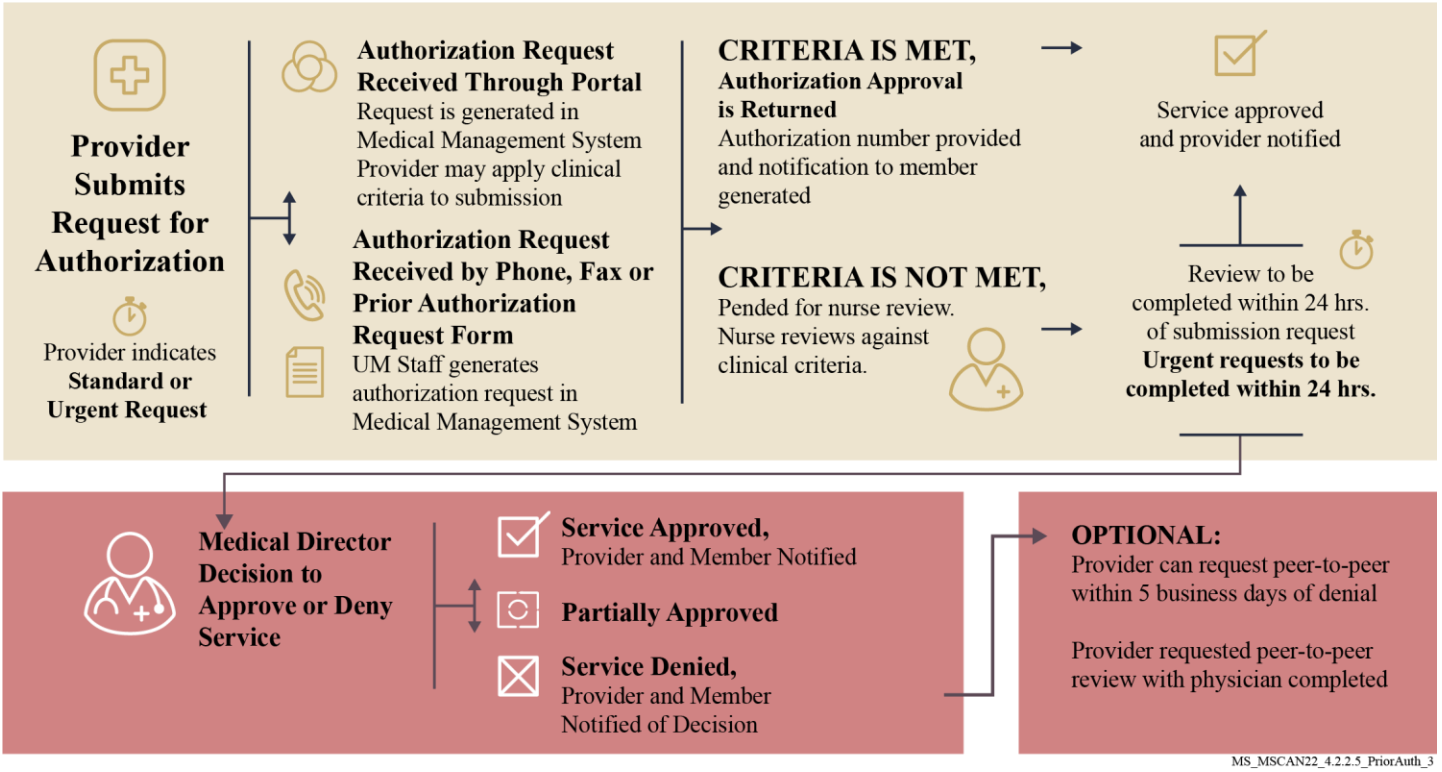
1. Mississippi Administrative Code
2. Mississippi Division of Medicaid Guidelines
3. Mississippi CCO contract
4. Clinical Practice Guidelines and Clinical Policies
5. MCG® Medical, Pediatric and Behavioral Health Guidelines
6. American Society of Addiction Medicine (ASAM) Guidelines
7. Peer-reviewed literature, Hayes, Professional Society Consensus

We follow internal protocols to ensure consistency in decision-making. We do not render denials or reduction of services solely based on diagnosis, type of illness or condition. Our clinical medical necessity criteria are never more restrictive than the state's fee-for-service criteria and guidelines. While we endeavor to contain costs by ensuring the cost effectiveness of services, we do not and will not refer members to publicly supported healthcare resources to avoid costs. We do not structure compensation to individuals or UM entities to provide inappropriate incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

We conduct authorization and prepayment review, which includes two levels of review in accordance with Appendix A, Section 4.3.1.4. Requests requiring clinical review, as demonstrated in Figure 4.2.2.5_B, are completed by an actively Mississippi-licensed, experienced, and appropriately trained clinical reviewer, and/or the medical director. Only licensed physicians can deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested based on the member's medical, BH, and/or long term and supports needs, and as outlined in Appendix A, Section 4.3.1.6, and Miss. Code Ann. Section 41-83-81.

Figure 4.2.2.5_B: Utilization Review Process Flowchart

Our prior authorization process ensures a positive member experience.



Fully Integrated UM/CM Platform
Our UM team uses a comprehensive, fully integrated clinical platform to house all UM, pharmacy, and CM data. This platform interfaces with our claims system allowing UM staff a comprehensive view of the member's clinical picture. A clinical reviewer with the appropriate credentials, e.g., medical doctor (MD), RN, reviews all records relevant to an authorization request, documents the medical necessity determination, notifies the member and provider, and signs the documentation all within the clinical platform.

Notifications
For requests that are not given an immediate determination through auto-auth and for fax requests, we follow federal, state, and NCQA decision and notification timeframes for all UM determinations, including prior authorizations and appeals. When regulatory and accreditation criteria differ, we adhere to the stricter timeframe requirement. Once we make an authorization determination or deny all, or part of, any service requested by a member or provider as a prior authorization, appeal, or expedited appeal, we notify the member and provider in writing. We comply with 42 C.F.R. Section 438.210 (b)(3), Miss. Code Ann. Section 41-83-31 and Appendix A, Section 4.3.1.6 regarding denials.

Peer-to-Peer Review
After an adverse determination, we offer providers a peer-to-peer consultation to better understand the member's needs and ensure access to appropriate and timely care. We provide opportunity for the provider to discuss the UM determination of a denial or a reduction of services, with a medical director within five business days after a service authorization letter is received. **The peer-to-peer process is independent of the appeal process and does not impact the timeframe by which the member and/or provider must appeal.** When the original medical director is not available at the provider's requested time, the discussion is scheduled with another available medical director to ensure a timely response. The medical director contacts the requesting provider or other authorized agent at the requested date and time. If the medical director upholds the determination (in whole or in part), the medical director informs the provider of the right to file an appeal. We perform predetermination peer to peer consultations to ensure all clinical information is obtained when clinically appropriate, i.e., when there are no criteria for the service requested.

Retrospective Review
We have established procedures to receive retrospective review requests within 60 days of the service date and conduct prepayment reviews. We routinely analyze all authorizations retrospectively to identify areas of high and low utilization and key drivers for aberrant utilization patterns, as identified in Appendix A, Section 4.3.1.7. We also use retrospective review data to inform our annual review of prior authorization services. We ensure the completion of determinations for retrospective reviews within 30 business days of receipt. In addition, during our utilization analysis, we submit potential cases of fraud waste and abuse (FWA) involving providers or members to our program integrity for investigation. We communicate opportunities for member education through engagement with care managers, on our website, through emails, or by letters. We use these reviews to identify members with chronic conditions who we refer to our disease management program for education and provision of self-management tools to foster greater self-sufficiency in managing their condition. Our transparent service delivery model is fully integrated with most of our providers and offers real-time bidirectional data exchange.

Inter-Rater Reliability
Our clinical quality management (CQM) team completes comprehensive and unbiased quality review audits each month on randomly selected UM, BH, and pharmacy denials and appeals for compliance with the NCQA UM file review standards. We complete and score audits using the NCQA file review workbooks. We provide immediate feedback and education via email to the individual contributor and their leader for errors given so steps can be taken to mitigate risk areas identified.

Each month, we prepare statistical reports (Aggregate Summary, SKU Report, Completed NCQA File Review Workbook, Top 3 Errors Report, and NCQA Must Pass Report) and analyze the results to uncover trends and

common errors. The CQM team shares this information during hosted monthly file review meetings with the leadership of each business area. The CQM team also shares quarterly aggregated data at the Mississippi QMIC which provides full transparency of all audit findings.

Program Evaluation

We evaluate our UM program annually, and our evaluation outlines the UM program accomplishments and barriers to meeting the program goals. We will submit a copy of our annual evaluation to the Division. The UM work plan outlines action items in place for the department throughout the year to assist in meeting annual goals. The goal outcomes are provided throughout this evaluation, along with opportunities for ongoing improvement. The UM program evaluation provides a written analysis of the effectiveness of activities of the UM program throughout the year. A multidisciplinary team re-evaluates initiatives and goals annually and throughout the year to evaluate successes and additional opportunities. The quality enterprise committee reviews and approves all initiatives and goals.

b. Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures;

Our UM policies and procedures define the administration of our UM program, and we update them at least annually or more frequently, when needed. Our UM/CM committee is first to review a policy and procedure, followed by the QMIC. We build UM tools to make decisions that exceed timelines required, and when able, support member and provider needs for increased efficiency and transparency using authorization automation, the provider portal, and documentation standards. Our UM policies follow federal, state, and NCQA decision and notification timeframes for all UM determinations, including prior authorizations, continuing authorizations, emergency admission reviews, retrospective reviews and appeals, including those outlined in Appendix A, Section 4.3.1.10. When regulatory and accreditation criteria differ, we adhere to the stricter timeframe requirement.

Policies and Procedures

Our UM program maintains written policies and procedures to guide clinical determinations and ensure clinical guidelines are applied consistently and uniformly in all medical necessity determinations in accordance with 42 CFR 438.210(b). Our UM program has developed and currently uses policies and procedures that we share with the Division, meet all NCQA standards, Appendix A, Section 4.3.1.10; and include appropriate timeframes for verbal and written notifications:

- Completing initial requests for prior authorizations.
- Completing continuing authorizations in accordance with Appendix A, Section 4.3.1.2.
- Completing initial determinations of medical necessity, including organ transplants.
- Completing retrospective reviews within three business days.
- Accepting prior authorizations for 90 days for members' transitions of care from another CCO.
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per state law.
- Notifying providers and members in writing of our decisions on initial prior authorization requests and determinations of medical necessity, including emergency admission reviews within four hours, nonemergency admission reviews, weekend, and holiday admission reviews within one business day.
- Notifying providers and members of our decisions on appeals and expedited appeals of PA requests and determinations of medical necessity.
- Notifying providers and members in writing or verbal for services other than inpatient hospital services as outlined in Appendix A, Section 4.3.3.

Development: Our Mississippi medical director has oversight for our UM program, including the development, implementation, and monitoring of compliance with UM policies. Our medical director oversees the development of all clinical policies that are governed through the UM/CM committee, provides clinical and administrative oversight for the UM program, and ensures compliance with federal and state requirements. The

medical director has oversight of UM policies, reports on effectiveness of these policies through key performance indicators (KPIs) and programmatic auditing and recommendations for changes, as needed.

Implementation: UM staff receive training on our UM policies and procedures upon hire, refresher courses, and annually. Supervisors work individually with UM review staff to ensure appropriate implementation for these policies.

Monitoring: To ensure compliance with requirements, we track metrics, including volume and turnaround times. Metrics are analyzed to identify accuracy of data entry, positive and negative trends, opportunities for education or other improvements. We report this information to the UM/CM committee monthly and to the QMIC quarterly. As discussed in more detail in the following, we also confirm consistent and appropriate clinical determinations and documentation between UM staff, pharmacists, and physician reviewers through ongoing audits and inter-rater reliability (IRR) activities.

Our UM program adheres to all relevant federal/state regulatory requirements, state contracts, NCQA accreditation standards, provider contracts and the standards for BH UM including the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Our UM program uses the same processes for medical and BH services, ensuring parity and we comply with Appendix A, Section 8.16, and Section 4.3.

c. Data sources and processes to determine which services require Prior Authorization and how often these requirements will be re-evaluated;

Our prior authorization workgroup includes representatives from all stakeholders in multiple departments across the organization and is tasked with reviewing authorization requirement appropriateness, over- and under-utilization of services, determination rates, cost of services and clinical efficacy of services. The workgroup reviews challenges related to changes, compliance requirements, and oversight of the end-to-end process for changes. They also review all current procedural terminology/healthcare common procedure coding system (CPT/HCPCS) codes for appropriateness of a PA requirement, both for existing and new codes.

The prior authorization workgroup receives suggestions for changes to the list and analyze and assess the potential impacts of the change. Impacts include consideration of regulatory requirements, historical utilization, approval rates (if an existing requirement), impact to the overall health of our member, and other overall impacts to the enterprise. Once the workgroup completes the analysis, they vote to finalize determinations. They take appropriate steps to ensure the configuration of PA recommendations, updates to the PA look up tool, notification to providers and members as needed, and impacted departments receive information about the changes. The workgroup chairperson, or designee, follows all necessary actions to ensure completion of all requirements for implementation of PA decisions.

Outside of standing review, any of the workgroup members can bring suggestions for ad hoc changes that are analyzed and determined through the workgroup. Our prior authorization workgroup regularly re-evaluates PA requirements and potential need for updates.

d. Process and resources used to develop utilization review criteria;

Our utilization management process is grounded by evidence-based practice and standardized decision-making. We review, on an annual basis, nationally and locally developed guidelines to assess for accuracy and relevance to current scientific literature; if changes are present, we review and revise on a more frequent basis.

To ensure consistency with evidence-based guidelines and industry best practices, we consult our provider advisory committee (PAC), composed of Mississippi practicing network providers. Pursuant to 42 CFR 438.210(b), the PAC reviews, makes recommendations, the clinical guidelines used to make medical necessity determinations.

Our clinical criteria consider the needs of members, and providers review the criteria annually at our PAC. The criteria reflect current clinical principles and are evaluated and updated at least annually by our medical director and UM clinical staff. Our criteria comply with Appendix A, Section 4.3.1.1. We will submit our criteria to the Division for approval annually.

Resources to Develop Utilization Review Criteria
We use nationally accepted and adopted evidence-based criteria developed by specialty organizations, national policy committees, industry recognized review organizations, and Mississippi Division of Medicaid and administrative codes, state or federal criteria or regulations, such as medical policy or internally developed criteria. We also consider physician, pharmacist, and clinician judgment to evaluate the necessity of requested medical services.

We develop clinical policies when evidence-based guidelines are unavailable, unclear, or inadequate to determine medical necessity. We develop policies in accordance with state and federal regulations and based on valid and reliable clinical evidence or consensus among clinical professionals in consideration of member needs. We will obtain approval by the Division prior to implementation and communicate to network providers 45 days prior to the effective date of the policy.

We employ a formal committee to evaluate and address new developments in technology and new applications of existing technology for inclusion in our benefit plan to keep pace with changes and to ensure members have equitable access to safe and effective care. Our medical technology subcommittee evaluates new or emerging technologies, product, or equipment innovations, which represent progressive developments for advancements within the medical field. The subcommittee conducts a quality and safety assessment of the proposed technology. The subcommittee participants include medical directors, pharmacy, and quality staff who review the evidence behind the emerging technology or equipment, including a review of information from appropriate government regulatory bodies, and a review of information from published scientific evidence, such as articles in peer reviewed literature and recommendations from professional societies.

We review nationally and locally developed guidelines annually to assess currency with the scientific literature and national trends. If the scientific trends or literature changes prior to the annual review, we review and revise guidelines more frequently, as needed. To ensure consistency with evidence-based guidelines and industry best practices, we consult our PAC for review.

e. Expected Prior Authorization clinical criteria by program area;

UM staff follow the Division and state administrative rules, regulations, and guidelines for medical necessity coverage and state or evidence-based PA clinical criteria as outlined in the hierarchy used in response to 4.2.2.5.A.1.a. We follow internal protocols to ensure consistency in decision-making and to avoid denials or reductions of required services solely based upon diagnosis, type of illness, or condition. The UM staff reviews all requested services that require prior authorization for medical necessity based on a hierarchy of clinical criteria and guidelines.

MSCAN Prior Authorization Clinical Criteria
We use MCG, clinical practice guidelines, and internal clinical policies for PA for MSCAN members**.** MCG criteria are noncompany customized versions of evidence-based guidelines reviewed annually by clinical editors. We use MCG’s acute inpatient, skilled nursing facility, acute inpatient rehab, long term acute care facility, and BH inpatient criteria, in addition to other outpatient criteria sets. We also use ASAM Criteria. These criteria provide practitioners and UM reviewers an educational tool for the treatment of substance use disorder (SUD) in consideration of the needs of the whole person. ASAM criteria includes discussion of treatment direction and goal setting to support outcomes.

CHIP Prior Authorization Clinical Criteria
We use pediatric relevant MCG Care Guidelines for CHIP members, along with our clinical practice guidelines, and internal clinical policies for PA. These evidence-based guidelines include inpatient and surgical care guidelines (including guidance for neonatal levels of care, common medical diagnoses, and surgeries such as appendectomy, and tonsillectomy) and pediatric relevant ambulatory care guidelines for outpatient care.

f. Process for regularly reviewing Prior Authorization requirements for their effectiveness and potential need for updates;

Our prior authorization workgroup reviews PA requirements and potential need for updates. The workgroup collaborates with our internal provider representatives who bring PAC recommendations to the group and reviews prior authorization codes to reduce practice variation and appropriateness of care and safety. These reviews are also based on Mississippi and national utilization data reviewed at least annually. Through thorough analytical review and input from our PAC, we continually review services that require a PA to reduce administrative burdens and facilitate prompt delivery of services. Using this process for a similar program, we removed **hundreds of authorization codes in 2021**, including home management of gestational diabetes and deep muscle biopsy. Analysis of our utilization data revealed that the rate of approval for these services was high and utilization upon retrospective review was appropriate, so PA for these services was determined to be unnecessary.

g. Prior authorization processes for Members requiring services from non-participating Providers or expedited Prior Authorization;

We ensure appropriate and high-quality care delivery for our members, and we provide the following approach when care outside our network is requested. In instances when a member receives services from a nonparticipating provider, our UM team:

- Approves services from a nonparticipating provider when continuity of care applies.
- If there is not a participating provider in the member's area, our UM team reviews the request for medical necessity and then follows the same review process for contracted and noncontracted providers.
- UM frequently engages with our provider network team to decrease service area gaps.

Our claims system automatically honors authorizations for new members receiving services from noncontracted providers for the first 90 days following enrollment, except members who are pregnant, where authorizations are approved until delivery. To facilitate smooth transitions and continuity of providers, treatment, and medications for new members, this authorization period enables us to preserve provider member relationships, particularly for those members in rural areas or with complex conditions.

Our Provider Services and Compliance teams continually collaborate and review nonparticipating provider claim submissions, noncontracted provider authorization requests, and any member grievances, to identify opportunities to enhance the network composition.

Nonparticipating providers have limited access to the provider portal; however, they can view member eligibility and claims status information. Nonparticipating providers can also view general operational information about policies, procedures, clinical guidelines, educational materials, newsletters, and other nonmember information from the portal, as well as our provider focused website. Regardless of their contract status, we offer these providers access to information about Mississippi specific programs, policies, and procedures.

Expedited Prior Authorization Process

For situations in which a provider indicates, or we determine, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, we provide an expedited authorization decision and notice no later than 24 hours after receipt of the request for service. We extend the 24 hours by up to 14 calendar days if the member requests an extension or we justify a need for additional information and how the extension is in the best interest of the member.

Our innovative auto-auth system, part of our fully integrated service delivery model, enables most PA requests to receive an expedited response. When providers attach the relevant clinical documentation to each PA request and submit it through the auto-auth system, the system sends an expedited, often immediate, response. Through a customized rules engine, auto-auth matches MCG criteria to the clinical information to authorize the procedure or admission automatically.

h. The Offeror's approach to reducing the number of Prior Authorizations required;

Reducing PAs to benefit the member and reducing the costs of requesting PAs for providers is our goal. To reduce the number of PAs required, we continually review services that require a PA using the process detailed in response to 4.2.2.5.A.1.c. We use retrospective review data to inform our annual review of PA services. The Prior Authorization Workgroup (PAW) reviews suggested PA removal provide analysis and the potential impacts of the change. Workgroup members bring suggestions for ad hoc changes and the workgroup analyzes these recommendations and determined through the workgroup.

i. How the Offeror will ensure that Prior Authorization does not delay treatment in an emergency; and

Emergency services are always available to our members without an authorization. We have established procedures to receive Emergency Admission Reviews notifications postadmission for admissions that are not planned or elective. **We ensure determinations for emergency admission reviews are completed within 24 hours of receipt of 98% of the time**. We provide all inpatient and outpatient emergency services in accordance with 42 C.F.R. § 438.114 for MSCAN and CHIP members. We cover and pay for emergency medical services, including, but not limited to, dialysis and dialysis access services, regardless of whether the Provider that furnishes the services has a contract with us. We comply with Appendix A, Sections 4.1.1. and 4.3.2.1. Our provider contracts require that providers give us notice regarding the use of noncontracted providers for emergency services. Such notice requirements shall provide at least a 48-hour period after the emergency services for notice.

Automation Improves Provider Access and Removes Administrative Burden
We acknowledge that provider partners may view some traditional UM processes as administratively burdensome, so we invest in automation and technology to support efficiency and timely authorization responses. Our fully integrated service delivery model enables providers to submit requests for service authorizations through electronic transmission. Through our Health Information Exchange (HIE) program, we offer real-time bidirectional data sharing focused on positively impacting health equity and member outcomes.

Prior Authorization Lookup Tool: Our web-based PA lookup tool allows providers to verify if a procedure code requires a PA. The information available to a provider is connected to our claims system so the provider can view how claims are currently paid. Through the PA lookup tool, we have reduced unnecessary authorization submissions relieving the administrative burden for our providers and allowing our members to receive quality care without delay.

Provider Portal: We encourage providers to utilize our provider portal for submissions of authorizations and concurrent and retrospective review requests electronically. All physical, BH, inpatient, and outpatient services may be requested through the provider portal. The portal is the central source for the coordination of all aspects of a member's care. Providers can submit all requests and notifications through the provider portal. Through transparent, bidirectional data sharing, providers have immediate access to view status for all submitted requests and may request updates to authorizations, including requests for continued stay review, discharge notifications, and date change requests.

Auto-Authorization: We were one of the first health plans to adapt this technology platform. Our automated technology reduces the administrative burden on our providers and facilitates faster determinations.

Our online portal requests through auto-authorization further enhance the provider's ability to obtain authorizations as quickly as possible. Determinations can be given in real-time when MCG criteria or other selected criteria are met. The auto-auth automation tool allows us to customize rules based on unique criteria allowing providers to submit requests and receive automated approvals in real-time. This means that providers can receive instant approval to implement the plan of care, and

AutoAuth Success

In another market Provider Auto-Auth use improved by 53.3% from May 2020 to May 2021.

The PA approval rate improved by 74.2% from August 2020 to May 2021.

our members receive care without the delay of waiting for an authorization from their insurance company. Our investment in auto-auth automation allows for real-time communication between our plan, providers, and members. Our real-time bidirectional data sharing strategy is focused on lessening provider burden.

Collaborative Platform: We offer the unique ability for providers to communicate in real-time with us using their EHR system. A healthcare provider will submit an authorization request or inpatient notification directly to us from their EHR, and the request is brought into our care management system. In turn, we (with auto-auth and our collaborative platform) can create customized rules to send an approved (or pended) decision to the provider electronically. The software also allows us to update pended reviews with additional information and/or an updated status, and for both us and providers to continue communicating beyond the initial review to the concurrent review. Through collaborative care, we achieve alignment in healthcare delivery through evidence-based practices and support maximum workflow efficiency.

278 N/R Transactions: We expanded automation capabilities using 278 transactions which provide a comprehensive approach to admission, discharges, and transfers. Electronic data interchange (EDI) 278N transactions exchange admission notification data between an inpatient facility and us in an industry standard format. The automation of 278 N/R includes real-time creation of a case and response back to the provider to confirm and reference the case identification. We also use this to automate case updates with discharge information.

Provider Representative Support: Our provider representatives support providers as they navigate the tools and resources; we offer to assist providers to streamline the UM process. The provider representative also partners with system configuration, IT, and the provider portal team for process innovation, system automation, and program implementation to support an enhanced provider experience. Through our Health Information Exchange (HIE) program, we maintain a real-time bidirectional data sharing strategy focused on reducing provider burden and positively impacting health equity and member outcomes.

j. Processes to ensure consistent application of criteria by individual clinical reviewers.

We have established protocols to ensure consistent and appropriate clinical determinations and documentation between UM staff, pharmacists, and physician reviewers and in compliance with Appendix A, Sections 4.3 and 8.16. Our UM supervisors oversee and work with staff individually, during team meetings, during rounds, and daily huddles. We also have an audit process to ensure consistent application criteria, as follows:

Internal Audits: Licensed health care professionals, serving as auditors identify opportunities for improvement in the medical determination process. They provide feedback at both the individual level and the group level, as appropriate and report findings up through the UM/CM and quality committees. The UM leadership team in conjunction with the enterprise medical directors coordinate action plans for improvement at the individual and programmatic levels. The quality monitoring review process includes monitoring all related regulatory requirements:

- Appropriate use of clinical criteria and following policies and procedures.
- Ease of members' ability to submit requests, expedited or standard.
- Staff ability to process timely expedited, standard, or extended determinations.
- Review of the number and types of appeals, denials, referrals, and modifications.
- Detailed and timely communications to members according to regulatory guidelines as outlined in the Member and Provider Notification of Initial Determinations.

Education / Oversight: We have a comprehensive evaluation process to review and evaluate consistency in our UM process; including applying established criteria, review of medical policy, and medical necessity review. Our organizational training team provides consistent education and re-education about our UM processes. The leadership team is tasked with internal auditing, staff coaching, and ensuring the performance of quality reviews. Quarterly, we evaluate the consistency and appropriateness in which staff apply clinical guidelines. Semi-annually, physician reviews are evaluated. Should a need dictate, a more frequent review is completed.

Each reviewer applies clinical guidelines to the same factually based scenario and answers questions regarding the case. Reviewers must score 90% or greater to pass their IRR assessment. We require reviewers who fail to meet the minimum passing threshold of 90% to repeat the IRR assessment once within the same testing period. Individuals noted to score below 90% on their first and second attempts are subject to a corrective action plan. We use the results of the IRR testing to identify further training and professional development opportunities. **In a similar program, our UM and medical review staff received an average score of 99.5% for IRR audit results.**

MCG Leadership Quarterly Meetings: We participate in MCG quarterly leadership meetings held to discuss new criteria revisions as well as for the plan to discuss improvements to the criteria. We also make suggestions for new criteria to be developed as new technologies change and identify any staff training needs.

4.2.2.5.B. Methods

We offer proven methods, experience, and innovative solutions to manage unnecessary, or avoidable, emergency room (ER) utilization, avoidable hospitalization, and readmissions. Our fully integrated, transparent service delivery model enables providers to use real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which will bring a new era of provider collaboration to Mississippi. We work collaboratively with the Division and hospitals on the quality incentive payment program (QIPP) to reach quality goals to utilize Medicaid funding to improve the quality of care and health status of the Mississippi Medicaid population.

4.2.2.5.B.1 Describe the methods the Offeror will use to manage unnecessary ER utilization, avoidable hospitalization, and readmissions. Include information regarding how the Offeror will use its telehealth policy in this response, as well as how the Offeror will utilize PCP visits and PCP assignments in its strategy.

Methods to Manage Avoidable ER Utilization

Our methods to manage avoidable ER utilization begin with using advanced data analytics and predictive modeling. Our fully integrated, transparent service delivery model utilizes bidirectional data from care managers in hospitals to identify trends in ER utilization and provider access and capacity challenges and design targeted interventions that address trends and challenges. We collaborate with primary care providers (PCP) and patient centered medical homes (PCMH) to expand access to care. We implement value-based purchasing (VBP) strategies that promote improved health outcomes and facilitate financial support for connections with a statewide health information exchange (HIE). We offer a 24-hour nurse advice line and 24-hour behavioral health crisis line, telehealth solutions, services in retail clinics, and urgent care centers. We leverage community health workers to maximize member engagement and regularly distribute targeted member education that reinforces seeking care in the appropriate setting.

Improvement in effectiveness data

In another market, we saw a 19% improvement in healthcare effectiveness data and information set (HEDIS®) ER utilization per 1000 members from 2018 to 2021. We used predictive methods to identify and outreach members with high ER utilization for potentially avoidable conditions.

Data Analytics and Predictive Modeling: We define members with high ER utilization as those with three or more non-emergent ER visits with no subsequent inpatient admission within 12 months, the most recent occurring within the past 90 days. For all members, we ensure access to real-time admission, discharge, and transfer (ADT) notifications via our connection to the health information exchange. We use ADT data to identify and rapidly engage members and participating PCPs before the member risks high utilization.

Important to our goal of reducing unnecessary ER utilization, we have developed a predictive model to identify members at future risk of ER utilization for non-emergent services/diagnosis or worsening conditions. Each member receives a risk score, which is then made available to care management teams who complete outreach and offer education on accessing the various levels of care and the benefits of participating in care management programs. We update outputs of predictive models monthly at the member level based on demographics, morbidity, and historical utilization.

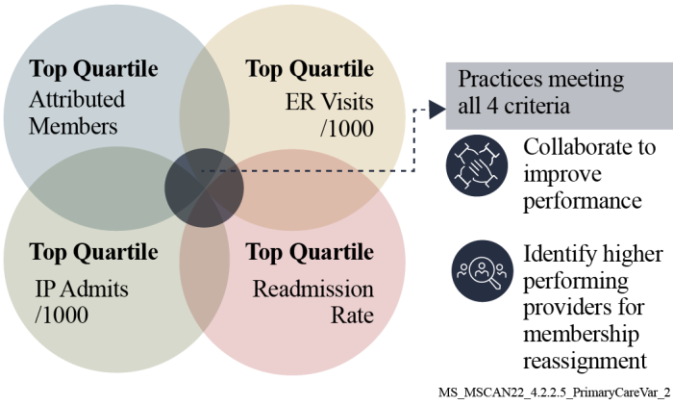
We reach out to members in rising risk situations to determine if they are engaged with their PCP or a PCMH, live in areas with limited access to primary care settings, or have barriers to attending PCP appointments. We offer support through our innovative care management program. **Our innovative programs and services are proven to consistently improve health outcomes for the Division's priority areas.**

We are committed to optimizing our population health strategies, through data analytics, to improve performance and inform our use disease and care management approach. Our Data Analytics team evaluates the data for disease prevalence to help inform performance improvement opportunities. We share geographic analysis of ER utilization patterns with our network operations staff, identifying access and provider capacity concerns. Where applicable, we collaborate with providers to implement pay-for-quality and shared savings arrangements that promote access.

We develop statistically meaningful benchmarks to stratify the performance of provider practices across a variety of metrics. Our approach leverages industry standard risk and case mix adjustment methods as well as stratification based on social determinant of health indices. Our benchmarks focus on quality measures, utilization, cost, and other VBP goals. Custom provider profiles, comparative data visualizations, outlier analyses, and self-service data visualization platforms allow us to actively identify opportunities and support providers by highlighting performance data with benchmarks to improve outcomes and value. For example, we create and run algorithms that cohort providers into peer group clusters and risk adjust the utilization, cost, and quality metrics to create a 360 view of a provider's performance versus their peer group benchmark. Based on analysis, we segment providers into quartiles and illustrate performance opportunities as shown in Figure 4.2.2.5_C.

Figure 4.2.2.5_C: Primary Care Variation Analysis and Opportunities

This PCP analysis monitors practice metrics to reduce ER visits, hospitalizations, and readmissions.



As part of our fully integrated, transparent service delivery model, we share data with PCPs to address members with continued utilization, as well as facility outliers, to ensure oversight and coordination. Real-time communication with ER teams ensures expedited response from the care management team for our highest needs members who have not responded to more traditional ER diversion strategies, including members who may have left the hospital against medical advice.

Afterhours PCP Coverage: To ensure members have access to their PCPs to accommodate their schedules and to avoid ER visits, we require PCPs to:

- Provide 24-hour telephone availability to our members or a backup provider who can triage for care. We do not allow phone messages that do not provide 'live voice' coverage after normal business hours. After hours coverage may include an answering service or a shared-call system with other providers. We use a combination of provider feedback and secret shopper calls to monitor 24-hour availability ensuring the MSCAN and CHIP members are receiving accessible services on an equal basis with the PCP's other patients.
- Have availability to see members at least three days per week for a minimum of 20 hours per week, or any combination of visits at no more than two locations.
- Provide members telephone access to the PCP (or appropriate designee) in English and Spanish 24 hours a day. Providers also have access to interpreter service for threshold languages.

Members can find a provider using our online provider directory tool, the Member Services department, and hard copy provider directories. We understand the Division may provide for a reimbursement rate for physician's services of up to 100% of the rate established under Medicare for physician's services that are

provided after the normal working hours of the physician, as determined in accordance with regulations of the Division, and adhere to this requirement.

Rapid Response Foster Care Team: We developed a 24-hour nurse department that deploys a Rapid Response team which quickly meets the needs of foster care members after-hours. This team is specialty trained to manage issues specific to the foster population and assists in filling the gap for issues related to placement changes. The rapid response team provides prior authorizations (PAs) to assist with facility placement and overrides medication and durable medical equipment (DME) refills to provide needed supplies if they were left behind during placement change. In collaboration with the Division of Medicaid, we implement a rapid response team for each market where we serve children in foster care.

PCP Visits and PCP Assignments: Members who personally connect to their doctor are more engaged in their health and more likely to access care in the appropriate setting rather than seeking primary or preventive care in urgent care or ERs. A member may be assigned to a provider through auto-assignment or self-selection. We offer members opportunity to select their preferred PCP based on needs and cultural and linguistic preferences. We provide members at least two choices of providers and connect members who are at highest risk for care management to PCMHs. For member ease of access, we include PCP and PCMH information in provider directories, providing transportation for appointments, and offering referrals.

Increasing Adoption of Patient-Centered Medical Homes and Health Homes: We recognize the power that PCPs and community BH providers have in improving our members' health and reducing unnecessary utilization. Enhanced access, including after-hours and weekend appointments, and integrated, team-based care that holistically addresses complex conditions are fundamental components of the PCMH or health home. We reward PCMH providers by optimizing our member assignment process to drive membership toward PCMH recognized practices. PCMH practices offer enhanced access, including after-hours and weekend appointments.

Assigning members to a PCP or PCMH ensures members have better access to their providers, which reduces their reliance on emergency settings for non-emergency care outside of providers' traditional office hours. Further, with support from our integrated care management (ICM) team, who are embedded through our regional staffing model, PCMH and health homes facilitate improved member outcomes with ambulatory care sensitive conditions, which reduce avoidable ER visits (e.g., severe asthma exacerbations or diabetic emergencies).

24-Hour Nurse Advice Line: We educate and encourage our members to seek care in appropriate settings by providing real-time clinical support through our nurse advice line. Nurse professionals address and treat symptoms and concerns 24 hours a day via a toll-free dedicated line. Our Nurse Advice Line promotes appropriate ER utilization by providing timely, relevant information necessary to direct our members to the appropriate level of care. We staff our nurse advice line with our nurses, as opposed to an outside vendor, and it is completely integrated within our ICM model. Our nurse advice line offers timely, caring interactions regarding our members' physical, dental, and behavioral health concerns, and solutions to assist with pharmacy. Our triage nurses also connect members to telehealth services in real-time via a warm transfer and help members schedule a telehealth appointment for a later date if they so choose. The nurse advice line offers referrals to care management whenever they identify a care coordination need or concern.

Telehealth Options: Our robust telehealth strategy prioritizes members' existing provider/practice relationships, while leveraging state and national telehealth programs to provide needed care and prevent avoidable ER utilization. By increasing access to primary and urgent care options via telehealth, members can receive the care they need without resorting to the ER, particularly in rural areas and areas with provider shortages. Our internal staff and contracted telehealth vendor providers cover preventive health, urgent care, behavioral health, maternal health, and chronic and/or complex conditions for our members. We direct members to telehealth resources only after in-person primary care routes are exhausted, and we encourage members to seek telehealth services from our network providers, especially PCPs/PCMHs, to maintain continuity of care and treatment. We support and prioritize local providers using telehealth platforms but augment local providers with other telehealth supports. Our efficient, convenient, private, and flexible telehealth access includes:

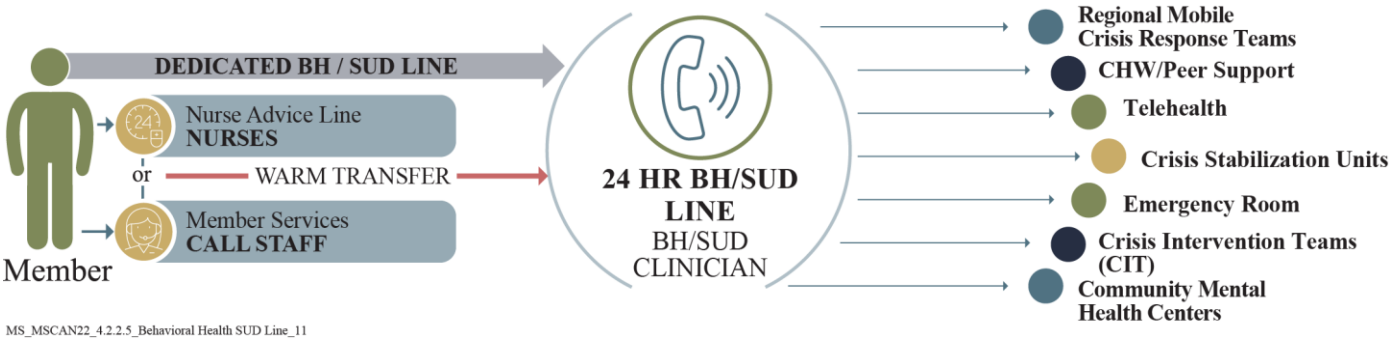
- **Telehealth Visits with PCPs and Other Network Providers:** Our network providers offer telehealth services, and we support their efforts through VBP, training, and telehealth platform accessibility. We work with all network providers to encourage and support them in offering telehealth as an adjunct to office visits for acute, chronic, and preventive services. Members schedule telehealth visits with their providers in the same way they schedule in-person visits. For members who are engaged in care management or community services programs, we can provide tablets or other Internet-ready devices through our member assistance fund. When Internet access is an issue, we help them find alternative locations.

Telehealth Services Offer Members Alternatives to the ER

While less than 1% of our members in another market received telehealth for behavioral health (BH) services before the pandemic, **63% of psychotherapy sessions** used teletherapy in 2020. (Data from another market)

- **Alternative Telehealth Services**: For members, whose providers do not offer telehealth alternatives or members living in rural/remote locations, we provide our nurse practitioner telehealth program and have established relationships with nationally recognized telehealth vendor for medical and behavioral telehealth care.
- **Nurse Practitioner Telehealth Program:** Our nurse practitioner telehealth program increases access to care for acute telehealth services and to close gaps in care, increasing member understanding of and adherence to medication plans, monitoring labs and vital signs, enhancing member knowledge of disease processes, and connecting the member back to their PCP/PCMH. Our Mississippi licensed nurse practitioners view the member's record including outreach attempts, assessments, care plans, PCP assignment, and progress notes in our integrated clinical platform and share information such as updated member contacts.
- **24-hour Nurse Advice Line:** Our 24 hours a day nurse line conducts a warm handoff to our telehealth vendor or the BH crisis line when circumstances warrant. For non-urgent needs, nurses provide information to the member about how they can schedule an appointment with our telehealth platform.
- **Nationally Recognized Telehealth Vendor:** We partner with a telehealth vendor to provide comprehensive virtual services including general medical and BH for urgent care, complex and chronic care, mental health, and specialty care provided by primary care providers, specialists, nurses, and therapists. We oversee telehealth vendor performance by tracking HEDIS outcome measures and member satisfaction, verifying documentation of diagnoses with care of conditions in claims, and monitoring for fraud, waste, and abuse.
- **Retail Clinics:** We partner with large retailers, in Mississippi to offer primary and acute care clinics onsite in their stores.
- **Urgent Care Providers:** We contract with urgent care clinics to provide an alternative to ERs for after hours, non-emergent care. Our network meets or exceeds access requirements for urgent care providers. We educate members on when urgent care clinics may be an appropriate alternative to the ER as a recurring topic in our outreach materials. In addition, our care management teams work to identify and reduce member barriers to access alternative care and direct members to the appropriate level of care.
- **Behavioral Health Crisis Response:** As illustrated in Figure 4.2.2.5_D, we maintain a **behavioral health crisis line** as part of the nurse advice line, staffed by licensed BH professionals 24-hours a day who assist members in crisis situations. When a member in crisis calls the nurse advice line, we warm transfer the member to a BH clinician who triage, deescalate the crisis, and contact the regional mobile crisis response team where the member resides to prevent ER utilization. Access to BH crisis response and the crisis line enables members with BH emergencies to access these services and avoid the unnecessary ER visits. We use our member handbook, website, member services, and care coordinators to educate members about the BH crisis line.

Figure 4.2.2.5_D: Behavioral Health Crisis Line
We respond to members' behavioral health needs through availability of specialty trained clinicians.



We provide additional resources to assist members before their condition becomes a crisis and reduce avoidable ER use. These resources include:

- **myStrength Resource Tool:** myStrength is an online resource tool that members can access at any time. The evidence-based tool incorporates cognitive behavioral therapy and mindfulness techniques to improve emotional regulation and well-being. The tool offers features such as a mood tracker, daily inspirational quotes, and educational videos about depression, anxiety, substance use disorders (SUD), and other BH conditions.
- **NAMI collaboration:** The National Alliance on Mental Illness (NAMI) offers a crisis text feature where a member in crisis can connect with a trained crisis counselor to receive free, 24 hours a day crisis support via text message to 741-741.
- **Mental Health First Aid Training:** We offer Mental Health First Aid (MHFA) training, a national program that teaches skills needed to respond to the signs of mental health and substance use issues, to providers and other interested MSCAN or CHIP members of the community. This includes training nurses and community health workers (CHWs) who have frequent contact with MSCAN or CHIP members and can refer to appropriate resources. These training events build our relationships with schools and the BH provider community and encourage agencies and their clinicians to contact us about their MSCAN or CHIP members who are transitioning to our CCO.
- **Community Health Workers:** CHWs are part of our ICM and who follow up with MSCAN or CHIP members to reinforce access to care options and help schedule appointments and transportation as needed. Our CHWs outreach MSCAN or CHIP members with inpatient behavioral health admissions, as well as medical admissions, to share information and help schedule BH 7- and 30- day follow-up appointments with outpatient providers. CHWs complete a reminder call a day or two prior to the appointment and after the appointment to ensure attendance. They receive training on MHFA and ambulatory sensitive conditions to support member education during outreach.
- **Crisis Intervention Training (CIT):** We support state efforts to expand the reach of CIT training to law enforcement. We partner with NAMI and other stakeholders, including Community Mental Health Centers, to identify priorities for expansion of CIT training and needed material support to enhance the promotion of CIT training throughout Mississippi. In other Medicaid markets, we provide grant funding to support rural and smaller police agencies with participation in the extensive training. The grant funds have been used to support the travel, administrative and shift coverage needed to make the training available to smaller police departments.
- **Transportation Services:** We will contract with a non-emergency transportation provider to provide non-emergent transportation. They offer a mileage reimbursement program so that MSCAN or CHIP members who can attend appointments can choose to receive mileage reimbursement instead of direct transportation helping MSCAN and CHIP members who reside in rural areas. The transportation provider uses a volunteer program to assist passengers in getting around their communities. Reimbursement for volunteers is based upon mileage. We educate members about transportation services through our new member welcome packet and the member handbook, posting on our website, and during calls to member services, nurse advice line, and care management teams.

- **Member Education and Engagement:** A core component of managing avoidable ER utilization includes developing targeted member education campaigns specific to the needs of MSCAN and CHIP members using the ER. We monitor ER utilization on an ongoing basis reviewing claims data, identifying geography such as rural service areas and whether there was a non-emergent diagnosis related to each ER visit. For example, the top five ER drivers for our plan include asthma, pneumonia, diabetes complications, epilepsy, and urinary tract infections. We use this information to develop health literacy education campaigns that are also based on the cultural and language needs of MSCAN and CHIP members. Our campaigns educate MSCAN and CHIP members on alternative services to using the ER, where those services are located, and how to access services. We reach out to these MSCAN and CHIP members to assess the reasons for the non-emergent ER use, educate them on the importance and benefits of primary and preventive care, provide information on PCMH and alternative care settings, offer referral to care management programs, and assist with any barriers, such as transportation, job search and food access.

[redacted]

We use digital campaigns to promote avoidable ER use.

In 2021 in a similar market, we launched a **statewide, digital campaign encouraging 5,000 Medicaid members living in rural counties with high emergency department use** to connect with a nurse via their computer or phone. Members received text or emails with links to our nurse advice line to increase awareness about alternative to the emergency department.

For MSCAN and CHIP members who are in care management, our ICM team uses motivational interviewing techniques to better understand why the member (or their parent/guardian) sought emergency care. The Care Management team also provides education and coaching to help the member access future care in a more appropriate setting. For example, we increase MSCAN and CHIP members' utilization of outpatient and urgent care facilities for non-emergencies by encouraging MSCAN and CHIP members to first contact their primary care provider/medical home or utilize our 24-hour nurse advice line to help identify the appropriate level of care if they are uncertain. We use our fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which will bring a new era of provider collaboration to Mississippi.

Reduced ED Utilization

In another market, an independent analysis found that members participating in the employment support program had reduced ER utilization (over 21%) and hospitalizations (over 17%) after six months in the program.

Methods to Manage Avoidable Hospitalizations and Readmissions

Our methods to manage avoidable hospitalizations and readmissions include use of our predictive analytics to identify trends and develop targeted solutions by member, provider, and/or service area. We manage avoidable hospitalizations and readmissions through use of our integrated, regional care and utilization management teams, community partner liaisons, discharge planning that supports health literacy, support for self-management and addressing social determinants of health (SDOH), and specialty care management programs. Our multidisciplinary care team promotes access to culturally appropriate quality care in the appropriate setting. Our methods to manage readmissions include increasing the number of providers who participate in VBP arrangements and/or PCMHs that support appropriate utilization, aligning hospital providers with incentives, offering enhanced support and reports to guide provider performance, and ensuring effective transition of care.

Predictive Modeling: We use a population-based, case-mix/risk adjustment predictive modeling methodology to prospectively identify individuals who are at risk for avoidable hospitalizations or worsening conditions. We update outputs of predictive models monthly at the member level based on demographics, morbidity, and historical utilization. We have developed a machine learning algorithm to predict all-cause 30-day readmissions with a two phased approach – one that is applied at the time of admission or at the time of discharge. One of the models help in an early detection of readmissions at the time of index hospital admissions while the other would identify risk of readmission based in risk during the hospital stay. Using the demographics, clinical factors, historical utilization data, and other social factors, as well as by incorporating the principles of industry accepted length of stay, acuity, comorbidities, and emergent (LACE) index, the model assigns risk scores for each admission.

We use this model to prioritize and enhance targeted clinical reviews and interventions to avoid preventable hospital readmissions and design a better discharge plan and transition of care. We also calculate a range for the expected future costs for each enrollee to allow cohorts based on predicted costs, and we accumulate specific diagnoses that have high rates of admission at the enrollee level to give another marker to identify highest risk enrollees. Our readmission predictive risk modeling tool uses a machine learning algorithm that augments risk data with member-level demographics, morbidity, social factors, and historical utilization data to predict all-cause 30-day readmissions. We run the readmission predictive risk model both at the time of a member's admission as well as at the time of their discharge. This approach enables early identification and better engagement of MSCAN and CHIP members during their hospital stay while also identifying those newly at risk based on the events of their stay. If the algorithm identifies a member as being of risk for a readmission, our ICM and transition of care (TOC) teams collaborate with the member, the hospital discharge planner, and treating providers to ensure all necessary discharge needs are met.

Transition of Care Support: Our TOC system promotes timely, coordinated, and safe transitions between health care settings to help prevent unnecessary readmissions and ER visits, or other adverse outcomes. When MSCAN and CHIP members receiving care management services require TOC support, their assigned care manager collaborates with them and their interdisciplinary team to develop transition plans. If the transitioning member is not currently in care management, we assign a TOC care manager to work with the member before, during, and after the transition. Our care managers ensure community supports (e.g., support groups, housing, nutrition) are in place prior to the transition, and we coordinate with social supports, community-based organizations, and medical, behavioral, and (SUD) providers to ensure they are prepared to support our member through the transition. Our care managers inform PCP/PCMH, BH providers, and specialists when their MSCAN and CHIP members are in transition, and we engage providers in developing member-centered transitional care plans. We notify providers when the member is admitted to an inpatient facility and no later than seven days post discharge. TOC care managers to ensure that scheduled outpatient follow-up appointments are attended.

We partner with hospitals and leverage expertise to prevent avoidable hospital readmissions in Mississippi, focusing on working with hospitals where our MSCAN and CHIP members are experiencing readmissions, to track MSCAN and CHIP members post discharge, and coordinate care management services to prevent future readmissions. Interventions include:

- Reaching out to high-risk MSCAN and CHIP members with a pre-service before planned admissions to initiate discharge planning.
- Engaging providers to ensure a discharge plan is in place and services and supports are established to reduce the risk of readmission for the member.
- Connecting to statewide health information exchanges for real-time ADT notifications to identify and rapidly engage MSCAN and CHIP members and their PCPs/PCMHs once they are admitted to the hospital.
- Leveraging locally embedded ICM staff to conduct member engagement and outreach to hospitalized MSCAN and CHIP members prior to discharge (with facility consent) to identify and address readmission risks.

- Referring MSCAN and CHIP members with significant social needs to our community services program, which supports MSCAN and CHIP members to overcome obstacles such as lack of education, employment, legal issues, and housing.

Integrated Care Management and Utilization Management Approach: We understand that managing avoidable hospitalizations and readmissions requires close collaboration between coordinated care organizations, hospitals, network providers, and MSCAN and CHIP members. We systematically address MSCAN and CHIP members' avoidable hospital utilization through a combination of preventive care management and proactive utilization management interventions tailored for MSCAN and CHIP members with high, low, or no historical utilization. We built our locally staffed ICM teams to better support our MSCAN and CHIP members and families, their providers, and community-based partners by addressing care needs in the context of each region. To best serve the diverse needs of our MSCAN and CHIP members throughout Mississippi, we staff our ICM teams with experts who are experienced in addressing the needs of complex populations. ICM teams are regionally located based on volume or areas of high need. Together, with our combined depth of knowledge of the local communities we serve, we can structure supports for our MSCAN and CHIP members. This structure promotes partnerships between providers and local hospitals, improving their ability to collaborate on reducing avoidable hospital utilization. Our ICM teams facilitate enhanced collaboration across primary care and specialty providers to help MSCAN and CHIP members avoid hospital utilization where clinically appropriate. Care management teams also work with hospitals and other inpatient facilities to improve discharge planning activities to reduce readmissions. Placement of these care staff in facilities and with other providers builds a stronger and more collaborative relationship with providers and our MSCAN and CHIP members.

Our localized approach will leverage the resources of Mississippi providers, our community services program, and community partnerships to promote best practices of healthy living and health equity. PCMHs and health homes are better equipped to improve outcomes for MSCAN and CHIP members with ambulatory care sensitive conditions with support from our ICM team, who are embedded in designated provider offices. Through our regional staffing model, our ICM includes registered nurses (RNs), and reduces the number of associated preventable hospital visits (e.g., severe asthma exacerbations or diabetic emergencies). Further, we directly embed care management staff, including RNs, in high volume and/or low-performing providers and hospitals across the state to provide additional direct supports.

Our care management and utilization management (UM) staff work together to identify and engage MSCAN and CHIP members who may need additional support. For example, when we identify a member who is newly diagnosed with diabetes, we refer that member to our care management team who can rapidly outreach the member to educate about the benefits of enrolling in our program(s). If the member is interested, we facilitate enrollment and coordinate a date and time to complete initial health assessments, based on the member's preferences and situation. Once we complete assessments and we understand the member's needs, care management staff can educate and aid the member in using primary care, outpatient, and supportive services, as clinically appropriate. If the member is not assigned to a PCMH, the care manager explains the benefits of using a PCMH and offers to help locate a provider and schedule an appointment based on the member's preferences. UM and care management staff also conduct weekly integrated rounds to review data and discuss identified trends, which promotes enhanced coordination of care at the local, regional, and state levels.

Discharge Planning that Supports Health Literacy: Our discharge planning care managers lead our discharge planning activities. Discharge planning care managers are supported by a larger multidisciplinary team that may include our utilization management, care management, and pharmacy staff. Our discharge planning care managers work closely and collaboratively with MSCAN and CHIP members, their families/caregivers, facility staff, and treating providers (including PCP/PCMHs, specialists, and/or BH clinicians). Upon notification of an admission, a local discharge planning care manager conducts member outreach within 48 hours to assess the member's current state, arrange services, and supports necessary for a timely and safe discharge. This assessment includes MSCAN and CHIP members' health literacy in addition to the member's physical, behavioral, social, and service needs, and a review of their linguistic and cultural needs and preferences. Based on a member's needs, preferences, and acuity, initial outreach may be telephonic, in-person, or through secure videoconferencing. Discharge planning care managers also engage with MSCAN and CHIP members' providers to receive supplemental information on MSCAN and CHIP members' condition and/or the events of their stay. As necessary, we coordinate interventions through the provider in instances where the member chooses not to engage with our staff.

Self-Management and Social Determinant of Health Support: One of the best ways to reduce hospital utilization for ambulatory care sensitive conditions is to improve MSCAN and CHIP members' health, including their ability to self-manage acute and chronic care needs. We design our population health and ICM programs to address physical and behavioral care gaps holistically as well as unmet social needs. All MSCAN and CHIP members receive condition-specific education materials, and MSCAN and CHIP members in care management receive enhanced engagement and supports based on their individual risks and needs to promote successful self-management of their chronic conditions. We also leverage plan-based CHWs and provider-based certified peer support specialists to help MSCAN and CHIP members navigate any identified barriers to care. By improving health outcomes, increasing utilization of primary and preventive care services, and addressing SDOH, we can assist MSCAN and CHIP members to avoid future hospital utilization.

Specialty Care Management Programs: We will offer our MSCAN and CHIP members access to life-changing programs such as our community services program that includes an employment support program and a re-entry from correctional facilities program. We connect MSCAN and CHIP members to life coaches, community justice liaisons, and other staff that help support MSCAN and CHIP members in securing and retaining employment, as well as connecting them to community-based providers and resources to address unmet social needs. Through our employment support program, we empower care managers and CHWs to access our member assistance fund, an enhanced benefit that provides limited financial support to address MSCAN and CHIP members' immediate needs, such as utilities or food, which could lead to a hospitalization if left unresolved.

In addition, in another market, for MSCAN and CHIP members who had an inpatient visit in a 12-month period, **60% of re-entry participants completed their 7-day follow up visit compared to 28.5% of Medicaid expansion plan members**, which leads to reductions in avoidable high-cost utilization.

Value-Based Purchasing Arrangements: We have initiated VBP arrangements and fully integrated with multiple hospital systems and providers who are aligned with our goals to reduce avoidable hospitalizations and readmissions. Through these collaborative partnerships, combined with the hospital and provider depth of knowledge about community-based resources, we are uniquely positioned to support MSCAN and CHIP members, PCPs, PCMHs, and specialist to deliver quality care.

Enhanced Provider Reports: Our data analytics team develops provider performance reports that show hospital utilization trends over time including a comparison to peers in their region and across the state. Regional quality improvement staff collaborate with providers to conduct root-cause analysis and design and implement targeted innovations to reduce avoidable hospital utilization.

4.2.2.5.B.2 Describe how the Offeror will cooperate with hospital providers regarding post-discharge efforts in relation to the QIPP PPHR program.

We cooperate with hospital providers for the Quality Improvement Payment Program (QIPP). We also work with the Division through our review of potentially preventable hospital returns (PPHR) reporting process as required in Appendix A, Section 7.8.8, and the 2021 Quality Strategy. We provide these reports to the Division to assist in reducing the overall PPHR and potentially preventable emergency department visits.

We will partner with hospital providers regarding discharge efforts using our data analytics and proven discharge planning/transition of care (TOC) processes to identify and prevent potential hospital returns. We will work with Mississippi hospitals to develop a tracking mechanism for post discharge and care management coordination to prevent future admissions. We embed care managers in high volume hospitals and provide dedicated care managers to support hospitals which have submitted a QIPP Corrective Action Plan to the Division in order to improve the discharge planning process and locate community providers and identify remote patient monitoring services which their patient, our member, may need to avoid a readmission. We are committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers using real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which will bring a new era of provider collaboration to Mississippi.

Data Analytics and Data Sharing to Engage Hospitalized MSCAN and CHIP Members

We run the readmission risk model with member admissions. This enables early identification and better member engagement during their hospital stay. If the algorithm identifies a member as being at risk for a readmission, our Integrated Care Management (ICM) and (TOC) teams collaborate with the member, the hospital discharge planner, and treating providers to ensure all necessary discharge needs are met. The member's care manager monitors that scheduled outpatient follow-up appointments are attended.

Our connection to a health information exchange ensures that we have access to real-time admission, discharge, and transfer notifications for our MSCAN and CHIP members. We use this data to identify and rapidly engage MSCAN and CHIP members and their primary care provider once they are admitted to the hospital. By using our regional staffing model, locally embedded ICM and TOC staff can conduct member engagement and outreach to hospitalized MSCAN and CHIP members prior to discharge to identify and address readmission risks and any barriers to care they may identify.

Providers have access to the statewide health information networks. This innovative provider data-sharing approach was recently recognized in the 2021 Comprehensive Quality Strategy as being well positioned to positively impact health care outcomes by providing hospitals, providers, commercial insurers, and appropriate State agencies improved access to clinical data. This real-time data sharing includes daily admissions, discharge, and transfer (ADT) feeds with information across all areas of the state, as well as member hospitalizations and emergency department (ED) visits. This data creates alerts in our care management platform, which our care managers use to identify MSCAN and CHIP members for outreach and to share information with outpatient providers. With over 60% of the hospitals in Mississippi fully connected, we will continue to partner with providers to connect to the health information exchange for a streamlined health information exchange and provide technical assistance as needed.

Partnering with Hospitals to reduce PPHR

We will partner with hospitals to reduce PPHR using data and our clinical staff member engagement. Upon notification of admission, either through an ADT alert via health information exchange or direct notification from the facility, a discharge planning care manager will initiate engagement with hospital-based discharge planners and treating providers. Throughout a member's stay, discharge planning care managers closely coordinate and collaborate with hospital staff members to assist in the development and maintenance of a member-led Individualized Transition of Care plan, which reflects the MSCAN and CHIP member's discharge-related care needs and preferences. This staff member documents discharge planning activities in our care management system, and the care manager notifies the hospital discharge planner of any appointments scheduled

during the admission to ensure these are reflected in the facility-provided discharge plan. As appropriate, we re-engage hospital staff throughout the post-discharge process to address any related care gaps or needs the member may identify, including a warm transition back into the hospital if a readmission becomes necessary.

By using our regional staffing structure, we will embed care managers and community health workers (CHWs) directly into designated hospitals. By embedding staff members, particularly in high-volume or low-performing facilities, we are better able to engage both our MSCAN and CHIP members and facility-based staff members to ensure meaningful coordination and collaboration from the point of admission through the completion of post-discharge follow-up activities. The relationships built between our TOC team and hospital-based staff members lead to more effective and efficient workflows over time.

Our multidisciplinary transition team, which includes nurses, social workers, and CHWs, provide care coordination for MSCAN and CHIP members who have had either a medical or BH hospitalization. The transition team members are cross trained in behavioral and physical health allowing for one point of contact for the member and family regardless of member needs. They provide care coordination during a hospitalization and up to 30 days post discharge and link the member to our ICM team if they identify ongoing care management needs. They promote member adherence with the discharge plan of care and ensure the member has follow-up appointments, review medication adherence, educate MSCAN and CHIP members on signs and symptoms of worsening conditions, educate the member on the importance of provider follow up and establishing a relationship with their provider, and identify and address barriers and care gaps. Prior to a 7-day and 30-day follow-up appointment, they check with the member on transportation needs and address any barriers to attending provider appointments. Following the appointment, they verify with the MSCAN and CHIP member and provider that the appointment was kept. They assess the member's social service needs and provide connections to appropriate community organizations.

Behavioral Health Readmissions Assistance

MSCAN and CHIP Members identified as having highest risk for BH readmission receive more intensive discharge supports including increased monitoring and engagement for up to 90 days post-discharge. The member's established care manager, or a BH TOC clinician, contacts MSCAN and CHIP members during an inpatient hospitalization or immediately upon receiving notification of a member's inpatient BH hospitalization. After obtaining a consent, the care manager notifies the member's primary care and BH providers of the hospitalization within two business days of receipt of notification of admission.

We will facilitate discharge planning and help the member schedule an outpatient follow-up appointment within seven calendar days following discharge from the inpatient BH hospitalization. After discharge, the care manager monitors to ensure the member is receiving services at the appropriate level of care and provides input on additional needed services and resources. MSCAN and CHIP members not already engaged in our ICM program are referred for care management services. MSCAN and CHIP members with significant social needs may also be referred to our community services program, which connects members aged 16 and older and parents/guardians of minor children who are members to a dedicated certified professional life coach to help members overcome life obstacles that prevent them from achieving their personal, professional, and health and wellness goals. Our community services program is the framework through which we address social determinants of health including food access, housing, social stability, workforce development, environmental factors, and employment.

We will offer the data-driven substance use disorder (SUD) Home model, using peer recovery specialists with lived experience, who work directly with our MSCAN and CHIP members to develop resiliency and sustain engagement in treatment. This relationship facilitates peer recovery specialists and other clinical staff working with our care management team to share data, complete clinical rounds, and collaborate to increase member engagement in appropriate treatment services.

Value-Based Purchasing Solution

We will align our value-based purchasing solution for hospitals to include QIPP PPHR metrics. Increased collection and analysis of quality, service and cost data resulting from VBP is beneficial for quality

improvement and preventing readmissions. Hospital providers can earn incentives for each metric-related service for which they meet or exceed the established target, such as readmission rates. We tie quality measures to one or more targeted achievement levels, using provider specific baseline data to establish measure targets. We make timely and actionable reports available to give providers regular insight into determining which care and referral decisions contribute to optimum results for quality, outcomes, and value. For a similar program in another market using targeted provider outreach and offering incentive payments to high-volume ED providers, our goal is to increase the percentage of follow-up visits within seven days for MSCAN and CHIP members 13 years and older with ED visits for substance use. We designed this provider quality outreach plan to improve member outcomes by connecting MSCAN and CHIP members to prompt and appropriate follow-up care and treatment.

We continuously engage network hospitals through regular and ongoing engagement activities including Joint Operating Committee meetings. We use these opportunities to solicit feedback and strategies to improve discharge planning and transition of care (TOC) activities while identifying and disseminating best practices and lessons learned. Hospitals also have an assigned provider ombudsman who identifies and addresses operational issues and barriers, including those related to discharge planning.

4.2.2.5.B.3 Describe how the Offeror will identify and address trends in over- and under-utilization.

Our QMIP, Program Integrity, UM and CM teams collaborate to review data to identify under-utilization and over-utilization of services using our established mechanisms to detect and to document the activities we conduct to address the under-utilization and over-utilization of services. All three areas examine the data to address root causes of inappropriate and inadequate utilization. We review under-utilization of services by assessing services with lower-than-expected use. We review service utilization trends regularly, and our quarterly reporting provides a set of standardized reports for monitoring utilization. We benchmark our utilization against historical data, traditional Medicaid, and other coordinated care organization’s performance to identify irregularities in the use of our services that may indicate fraud, waste, or abuse. Our UM/CM Committee documents, reviews, and analyzes such instances and reports the findings to the QMIC, QEC, Program Integrity, and other appropriate teams. Our QMIC reports to our Joint Development and Operations Committee (JDOC), which relies upon the Quality Enterprise Committee (QEC) to facilitate sharing of best practices for expediting improvements across the system. The QMIC and QEC share decisions, garner input from peers and others experienced in the quality initiatives and share results across markets and products to ensure the design and implementation of effective programs and best practices. To improve health outcomes, the committee documents the actions and provides oversight of any related clinical studies or improvement initiatives to confirm we are effective in improving MSCAN and CHIP members’ prompt access to needed services.

We identify outliers using reports generated monthly from our population health analytics team on claims and utilization trends. Quality, UM, and Program Integrity programs share data bidirectionally to recognize and rectify potential instances of fraud, waste, and abuse using standardized procedures. We resolve deviations from customary practices through member or provider education, prepayment review, elimination from the provider network or referral to the Medicaid Fraud Control Unit. Those patterns may include over and under-utilization of ED services, inpatient services, transportation, drug utilization, preventive care, and screening exams. This monitoring also enables us to identify aberrant provider practice patterns.

We monitor over- and under-utilization to detect and correct any patterns of potential or actual inappropriate and inadequate utilization. We analyze relevant data quarterly, at a minimum. The UM/CM Committee reviews this information and reports the results of the monitoring and analysis to the QEC and any other appropriate committee based on findings. We submit potential cases of fraud and/or abuse involving providers or MSCAN and CHIP members detected during the analysis of utilization to the Program Integrity department for investigation. We monitor over-utilization and under-utilization through the evaluation of data gathered from activities such as authorizations, appeals, clinical practice guidelines, claims, and member and provider satisfaction surveys. We identify a select list of reports our UM staff members use for utilization monitoring such as:

- Claims and authorization trending reports
- Readmission predictive modeling
- Admission, Discharge, and Transfer (ADT) notifications
- Key Indicator Reports that show average length of stay (inpatient stay data), neonatal intensive care unit per thousand, outpatient per thousand, and inpatient admissions per thousand
- ED predictive Modeling
- Gaps in care data

We also use a variety of predictive analytics developed by our expert data analytics staff members and other resources to identify utilization patterns.

Behavioral Health Utilization Monitoring

We hold a BH Advisory Workgroup for our Mississippi program, which meets bimonthly to review BH utilization trends, including inpatient, outpatient, partial and intensive hospitalization, readmission, follow-up after hospitalization, and initiation and engagement of alcohol and other drug abuse or dependence treatment rates. This workgroup monitors service utilization by MSCAN and CHIP members with BH conditions, including severe mental illness or substance use disorder. Through monitoring BH service utilization, our UM team identifies MSCAN and CHIP members with a diagnosis of severe mental illness or substance use disorder which provides opportunities for BH care management, outreach, and engagement. We send quarterly BH utilization reports to the Division that capture our volume of service requests and compliance with turnaround times of decisioning for pre-service, urgent, concurrent, and retrospective BH requests. The UM/CM Committee reviews and analyzes over- and/or under-utilization and to identify opportunities for improvement.

Strategies Resulting from Over-utilization and Under-utilization Monitoring

We employ mitigation strategies to address inappropriate utilization trends for MSCAN and CHIP members. These examples include the under-utilization and over-utilization.

Under-utilization of Well-Child Visits

We actively monitor data to ensure quality of care and adherence to vaccination and screening standards in members from birth through age 20. In 2018, our data identified outliers to our well-child visits, which affected our rates in another market. Therefore, we developed a quality improvement project to expand access to well-child services for children ages 3 to 6 years. Commonly cited barriers include appointment availability during times convenient for parents or guardians who work, having younger or multiple children, or special transportation needs. In calendar year 2019, we initiated practitioner-level in-home assessments as a bridge to help close the gap in well-care visits for members temporarily challenged by barriers to accessing care. While these services are available to the entire plan population, we placed an emphasis on promoting in-home assessments to children ages 3 to 6 years living in geographic areas with the lowest well-child, 3rd, 4th, 5th, and 6th years of life (W34) rates. HEDIS® rates for well-child measures in CY 2019 demonstrate our success in increasing access to preventive care for children across the state. During this measurement year, in another market the rate of well-child visits for children 3 to 6 years in targeted counties improved significantly over the prior year. **County 1 showed a 18.8% improvement; County 2 increased by 31.0%; County 3 realized a 3.1% improvement; County 4 increased 3.0%; and the NW region increased 16.4% when comparing year over year final rates.**

Over-utilization of Urine Drug Testing

Urine drug testing (UDT) is another example of how we monitored and addressed services vulnerable to over-utilization. In another market, from March 1, 2019, to February 29, 2020, we conducted an analysis on over-utilization of UDT. Based upon our analysis of claims trends, we spent $3,284,632 on UDT for 7,805 members for 92,391 units. We identified the highest utilizers as independent labs. The codes with the highest spend were 80307, G0483, G0480, G0481, and G0482. Once we determined over-utilization, we provided education to our providers and the labs and updated clinical policies to reflect more appropriate and cost-effective utilization.

4.2.2.5.B.4 Describe how the Offeror will analyze pharmacy utilization patterns to improve care and reduce costs. In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all its Members.

We commit to supporting the Division in all drug utilization review (DUR) activities and will partner with the pharmacy benefit administrator (PBA) on prospective DURs. We will use our fully integrated, transparent service delivery model with real-time bidirectional data exchanges to bring a new era of provider collaboration (including pharmacy) to Mississippi. Our clinical pharmacist will attend the quarterly DUR Board meetings and implement Mississippi Evidence-Based DUR Initiatives as part of our policies and procedures. Additionally, our internal retrospective DUR (rDUR) efforts described below enable our best-in-class pharmacy intervention center clinical team to implement and operate member and provider facing rDUR programs.

Our clinical team, which represents the member and provider-facing aspect of our DUR programs, is comprised of pharmacists and certified pharmacy technicians who provide exemplary member and provider service across all markets. We commit to meeting all necessary reporting milestones and requirements to ensure the Division successfully submits its annual report to the Centers for Medicare and Medicaid Services (CMS) according to the established schedule. **Our ability to deliver operational excellence demonstrates that we respect MSCAN and CHIP members and providers and will be a valued and trusted partner for the Division.**

Analyzing Pharmacy Utilization Patterns to Improve Care and Reduce Costs

Our rDUR program utilizes pharmacy and medical claims data to better identify drivers and patterns of potential drug therapy issues including therapeutic duplication, drug-disease contraindications, drug-drug interactions, over-utilization, and under-utilization. This program focuses on four primary intervention opportunities: 1) improving care coordination; 2) avoiding adverse drug risks; 3) identifying and closing care gaps, including omissions of drug therapy; and 4) identifying and preventing fraud, waste, and abuse. Through reviewing pharmacy and medical claims and creating rDUR dashboards, we identify MSCAN and CHIP members who require adjustments to their therapies, as well as providers that require individualized outreach and education about evidence-based clinical guidelines and best practices to improve member outcomes and decrease cost of care.

Improving Care Coordination

In our sickle cell management program, we use rDUR to identify MSCAN and CHIP members with a sickle cell diagnosis who either do not have any recent paid claims for hydroxyurea, are non-adherent to their hydroxyurea, or who may need an eye exam as part of hydroxyurea monitoring. We send notifications to the prescribers serving these identified MSCAN and CHIP members requesting that they take action to close these gaps of care to improve member outcomes and reduce costs by decreasing emergency department (ED) visits and hospitalizations.

Another example of care coordination success is demonstrated in our attention deficit/hyperactivity disorder (ADHD) provider follow up program that improves the continuity and coordination of care between medical and behavioral healthcare providers around the treatment and management of children diagnosed with ADHD. This program specifically works to improve the rate of follow up for children who are new to ADHD therapy while also providing prescribers additional education on the proper management of ADHD. Our pharmacy intervention center team performs outreach calls to the child's prescriber to ensure that a follow up visit is scheduled and simultaneously mails letters to the prescribing provider and primary care provider of the child. This program has improved the care of children with ADHD significantly, with 80% of providers agreeing to schedule a follow up visit with the member to assess tolerability and effectiveness of therapy within 30 days of starting the medication. In another market, **from April 2021 to December 31, 2021, the follow-up for children prescribed ADHD medication improved from 46.58% to 50.34% which moved our health ranking for this measure to the 75th quartile HEDIS® ranking**. After review of the CMS DUR annual report, we understand that Vyvanse and additional ADHD medications are of the highest spend and highest utilized medications in Mississippi and our ADHD program will improve the follow up rates and care that MS children receive while taking ADHD medication.

Avoiding adverse drug risks

Our analysis of pharmacy utilization trends drives our initiatives as part of our comprehensive opioid management program. In partnership with providers, we will actively pursue the objective to reduce the frequency of new opioid utilizers progressing to chronic use or escalating doses. We outreach to prescribers of MSCAN and CHIP members who are at an increased risk of chronic opioid use based on retrospective analysis of their opioid prescription claims. Providers are notified of the impacted MSCAN and CHIP members, asked to suggest alternative therapies, and further educated on the importance of naloxone for all members for whom they are prescribing opioids. Additionally, we analyze members' morphine milligram equivalent (MME) dose and conduct outreach to prescribers who prescribed ≥ 60 days of opioids at or above 90 MME/day. This outreach provides the prescriber a population health view of their opioid prescribing and emphasizes the risks associated with the use of high-dose opioids for targeted members. **In another market, we have seen over a 30% reduction in MME for the members that were identified for the intervention.** We also utilize pharmacy claims to send medication disposal kits to members who are receiving short term opioid supplies. While this is standard practice across all our markets, we can and will adjust monitoring and clinical outreach to meet state specific requirements and initiatives as required or encouraged by the Division. This provides a resource for members to discard of any unused or unwanted medication along with education on the safe use, storage, and disposal of opioids.

To prevent adverse drugs risks in children who are receiving complex behavioral health medication treatment regimens, our pharmacy intervention center behavioral health (BH) pharmacist performs a comprehensive chart review for identified MSCAN and CHIP members and assesses the appropriateness of therapy, lab monitoring, and the need for any additional support services. The BH pharmacist then performs provider and caregiver outreach to further determine appropriateness of therapy and provides suggestions for therapy adjustments if deemed necessary after the outreach. In 2021, there were more than 10,000 children enrolled in our SUPPORT Act program. Our results per 1000 members reviewed required 348 prescriber outreaches which resulted in 72 providers confirming appropriate therapy and 20 therapy changes. The SUPPORT Act program clinical review outcomes are integrated into our care management platform. This provides our care management team a person-centered view of each member in the program.

Identifying and Closing Care Gaps

For members who are at highest risk for heart attacks and strokes, and in accordance with HEDIS® technical standards and clinical guidelines, we analyze pharmacy and medical claims to identify members who qualify for statin therapy based on diabetes and/or cardiovascular diseases. To support therapy optimization and risk reduction, we have an extensive outreach program for these members and their providers. We provide printed materials to both members and providers with recommendations, clinical rationale, and medication education. Outreach to our members and providers occurs by the clinical team specific to the opportunity. **In 2021 in another market, the members who were eligible for this suite of services had a compliance rate of 88%, which was a 4% improvement compared to 2020 performance.**

Identifying Fraud Waste and Abuse

We identify suspected cases of fraud, waste, and abuse (FWA) through drug utilization review programs. When we identify suspected cases, our Program Integrity department provides triage and investigation. We outreach to prescribers for state-defined maximum daily morphine equivalent for treatment of chronic pain, member concurrently prescribed opioids, potential fraud, or abuse of controlled substance by adult members with Medicaid. Additionally, we conduct reviews on providers who exceed two standard deviations from their peers in the same practice type/market area as outliers for prescribing patterns. Provider education and resources are provided for state-defined maximum daily morphine equivalent for treatment of chronic pain, members identified as receiving between 14 days and 90 days of prescribed opioid therapy except for those diagnosed with cancer, palliative care, and sickle cell disease. We send monthly letters to prescribing providers identifying their "rising risk" patients and encourage a personalized plan for each member regarding their opioid use to minimize chronic opioid use. We also provide prescribers specific controlled substance report that can be

accessed 24 hours a day on our provider portal. This report is a tool that can show potential controlled substance over-prescribing. We use multiple resources, to identify potential member FWA such as inappropriately using or selling controlled substances, altering prescriptions, sharing ID cards, or misrepresenting eligibility. As part of our review, we examine medical claims, dental claims, and pharmacy claims. Our analytics tools can detect when a member receives a benzodiazepine or opioid prescription shortly after an overdose diagnosis; determine outlier distance between pharmacy and prescriber zip code; and produce standard reports monitoring for risky combination of drugs. These reviews may result in referrals to care management for interventions or referral to a state program when appropriate.

We will partner with the Division and PBA to address any FWA concerns. We can and will provide education and FWA resources to meet state specific requirements and initiatives as required or encouraged by the Division. The cases for which the investigation substantiates FWA will be reported in the manner and timeframes as specified by the Division and as described in Appendix A, Section 10.

4.2.2.5.B.5. Describe the process for ensuring medication continuity of care upon Enrollment and ongoing. In answering this question, assume that a winning Contractor will have access to pharmacy claim information for all its Members.

Maintaining continuity of care is our priority as MSCAN and CHIP members enroll in our plan and continue through their healthcare journey. We have a multifaceted strategy to achieve the objective of ensuring medication continuity of care upon a member's enrollment and in compliance with Appendix A, Section 4.4.4.3.

Having access to MSCAN and CHIP members' pharmacy claims, we review and address claims for non-preferred or non-formulary medications requiring prior authorization. Leveraging our clinical intervention center pharmacists, we will engage the member and prescriber to identify a preferred or generic equivalent covered on the state's Universal Preferred Drug List. This process results in helping MSCAN and CHIP members get access to appropriate drug therapy and ensures members experience continued care. We will implement this process in cooperation with the PBA if directed by and in accordance with Division guidelines. .

Medication Therapy Management

A cornerstone of our medication continuity of care pharmacy offering is our innovative and comprehensive Medication Therapy Management (MTM) Program. We were amongst the **first Medicaid health plans in the nation to offer MTM to Medicaid enrollees**, and we will drive innovation in this space to help MSCAN and CHIP members achieve their health care goals. **Our innovative programs and services are proven to consistently improve health outcomes for the areas the Division has designated as priorities.**

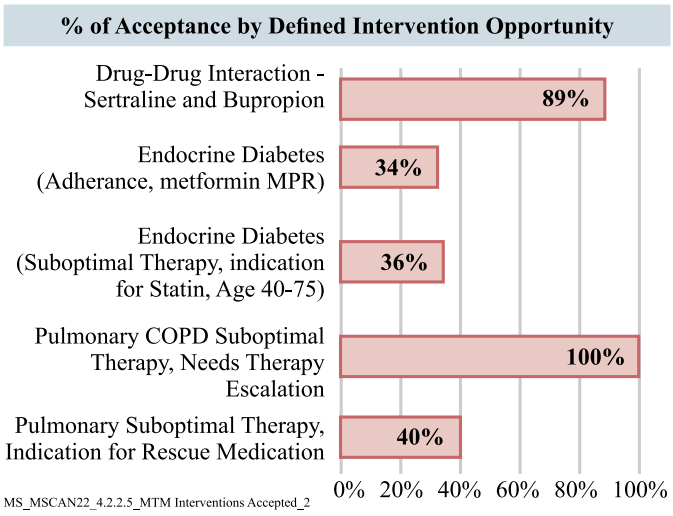
We understand the needs of our MSCAN and CHIP members, and, as such, we maintain an MTM program tailored for the populations we serve. Our program expands on traditional, limited interventions by providing pharmacists the opportunity to assist in disease state management programs. These novel programs empower pharmacists to consult with members on their medications and expand their access to care, medications, and disease state management. We identify MSCAN and CHIP members in need of these services by using pharmacy and medical claims data. Based on the data, we will use our partnerships with our MTM network of community and independent pharmacies, and our pharmacy intervention center resources, to meet MSCAN and CHIP members where they are in their healthcare journey. We understand the rural environment may create member barriers to access pharmacies easily and in those situations our pharmacy intervention center can service these member's needs and opportunities telephonically.

Our program offers a welcome letter to MSCAN and CHIP members detailing both our MTM program and safe ways our MSCAN and CHIP members can dispose of medication. Our targeted medication recommendation library contains more than 2,500 recommendations that we can customize for the member population, such as MSCAN and CHIP members with special needs. This flexibility far exceeds the industry standard of approximately 400 recommendations. As seen in Figure 4.2.2.5_E, in 2021 our Medicaid MTM provider recommendations had high acceptance rates in many of the defined intervention opportunities. We offer MTM as a vital tool to all MSCAN and CHIP members at no additional cost to ensure our members remain healthy.

Our pharmacy intervention center pharmacists and technicians serve as the core to our MTM program and will reach out to MSCAN and CHIP members who have not been contacted by their local pharmacy. Our MTM program remains fully adaptable and innovative to ensure our targeted medication reviews increase patient adherence, decrease adverse events, and improve member outcomes. This approach to MTM includes direct contact to prescribers to ensure the entire healthcare team is working for our MSCAN and CHIP members. We commit to enhancing the provider and pharmacist experience by providing claims data, lab values, and notifications of MTM services provided to the member.

Figure 4.2.2.5_E: Percent of MTM Interventions Accepted In Another Market

Our MTM process ensures members have the right medications to treat their conditions.



Continuity of Care Collaboration and Outreach

To establish and enhance continuity of care, we document interactions and interventions in our centralized care management platform. This process enables all clinicians to have a unified view of each member. We understand the importance of a member's continuity of care during any transition in care levels, and we have developed a robust medication reconciliation process with our Care Management team for MSCAN and CHIP members who are discharged from the hospital. The pharmacist compares the member's pre-admission medication list to the one given at discharge from the hospital. Our fully integrated, transparent service delivery model's process ensures the member and prescribing providers are aware of the current care plan and it identifies and prevents any medication therapy problems that may occur, such as not properly discontinuing, initiating, or continuing the correct medications.

Our commitment to supporting our MSCAN and CHIP members continuity of care extends beyond just the initial transition of care and expands to addressing medication adherence needs. We have developed data-driven clinical and medication adherence programs that improve MSCAN and CHIP members' health outcomes. For example, when a MSCAN or CHIP member begins a targeted medication, we send the MSCAN and CHIP member a medication adherence kit via US mail. This adherence kit includes a weekly pillbox with removable compartments, a welcome to therapy letter, a medication list template, and a whiteboard for tracking doses and medical appointments. Our year-over-year data from another market shows that members who received these kits showed a consistent proportion of days covered (PDC) (a widely accepted medication measure of adherence) improvement across various disease states compared to those who did not receive a kit. In another market, for those members who were on the targeted medications in 2020, and then received a kit at the beginning of 2021, we observed between a **7.40 and 14.26 percentage point increase in PDC** on average! For all maintenance medications, we send MSCAN and CHIP members push notifications, through our mobile app or online portal, when a medication is nearing refill (90% depletion), and a second notification to remind the member after a missed refill. Another compelling technology solution we offer to MSCAN and CHIP members is an **Amazon Alexa Skill. This HIPAA-compliant application is the first of its kind** and intelligently reminds members to refill specific medications using their smart home devices based on claims availability in our system.

For more targeted and intensive support, we rely on our pharmacy intervention center pharmacists and technicians to develop clinical programs and execute on adherence and clinical goals. These capabilities include outreach phone calls, text messages, mailed letters, and emails. This approach allows us to provide high quality care to meet the needs of MSCAN members. Our current campaigns can continue to be adapted to assist in the care of MSCAN and CHIP members. Examples of these initiatives include filling gaps in therapy such as statins in patients with diabetes or cardiovascular disease, diabetes and hypertension medication management, and medication optimization. We have developed programs spanning an array of disease states which can be

beneficial during any transition of care experienced by our MSCAN and CHIP members whether being discharged from the hospital or new to our plan. Combined, these approaches support MSCAN and CHIP members' continuity of care from the time of enrollment and throughout the member's healthcare journey.

[END OF RESPONSE]

4.2.2.6 INFORMATION TECHNOLOGY

Our Coordinated Care Organization (CCO) operations are supported by a highly reliable, scalable, flexible, and secure enterprise Medicaid Management Information System (MMIS) platform. This platform supports millions of members across our Medicaid markets. Our core systems operate at peak efficiency, enabling us to focus on adding value for our clients in critically important areas, such as population health, claims, interoperability, and advanced health analytics. Our MMIS, coupled with an efficient and effective information technology (IT) operating model **and an experienced** information services team, promotes the **delivery of operational excellence, and demonstrates our deep respect for members, providers, and the Division.**

Information technology is the engine that powers us. We leverage our rapid, high-quality IT solutions to ease administrative burden, deliver cost-effective health care coverage, and accomplish Division program goals. Our systems continuously evolve as we accelerate and optimize technology's role in improving health, lowering costs, elevating performance, and streamlining the user experience.

We are a CCO committed to changing the trajectory of Mississippi's healthcare system and bringing **a new era of provider collaboration to Mississippi** via our transparent service delivery model which is fully integrated with the majority of providers through real-time bidirectional data exchange. Our mission is to ensure Mississippians can easily access their benefits, our next generation member engagement and education, and community-based coordinated care to help them lead healthier lives while we prudently manage State resources.

4.2.2.6.A Claims Processing

4.2.2.6.A.1. Describe the Offeror's claims processing system including:

a. A systems diagram that describes each component of the claims processing system and the interfacing or supporting systems used to ensure compliance with Contract requirements, and

We process all claims in compliance with HIPAA regulations and in accordance with 42 C.F.R. § 447.46 and Appendix A, Sections 9.1.1 and 16.5.1. **We exceed all contractual timeliness requirements. We process 98% of clean claims within five days of receipt**. **We process 100% of claims within 30 days**, including those suspended for additional information. We will be a worry-free partner to the Division and to our providers.

We monitor and report on claim processing metrics using tools that refresh in near real-time to ensure prompt prioritization of any potential issues, without disruption to our providers. Appendix 4.2.2.6.A.1 provides an overview of our claims processing system.

b. How each component will support major functional areas of the Mississippi Medicaid Coordinated Care program.

We use customized automated tools to build a compliant, accurate claim lifecycle. Our integrated process meets the speed and accuracy requirements of Medicaid managed care programs across the country. This process incorporates end-to-end monitoring of claims at every stage, from receipt to remittance. Key functional areas that support Mississippi Coordinated Access Network (MSCAN) and Children's Health Insurance Program (CHIP) include provider submissions, validations, adjudication, denial management, data sharing and monitoring, payments, and encounters (Table 4.2.2.6_A).

Table 4.2.2.6_A: Key Functional Areas Supporting MSCAN and CHIP

Functional Area	Description
Provider Submission	We will prioritize partnering with providers to reduce administrative burden and allow providers to send claims in a variety of ways (e.g., electronic data interchange (EDI), paper, electronic fax, or our provider portal). Currently, across all our markets, Medicaid providers submit 98% of claims via EDI**,** 1.5% via paper, and .5% through the provider portal.
Validations	We validate all claims for adherence and HIPAA compliance. We apply Strategic National Implementation Process (SNIP) level edits and custom edits to support market-specific requirements. The system rejects claims that fail SNIP edits and other industry standard billing errors. After ingestion of claims through our EDI processing system, it checks all claims for compliance to 5010 HIPAA standards. Claims that fail these validations are rejected and sent back to the provider, along with clear reasoning for

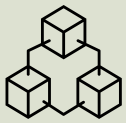
Functional Area	Description
	rejection, to facilitate correction and resubmission. Added validations throughout the adjudication process include post-adjudication and pre-payment reviews to ensure accurate, efficient adjudication and encounter submission of all claims.
Adjudication	Our claims processing system integrates all adjudication functions, including ingestion of data from supporting systems, core configuration within our adjudication system, and our own automation tools that uniquely enhance the core system to drive an efficient and accurate end-to-end claim process. Processes include member enrollment and disenrollment, application of utilization management, benefit application, pricing, coordination of benefits (COB) and third-party liability (TPL), and payment of the claim.
Denial management program	Our comprehensive denials management program consists of a wide array of methods and tools, such as data analysis, artificial intelligence (AI) and machine learning (ML), governance committee oversight, and our Mississippi Provider Innovation Collaborative and provider services ombudsman. We focus on proactive monitoring of patterns of denials both globally and at the provider level to quickly initiate analysis by our teams to minimize issues and unnecessary provider administrative effort. We notify our providers of claim denials through a variety of mechanisms including, 277CA rejection, the EOP, 835 file, through our call center, our portal (for systemic issues), and provider representatives.
Data sharing and monitoring	Support for claim adjudication includes integration of data from all systems, including subcontractor adjudicated dental and vision claims, into the Online Data Store. This data platform ensures accurate, complete data that drives monitoring tools and reporting, claim encounter processes, member explanation of benefits, and provider explanation of payment.
Payments	Provider payment is issued within our claims processing system through our payment processing system, with an electronic status report indicating the disposition for every adjudicated claim. We have flexible check write capability to issue payment as often as daily, and we ensure regularly scheduled check writes at least weekly. Most of our providers choose automated clearinghouse (ACH) payments through electronic funds transfer (EFT), with the companion HIPAA 835 electronic remittance advice.
Encounters	Our encounters processing system manages encounter data, which collects and aggregates into Division-specific submission files according to the requirements stated in the Companion Guide. We review encounters with rigorous accuracy validation. Submission of encounters consistently exceeds >99% timeliness and completion rates, exceeding regulatory thresholds in each of our markets.

4.2.2.6.A.2. Describe modifications or updates to the Offeror's claims processing system that will be necessary to meet the requirements of this program and the plan for completion.

Our claims processing system uses highly configurable modules that support (without modification) all MSCAN and CHIP program requirements, as required by applicable law and regulation, including but not limited to 42 CFR § 433.116 and Appendix A, Section 9.1.2, and reporting requirements in Section 16.2.4.

Our information retrieval process ingests claims history data from the Division or its Agent. Our claims processing system automates member management, provider, and network data management, claims processing, claims payment, and COB for claims with TPL. We use multiple editing systems that integrate into standard and custom clinical and claim billing edits. We anticipate the following MMIS configuration specific to claims processing:

Proven Stability



Our experience in multiple Medicaid markets affords swift, accurate, and efficient implementation of all State-specific requirements and seamless provider integration.

Mississippi Medicaid benefit configuration

- Provider fee schedules, with the ability to load and test fee schedules near real-time, including analytics and monitoring to assure high quality
- Mississippi-specific pre-adjudication edits, including Division-mandated claim acceptance requirements
- Pre- and post-adjudication edits, in accordance with Division-specific requirements
- Delegated vendor collaboration to set up payment processing

We have a well-defined technology roadmap, coupled with a disciplined practice for executing software enhancements and releases. Our established software testing core competency includes dedicated software quality assurance, user acceptance, and end-to-end testing practices.

4.2.2.6.A.3. Describe the Offeror's claims processing operations including:
a. The claims processing systems that will support this program;

We demonstrate compliance with effective and efficient policies, procedures, and mechanisms to drive accurate, prompt claim adjudication. **Our IT and Operations departments employ technology and efficient operational processes to consistently achieve excellent claim and encounter accuracy and timeliness**. Our claims processing and retrieval systems comply with all applicable laws and regulations, including but not limited to all components of 42 C.F.R. § 433.116.

Claims Adjudication Process
We perform all required edits including (SNIP) level validation, HIPAA-compliant edits, and custom edits to support specific market requirements. For paper claims, providers receive written notification of rejected claims by mail within seven days of the claim receipt date. We convert paper claims that pass edits to EDI X12 HIPAA-compliant files and process them in the same manner as the EDI files received through EDI. Claims that do not meet these criteria are rejected and returned to the provider through a 277 EDI transaction, with the reason for rejection clearly conveyed to ensure correction and resubmission. Providers can check and track the status of their claims through our secure provider portal, electronic 276 transaction, or by contacting Member Services and Provider Services with claims questions.

Once the claims processing system accepts the claim, it assigns a unique claim identification number (ID) and uses the ID for tracking and reconciling throughout the entire life cycle of the claim. The system keeps claims data, including claim receipt date, adjudication status, and provider payment date, and validates claims against edits, such as member eligibility, provider eligibility and network participation, fee schedules and pricing, and benefit management rules. Claims validate against the following edits:

- Provider eligibility to render the services billed
- Missing, invalid, or mismatched provider NPIs, CLIA certifications, and/or TINs/EINs
- Prior authorizations and approvals
- Duplicate claims, including flagging possible duplicate claims for further review or denial
- Medical necessity, including validating whether services are appropriate in amount, duration, and scope, as billed
- Covered service under the contract and eligibility for payment
- Member benefit limits
- National Correct Coding Initiative (NCCI) edits
- Field and general claim edits
- Date of service
- CPT® codes
- Healthcare Common Procedure Coding System (HCPCS)
- ICD-10 coding
- Age and gender
- Timely filing of claim within 180 days from date of service

The claims processing system applies member TPL, COB, copayments, and applicable interest amounts and stores all claims information in accordance with record retention requirements.

Our claims editing system implements standard and custom clinical and claim billing edits. This system has a transparent open-architecture and rules-based application that provides NCCI and Outpatient Code Editor (OCE) knowledge base of edits and uses date-sensitive processing to adjudicate both professional and institutional claims. We monitor all clean and non-clean claims through near real-time updated interactive dashboards for timeliness and prioritization, from adjudication to claims payment. Less than 2% of Medicaid claims require manual intervention. All claims follow strict service level agreements and adhere to all regulations including prompt pay and Division-directed suspension of claims under investigation for fraud and abuse.

Once a claim is adjudicated and finalized, it processes through a check write process for provider reimbursement. We pay claims routinely, at least weekly, through check writes that can be scheduled daily. The check write process triggers an explanation of benefits (EOB), electronic remittance advice (ERA), and

explanation of payment (EOP), which we send to the member and provider. We monitor claim denials through a comprehensive denial management process that allows us to foster a collaborative provider experience that brings forth partnership and improved understanding of our denial policies.

We submit to the Division all policies and procedures for review and approval. Documented, electronic policies and procedures establish transparent guidelines for processing transactions, monitoring, and auditing provider claim submissions and claim adjudication accuracy. These policies and procedures aid us in consistently responding efficiently and quickly to any changes in the Division's requirements. We submit our criteria for authorization or denial of payment for services rendered by out-of-network providers to the Division for review and approval 60 calendar days prior to use. We also distribute these approved criteria to out-of-network providers and facilities providing emergency medical services. Upon notice by the Division, we complete any updates to our claims system within 60 calendar days, implement all subsequent updates using the same effective dates as the Division, and implement changes in State Plan Amendments by the effective date of those amendments.

b. Standards for speed and accuracy of processing and measures to ensure standards are no less than the Medicaid Fee-For-Service program;

We exceed all prompt pay requirements, as required by applicable law and regulation, including but not limited to 42 C.F.R. § 447.46, 42 C.F.R. § 447.45, and Appendix A, Section 9.1.1. We process 100% of clean and non-clean claims within 30 calendar days of receipt. We have an automated process that ensures providers would be notified if any claim were not finalized within 30 days. We use our auto-adjudication capabilities to adjudicate **98% of clean claims within five days of receipt.**

Process for Ensuring Timely Claims Processing

Claims Operations, in coordination with IT and Regulatory departments, monitors and reports claim timeliness to ensure end-to-end processes, from claim receipt to claim payment, to adhere to prompt pay regulation. **We consistently meet 100% of all regulatory claim timeliness metrics, as well as our internal heightened timeliness thresholds.** We adjudicate all claims, including paper and non-clean claims, within the most aggressive prompt-pay timeframes. We treat all claims as electronic clean claims relative to processing speed. Our integration of key functions, including authorization, claim processing, billing, enrollment, and accounts receivable creates an efficient end-to-end process for processing and reporting claim outcomes. Providers can receive non-electronic payment or paper remittance advice statements; however, we strongly advocate our provider's use of automated clearinghouse (ACH) payments through electronic funds transfer (EFT) with the companion HIPAA 835 electronic remittance advice. Across our Medicaid markets, 93% of our providers receive payments electronically.

Real-Time Claims Payment for Providers Serving Rural Members

Our real-time claims payment capability supports expedited payment to select provider groups serving our rural members. This capability improves the associated cash flow for providers serving members in rural locations to improve access to care and the quality of member health care. Participating providers can send claims through the portal or through normal EDI claim transactions. Upon receipt of the claim, we use an innovative real-time claims process to adjudicate the claim for payment determination. We will also work with a payment fulfillment partner to deliver payment that is **available to the provider in near real-time (within minutes)** through an e-check process. Providers can immediately access the e-check and deposit the payment.

Meeting Prompt Pay Requirements

All claims follow strict service level agreements and adhere to all prompt pay regulations, which we consistently exceed. We proactively monitor claims performance to ensure compliance with prompt pay requirements through near real-time claim aging dashboards and outcome reporting. **Since Q1 2020, we have processed 100% of claims within the most stringent regulatory prompt pay timeframe requirements in all Medicaid markets.**

c. The Offeror's process for dealing with discovered compliance issues through an expedited process

Upon discovering any compliance issues, our issue resolution team expedites triage and remediation processes to minimize the impact on claims processing accuracy. We expedite investigation of all inquiries. We acknowledge receipt of the inquiry within one business day and resolve it within five business days unless otherwise negotiated with the Division. If the issue impacts multiple providers, we post the issue on our portal to give our providers the most current information. Additionally, we notify the Division of the discovery with the expected resolution timeframe. Our Operations department performs claims auditing and monitoring. We categorize our various quality controls into the following four pillars.

1. **Prospective Auditing:** We perform nightly scans of our system configuration, provider, and member data to proactively identify avoidable data entry errors.
2. **In-Process Monitoring and Controls:** We continuously monitor claims during the adjudication process. Currently, we execute daily automated reviews of in-process claims for 18 specific scenarios, with continual additions and revisions. Claims are continuously monitored via end-to-end reconciliation to track and ensure systematic accounting through claim finalization.
3. **Retrospective Monitoring:** We continuously monitor finalized claims for identification of anomalies or trends that may be indicative of potential errors. Processes include systematic and manned reviews of the configuration post-production changes, encounters editing, and reject analysis. We have also developed anomaly detection tools using AI/ML algorithms to identify improper denial patterns on claims in process. Data gathered through the reporting of issues from our Provider Services call center and our grievances and appeals process are used to augment the analysis to identify trends, patterns, or anomalies requiring attention.
4. **Retrospective Auditing:** We have developed a multifaceted retrospective audit program to reduce claims errors and support continuous improvement across the functional areas that drive the quality of claim adjudication.

As the controls within these pillars find issues, we investigate them for root cause and review them for full impact. We then remediate the issues, which the operations leadership reviews to ensure prompt action and thorough resolution. As we identify new issues, we thoroughly research them to find the root cause, swiftly resolve issues, and evaluate them for new quality controls to prevent future recurrence. This approach results in a learning design that continuously improves the claims experience for providers and members.

We formally report all claim accuracy outcomes monthly to executive leadership, including our chief operating officer. Figure 4.2.2.6_A illustrates the quality control steps that result in increased access to care, improved claims payment accuracy, and improved claims financial accuracy compliance.

Figure 4.2.2.6_A: Claims Quality Control Monitoring
Our commitment to claims accuracy continous improvement.

d. The Offeror's process for and timeframe to correct programming errors and timeline for correcting any claims that were misprocessed as a result; and

Programmatic error identification and notification can originate from provider outreach to our call center, from provider outreach to our provider representatives, through our proactive claims monitoring analytics capabilities, grievance and appeal requests, and from our ongoing claims auditing processes.

Our dedicated issue resolution team triages and ensures the correct department investigates the concern. This team uses an issue-tracking ticketing application that monitors and drives optimal resolution and turnaround timeframes to minimize the impact of programmatic errors on providers. The assigned lead on the ticket has access to all Operations and IT departments to triage and address the issue. Following thorough testing of the solution and implementation, we generate a report to capture any cases that require correction or reprocessing.

On average, we triage, design solutions, make the corrections, and reprocess previously impacted claims within 25 days. Root cause analysis occurs after each error to understand the cause(s) and establish a monitoring plan to capture future issues. As required, we comply with all applicable laws and regulation, including all components of 42 C.F.R. § 433.116 and Appendix A, Sections 9.1.2 and 9.1.6. We do not employ off-system adjustments when processing corrections to payment errors without prior written authorization from the Division. Any deficiencies or contract variances identified by the External Quality Review Organization (EQRO) are promptly addressed, in accordance with the Division-determined schedule.

e. The process of identifying and addressing deficiencies or contract variances from claims processing standards, and an example of how the Offeror has addressed these deficiencies or variances.

We use multiple claim oversight mechanisms, including auditing claims over certain thresholds, reviewing claim outliers, and monitoring financial and payment accuracy. Our audit program targets all process components that contribute to the ultimate payment accuracy of claims.

Interactive Dashboard Monitoring

We use advanced AI and ML dashboards for real-time monitoring and reporting to proactively identify and address any potential claim issues without disruption to our providers.

We use multiple interactive, highly transparent reporting dashboards, including AI/ML tools, to monitor and track claim processes and outcomes. Included in those tools is an application of AI that reduces provider burden by proactively finding anomalies and trends in claim denials. This comprehensive denial management process improves provider and member experience by proactively identifying unanticipated claim denials, identifying provider outreach opportunities for billing errors, and improving operational efficiency:

- Proactively identifying unanticipated claim denials
- Identifying provider outreach opportunities for billing errors
- Improving operational efficiency

Our AI/ML tool provides dashboard monitoring explanation codes (e.g., codes that depict the disposition or action taken on a claim) through multiple views and scenarios to illustrate potential anomalies. Through this claim denial anomaly tool, we proactively identify and correct multiple anomalies promptly, including adjustments to correct impacted claims, without necessitating provider outreach to us.

Addressing Contract Variances: For compliance issues received directly from the Division, we promptly expedite investigation of the inquiry. In accordance with Appendix A, Section 1.10, we acknowledge receipt within one business day and resolve within five business days, unless otherwise negotiated with the Division. Upon receipt by our regional regulatory office, we catalogue and route the issue to the proper team for timely resolution and satisfactory closure with the Division.

Operations Excellence Audit Team: Our Audit team handles the independent and objective evaluation of operational processes, including audits of claims processing and payment accuracy. The Audit team is

independent of the Claims Processing department. We maintain standard operating procedures that establish guidelines for processing transactions, monitoring and auditing claim submissions, and payment processing, in adherence to State and federal processing rules, fee schedules, and prompt payment requirements. Our dedicated Mississippi compliance officer oversees claims processing operations to ensure operational compliance. The Audit team performs monthly audits on processed new (original) claims, manually processed claims, including original claims and adjustments to previously processed claims. Our audits focus on procedural, payment, and financial accuracy; claims entry; adjudication processes; authorizations; COB and TPL; fee schedules; provider contract provisions; and determinations on enrollment and benefits.

Example of Addressing Deficiencies or Variances: The following example of **how we address deficiencies or contract variances is a self-identified issue.**

- **Issue:** A "No CLIA Waiver or Certification on File" denial was flagged by our proactive monitoring tool. This technology detects signals on small deviations from standard claim processing and alerts our team.
- **Solution: We updated the contract terms in our claims systems to remediate the error and reprocessed 1,200 claims.**
- **Outcome: We identified and corrected** issue within 24 hours without complaints from providers or the State. Our ability to monitor systems using advanced technology enables us to minimize negative impacts to our members and providers.

4.2.2.6.B Technological Systems

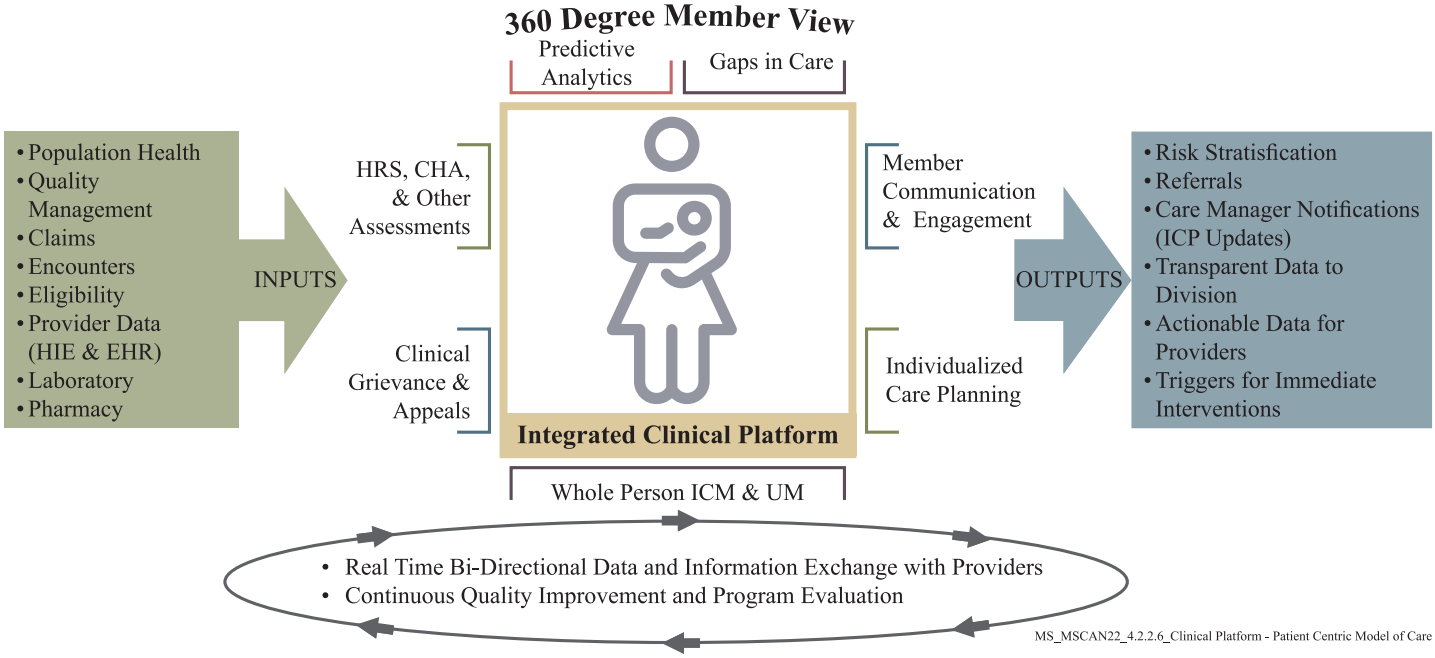
4.2.2.6.B.1. Describe how the Offeror will leverage its technology to ensure it produces a consistently effective Care Management System.

Our enterprise MMIS provides the foundation for all the technology we leverage to produce a consistent and effective care management (CM) system and fully integrated service delivery model for MSCAN and CHIP members and providers. In accordance with Appendix A, we will maintain an enterprise MMIS that collects, analyzes, integrates, and reports member and provider data in support of our integrated care management (ICM) system. A key component of our MMIS is our integrated clinical platform, which includes CM functions and capabilities (see Figures 4.2.2.6_B and C).

Our integrated clinical platform provides real-time, bidirectional sharing of clinical data and supports electronic health record (EHR) integration and exceptional member service; tailors reporting, enabling successful administration for Division programs; and supports our population health approach improving health for Mississippi members experiencing health disparities, acknowledging the impacts of health inequity and unmet social needs.

Figure 4.2.2.6_B: Our Integrated Clinical Platform Supporting our Care Management System

Our integrated clinical platform creates a holistic member view ensuring an effective CM system and facilitating coordination with utilization management (UM) and quality management (QM), and interoperability and data sharing with our network providers.



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Our **commitment and collaboration with the Division** in implementing its health information technology (HIT) strategy improves the quality of care for members through sharing electronic health information and promoting meaningful use of HIT. Our MMIS and technology design meets the needs of Medicaid members and aligns with Mississippi State Medicaid Health Information Technology Plan (SMHP) objectives.

Our integrated clinical platform, inclusive of our CM system, is the central repository for all relevant care coordination detail and provides the CM team “one stop” access to all information pertaining to the member. Our integrated clinical platform ingests information from multiple platforms (e.g., population health, QM, UM, claims and encounters, eligibility, pharmacy, and provider data), integrating data into a 360-degree view of the

member. This data integration enables in-depth analysis of risk factors and provides real-time actionable data to support CM functions. We provide more information on our integrated clinical platform's CM capabilities and functions in Table 4.2.2.6_B.

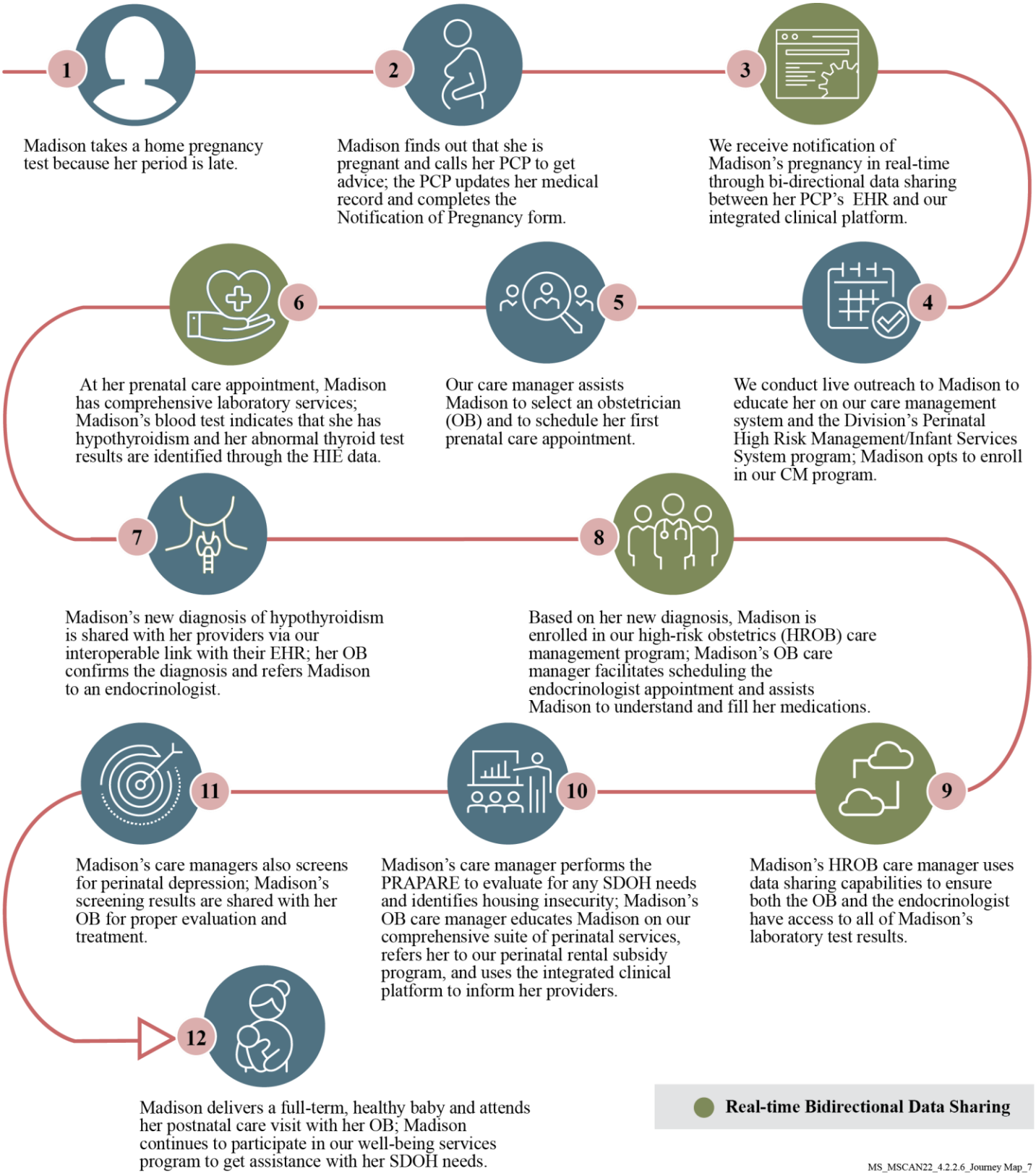
Table 4.2.2.6_B: Care Management Platform Capabilities and Functions

	Functions and Capabilities
Capabilities for Members	▪ Member self-management through communication of person centered clinical and non-clinical (SDOH) information ▪ Bidirectional communication between members and care managers via the member portal ▪ Allows members and their representatives to view information on their assigned care manager, PCP, and individualized care plan ▪ Makes the HRS available to members and their representatives via the member portal (Section 7.4.3.1 of Appendix A) ▪ Interoperates with our member mobile application for member education and support for referrals ▪ Manages member grievances and appeals related to clinical issues
Capabilities for Providers, Stakeholders, and the Division	▪ Allows providers and external case managers (Mississippi Department of Child Protection Services) to view member care plans and authorizations ▪ Exchanges data compliant with HIPAA standards for electronic exchange, national provider identifier (NPI), and privacy and security requirements (45 CFR 162 and 164) and Appendix A, Section 16.5 ▪ Manages provider grievances and appeals related to clinical issues Supports making all collected data available to the Division, CMS, the Mississippi Department of Insurance, and any other oversight agency ▪ Allows for bidirectional communication between providers and care managers via the provider portal
Capabilities for Care Managers	▪ Assists care managers with making referrals for physical health, BH, and social services to close gaps in care ▪ Identifies members at risk for readmission needing transition of care services ▪ Connects to CM and population health dashboards to integrate, analyze, and visualize data to support care managers and providers with easy-to-use, actionable data ▪ Compiles member demographic and health information including utilization history, health status, medications, and social determinant of health (SDOH) factors to inform CM activities ▪ Risk stratifies members monthly into high, moderate, and low risk categories, using predictive analytics, industry standard tools, and members' health risk screening (HRS), comprehensive health assessment, and other screenings ▪ Identifies members for outreach, assessment, and engagement in CM, including members of priority populations the Division identified ▪ Notifies care managers of initial and updated assessment and care plans due ▪ Set reminders for care managers to review status of referrals closing the referral loop for clinical and social services ▪ Uses member specific assessments using branching logic in comprehensive health assessment protocols to include additional tools, such as condition specific elements, PRAPARE, and behavioral health assessments such as the PHQ9

Figure 4.2.2.6_D depicts a member journey, highlighting how we will use our unique model of provider-payer integration and our unparalleled access to real-time data through connection to a statewide health information exchange (HIE) and interoperability with our providers' EHRs improves coordination of care between our care management teams, members' PCPs and specialists, and community-based partners, resulting in improved health outcomes and decreased avoidable high-cost utilization.

Figure 4.2.2.6_D: Madison's Journey to a Healthy Delivery Supported by Real-time Data Sharing

Our real-time bidirectional data sharing capabilities support the timely and effective delivery of care.



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4.2.2.6.B.2. Describe how the Offeror will leverage its technology to measure the success of Quality Management strategies.

Our technology capabilities consistently measure the success of our quality management (QM) strategies, including our quality improvement, population health management, and value-based purchasing (VBP) programs and our performance improvement projects (PIPs). We use our technology to support and comply

with the Division's Comprehensive Quality Strategy as outlined in Section 8 of Appendix A, including all QM reporting requirements in Section 11 of Appendix A, and 42 C.F.R 438.330 requirements for systematic data collection of performance and member outcomes. We are committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based care, and operational excellence which brings a new era of provider collaboration to Mississippi. For MSCAN and CHIP members, through our technology **we will transform** the delivery system by assessing and improving:

- Delivery of quality health care services close to real-time.
- Access to care, addressing barriers related to social determinants of health and geography.
- Overall cost of care, reducing avoidable high-cost utilization.
- Member outcomes (closing care gaps, improving healthcare effectiveness data and information set (HEDIS) scores, reducing potential quality of care concerns, addressing social determinants of health (SDOH), etc.).

We work to aggregate and standardize data across multiple sources into a unified data structure that enables us to accurately measure the impact of various programs and initiatives on member health outcomes. We use a **modern data platform** to aggregate data for quality management purposes; we perform integration and regression testing and apply Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) protocols and the National Committee for Quality Assurance's (NCQA) HEDIS® technical specifications to confirm the integrity and completeness of the aggregated data (Figure 4.2.2.6_F).

Our **end-to-end QM, business intelligence and analytics platform**, provides a suite of pre-built, configurable analytics tools, dashboards, and rich visualizations. Leveraging the real-time bidirectional EHR data feeds, it creates a 360-degree view of member and providers' QM measures to support trending and benchmarking, traceability, and quality improvement initiatives (Table 4.2.2.6_C.)

Table 4.2.2.6_C: QM Platform Capabilities

Module	Capabilities
Measure Engine	▪ Access to over 750 key performance indicators (KPIs), including HEDIS and CMS core sets – the largest measure library in the industry ▪ Configurability and flexibility to support subpopulation and cohort-level measurement, including compliance studies for individual members
Medical Record Review (MRR)	▪ Automated MRR, with flexible management of campaigns for priority MRR objectives ▪ Rules library to support configurable prioritization of medical record data requests
Data Submission	▪ Generation of files for NCQA, CMS, and Division submission of QM data ▪ Automated reconciliation and validation of data for submission
Analytics and Reporting	▪ Standard reports for all QM needs, including HEDIS measures, CMS core sets, and provider-level data ▪ Built-in data science capabilities to predict a members' measure denominator qualification, measure compliance rate, and identify a focused member list for outreach

The QM platform takes feeds from the modern data platform to automate our quality measurement processes. The platform has additional flexibility to add custom reports or modify the existing user interface. The QM platform provides a holistic view of providers, members and measures with rate benchmarking, rate trending, rate traceability, member drilldowns and provider scorecards (Figure 4.2.2.6_G).

In addition, we use the QM platform to measure provider performance as part of our VBP program. The end-to-end QM platform includes customized, built in KPIs and analytics across all types of quality management measures, (e.g., clinical quality, financial, operational, and utilization measures), giving us and our VBP providers a comprehensive view of all performance measures related to their unique VBP agreement. The end-to-end QM platform supports measurement of the success of our VBP program by:

- Leveraging artificial intelligence (AI) and data science models to support decision-making for a VBP provider by providing information on benchmarks and target outcomes.
- Supporting the alignment of quality strategies and driving efficiencies in quality improvement efforts across the provider network for VBP initiatives.
- Offering VBP providers self-service tools to empower them to manage their own gaps and metrics independently.

Our real-time data exchange capabilities allow us to have a more complete and accurate view of provider performance and member care needs to resolve data gaps more quickly (e.g., lab values, historical information on procedures, etc.). We capture data within our systems which we analyze and push back to the providers' electronic health records (EHRs) and analytics systems, such as information related to pay for performance metrics, HEDIS measures, over and underutilization, potentially avoidable admissions and readmissions, gaps in care, encounters, member SDOH, etc. Our modern data platform and end-to-end QM platform pull and push information between our systems and provider EHRs, allowing for real-time access to actionable data for all parties involved in member care. Our technology allows providers to review information related to our members in their care and to act upon care alerts. We send gaps in care data to providers' EHRs, specific to the members they serve, and receive clinical data from the EHRs allowing us to track gap closures and feed the QM platform to evaluate financial impact. This technology supports our providers in meeting quality initiatives such as the Quality

Incentive Payment Program (QIPP) by reducing administrative burden (e.g., chart review requests), improving discharge planning, and assisting them in identifying and closing gaps in care for their assigned members.

[redacted]

4.2.2.6.B.3. Describe how the Offeror will leverage its technology to effectively analyze utilization and create strategies to ensure that utilization is appropriate.

Our enterprise MMIS incorporates systems that enable thorough, timely analysis of utilization and the development of strategies that ensure utilization is appropriate, per the requirements of Appendix A. Through our utilization management (UM) technology, we monitor service utilization patterns, including volume of requests for services, inpatient services, outpatient services including behavioral health, and preventive care, per Section 8.16 of Appendix A. In all UM functions, our technology complies with Appendix A, Sections 16.5 and 16.7.1.

We use our integrated clinical platform, to manage appropriate utilization across all products and markets. Our system assures **transparency and accountability to our members** by guiding our determination and supporting the delivery of appropriate care, **and to the Division for prudent stewardship of public funds**. Our clinical platform is integrated with MCG, our member and provider portals, and our claims processing system. As part of our fully integrated service delivery model, our integrated clinical platform also provides a holistic member view facilitating coordination between the UM, care management (CM), and quality management (QM) departments. Additionally, there are processes and reporting in place within our integrated clinical platform system to enable referrals from UM to CM or QM.

Our Provider Friendly Strategy. Our innovative platform integration supports our commitment to transforming health care continuity for Mississippi members and will elevate our partnership with providers. Our platform allows ongoing bidirectional data analysis and real-time reporting of member care needs and utilization opportunities. It supports bidirectional conversation with the provider, analysis of the information we receive, and creation and sharing of actionable data with providers The integration between our provider portal and our integrated clinical platform allows providers to easily submit requests for prior authorization (PA), which reduces burdensome administrative processes and supports members' timely access to needed in care. Our providers have several ways to communicate with us via easy-to-use, intuitive technology. These include:

Submission of Prior Authorization Requests Using the Provider Portal: In accordance with Section 4.3.1.9 of Appendix A, we make available to our providers and Division staff a secure web-based, electronic review request system, through which:

- Providers may submit requests and view determination for all services
- We accept supporting documentation for PA requests, via secure electronic upload through the web-based system. Our web-based, electronic review request system for PA and prepayment review allows for data input by the submitting providers.
- We use our capability to run an automated criteria/rules-based certification system.
- Providers can submit electronic requests for PAs for inpatient and outpatient services for physical and behavioral health including initial, continued stay, discharge notifications and more. We record real-time transactions when using our provider portal.
- Providers may use our PA look up tool. This tool relieves providers and UM staff of administrative burden assuring submission of PA requests only when necessary.
- Providers have immediate access related to current authorization status including if under review or with a final determination.
- When criteria are met, our PA tool embedded within our portal, provides an automated and immediate determination. Through this tool we can customize rules based on unique criteria incorporating MCG guidelines or other internally approved guidelines used for review.

Submission of Prior Authorization using Technology: Our innovative technology allows a provider to submit an authorization request directly from their electronic health record (EHR), allowing for **bidirectional communication with our UM staff**. The integration between our authorization technology and our web-based tool for automated PA creates for the provider a real-time notice of our receipt of authorization requests and notification of approval or adverse determination for many requests. This system improves communication with providers and collaboration on evidence-based criteria, especially for urgent inpatient admission.

Our technology also allows us to update pended reviews with additional information and/or an updated status, and for both us and providers to continue communicating beyond the initial review to the concurrent review. Through our technology, we achieve alignment in healthcare delivery through evidence-based practices and support maximum workflow efficiency.

Use of Technology to Improve Utilization Management Processes. In addition, our technology encompasses a variety of innovations developed by our expert data analytics and information technology teams, designed to streamline UM processes, and build efficiency. Innovative technology we use to effectively analyze utilization and ensure utilization is appropriate include:

- **Predictive analytics**: Identifies avoidable potential future utilization including:
  - **Prediction of readmissions** – This model establishes the risk of readmission based on demographics, social determinants of health (SDOH), clinical diagnosis, medical history, and the industry standard length of stay, acuity, comorbidities, and emergent (LACE) index. We isolate the data of members with behavioral health

and other complex conditions to help understand the specific challenges that might escalate their readmission risk.

  - **Inpatient large case predictive model** – This model evaluates active inpatient cases and predicts which are likely to result in an unusually long length of stay or adverse post-acute outcome. We use this tool to actively manage inpatient admissions for an appropriate length of stay, support concurrent review, and to more accurately reserve costs.

- **Tracking and Trending PA Approvals:** Supports identification of codes for removal of PA requirements to reduce provider burden and facilitate timely access to appropriate health care services for members
- **Medical Cost Dashboard:** Tracks comprehensive UM data supporting analysis of inpatient, outpatient, ED, pharmacy utilization; facilitates creation of strategies to ensure that utilization is appropriate.
- **Geospatial mapping**: Enables UM staff to monitor service utilization patterns within geographic areas to target interventions
- Receipt of Admission, Discharge, Transfers (ADT) through 278 Transactions: Relieves the burden of hospitals to notify us of admission through:
  - Automated capabilities using 278 transactions to include real-time creation of a case and response back to the provider to confirm and reference the case identification
  - Automated case updates with discharge information

4.2.2.6.B.4. Describe how the Offeror will leverage its technology to measure the efficacy of Population Health Initiatives and adjust Population Health strategies.

Our population health technology is vital to the collection, analysis, integration, and reporting of data that supports the measurement of the efficacy of our population health initiatives. We use our technology to analyze comprehensive data sources including publicly available population health data, Division and other state agency reports, enrollment data, claims, pharmacy data, member screenings and assessments, and member and provider feedback, among others, to identify member needs and establish baseline measures against which to measure population health strategy impacts. We are committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi.

We use a data-driven, outcome focused approach to inform population health initiative design to achieve and exceed the requirements of Appendix A, Section 16.5.2, including improving health outcomes, reducing the total cost of care for Mississippi Medicaid members, and supporting the Division to modernize and execute data analytic strategies. We affirm that we use any common data platform, analytical framework, or other data use architecture provided by the Division for population health management.

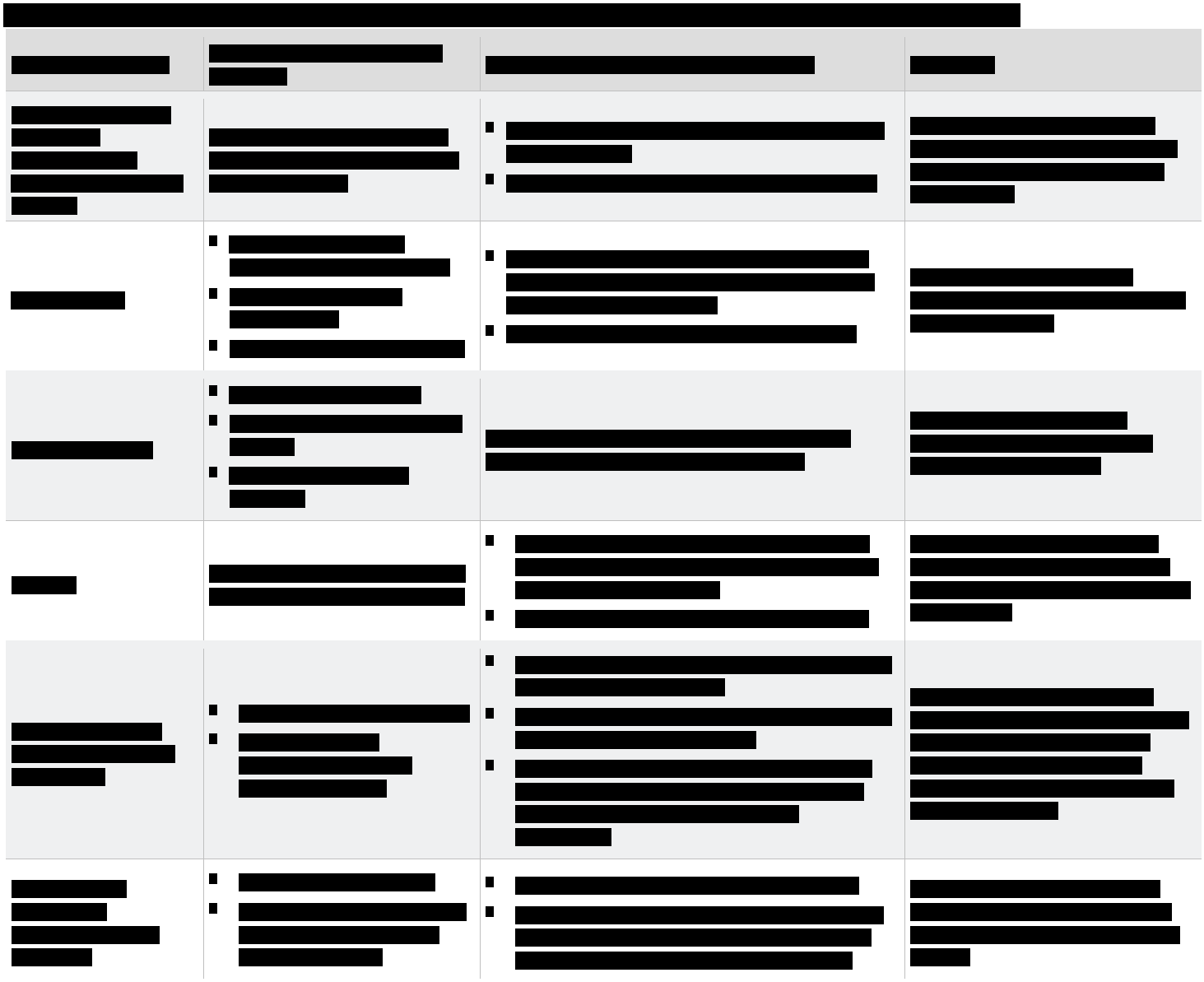
Our technology supports the measurement of the efficacy of our population health initiatives by collecting data including geography, race, ethnicity, income, age, gender, language, disability, and social determinants of health (SDOH) to support identification of disparities in health outcomes and access to care. We use our technology to conduct predictive analytics and identify member populations with special needs, risks, and health considerations. Our innovative models include identification and stratification of high-risk pregnancies, identification of members at risk for homelessness, prediction of readmissions, member specific SDOH indices (e.g., economic stability, education, etc.) and disease/comorbidity identification and risk stratification.

Predictive modeling is key to identifying members who would benefit from our population health initiatives, allowing us to measure their health status before and after participation through self-reporting, health care utilization data, claims, and total cost of care.

Using the principles of continuous quality improvement and a plan-do-study-act methodology, we use our technology to collect measurement indicator data for areas of clinical priority and quality of care, aligned with the Division's objectives, national, regional, and local best practices, or clinical practice guidelines reviewed and approved by our provider advisory committee. We use the population health analytics supported by our technology to develop member-centric, culturally and linguistically relevant, and trauma-informed programs and initiatives with detailed specific, measurable, achievable, relevant, and time-bound (SMART) objectives. These analytics help us establish baseline data for key performance indicators (KPIs), targeted milestones and benchmarks for our population health objectives, and pre-/post-analysis and/or comparative studies to measure the effectives our initiatives.

We use our population health dashboard (Figure 4.2.2.6_H) to filter data by population cohort (e.g., behavioral health (BH); intellectual and developmental disabilities (IDD); serious mental illness (SMI); substance use disorder (SUD); and foster care). Within each cohort, the dashboard breaks the membership down by variables, including age; ethnicity; geography; attributed primary care provider (PCP); SDOH; quality gap; and BH. Users can select a population of interest, explore meaningful characteristics of the population, filter down to specific member lists of targeted subpopulations, and export and share data with others.

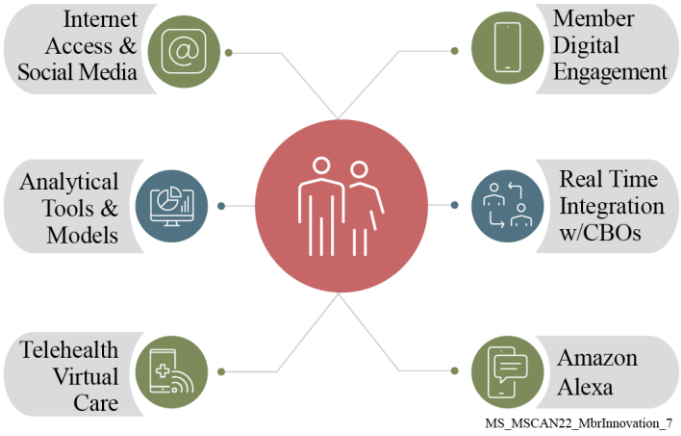
Table 4.2.2.6_D highlights our success across multiple states in applying data to drive interventions that had a measurable impact on member outcomes.



4.2.2.6.C. Innovation

We have built an information technology foundation designed to enable innovation. We focus on driving improvements for both members and providers by introducing innovative technologies. We expanded our digital footprint to incorporate a call center that supported natural language processing; we transformed our systems to enable artificial intelligence (AI) and machine learning (ML) technologies. Our enterprise Medicaid service delivery solution is optimized to leverage process automation and interoperability and quickly introduce highly reliable, available, and resilient IT solutions for members, providers, and the Division. With a foundation in place, as shown in Figure 4.2.2.6_I, our platform includes process automation and offers future benefits to the Division, its members, and its providers. With ready access to a broad spectrum of data sets, our innovation continuum provides access to a **technology footprint with a solid foundation for innovation, digital enablement, capabilities, integrated care capabilities, and advanced analytics and decision making.**

Figure 4.2.2.6_I: Member Innovations
Our innovations impact member outcomes and improve service delivery to our members.

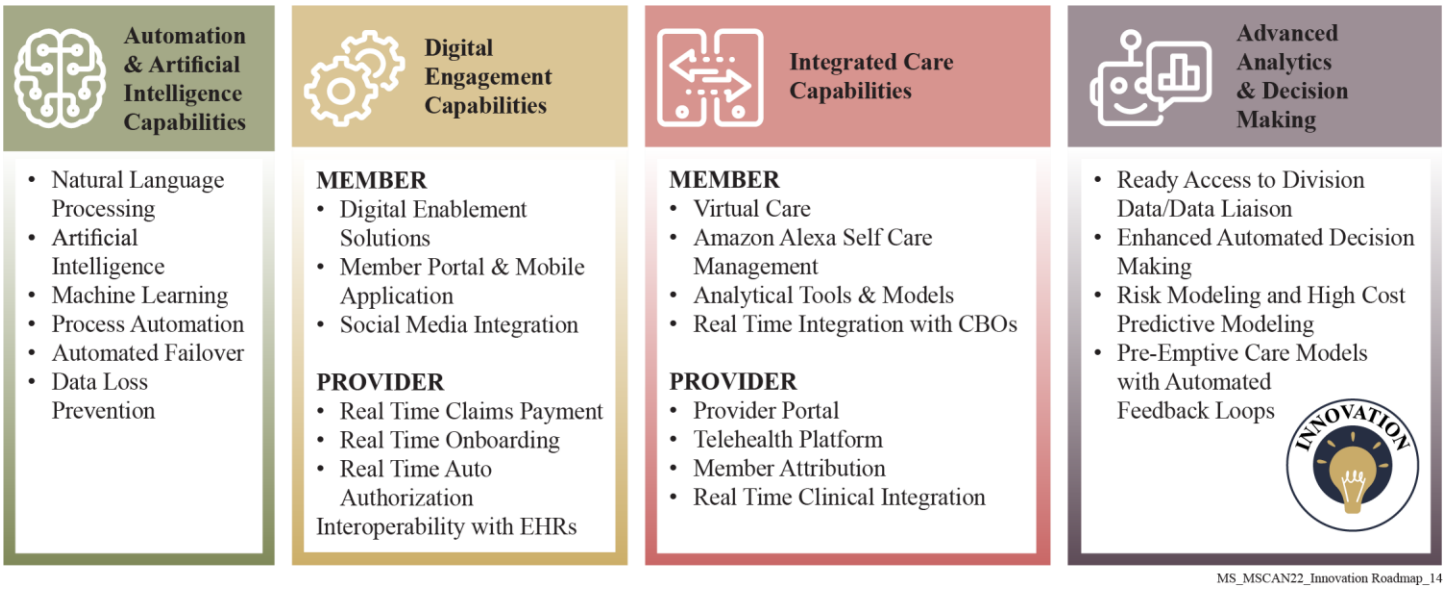


4.2.2.6.C.1. Describe what innovative technological methods, if any, the Offeror will utilize in the delivery of services to members.

Our digital enablement solutions encourage a digital culture and improve the delivery of services to our members, providers, and the Division. **Our innovative programs and services consistently improve health outcomes for the Division's priority areas.**

Our solutions enhance data collection, provide data-driven insights, use our internal business and information technology (IT) resources more effectively, and meet all federal standards for accessibility. Figure 4.2.2.6_J highlights our member innovations including those that drive positive outcomes through **digital engagement, analytical tools and models impacting member outcomes, real-time integration with community-based organizational data, and support for virtual care.**

Figure 4.2.2.6_J: Technological Innovations
Our technological innovations improve the operational experience for Mississippi Medicaid members and providers while meeting Division goals.



Member Digital Engagement. Our member portal makes it easy to find a doctor, obtain an identification (ID) card, review claims, make payments and engage with care managers, nurses, life coaches, and providers via our telehealth platform. Our sophisticated member/mobile application offers a personalized health guide based on a member's specific health risk or condition. Our application provides support for emotional health, providing a tool to strengthen the mind, body, and spirit. Our members enjoy secure communications with our care team or their provider and can participate in online focus groups. Our member chat community solution offers access to educational discussions. Members who enable text messaging can complete their health risk assessments electronically. We offer an online community that connects teens to school resources and community services; has peer-to-peer testimonies and advice columns and fosters resilience by giving teens a safe space to share their behavioral health stories and access behavioral health resources.

Self-Care Management Technology. We are breaking ground in secure member communications with an Amazon Alexa home device to help members, especially those with limited mobility, engage with us. This technology can mitigate health disparities related to the lack of technology and mobility and can positively impact self-management. Through secure links to the member's portal account, members hear real-time information on pharmacy refills, eligibility status, access, can communicate with the care team, and review the most relevant health information.

Social Media Engagement. We **leverage social media** to provide two-way communication when, where, and how the member wants to engage. This includes a streamlined path to telehealth services and access to immediate online help, as well as coordination with the member's primary care provider. We offer dedicated MSCAN and CHIP Facebook pages, administered by dedicated social media staff during business hours, and customized chatbots to enable self-service 24 hours a day. We are available on Instagram, Twitter, LinkedIn, YouTube, Google Reviews, and Google Business Message. We also monitor and follow Reddit, Tumblr and TikTok, and other emerging platforms as a social media scan to determine changes in member sentiment. We find social media to be extremely effective in creating a customer care dialogue, as shown by the 1,100% increase in consumer care interactions (i.e., flu shot reminders) due to our social media presence in other Medicaid markets.

Analytical Tools and Models Impacting Member Outcomes. Our predictive modeling toolset directly impacts health outcomes for our members. Predictive analytics focuses on all aspects of the member experience. Our tools and models allow us to parse our diverse data set to fully integrate our delivery of care and proactively assist members with high risk factors. Our models provide insight and predict outcomes including:

- Health disparities and disproportionate impact of chronic disease
- Stratification data including high risk pregnancies and homelessness
- Social determinants of health (SDOH) algorithms to benefit outcomes for children
- Identification of high acuity inpatient cases to support prioritization of safe and efficient transitions of care
- Bidirectional data sharing with the Division's pharmacy benefit administrator into our clinical systems in near real-time

Real-Time Bidirectional Integration with Community-Based Organizational Data. We recognize, value, and collaborate with community-based organizations (CBOs) to extend our outreach strategy to engage members. Our integrated care team members and community services staff make direct referrals via warm handoffs to CBOs to connect members to needed services (and document those referrals in our integrated platform to ensure tracking and follow-up). We will support specific Mississippi CBOs to address critical needs and real-time bidirectional sharing, supported by our interoperability capabilities, of information for our members to improve health outcomes and address SDOH. Our initiatives are detailed in Table 4.2.2.6_E.

Table 4.2.2.6_E: Real-Time Bidirectional Integration with Community-Based Organizational Data

Initiative	Description
[redacted]	[redacted]
CarePortal	We will partner with CarePortal, a national faith-based, digital platform that connects child-serving agencies, local churches, and community champions throughout Mississippi. When a care manager, life coach, or child welfare worker needs resources for one of our members, they log the request in CarePortal and have specially trained church organizations to respond to the needs of our members in real-time. Our members and child welfare case managers access resources through the CarePortal platform. Referrals and resource information automatically feeds into our integrated clinical platform to "close the loop," ensuring impact of those referrals in our members' lives. In 2021, CarePortal technology supported over 3,100 churches in 28 states, fielding 21,500 requests and met 75% of all requests. The technology helped 33,800 children and families with an economic impact of $13 million.
Housing Locator System	We will partner with a national housing locator vendor to provide professional housing location and listing services for members who are experiencing housing instability or homelessness. The housing locator allows our community-based team to help displaced households in finding new housing and offer waiting list opening support. The service is a powerful platform for finding critically needed affordable, accessible, and special needs housing. The housing locator integrates into our single member view in our integrated clinical platform and can pinpoint housing units for members based upon their unique circumstances. The platform provides reports and analytics on user activity and other key metrics so that our SDOH leaders can gauge housing gaps and develop interventions to meet our members' most basic needs
Bridging the Digital Divide	Access to technology and connectivity often presents disparities among our members. We understand this is an issue of concern in Mississippi. To address this issue, we will partner with local agencies and Mississippi-based communications firm CSpire to drive access to high-speed internet and devices. Anticipated impacts include education support, employment opportunities, access to telehealth, online health communications, and increased member engagement.

Telehealth Virtual Care and Remote Patient Monitoring. Our culture of innovation drives us to understand the importance of meeting our members where they are. That means creating solutions for our members to interact with us in ways that work best for their unique situations and needs and methods that are convenient, easy, efficient, and allow for secure exchange of health care information.

Mother and Child Prenatal and Postpartum Telehealth Visits. We offer prenatal and postpartum telehealth care for mothers and babies. Virtual prenatal services include telehealth doulas support, behavioral health, and coordination with primary obstetricians. Postpartum telehealth visits engage members with our nurse practitioners assisting members in rural areas with limited services. Telehealth visits, with a disease management focus, also engage mothers and children over two years of age, augmenting care from providers and addressing preventive health needs and clinical concerns.

Remote Patient Monitoring. We offer remote patient monitoring (RPM) to empower members managing chronic conditions (i.e., hypertension, high-risk pregnancies, diabetes, congestive heart failure, obesity, asthma, COPD, and behavioral health). RPM assists members in rural areas or where access to a provider is difficult. Members can connect to the member portal for synchronized feeds of their biometrics and track progress with their self-paced care plan activities. Members have access to self-paced learnings and can access telehealth for video consults with the care team. Our RPM program is an extension of the clinical care team to offer surveillance and early intervention to encourage the member to manage their chronic conditions and promote optimal wellness. The RPM technology allows for compliance tools attached to our integrated clinical platform; individualized modules; self-care protocols and patient teach-back; nutritional support; and care team data feeds and communication.

4.2.2.6.C.2. Describe what innovative technological methods, if any, the Offeror will utilize in development and maintenance of its provider network.

We understand that supporting the development and maintenance of our provider network is a continuous process where we evaluate performance, identify gaps and drive improvements for our provider communities. Building a strong network is linked to offering **digital enablement, interoperability, real-time clinical data exchange** for our providers. Our innovative solutions, shown in Figure 4.2.2.6_K, benefit providers, streamline

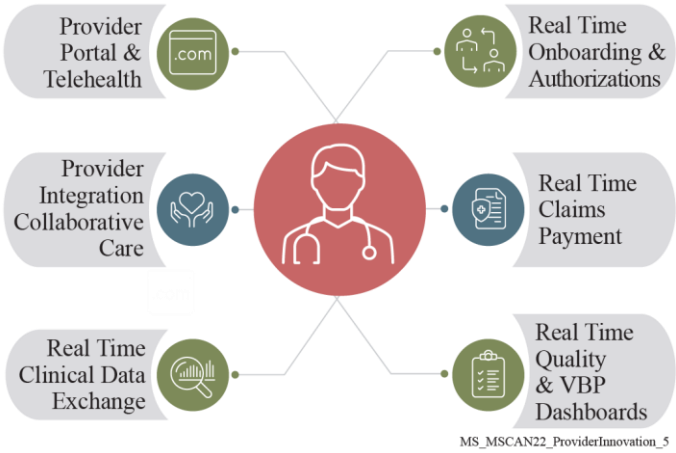
administrative activities allowing them to focus on patient care, and provide real-time data so they can achieve better healthcare outcomes for MSCAN members.

Provider Portal. We offer a best-in-class secure provider portal. It is an essential self-service tool that enables quick access to information related to member care and allows providers to securely submit medical documentation for prior authorizations, claims, disputes, and appeals. **If a provider is currently not contracted with us, our portal allows them to initiate an official contract request and submit the appropriate forms in a near real-time manner.** Providers can communicate with our provider representatives using a secure chat feature. We release ongoing innovations and enhancements of provider portal functionality, such as improved interoperability with our integrated clinical platform, throughout the year targeting highly requested features identified through the provider feedback mechanisms.

Telehealth Platform Access for Providers. We support our provider community through access to a telehealth platform. if they do not already have access to one through their organization. Our platform allows members expanded access to behavioral health and rural health providers. We work with all network providers to encourage and support them in offering telehealth as an adjunct to office visits for appropriate acute, chronic, and preventive services while reinforcing the importance of in-person visits. Members schedule telehealth visits with their providers the same way they schedule in-person visits, including online scheduling through the member portal. For members engaged in care management or community services programs, we can provide tablets or other internet-ready devices through our member assistance fund. The technology platform supports on-demand video chat and scheduling.

Figure 4.2.2.6_K: Telehealth Platform Provider Access

Our innovations put real-time data in the hands of our providers.



Real-Time Claim Payment. Our provider portal allows for a real-time claims payment feature. Real-time claims payment capability supports expedited payment to select provider groups. This capability improves the cash flow associated with providers serving our members in rural locations to improve access to care and the quality of member health care. Using the real-time claims payment feature, select rural providers, which rely heavily on Medicaid reimbursement for daily cash flow, can submit specific procedure codes **for immediate processing and receive their payment within minutes**.

Real-Time Provider Onboarding Status Monitoring. As part of the onboarding process, providers can check their contracting and credentialing status on our provider portal. Providers have real-time information to keep them updated and streamline the onboarding processes so they can better serve our members.

Real-Time Authorizations. Through integration with our provider portal and a clinical support tool, providers can obtain an authorization in seconds. Providers submit prior authorization requests and **receive near real-time responses** for over 1000 current procedural terminology (CPT) codes if the pre-guideline criteria are met, and over 150 services if the provider-completed service guideline criteria are met.

Provider Integration with Our Web-Based Authorization Tool. We leverage our integrated care system and engage in real-time exchange with provider electronic health record (EHR) systems, leveraging our interoperability capabilities. By eliminating the need for fax or separate portal access, we can exchange data directly with providers and automate authorizations, concurrent review, and health information exchange directly with provider information systems. Data exchanges include medical records, notification of admission, requests for additional information, and discharge date.

Real-Time Clinical Data Exchange. We have an end-to-end quality management platform to drive quality improvement and boost network engagement across our populations. Our platform, with AI/ML-based advanced analytics, automated workflows, quality improvement consulting expertise, and coordinated approach protocols—complements and elevates our efforts to drive equitable health care and reduce the administrative burden on providers. Our quality management platform also interoperates with and unifies information from diverse systems for data driven decision making, helping quality teams implement multiple initiatives, streamline provider engagement, and enhance care outcomes. It includes an extensible library of 700+ pre-measures across financial, operational, cost, care quality, and value-based programs. It also offers powerful provider self-service capabilities and an AI-driven recommendation engine. We incentivize our providers to achieve peak performance. Our programs rely on quality parameters defined through our quality analytics efforts reinforcing best practices in prevention, health, and wellness, HEDIS, complex care, and population health. We also use a provider profiling methodology to analyze clinical and administrative data and determine the value-based reimbursement program best suited for a provider. We have a model built on artificial intelligence that allows us to monitor member-to-provider (primary care provider (PCP), patient centered medical home (PCMH) assignment. Our data model takes into account care programs, claims, product differences, and provider quality nuances. Attribution addresses value-based reimbursement in understanding quality of care and provider interaction with attributed members. Over time, our model evaluates and can reassign members to the most appropriate provider.

Using our interoperability capabilities, we offer direct EHR data sharing with large health systems and PCMH providers. Communication occurs directly with the provider's EHR vendor, such as Epic, Cerner, eClinicalworks, and others to tailor a solution for data sharing. This platform uses bidirectional feeds; electronic medical records data from the EHR system to us and to deliver gaps in care including gaps closed at other provider locations as frequently as desired by both parties. We demonstrate the ability to connect with the provider's EHR system by showing the number of sites and interfaces currently linked and demonstrating the platform's aggregation of medical records from the EHR and the direct record transmission to us. This data exchange not only allows us to share member information and gaps in care directly into the provider's EHR but also eliminates the administrative burden associated with chart review requests. To help get members to see their primary care provider at an FQHC or RHC, we use a centralized data reporting and analytics solution that facilitates care transformation, drives quality improvement, aids in cost reduction, and simplifies mandated reporting. With our solution, providers have access to the most accurate information, including quality reporting that assists in member scheduling and reporting for gaps in care, leading to a better care experience.

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

We have an established technology foundation that the Division can leverage across all its members. Using AI/ML technologies and our modern data platform, we make decisions and take actions that directly impact the care and improve the health of members more efficiently and effectively. Our technologies and data sharing methods enable us to provide information and insights to the Division in new and innovative ways.

Digital Ecosystem Built for the Future. Our ecosystem includes comprehensive data analytics and reporting capabilities that deliver true value to the Division. Our models enable our business operations to improve health outcomes, reduce medical costs, manage administrative costs, increase the ability to respond to market disruptors, expand value to members, and efficiently react to the Division's and federal changes. We also use analytics to ensure accurate claims payment and identify potential fraud, waste, and abuse to help minimize disruption and inefficiency in the delivery of medical services. With our move to cloud-based infrastructure, predictive modeling has an automated flow into our integrated clinical platform enabling faster and more actionable use of the Division's data for informed decisions.

Sources of Data to Help State of Mississippi. The data we gather on behalf of the Division into our platforms helps many aspects of managing our contractual requirements and goals, we use our platforms to share this information with the Division and its related agencies. Our unparalleled access to real-time data through

connection to a statewide HIE and interoperability with our providers' EHRs improves coordination of care, resulting in improved health outcomes and decreased avoidable high-cost utilization. We are committed to ensuring all the Division's agencies have access to the information they need to be successful. In our other markets, we have given direct read only views to our care management platform and developed generic data sharing file formats that go much deeper beyond the common healthcare data exchanges. One of our staff members serves as a Data Liaison to the Division, to collaborate with the Division's data analytics needs and offer facilitation, further insight, and orientation to the use and interpretation of the analytics we provide. For example, we will **provide the Division a customized essential indicators dashboard** with the ability to filter for region, gender, care management status, and Patient Centered Medical Home assignment where applicable. Our data liaison will collaborate with the Division regarding which data elements to include in this dashboard. Working with the Division's partners in guiding our roadmaps and capabilities will ensure we are looking beyond today's healthcare data needs.

Priority on Interoperability and Health Information Exchange Capabilities. We are fully compliant with CMS interoperability and patient access requirements in 42 CFR 438.242, 42 CFR 457.1233; 42 CFR 457.760, 42 CFR 438.62, and 42 CFR 438.10 introduced in the Interoperability and Patient Access Final Rule.

[redacted] We leverage real-time data from our innovative CMS interoperability effort to drive decisions for quality efficacy.

We currently participate in HIEs in all markets to where states have them established. We will partner closely with each state's Medicaid administration to develop ADT notifications and other important HIE features. We will partner with multiple leading population health technology companies, which provide plan-to-provider bidirectional information sharing and data-driven reporting and analytics. In multiple states, we have developed a bidirectional electronic information-sharing. Through this arrangement, we provide member-specific gaps in care to FQHCs. In turn, they share information about appointments, encounters, member records, and SDOH data. Using our HIE experience in other markets will enable the successful implementation of our partnership with statewide HIEs in Mississippi. These HIEs provide ADT notifications and offer a comprehensive view of needed preventive and follow-up procedures, as well as an aggregate, practice-level view that enables providers to better plan and manage care for their members. Because HIEs provide an avenue for improved provider collaboration, it is important to achieve high levels of provider interaction with the HIEs. We proactively promote providers' use of the HIE through review of its benefits, the process to gain HIE access during provider orientation, provider meetings, and through our provider portal and newsletters. We emphasize the benefits of HIE use in discussion with PCPs and PCMHs in particular.

Access to Leadership Experience and Insight. Many of our leaders are active participants in workgroups, committees, advisory boards, and strategic initiatives across our many data sharing platforms to ensure we are continuously learning, growing, and evolving in this area. Active participation in HIE industry workgroups includes the NCQA Learning Collaborative, the InterSystems HealthShare Payer Work Group, and American Health Insurance Plans (AHIP)'s HIT and Interoperability Workgroup. Our organization will leverage this engagement as we invest in our partnership with the Division, sharing our depth of experience and technical assistance.

4.2.2.6.D. Continuity of Operations

We are committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of providers through real-time bidirectional data exchanges. Our business resiliency program is a cross-functional discipline designed to ensure that, should a disaster or disruptive incident occur, business operations can continue with as little downtime as possible. Our business continuity plans contain critical business processes and include emergency alternate procedures for ensuring continued operations. Our incident management and communication plans ensure a cohesive, consistent response to any event. The information technology (IT) disaster recovery plan (DRP) has documented procedures to support the invocation of the plan, restoration, recovery, and resumption of IT services to ensure

continuous operation of our services. We have a highly resilient data center architecture using redundant network, infrastructure, and near real-time data replication which allows us to adeptly pivot as needed.

4.2.2.6.D.1. Describe the Offeror's proposed emergency response continuity of operations plan. Attach a copy of the Offeror's plan or summarize how the Offeror's plan addresses the following aspects of pandemic preparedness and natural disaster recovery, including:

Per Amendment 5, our response to this section can be found in Appendix 4.2.2.6.D.1.

[redacted]

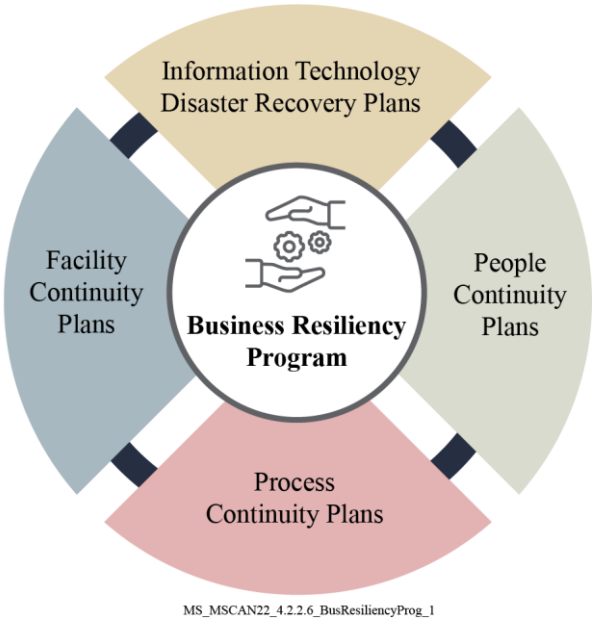
4.2.2.6.D. Continuity of Operations

4.2.2.6.D.1. Describe the Offeror's proposed emergency response continuity of operations plan. Attach a copy of the Offeror's plan or summarize how the Offeror's plan addresses the following aspects of pandemic preparedness and natural disaster recovery, including:

Our business resiliency program defines business continuity (BC) and IT DR as separate but tightly integrated functions within the overall resiliency program. We leverage NIST 800-34 as a framework for our program, which protects our functionality and services in case of any adverse operating conditions. Our business resiliency program includes people continuity plans to address loss of staff or key individuals, business process continuity plans to ensure critical business functions continue during an event, facility continuity plans to address the loss of a facility, and IT DRP to address the loss of applications or infrastructure as depicted in Figure 4.2.2.6.D.1_A.

Figure 4.2.2.6.D.1_A: Business Resiliency Program Components

Our continuity plans ensure we can continue to serve members and conduct business operations, even when facing or recovering from a disaster.



The business resiliency program integrates into business operations, which ensures alignment of the continuity plans with business requirements and addresses all levels of incidents and disruptions, enabling critical business processes to continue to function regardless of extenuating circumstances. Redundancy and resiliency are core design elements of our technical solutions, which reduce the impact of an incident.

Our IT DRP includes comprehensive data backup plans to ensure data is protected from loss and corruption, technical recovery plans to provide for timely recovery of the IT systems, and emergency alternate procedures for critical business processes, which enable the business to continue functioning while IT recovers the systems in the event of an unforeseen outage. As part of our business impact analysis (BIA) process, we review application and data criticality at least annually. We integrate the results of the BIA along with any findings from BC and IT DR exercises as well as updated industry best practices into our plans, resulting in an ongoing evolution of our business resiliency program.

Our business resiliency program incorporates the following activities:

- **Risk Reduction**: Management of risks to prevent an incident and/or disaster
- **Business Impact Analysis**: Departmental review of risks and mitigation plans
- **Incident Management Planning**: Location based management plan for incident response
- **Business Continuity Planning**: Plans for continuation of essential business operations
- **Third Party Supplier Resiliency**: Controls to reduce the risk to the business
- **IT Disaster Recovery Preparedness**: Restoration of critical data and systems at an alternate location
- **Awareness and Training**: Continual initiatives on the Business Continuity and Incident Management Plans
- **Plan Maintenance and Testing**: Ongoing validation and maintenance of processes defined in the plans

a. Employee training;

Employee Awareness and Training

Business continuity training is part of our annual education process to ensure the organization is aware of the BC plans for their departments. We facilitate additional awareness of BC and IT DR through the annual compliance training as well as quarterly, companywide messages around winter weather planning, tornado

season, travel safety, and hurricane season. We hold quarterly meetings with the BC plan owners to review and prioritize program improvement opportunities. Our technical teams review IT DR plans at least annually during tabletop exercises and after any significant organizational or technology changes. Our BC team review plans before the execution of IT DR exercises, providing additional opportunities for training and awareness for the technical teams.

b. Essential business functions and responsible key employees;

Mission critical business processes include but are not limited to the uninterrupted continuity of care and availability of services to MSCAN and CHIP members, care management, claims processing, eligibility and enrollment processing, service authorization management, provider enrollment, and encounter data management.

Our BIA identifies the operations and processes in each location that are essential to business continuity. The objectives of the BIA, assuming a worst-case scenario, include:

- Estimating the financial impacts for the department
- Estimating the operational impacts for the business
- Defining the estimated number of critical staff needed for continuity of the business
- Identifying the critical processes and their supporting assets with recovery objectives
- Identifying critical skill sets for staff to eliminate single points of failure through training and process documentation
- Defining the critical applications and determine their recovery capability
- Defining the complexity of continuity processes
- Identifying any vital records and legal or regulatory requirements
- Reducing the risk to the business due to deficiencies in third party continuity planning and pandemic response planning

The annual BIA review process includes updating criticality of the business processes for each department.

Responsible Key Employees
Our crisis management framework embraces the operational concept of a unified leadership structure, which ensures all functional areas of an organization determine the decision-making and incident resolution process. We leverage our enterprise capabilities and local in-state resources to synchronize both actions and communications related to incidents that may affect the Division.

The director of business resiliency is responsible for managing our business resiliency program and team. Through our unified command structure, we have successfully navigated significant events including, but not limited to pandemics, weather emergencies, civil unrest, natural disasters, cyber-attacks, water and power outages, and acts of terrorism. Our incident management team (IMT), shown in Table 4.2.2.6.D.1_A, provides focused, direct support to localized, situational events. Our incident commander leads this team and brings together support from enterprise and local market resources. These resources ensure high-level visibility across our resiliency program and guarantee situational awareness of corporate and regional incidents to ensure an appropriate foundational response for future incidents in Mississippi. Leaders from key business areas form the IMT to evaluate incidents, establish criticality and impact levels, and formulate a coordinated response to an incident that affects a building, processes, or people that is unforeseen. This team assesses and responds to developing or potential incidents supported by the appropriate communication to members, providers, staff, and stakeholders.

Table 4.2.2.6.D.1_A: Sample Incident Management Team

Responsible Key Employee	Tasks / Duties
Director Business Resiliency	Enterprise leadership and coordination
Incident Commander	Leadership of crisis management team resources

Responsible Key Employee	Tasks / Duties
Local Market Compliance Lead	Manages communications with state
Local Market Leadership	Oversees market level recovery efforts
Physical Security and Safety Lead	Arranges and manages security at the incident
Facilities Lead	Provides status and recommendations concerning site and infrastructure
Human Resources Lead	Coordinates support for employees impacted by the event

c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

We have developed our business continuity plans to exceed proven industry standards. Our plans contain information on emergency contact details, mitigation strategies, emergency alternate procedures, communication processes, and staff relocation strategies to move work to other sites or home offices and workload relocation strategies to move the work to alternate resources or locations for large-scale disasters. Our business continuity plans allow departments to adjust quickly and efficiently to changing situations, such as incapacitation of key employees or the loss of a primary workplace, with minimal impact to members or providers. During an incident, our emergency alternate procedures allow critical business processes to continue to operate throughout an incident.

We perform regular monitoring of the risk to our locations where we have an existing presence. This includes events ranging from weather emergencies and cyber attacks to terrorism and pandemics. Our weather communication plans include processes for advance preparedness for pending storms as well as post event employee health and safety assurance. Our pandemic response strategy is based on the advice and pandemic preparation plans of the Centers for Disease Control and Prevention (CDC) and coordinated through our pandemic governance model.

In 2020, we mobilized resources across the company to support our members and communities to address the impact of the COVID-19 pandemic including:

- Ongoing investments in technology such as virtual private network (VPN) and network capacity ensured daily operations are maintained with no impact on productivity.
- The incident management team provided the organization with centralized communications and issue management, which allowed leadership to stay informed while keeping focus on their business units.
- Our business resiliency program ensured we were able to quickly and efficiently scale operations to address a large increase in regulatory changes to ensure members had access to the care they need.
- Our website, member portal, and provider portals are updated with COVID relevant information, helping our members stay informed and to obtain the care they need.

Our fully integrated, transparent service delivery model promotes provider collaboration and communication to ensure Mississippians can easily access their benefits to live healthier lives particularly during difficult times. We successfully executed the business continuity plan utilizing our existing Pandemic Playbook. We were able to move 90% of the staff home the first day following the declaration of the national emergency with an additional 9% in the following few days. There was no impact on business processes or our members during this change and it has allowed us to continue supporting our members during this most difficult time.

d. Communication with staff and suppliers when normal systems are unavailable;

We maintain emergency communication plans for each market as well as for the corporation. This allows for targeted communications during emergency events based on the impact of the incident and provides flexibility to include timely communications with state agencies or outside parties as needed. We utilize an externally hosted emergency communications tool to communicate pre-formatted messages to targeted audiences via text,

email, and voice. This tool helps ensure a detailed explanation of the impact of a disaster on mission critical business processes reaches the right audience, including staff members and suppliers, in a timely manner.

During a post-incident review of recent weather events, we identified a need for coordinated outreach to members during emergency events. We developed Market Emergency Response Teams (MERT) to mobilize the resources needed to support our members. The MERT provides additional member outreach during or after an event, gives recommendations to support agencies such as the Red Cross, expedites system changes in response to regulatory changes such as prior authorizations or prescription limit changes, or sends a reminder of our Member Support phone number. Additionally, we have added seasonal emergency preparedness articles, tips, and suggestions to our quarterly member newsletters to help inform members how to prepare for various situations. From the success of our MERT initiative, we have standardized our processes and communication for all markets.

We tightly integrate our corporate incident management process with IT, cyber security, and privacy incident management to mobilize and ensure the right resources for a rapid and comprehensive response to any situation.

e. Plans to ensure continuity of services to Providers and Members, including the Recovery Time Objective for major components;

Our IT DRP includes documented procedures to support the invocation of the plan, restoration, recovery, and resumption of IT services to ensure continuous operation of our services. We comply with Appendix A, Section 5.1.6. We assign applications a tier based on business criticality from the BIA. Each tier has an overall recovery time objective (RTO) and recovery point objective (RPO) which we use to develop technical recovery solutions. Table 4.2.2.6.D.1_B lists the tier, RTO, RPO, and service class.

Table 4.2.2.6.D.1_B: Business Criticality Tiers

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

We use leading edge data replication technology to continually replicate data across redundant servers and databases in primary, secondary, and tertiary data centers for applications that support mission critical business processes. These processes include claims processing, eligibility and enrollment processing, service authorization management, provider enrollment, encounter data management, and the uninterrupted continuity of care and availability of services to MSCAN and CHIP members. While we provide full business continuity and backup procedures through a multiple data center configuration, our call center also uses virtual desktop and voice over internet protocol (VoIP) technology (soft phones). Our customer service representatives can work from any approved location using this soft phone technology and have secure access to our customer relationship management and member support systems. Our solution enables 24-hour call center functionality independent of location or situational emergency.

Our online backup strategy facilitates a seamless failover to our systems in the secondary data center should a localized incident occur within the region. We restore critical services in our tertiary, out of region, DR data center in case a regional disruption affects both the primary and secondary sites. Restoration of critical services completes in under 24 hours and restoration of normal business functions occurs within seven days of a disaster. We review, test, and update our IT DR plan at least annually.

f. Security and privacy requirements; and

Our information security and privacy programs ensure the creation, access, storage, and transmission of health information is compliant with health insurance portability and accountability act (HIPAA) standards in 45 CFR 160, 162 and 164 and Appendix A, Sections 15.1 and 15.29. The programs include compliance with:

- Administrative procedures and safeguards (45 CFR 164.308)
- Physical safeguards (45 CFR 164.310)
- Technical safeguards (45 CFR 164.312)
- Policies and procedures and documentation requirements (45 CFR 164.316)

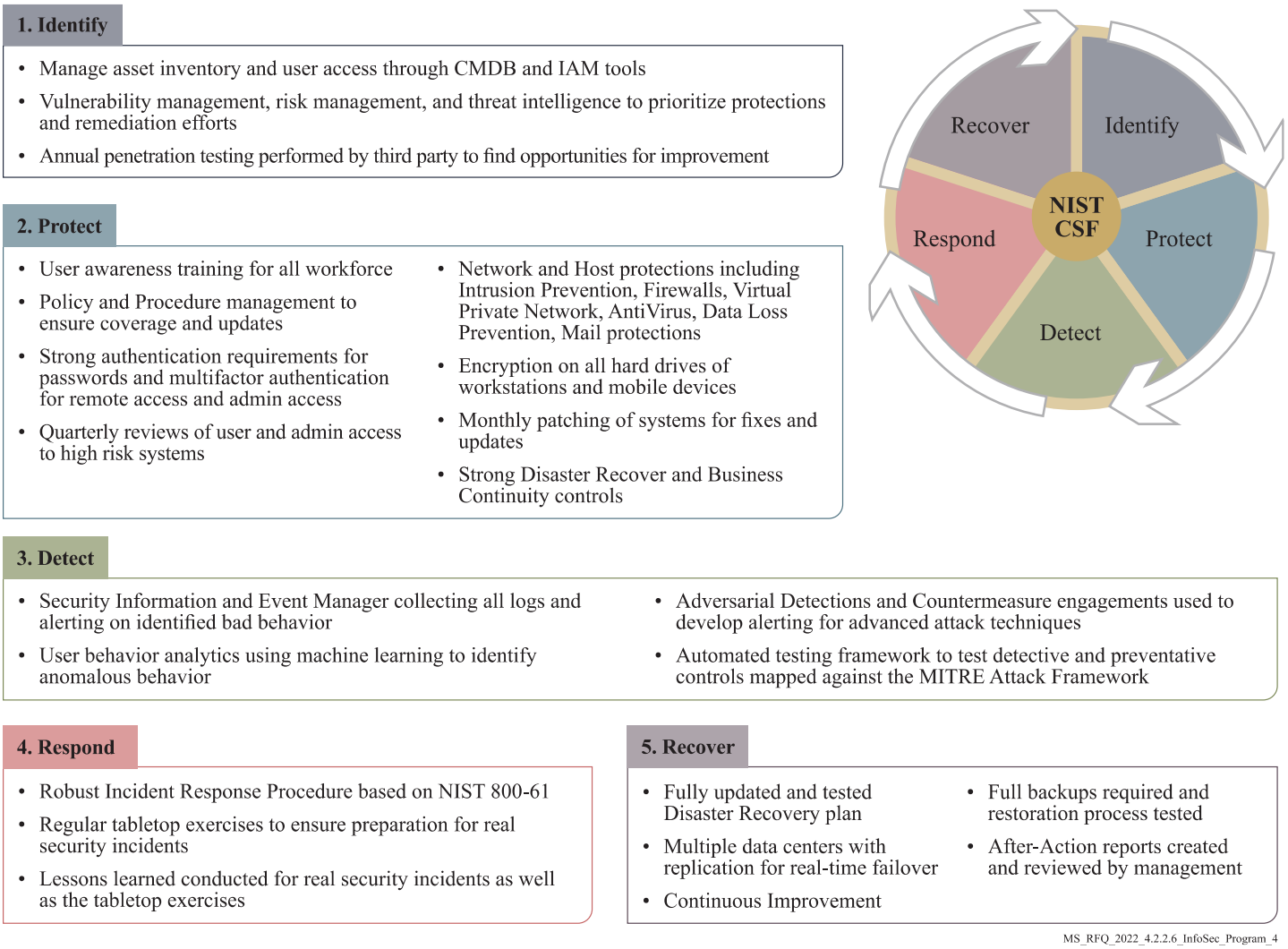
Policies Protecting PHI: Our comprehensive suite of privacy policies and procedures ensure we operate within the HIPAA Privacy and Breach Rules including but not limited to member rights (access, restriction, accounting of disclosure), use and disclosure of protected health information (PHI), minimum necessary, and breach notification. The information security policy and procedure sets address the technical requirements of the security rule including but not limited to information classification, encryption, password policies, physical security, and access. The privacy officer and privacy team maintain and enforce these policies in collaboration with our Compliance and Legal departments.

Safeguards and precautions protecting PHI: We use robust administrative, physical, and technical safeguards to protect the privacy and security of PHI and limit incidental disclosures. We conduct regular HIPAA risk assessments, as required by the regulation. Our most recent assessment had favorable results without any findings of noncompliance. All members of our workforce take precautions to avoid unauthorized disclosure of PHI (including electronic PHI) and ensure the destruction/disposal of such information when necessary and appropriate. We limit access to PHI to those with a business need and with initial and quarterly management approval. We carry out destruction and disposal of PHI and personally identifiable information (PII) in every form following federal and state laws and regulations and our corporate policy. We suspend the destruction and disposal of PHI for records involved in any open investigation, audit, or litigation. All employees must complete new hire and annual privacy and security training.

We leverage the National Institute of Standards and Technology (NIST) Cybersecurity Framework (CSF) to ensure a comprehensive information security program employing widely accepted practices mapped to the NIST 800-53 R4 standard as a benchmark for controls in conjunction with a robust risk management program. Figure 4.2.2.6.D.1_B provides an overview of the information security program by the components of the NIST CSF:

Figure 4.2.2.6.D.1_B: Our Information Security Program

National Institute of Standards and Technology (NIST) Cybersecurity Framework (CSF) ensures a comprehensive security program.



We accept the Division's Confidentiality, Security, and Privacy of Personal Information contractual terms and comply with standards, policies, and guidelines.

g. Testing plan, which should be provided to the Division on an annual basis within 30 days of the request.

All our testing plans are conducted on an annual basis and can be made available to the Division within 30 days of request. We conduct an enterprise-level business continuity exercise on an annual basis. Additionally, we conduct departmental and market level tests as needed to address changes to the organization, business processes, or technology throughout the year. These tests consist of different scenarios ranging from accidental damage localized within a department, widespread accidental damage, natural events or disasters, and deliberate malicious incidents and responses. The process includes a pre-planning phase with tasks such as defining the scope, timeframe, participants, and expected outcome. The execution phase may be a simple meeting with key resources to review the plan tasks or may be more involved with actual recovery of IT systems at our alternate location or relocation of staff to alternate work locations. Post-exercise activities include close out meetings to capture key findings, an after-action report which summarizes the overall test and follow-up action items such as process or documentation improvements, and we track remaining follow up items to completion.

Our IT department conducts tests of its IT DRP at least annually or as needed based on technology or organizational changes to ensure the documented procedures are current and effective. The primary objective of the test is the successful recovery of application/services and data, in the designated RTO and within the RPO. The scope of the test varies based on business objectives but includes the recovery of critical applications and systems. We conduct regular cyber security tabletop exercises to better prepare in the case of a real incident and we utilize a third-party security company to conduct an annual network penetration test.

We provide an annual IT DRP test report to our Medicaid markets summarizing the test scope and objectives, timeline, observations, findings, including failure points and corrective action plans, as applicable, and recommendations. We also provide business resumption documents for DRPs, business contingency plans, facility plans, threat and risk assessments, and all other related documents as requested by the Division on an annual basis within 30 days of request.

[END OF RESPONSE]

4.2.2.7 SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION

4.2.2.7.A Services to be Subcontracted

4.2.2.7.A.1 Describe what services the Offeror will plan to subcontract if chosen as a Contractor.

We subcontract with vendors that demonstrate operational excellence, local knowledge, and expertise, and offer a substantial benefit to Mississippi, the Division, and our members. **Through committed collaboration with our subcontractors, we promote access to care, address social determinants of health (SDOH), foster health equity, create operational efficiencies, and improve member outcomes.** We select subcontractors who have earned our trust and demonstrate performance that exceeds the requirements in Appendix A, Section 13.

We subcontract for the following services:

- Call center quality monitoring
- Dental services management
- Lab benefit management
- Oncology services management
- Print services
- Social determinants of health
- Radiology utilization management
- Telemedicine
- Transportation services
- Vision services management
- Community based organization closed loop referral system

We are committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives. We select vendors to ensure Mississippi receives the "best in the industry" for these specialty services. We start with an analysis of internal vs. external capabilities. Where we find potential external vendors with the expertise, systems, and/or footprint that provides exceptional efficiencies, member service, or economies of scale, we undertake a rigorous procurement process to determine if they can perform at our heightened service level expectations. Our approach utilizes request for proposals, interviews, on-site visits, and a pre-delegation assessment to vet each vendor to arrive at a shortlist. Candidates who score high on our cross-functional review advance to the next step which entails reducing relevant contract terms and service level agreements (SLA) to writing and securing best and final offers. These steps guarantee that we fully disclosed our contract terms and requirements and mutually establish expectations. To assure continuous excellent performance from our vendors, we validate accountability through careful monitoring of stringent SLAs, member satisfaction surveys, and complaint submissions. Our delegation oversight committee, quality committee, compliance committee, subcontractor oversight process, and our fraud, waste, and abuse program perform these oversight functions.

4.2.2.7.A.2 Describe the Offeror's relationship to any potential subcontractors for each service the Offeror plans to subcontract. In describing this relationship, include the business relationship the Offeror has with each subcontractor and the length of experience the Offeror has with each subcontractor.

These subcontractors are non-related independent entities selected through our own transparent and rigorous procurement process. Subcontractor relationships are governed by delegated and other service agreements. These transparent agreements ensure we comply with Division and Appendix A requirements, subcontractor obligations, performance measures, reporting requirements, corrective action, and escalating penalties for recurring non-compliance. We have been overseeing service agreements across multiple markets for over three decades and use outside independent auditors to validate our findings. Table 4.2.2.7_A shows our relationship and experience with each subcontractor by service type.

Table 4.2.2.7_A: Subcontracted Services

Subcontracted Service	Business Relationship	Length of Experience
Call Center Quality Monitoring	Delegated Services Agreement	4 years
Dental Services Management	Delegated Services Agreement	9 years

Subcontracted Service	Business Relationship	Length of Experience
Lab Benefit Management	Delegated Services Agreement	1 year
Oncology Services Management	Delegated Services Agreement	4 years
Print Services	Delegated Services Agreement	30 years
Radiology Utilization Management	Delegated Services Agreement	6 years
Telemedicine	Delegated Services Agreement	6 years
Transportation Services	Delegated Services Agreement	8 years
Vision Services Management	Delegated Services Agreement	5 years
SDOH	Community-Based Service Agreement	8 years
Community Based Organizations	Community-Based Service Agreement	8 years

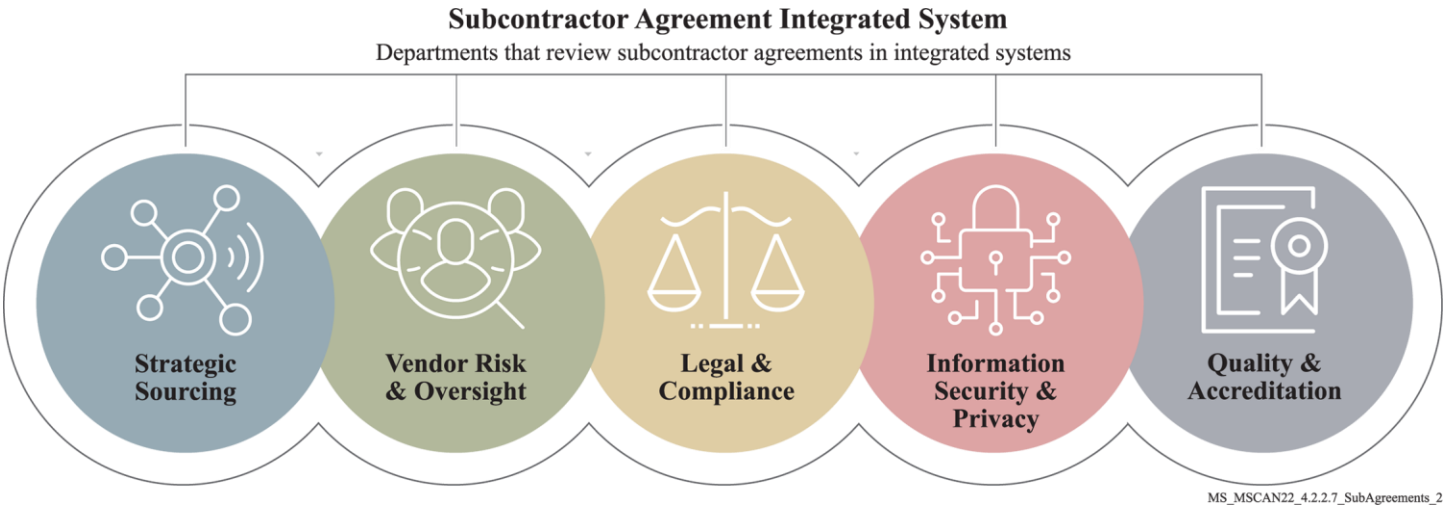
Our vendor contract procurement and oversight processes align and comply with Appendix A, Section 13 requirements, including, 1) obtaining the Division's prior approval of all subcontractors and changes, 2) continuous monitoring and evaluating of subcontractor performance and financial stability, and 3) submitting all required reports on time. We retain ultimate liability and legal responsibility for the performance of our vendors. Completion of the subcontracting process occurs only after we complete a thorough due diligence analysis to ensure subcontractors can meet the requirements of the Draft Contract including provisions against balanced billing and the offering of gratuities. Once we are fully satisfied that the potential subcontractor can deliver the value and quality performance expected by the Division and us, we submit to the Division for approval per the requirement in Appendix A, Section 13.2.3.

4.2.2.7. B Subcontractor Oversight

4.2.2.7.B.1 Describe the Offeror's Subcontractor oversight program. Specifically describe how the Offeror will:
a. Provide ongoing oversight of the Offeror's Subcontractors, including a summary of oversight activities, organizational infrastructure that supports Subcontractor oversight, and the types of reports required from each Subcontractor;

We ensure transparent delivery of high quality administrative and appropriate clinical services in adherence to all state and federal laws, including 42 CFR §438.230 and Appendix A, Section 13, including the right to audit. We own responsibility for program delivery, administration, and transparent management of our subcontractors. Our specially trained vendor oversight team, in collaboration with our subject matter functional experts, supported by policies and procedures and a robust committee structure, manages our subcontractor oversight processes. Figure 4.2.2.7_A shows the framework we employ which governs written agreements with all subcontractors. This framework ensures we have written agreements with all entities with whom we subcontract that define subcontractor activities, reporting, and penalties if the subcontractor does not meet its requirements.

Figure 4.2.2.7_A: Subcontractor Oversight
Our integrated departments govern all agreements with subcontractors.



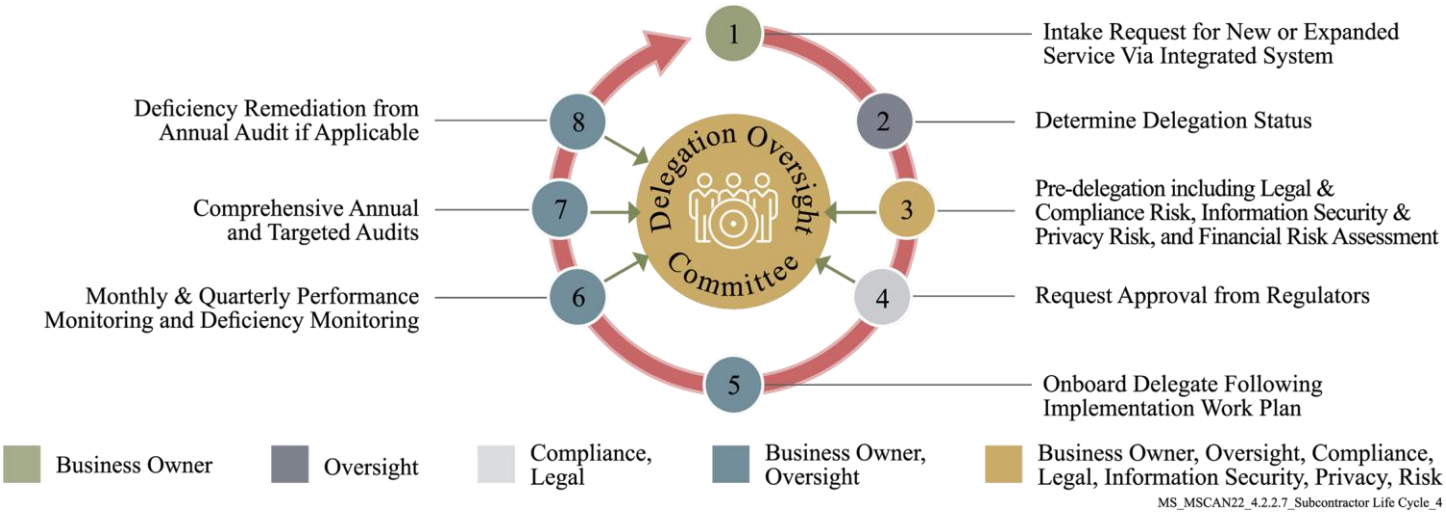
Summary of Oversight Activities

Prior to submission to the Division for approval, our strategic sourcing, vendor risk and oversight, legal, information security and privacy, and quality and accreditation teams review and approve all subcontractor candidates via an integrated and transparent process and platform (discussed in Subsection D). Our vendor risk and oversight team continuously monitors and evaluates subcontractor operational and financial performance through both proactive and pre-emptive activities, demonstrated in Figure 4.2.2.7_B, to identify critical vendor issues before they emerge. We prepare and submit comprehensive reports to the Division as required or requested.

Figure 4.2.2.7_B displays the life-cycle relationship with subcontractors. Accountability standards begin on day one with rigorous conditions set in the preselection process.

Figure 4.2.2.7_B: Subcontractor Life Cycle

Our life cycle of the subcontracting process from Intake to Remediation helps ensure we meet all contractual requirements.



We hold our subcontractors to a higher standard than required by state contract requirements. Our vendor oversight database provides metrics and scorecards for review with subcontractors. Beyond regulatory SLAs, these activities, as shown in Table 4.2.2.7_B, are monitored proactively for changes in performance and regulatory reporting.

Table 4.2.2.7_B: Subcontractor Activities

Subcontractor performance management is a collaborative effort between our business operations, vendor oversight, compliance teams, and the subcontractor.

Timing	Subcontractor Monitoring Activity	
Daily	▪ Daily communication and dialogue as needed to address immediate or urgent performance concerns or regulatory notifications ▪ Subject matter functional expert integrated monitoring of subcontractor and our performance ▪ Review daily data feeds and daily reports where applicable ▪ Integrated sharing with member and provider call center information	
Monthly	▪ Collaborative meetings occur at least monthly. Detailed subcontractor performance scorecards are reviewed to track performance, identify trends, and mitigate potential concerns early in conjunction with subject matter functional experts. ▪ Delegation Oversight Committee reviews and discusses new potential subcontractors, subcontractor performance, and presents and discusses annual audit and risk review summaries	▪ Data reconciliation activities and quality reviews ▪ Required attestations and delegate updates ▪ Program integrity fraud, waste, and abuse audits ▪ Financial reconciliation
Quarterly	▪ Quarterly Business Reviews to include quarterly performance, reporting, industry trend, innovations, and strategic partnerships ▪ Random targeted audits ▪ Compliance and Quality committees review new and termed subcontractors, subcontractor deficiencies and mitigation plans, CAPs	

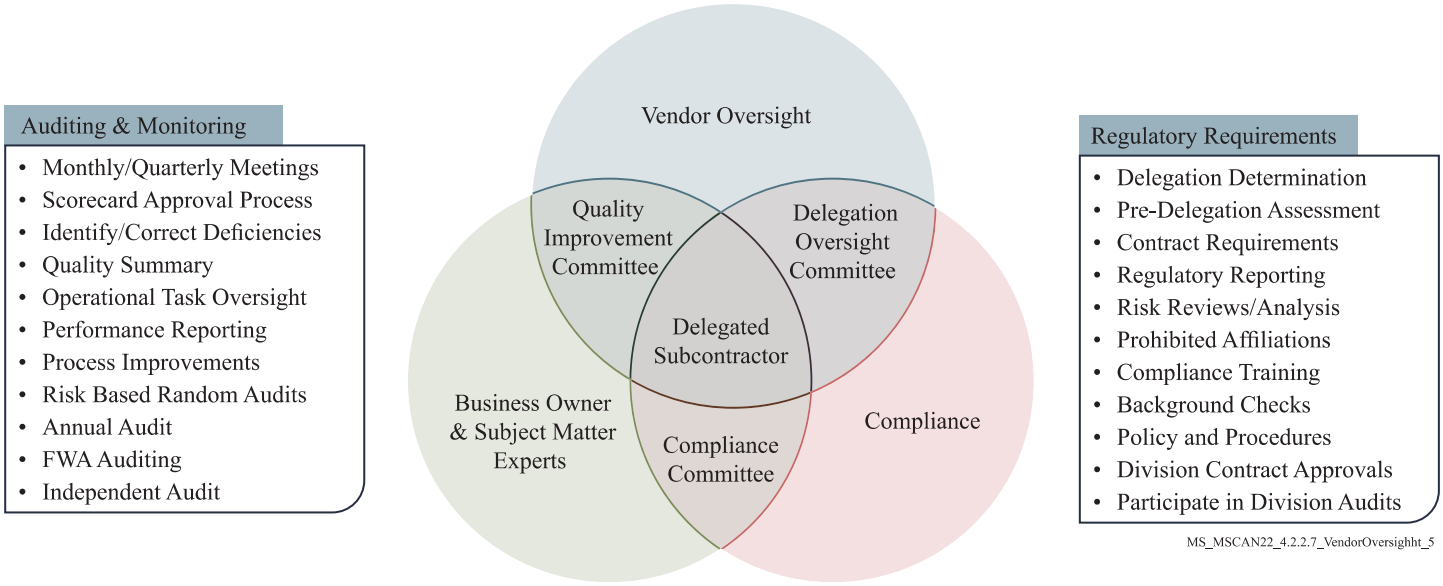
Timing	Subcontractor Monitoring Activity	
Annually	▪ Subcontractor annual audit includes review of policy and procedures, employee compliance verification, performance and reporting verification, accreditation and quality performed by subcontractor oversight, business owner and functional subject matter experts ▪ Annual risk review	▪ Annual Information Security Review ▪ Trended performance and review for annual performance improvement plan ▪ Annual delegate surveys for feedback on delegate performance

Organizational Infrastructure Supporting Subcontractor Oversight

Our Compliance Committee serves as the oversight body monitoring market performance and ensuring compliance with the requirements outlined in Appendix A. The Compliance Committee consists of key market leaders and the compliance officer and is responsible for the review of high-risk compliance items, including internal and external audit results, corrective action plans (CAPs), and material regulatory sanctions. The Quality Improvement Committee and the Delegation Oversight Committee support the Compliance Committee. These committees provide oversight of performance measures, performance improvement projects, evaluation of underutilization and overutilization, assessment of the quality and appropriateness of care, member experience with the health plan network, and grievances and appeals trends. The committee is responsible for identifying, reporting, and remediating performance issues. Figure 4.2.2.7_C illustrates our subcontractor oversight infrastructure.

Figure 4.2.2.7_C: Organization Infrastructure

Our corporate infrastructure is designed to ensure our subcontractors perform beyond State expectations.



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Division Reporting Requirements

Our comprehensive and transparent subcontractor oversight program meets and exceeds the Division's reporting requirements. We include SLAs within subcontractor contracts that require all subcontractors to submit required reports on a regular cadence and at a specified date. All reporting is also subject to scheduled and unscheduled audits to ensure compliance. Examples of these types of reports include the following: call

center reporting, claims payment reports, encounter reporting, utilization management turnaround time reports, credentialing turnaround time reports, enrollment reports, printed materials and delivery reports, network adequacy, and others as the contract and SLAs require. We incentivize compliance with these SLAs using escalating penalties for recurring non-compliance with the opportunity to earn those back upon long-term resolution. The SLAs follow the regulatory requirements, specify the required data at the transactional level, require monthly, quarterly, or annual summaries depending on volume, and all Appendix A reporting requirements. Constant testing and the conducting of performance audits ensure the accuracy of these reports. We own responsibility for the accuracy, completeness, and timeliness of all reporting requirements of the RFQ and Appendix A, Section 13, including provisions governing notification due to subcontractor termination and the plan for continuity of services provided by terminated vendors.

b. Ensure receipt and reconciliation of all required data including encounter data

We ensure receipt and reconciliation of all required data, including encounter data, through written agreements with our subcontractors and pre-delegation confirmation of the use of operational processes like those we employ as a coordinated care organization. These agreements establish expectations on reporting and reconciliation of all data, including SLAs on timing, accuracy, completeness, and escalating penalties for noncompliance and pass-thru liquidated damages. All reporting is also subject to scheduled and unscheduled audits to ensure compliance. We review encounter data following National Committee for Quality Assurance (NCQA) methodology guidelines. In the event of non-compliance, we collaborate with the subcontractor to develop a mitigation plan to correct the issue or terminate the relationship if the subcontractor fails to comply.

Ensure Receipt of all Required Data Including Encounter Data

Our comprehensive automated and integrated data system complies with HIPAA standards and meets the requirements outlined in Appendix A. Our information technology (IT) team collaborates with subcontractors to establish data transfer systems and other arrangements to ensure the routine exchange of required data. Subcontractor contracts include SLAs to provide data that allows us to measure data delivery and data accuracy and impose escalating penalties for non-compliance. Additional SLAs govern the reconciliation of data and define the process that the subcontractor will follow to correct any issues. Examples of the kinds of data we share with our subcontractors include:

- 834 eligibility data
- Provider roster files
- Claims payment data
- Third-party liability (TPL) and coordination of benefit (COB) information
- Call center tracking information

Our encounter management platform ensures data security, streamlines administration of encounter management, and adherence to Division-specific encounter submission guidelines. To ensure compliance, our encounters team regularly reviews state companion guides and other regulatory guidelines and collaborates with electronic data interchange (EDI), e-business, and clinical editing teams to ensure the appropriate implementation of edits within our claims gateway.

Ensure Reconciliation of all Required Data Including Encounter Data

We require subcontractors to submit weekly attestation reports along with the previous week’s reconciliation and key performance indicator (KPI) dashboards to reconcile and remediate any variance between reports and data received. Using both claims and encounters stored in an encounters data warehouse, we perform reconciliation of claims-to-encounters for completeness of submission to strengthen oversight of the delegated services. Our encounters team reviews data received from subcontractors, tracks their performance, and collaborates with the subcontractor if there are any submission issues or outstanding rejections. This process manages subcontractor data accuracy, timeliness, and completeness of data, including encounter data, claims data, utilization tracking, and financial reporting. Examples of high rates of encounter data timeliness and completeness our process produces is shown in Table 4.2.2.7_C.

Table 4.2.2.7_C: Sample Encounter Data Reconciliation

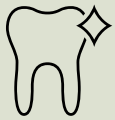
Subcontractor Service	Category	Measurement	Current Statistics
Dental Subcontractor	Encounters Timeliness Rate	Timeliness Submission of Encounters within the respective Medicaid states SLAs	99.99%
Dental Subcontractor	Encounters Completion Rate	Completeness Submission of Encounters within the respective Medicaid states SLAs	99.88%
Vision Subcontractor	Encounters Timeliness Rate	Timeliness Submission of Encounters within the respective Medicaid states SLAs	99.95%
Vision Subcontractor	Encounters Completion Rate	Completeness Submission of Encounters within the respective Medicaid states SLAs	99.95%

c. Ensure appropriate utilization of health care services

By continuously monitoring and evaluating subcontractor performance against each subcontractor's clearly defined performance metrics, we ensure the appropriate utilization of health care services. We include program expectations, KPIs, access to service expectations, service utilization and timeliness requirements, and Draft Contract requirements into our delegation agreements. We developed a playbook of performance metrics for each service category that compliance staff and business owners routinely review and evaluate. Our utilization management (UM) program monitors and determines medical necessity through a variety of methods, including prior authorization, concurrent review, retrospective review, and integration with our care management team. Evaluation activities include analysis of performance trends over time and measurement against industry standards and contract requirements for issues such as access, quality, timeliness, and grievances. The subcontractor oversight process includes program integrity audits for overutilization of services and financial auditing for underutilization of services defined in the subcontract. We offer technical assistance to subcontractors to assist them in meeting contractual requirements, overcome performance issues, and continually improve performance.

Ensuring Appropriate Utilization of Services

In another market, an innovative approach leveraging the principles of person-centered care and coordination to promote access to care led to preventive dental visits increasing by 15% while lowering costs.



We use an onboarding guide, delivered to, and discussed with all delegated subcontractors to provide information that describes their obligations, who to contact, how to report issues, compliance standards, and reporting requirements. This guide serves as a training manual for the subcontractors to help them be successful in this partnership to deliver positive health outcomes to our members.

d. Ensure delivery of administrative and health care services meets all standards required by this RFQ

We ensure the delivery of administrative and health care services meet all RFQ standards using an integrated process and platform. This platform directs the review of a potential subcontractor's corporate ownership, financial records, insurance coverage, OIG/SAM status, business continuity, policies, training, and security measures to safeguard members and provider protected health information (PHI), ePHI, and personal identifiable information (PII) as well as meet program requirements. All teams involved in the vendor selection process use the process and platform, including our vendor risk and oversight, strategic sourcing, legal, accreditation, and information security teams. We conduct a pre-contract assessment of all proposed delegated subcontractors and delegated providers to assess their capability to perform services. Additionally, we conduct a comprehensive review of compliance policies and procedures, resource compliance adherence, debarment, reporting, NCQA standards (if applicable), and performance metrics.

We carefully conduct due diligence analyses with all our potential subcontractors to ensure competence in their operations and ability to provide quality services to our members. Our pre-assessment process is pass/fail only. If a subcontractor passes our pre-assessment process and we decide to move forward with the relationship, we

request prior written approval from the Division. If approved by the Division, we enter into a written agreement with the subcontractor to establish clear expectations, responsibilities, and reporting requirements.

In conducting ongoing monitoring, we use a vendor oversight database that tracks utilization and performance metrics and scorecards for review with our subcontractors. Beyond regulatory SLAs, these metrics can be trended and monitored proactively for changes in performance and regulatory reporting. From these reports, we produce a monthly scorecard measuring the trended performance of our subcontractors. Accountable business owners review all scorecards for errors or issues in a workflow that provides an audit trail. The performance scorecard and any audit data are available on our subcontractor portal to use for collaboration on outstanding issues. An example of scorecard metrics we use is shown in Table 4.2.2.7_D.

Table 4.2.2.7_D: Sample Scorecard Metrics

All applicable business areas meet monthly and quarterly with each subcontractor to review and evaluate:

- Reporting requirements
- Compliance with regulations
- Adherence to contract SLAs
- Stories of exceptional service delivery
- Prohibited affiliations for staff and providers
- Quality and outcome metrics
- Member complaints, surveys
- Subcontractor scorecards

Additionally, we conduct member surveys on the performance of subcontractors providing dental, vision, transportation, and member materials. Lastly, we conduct an annual survey of our all subcontractors and their internal business owners regarding the performance and relationship of each to help form the basis of an annual quality improvement plan.

Addressing Appropriate Utilization – Examples

As an example of addressing the under-utilization of health care services, in another market, in monitoring our utilization database and performance metrics scorecard, we observed a trended utilization of dental preventive visits start to decline. Our team began working with our dental subcontractor to address the issue and put in a targeted outreach process and leveraged our dental home model to correct utilization. This included expanded office hours and collaboration with a statewide coalition for a target campaign on member education and outreach.

As an example of addressing over-utilization, through our audit protocols, we discovered a transportation vendor with overutilization of mileage reimbursement. In the following remediation discussion, the subcontractor agreed to offers a solution that included GPS monitoring as part of the reimbursement benefit, allowing for stricter oversight and prevention against fraud, waste, and abuse.

We ensure the subcontractors meet all regulatory requirements and Division requirements and expectations, and we monitor the subcontractor's compliance with these requirements through periodic reviews and audits. We provide notification of any applicable changes in state or federal regulations to our subcontractors through

contract amendments when appropriate. As the Division updates its expectations or regulatory requirements, we update our metrics to monitor the subcontractor's performance based on those changes.

e. Ensure adherence to required Grievance policies and procedures; and,

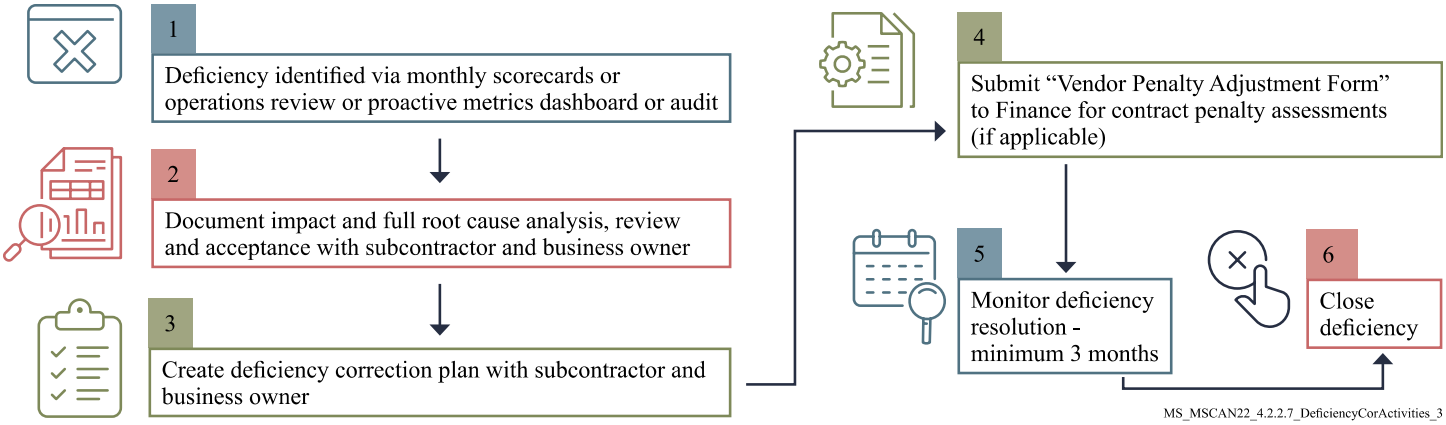
To ensure strict oversight of all complaints and grievances and to make certain our subcontractors are accountable to member rights, **we do not delegate grievance and appeal (G&A) processes**. When needed, we require subcontractors to participate in the complaint and grievances investigation process. Our complaint and grievances system processes are outlined in our detailed policies and procedures, member handbook, and provider manual and we discuss these requirements during the onboarding and implementation processes. Well-defined processes ensure we resolve member complaints within one business day of receipt, and we resolve grievances within 30 business days of receipt per Appendix A requirements. As an example, our contracts include an SLA requiring that any subcontractor receiving an urgent member complaint must report it to us within four hours and all other member complaints within 24 hours. We also include information on member rights and member grievance and appeals requirements in subcontractor contracts.

f. Address deficiencies or contractual variances with the Offeror's Subcontractors, including an example of how the Offeror has addressed a deficiency or contractual variance with a Subcontractor.

In the event a subcontractor does not meet performance metrics, we collaborate with the subcontractor to identify the cause of the deficiency and immediately implement a mitigation plan to correct any issues**. Such proactive interventions contributed to us having no CAPs related to subcontractor performance in 2021.** We impose escalating penalties as outlined in the subcontract if the deficiency is not corrected or the mitigation plan is not implemented. Continual or repeated deficiencies may incur **double and triple penalty** fees and may lead to our Corporate Compliance Department issuing a compliance corrective action plan and/or terminating the agreement. Figure 4.2.2.7_D illustrates our activities when remediating a vendor. In addition, we report subcontractor deficiencies to the appropriate committees for awareness, recommendations, and process decisions.

Figure 4.2.2.7_D: Deficiency Correction Activities

We have a well-defined process to remediate a vendor deficiency.



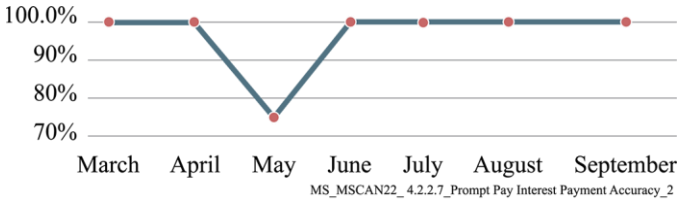
To help subcontractors remediate deficiencies, we actively recruit professionals in our oversight roles who have demonstrated expertise in their specialty, including depth of industry experience, education, diversity, licensure, and certifications in compliance management. These highly qualified healthcare and oversight experts include those who are:

- Certified in Healthcare Compliance
- Certified Supply Chain Professional
- Certified Professional in Healthcare Quality
- Certified Information System Auditor
- Juris Doctorate
- Six Sigma Certification
- Certified Purchasing Managers
- Registered Nurse
- Project Management Professional
- Other clinical specialties

As an **innovative practice to help improve health outcomes** for our members, in the rare instance that a subcontractor experiences a deficiency, these specialists offer the support they need to reach compliance and exceed subcontract requirements. Our specialists work directly with a subcontractor to identify deficiencies and the best course of action. We aid each subcontractor within the boundaries of regulatory, accreditation, and contract requirements. The alerts and gentle nudges our team applies using dashboards, scorecards, and one-on-one meetings help keep a subcontractor compliant and deliver value and quality services to our members. If a subcontractor's performance begins to deteriorate, we identify the performance issue and put a mitigation plan in place.

Figure 4.2.2.7_E: Prompt Payment Remediation

Subcontractor collaboration results in quick issue resolution.



Mitigation Plan – Example

- **SLA**: Prompt pay interest payment accuracy.
- **Description of Infraction**: Through audit, we discovered that prompt pay requirements fell short of key performance indicator benchmarks and were not being paid with the correct amount of interest as specified for late payments. The subcontractor used an incorrect calculation to determine interest rates on payments.
- **Root Cause Analysis**: The process the subcontractor used to calculate interest payments on late prompt pay requirements did not align with the internal calculation modeling we used. This was identified through audit and, once discovered, action steps were taken to remediate the identified issue. The subcontractor's calculation modeling was not based upon the criteria used internally, which adheres to the strictest regulatory standard with controls designed to ensure we exceed expectations of any state or regulatory mandate while also ensuring we maintain a sound partnership with our payees. Through training and collaboration, the two parties altered the subcontractor interest rate payment calculation process to ensure our practices aligned.
- **Monitoring and Closure Summary**: The process was monitored and audited for accuracy. No further process problems were identified (see Figure 4.2.2.7_E).

g. Also include acknowledgement of the requirement to perform annual quality review of Subcontractors, which should be included in the Annual Quality Management Program report to the Division.

Our applicable business areas meet monthly and quarterly with each subcontractor to review and evaluate service and quality metrics, including access and outcome data, NCQA responsibilities, and accreditation. Additionally, we conduct a comprehensive annual audit for all delegated subcontractors and quarterly targeted audits when indicated. This audit includes NCQA audit sample size adherence for audit review of any NCQA service category and a collaborative review and assessment to verify that any self-reported metrics from the subcontractor are accurate. When applicable, we do onsite visits.

Our annual audit includes the following mandatory reviews:

- Employee background check
- Employee debarment checks
- FWA training
- Policies and Procedures review
- Insurance requirements and certificates
- Annual Compliance attestation
- Compliance training
- Subcontractor and downstream entity review
- Employee licensure checks
- HIPAA training
- Financial review
- NCQA responsibilities grid and certificates
- Reputation and litigation review

The subcontractor must pass the annual audit. Any deficiencies documented must be remediated within 30 days and monitored for 90 days in accordance with our deficiency monitoring process. Our compliance officer reviews violations of regulatory requirements not previously discovered in prior performance reviews. Subcontractors, business stakeholders, and committees receive an annual audit summary for review. We document and store the annual audit tool in the annual audit work plan. We compile an annual quality review of the subcontractor's report and include it in the Annual Quality Management Program report to the Division.

h. Describe how the Offeror will ensure the proper classification of all subcontractor expenses between administrative and medical in accordance with the Division's policies.

Our delegated service agreements set out the proper classifications for administrative or medical expenses in accordance with the Division's policies. We ensure our accounting department understands the contractual language to correctly capture and report expenses. Our integrated data system tracks and reconciles these expenses. Our accounting team performs reviews of actual-to-budget and actual-to-forecast spending and produces quarterly spending reports while the audit team conducts regular periodic audits to check results. Corporate accounting reviews non-claims-based vendor contracts before leadership approves them for proper coding and classification as medical or administrative expense. In circumstances where both medical and administrative functions may be performed, we ensure the contract sets forth a fee schedule that delineates the functions and costs associated with each. The business owner and the vendor evaluate expenditures to determine what portion of the delegated expense is related to administrative work. Corporate accounting conducts an analysis to ensure pricing is fair and transparent.

We ensure the proper classification of expenses for inclusion in our minimum loss-ratio (MLR) reporting through sound internal policies and proven reporting processes. Our market finance team aggregates the membership and medical costs (including IBNR), while the accounting team aggregates the capitation premium revenue, expenditures on health care quality improvement activities, and any other non-claim costs. While non-claim costs are not included in the MLR calculation, they are included in the MLR reporting requirements, in accordance with Appendix A, Exhibit C. The methodology for any costs requiring allocation among various populations or lines of business are provided to the Division, along with the MLR report, and based on generally accepted accounting principles.

[END OF RESPONSE]

4.2.2.8 FINANCIAL AND DATA REPORTING

4.2.2.8.A. Financial Reporting

4.2.2.8.A.1. Describe the Offeror's approach for supplying data as determined by the state to satisfy the requirements for base data needed to develop actuarially sound capitation rates, as described in 42 C.F.R. § 438.5 (c).

Timely, consistent, and accurate report submissions (both scheduled and ad hoc) strengthen **our ability to deliver operational excellence to our members, providers, and the Division.** We offer a fully integrated, transparent service delivery model offering real-time bidirectional data exchange with the majority of providers. Our policies, procedures, and processes ensure accurate and timely submission of financial and non-financial performance data. Our history of excellence in preparing, validating, and submitting reports and data for Medicaid programs, as well as producing federal reporting, as required by the Centers for Medicare & Medicaid Services (CMS) and other agencies, is well documented. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the resources.

Approach to Supplying Data to Satisfy Requirements for Base Data Needed for the Development of Actuarially Sound Capitation Rates

With sound internal policies and proven reporting processes, we ensure proper submission of data to aid in the development of sound capitation rates, as required by 42 C.F.R. § 438.4, and in compliance with Appendix A, Section 11.1.1.2 Capitation Payment Calculation and Appendix A, Section 11.1.1.3 Capitation Payment Rate Development. Data submitted for this purpose is performed in accordance with 42 C.F.R. § 438.604 and generated to include base data, as described in 42 C.F.R. §438.5 (c).

Encounter Data Management Excellence

We consistently achieve excellent encounter submission rates, with **99.94%** timeliness, **99.95%** completeness, and **99.84%** accuracy across all markets.

In accordance with the State Fiscal Year 2022 MSCAN Preliminary Rate Calculation and Certification in Appendix C, we submit complete, timely encounter data and financial cost reports to the Division and its actuaries. Our approach to encounter data management is described in section 4.2.2.8 B. Following is our approach to meeting financial reporting requirements. We generate financial cost reports by leveraging the following data sources:

- Eligibility data tables loaded with 834 files from the Division. The tables are used to retrieve membership by rate cell and region for entry into the cost report. Delivery counts are reconciled with our accounting team.
- Medical claims data tables with data directly from our claims payment system. We use the tables to retrieve detailed claim line data and group them into categories of service, as defined by the Division.
- Medical costs paid outside our claims payment system are manually included in the submission. This may include provider incentives, true-ups for Accountable Care Organizations, vendor reconciliations, capitated vendor payments, and provider settlements. Capitated vendor contracts not paid through our claims payment system are reviewed by the accounting team and approved by leadership for proper coding and classification between medical and administrative expenses.
- Incurred But Not Reported (IBNR) data is prepared monthly by our Actuarial team and represents claim costs for members tied to historical time periods not yet reported or paid by the health plan. The data is manually included in the cost report, in accordance with the guidelines defined by the Division.

Following completion of the financial cost report, we use a collaborative approach for reconciliation and review to ensure accuracy and completeness. Accounting and market finance teams collaborate to reconcile the medical claim data to the financial statements and investigate/resolve any discrepancies, which typically relate to timing differences or settlements outside the claims system. Resolution is achieved and approved by the market finance chief financial officer and director of accounting. We investigate and evaluate root causes of discrepancies for process improvement and monitor potential areas for focus during the review. This improves the overall quality of data and reporting turnaround time.

Following completion and reconciliation, and prior to submission to the Division, the market finance chief financial officer, director of accounting, and chief actuary review and approve the financial cost report. Upon successful submission of the report, the Division receives notification via an automated ticket and submission system. Our regulatory team then sends an additional confirmation email to the Division of the cost report.

We employ a rigorous process to collect, prepare, and validate our encounter data submissions and use them to develop capitation rates. Our integrated encounter data collection and encounter management system is configured to the Division's Companion Guide requirements and highly customizable to address any future changes required, based upon the Division's Companion Guide and encounter submission requirements. Our encounter management system and our internally developed enterprise data warehouse provide reliable reporting built on complete and accurate data. These tools enable our encounters teams and leadership to monitor the timeliness, completeness, and accuracy of encounters submissions. Additional details on this process are included in our response to section 4.2.2.8.B.1, Encounter Data.

Upon Division review of both the completed cost report template and the encounter data to be used for capitation rate setting, our market finance, and accounting teams will work collaboratively to review and respond to any observations or questions from the Division, including preparing additional data or necessary supplemental information. Should the Division desire the data to be reported differently, or if any corrections are necessary, the template will be resubmitted to the Division, as requested.

4.2.2.8.A.2. Describe the Offeror's approach for the timely completion and reporting of the Medical Loss Ratio (MLR) reporting requirements, as described in the Contract (in accordance with 42 C.F.R. § 438.8 and 438.74), to include the Offeror's computation of medical claims cost and non-claims cost (administrative expenses) to include the costs associated with any subcontractors utilized.

We adhere to all required minimum MLR thresholds for each year of a contract and submit MLR reporting, as described in Appendix A, Section 11.4, Medical Loss Ratio, and detailed in Exhibit C: Medical Loss Ratio (MLR) requirements. Account expenditures may be included in both the numerator and/or denominator of the MLR calculation. Our accounting system enables us to calculate MLR on various lines of business separately, allowing us to provide the actual and target MLR calculation requested.

Additionally, we currently comply with 42 CFR 438.8, CMS guidance, as well as the clarifications provided by the Division in Appendix A, Section 11.4, and Exhibit C, Requirements, for calculation. We adhere to the following guidelines when submitting quarterly and annual MLR data, adjusting, as required, and reflected in future amendments to Appendix A, Section11.4:

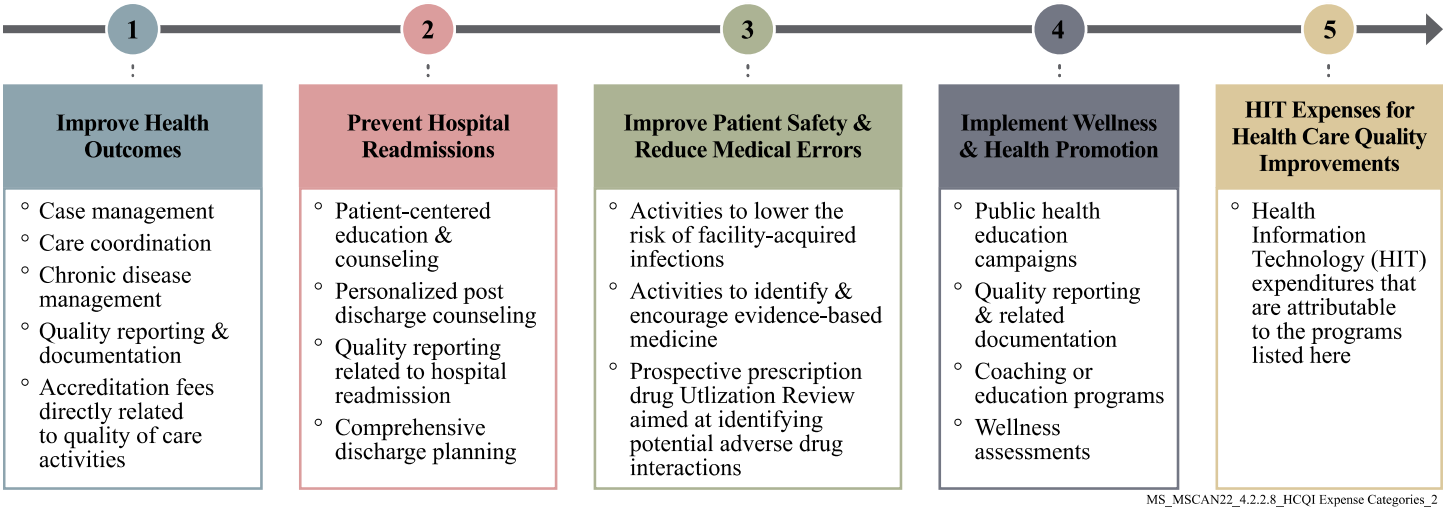
- For each annual MLR report, we calculate based on a 6-month incurred claim run-out period. For each quarterly MLR report, we calculate based on a 30-day run-out incurred claim run-out period. In the event we enter a sub-capitated or subcontracted arrangement, we only include payments made to providers for covered services and supplies as incurred claims.
- MLR only includes claims for members enrolled in the plan at the time of the incurred cost.
- If the MLR is less than the minimum MLR requirement (currently eighty-seven-and-one-half percent 87.5%), the Division is refunded the difference no later than the tenth business day of May following the end of the MLR reporting year.

We comply with the following requirements concerning capitation payments received and expenses related to MSCAN and CHIP Members [42 CFR 438.8(a)]. Any further reporting or data is provided, as necessary, enabling the Division to adequately assess our MLR Report.

Expenditures on quality improvement activities related to health care quality improvement (HCQI) and health care information technology (HIT) are individually identifiable, tracked, and reported, in accordance with 42 CFR 438.8(e)(3). Figure 4.2.2.8_A defines these activities, in accordance with 45 C.F.R. 158.150.

Figure 4.2.2.8_A: HCQI Expense Categories

A survey with the functional areas is conducted annually to ensure accuracy and to confirm activities meet the definition of HCQI expenses.



With sound internal policies and proven reporting processes, we ensure the proper submission of MLR reporting data. Our market finance team aggregates the membership and medical costs (including IBNR), while the accounting team aggregates the capitation premium revenue, expenditures on health care quality improvement activities, and any other non-claim costs. While non-claim costs are not included in the MLR calculation, they are included in the MLR reporting requirements, in accordance with Appendix A, Exhibit C. The methodology for any costs requiring allocation among various populations or lines of business is provided to the Division, along with the MLR report, and based on generally accepted accounting principles. Data is derived from the following sources:

- Eligibility data tables loaded with 834 files from the Division. The tables are used to retrieve membership by rate cell and region for entry into the MLR report.
- Capitation premium revenue is retrieved from the accounting subledger using our internal reporting tool. Revenue is generated by rate cell using the most up-to-date rates provided by the Division of Medicaid and internal enrollment records from our eligibility data tables. Any capitation revenue accruals, driven mostly by the timing of the receipt of rates, are layered on top of these generated amounts.
- Medical claims data tables with data directly from our claims payment system. We use the tables to retrieve detailed claim line data and group them into categories of service, as defined by the Division, over the incurred period specified.
- Medical costs paid outside our claims payment system are manually included in the report. This may include provider incentives, true-ups for Accountable Care Organizations, vendor reconciliations, sub-capitated vendor payments, and provider settlements. For sub-capitated vendor contracts, an evaluation is performed with the business owner and the vendor to determine what portion of the expense is related to administrative work. Proper consideration is given to identify and appropriately classify any quality improvement activities within those administrative expense costs. Costs are then reviewed by the accounting team and approved by leadership for proper coding and classification between medical and administrative expenses per 42 CFR 438.8.
- Incurred But Not Reported (IBNR) data prepared monthly by our Actuarial team represents claim costs for MSCAN and CHIP members tied to historical time periods not yet been reported or paid by the health plan. The data is manually included in the MLR report, in accordance with the guidelines defined by the Division.
- Non-claim costs related to general and administrative expenses and community benefit expenditures are aggregated by accounting and split into direct and indirect costs. Direct costs are those directly attributed to

the specific market and line of business. Examples of these costs include staffing expenses for employees working directly for the market, real estate expenses for market specific operations, administrative fees for the use of dental and vision networks, or fees charged as commissions for the collection of coordination of benefit recoveries. Indirect costs are those that require allocations among departments/cost centers. Examples of indirect costs include staffing expenses for employees supporting more than one market, expenses tied to IT related systems and processes, claims processing, and customer advocacy. The allocations are based on metrics most pertinent to the cost center allocated, such as MSCAN and CHIP membership, revenue, member/provider calls, etc.

- Expenditures on health care quality improvement activities are sourced from our annual review process. This review includes a high-level assessment of cost centers with a high likelihood of quality improvement activities. It involves an in-depth process wherein the owner of the cost center completes a template that assigns percentages of these activities at the job title level and includes an assessment of these activities related to vendor spending. These survey results are reviewed with external third-party experts to ensure compliance with 42 CFR 458.150.

After the MLR reports are populated with the appropriate data, we work to reconcile and review for accuracy and completeness. Accounting and market finance teams collaborate to reconcile the data to the financial statements and investigate/resolve any discrepancies, which typically relate to timing differences or settlements outside the claims system. Resolution is achieved and approved by the director of market finance CFO and director of accounting. The root causes of discrepancies are investigated and evaluated for process improvements or monitored as potential areas to focus on during review. This improves the overall quality of data and turnaround time.

Once completed and reconciled, the MLR report is reviewed and approved for completeness and accuracy by the market chief financial officer, director of accounting, and chief actuary prior to submission to the Division. Upon successful completion of the reconciliation and review processes, the Division is notified via an automated ticket and submission system. Our regulatory team then sends a confirmation email to the Division, notifying them that the cost report has been submitted.

Following its review of the completed MLR report, if the Division requires any further data, our market finance and accounting teams review and respond with additional data or supplemental information. Should the Division require a retroactive change to the capitation payments for the MLR reporting year after the MLR report is submitted, new data is aggregated, and we resubmit the MLR report, as requested.

4.2.2.8.B.1. Encounter Data

4.2.2.8.B.1.a. Describe the Offeror's approach for collecting, validating, and submitting complete and accurate encounter data in a timely manner to the Division consistent with required formats. Include how the Offeror proposes to monitor data completeness and manage non-submission of encounter data by a Provider or a Subcontractor. Provide the key components of the Offeror's encounter completeness plan.

Our comprehensive encounter data management process ensures effective oversight and execution of collecting, monitoring, and submitting of complete, accurate, and timely encounter data in accordance with 42 C.F.R. § 438.242 and 42 C.F.R. § 438.818.

The encounters operations and encounters information technology (IT) teams work in tandem to ensure a compliant, efficient encounters process. Our encounters operations team reports to our claim operations executive leadership team, providing a cohesive oversight process that aligns end-to-end encounter processes to claims receipt, compliance, adjudication, and provider claims denial management. Reporting to our claims vice president is our dedicated senior director who leads the encounters operations team, with two managers overseeing encounters operations and subcontractors. Our encounters team works directly with senior and executive leadership to review and monitor encounter processes. The compliance officer and data compliance manager, located in Mississippi, coordinate all communications between the encounters operations team and the Division to ensure a transparent, compliant encounters program. The encounter operations team is responsible for data processing and the provision of accurate and timely reports of MSCAN and CHIP member encounter

data to the Division that meets Federal requirements and allows the Division to monitor the program at least monthly following the month in which the claims are adjudicated (paid, amended, or denied status). The team serves as a liaison to the Division to help resolve any discrepancies or issues regarding encounter data submissions and remediation activities. The encounters IT team develops, maintains, and enhances the claims extraction process to encounter management system, which batches, stages, and transfers files to the Division.

Our policies, procedures, and processes assure compliance with federal requirements to collect, validate, and submit complete, accurate, and timely MSCAN and CHIP member encounter data to the Division, in accordance with 42 C.F.R. § 438.242 and 42 C.F.R. § 438.818. Our policies and claims payment systems are routinely updated to align with clean claims standards, as well as national benchmarks and industry standards. Providers are encouraged to submit claims as soon as possible, but no more than 180 days after the service date. Along with our subcontractors, we collect every MSCAN and CHIP member encounter with a health care provider for all reimbursement models, including FFS, capitation, and value-based programs. All adjudicated claims and their status (e.g., paid, amended, adjusted, or denied) are reported as an encounter to the Division, in accordance with Appendix A, Section 16.7, and the Division's encounter companion guides for professional, institutional, and dental encounters. Reporting is performed within two business days of the end of the payment cycle. For all other claim types, MSCAN and CHIP member encounter data is submitted within 30 calendar days of adjudication and no less frequently than weekly. All submissions, including subcontractor data, are validated by our encounters team to ensure all required data elements, including providers' NPI, is included, as defined in Appendix A, Section 16.7 and the State Companion Guide(s). Figure 4.2.2.8_B illustrates the process used by these teams for gathering claims encounter data, submitting encounters to the State, and reconciling all medical claims, including those received from subcontractors.

[redacted]

Encounter Data Collection and Submission

Providers submit claims electronically, on paper, and through our provider portal. Paper, non-electronic claims, and provider portal claims are converted to a HIPAA-compliant EDI format. All claims are then processed through our claims gateway. We ensure all required data elements are present, are HIPAA-compliant, and abide by CMS, Division, and our internal claims and encounter data submission requirements. Clearinghouses are contractually required to meet all 5010 HIPAA-compliant submission edits and standards, including edits to validate correct coding. Our encounter management system applies additional edits prior to claims adjudication

to validate the provider's eligibility to render service, duplicate submission filtration, and National Correct Coding Initiative (NCCI) edits. These validations all ensure claims are compliant upon acceptance. Claims failing edits are rejected, with a clear delineation of reasoning. Both rejections and claim denials are managed through a comprehensive denial management program promoting provider partnerships and collaboration to ensure all MSCAN and CHIP member encounters are accounted for and received timely.

Subcontractors and sub-capitated providers are required to submit all adjudicated claims (paid and denied) following each adjudication cycle for every service rendered, including alternative payment model (APM) and value-based purchasing (VBP) agreements. Following critical data elements validation, this data is ingested and stored with all claims data within our encounters data warehouse.

Our integrated encounter data collection and encounter management system, is configured to the Division's Companion Guide(s) requirements and is highly customizable to address any required future changes, based upon the Division's Companion Guide(s) and encounter submission requirements. Our encounter management system supports HIPAA-Accredited Standards Committee (ASC) X12N 837 Professional/Institutional/Dental for both claims and encounter transactions; ASC X12N 834 Benefit Enrollment and Maintenance; ASC X12N 835 Claims Payment Remittance Advice Transaction; ASC X12N 277 Claims Status; and other formats specified by the Division.

All claims, including subcontractor claims, are extracted to the Encounter management system, which applies the same set of rigorous validations as our medical adjudicated claims, aggregated into unified encounter submissions, and submitted to the Divisions agent on HIPAA-compliant ASC X12N 837 transaction formats (P – Professional, I – Institutional and D- Dental) as required.

Our processes ensure no duplicate MSCAN and CHIP member encounter data is submitted to the Division, and that we maintain compliance with correcting and resubmitting any rejected encounters, including voiding a previously submitted encounters, as applicable, within 30 calendar days from the date of receipt of rejection. We employ proven processes and follow secure and documented procedures for submitting encounter data to the Division or its agent. Multiple security measures are used to ensure all data is securely transmitted. We send files via secure file transfer protocol (FTP); employ virtual private networks (VPN); protection encryption; Transport Layer Security (TLS); and certificate-based secure socket layer, as required. Complete batches of encounter submission files for institutional, dental, vision, transportation, and other professional services are picked up from staging locations and transferred to the Division or its agent's secure FTP site using file transfer protocol on the day of the week and time specified by the State, and in accordance with 42 CFR 438.242, 42 CFR 438.818 and Appendix A, Section 16.7.

Our platform enables us to customize the secure FTP processes, as specified by the Division. Detailed encounter file reconciliation activities are performed at both a file and encounter level throughout the submission process, checking the status of the outbound file submission for batched encounters, the number of encounters, the status of the outbound file, and the status of Division acknowledgment. Once files are sent, our Encounters IT team retrieves, analyzes, loads, and tracks the Division's response files to ensure all records are successfully processed. The encounter management system oversees the tracking, review, and correction of rejected encounters, as required by the Division. Our encounter submission process ensures we meet all standards for timeliness, with the highest degree of accuracy and completeness.

Encounter Data Validation and Monitoring

Collected encounter data is validated and monitored via comprehensive reporting tools, including server integration services (SIS), business intelligence platform (BI), statistical analysis system (SAS), and custom-built automated, real-time operational and executive dashboards.

These tools help our encounters information technology (IT), encounters operations teams and leadership monitor timeliness, completeness, and accuracy of encounters submissions. Our encounters information technology and operations teams share responsibility for encounter data, identifying and applying best practices

across all Medicaid lines of business. This oversight model of thorough validation and application of our comprehensive claim denial management program ensures all claims, including claim rejections, are managed to optimize encounter completion and accuracy. We consistently achieve excellent encounter submission rates.

Table 4.2.2.8_A: Encounter Data Management Excellence Across All Markets

All adjudicated claims (paid, amended, adjusted, and denied) are extracted to the encounter management system through an IT process that reconciles total claims adjudicated against the total claims successfully extracted to ensure every claim is accounted for and tracked. Extractions are scheduled from the claim system to run after the claim adjudication cycle; this extraction contains all claims adjudicated since the prior extract. The IT team quickly identifies any reconciliation discrepancies, including claim counts or paid amounts mismatched, and resolves them by re-extracting those missing claims. For issues stemming from missing critical data elements, the encounters team investigates and corrects the extracted claims. Our successfully extracted universe of adjudicated claims runs through two sets of validations. The first validation includes compliance and data integrity checks (based upon HIPAA and SNIP guidelines), and all MSCAN and CHIP members encounter data elements required by the Division to report to CMS under 42 C.F.R.§ 438.818, including:

- Accurate enrollee and provider identifying information
- Claim adjudication date
- Billing, rendering, ordering, referring attending and prescribing providers' identification numbers (NPIs) both at claim and/or service line level, as applicable
- Date of service
- Allowed amount and paid amount
- Claim receipt date
- Claim payment dates
- Procedure and diagnosis codes
- Third party liability amounts

The second validation is based upon our business rules design on National Correct Coding Initiative (NCCI); National Uniform Billing Committee (NUBC); National Uniform Claim Committee (NUCC); State Companion Guide(s); and other State or federally mandated regulatory guidelines, to check encounter data compliance. Adjudicated claims passing these validations create encounters for submission to the Division's agent through HIPAA-compliant ASC X12N 837 transaction formats (P – Professional, I– Institutional, and D- Dental).

The encounter operations team, in close collaboration with the claim leadership team, manages our data completeness monitoring program. This team focuses on ensuring all claims and encounters are submitted by providers and subcontractors accurately and timely to the Division's agent and monitors to confirm denied and rejected encounters are resolved and resubmitted. Continuous evaluation is conducted on providers and subcontractors to measure compliance with contractual reporting requirements. We employ rigorous policies and procedures to act upon information from the monitoring program and take appropriate action to ensure full compliance with MSCAN and CHIP member encounter data reporting to the Division. This oversight model incorporates the proactive claim denial management program into encounter completeness monitoring and reconciliation to ensure providers and sub-contractors are submitting all encounters and precluding occurrence of non-submission of encounter data.

To specifically monitor and reconcile subcontractor data, adjudicated claims data is reconciled against invoices and monitoring reports received from subcontractors and sub-capitated providers to ensure volume alignment. Subcontractors and sub-capitated providers must submit weekly attestation reports, along with the previous week's reconciliation and key performance indicator dashboards, to reconcile and remediate any variance between reports and data received. Our encounters team includes dedicated resources to review reports from subcontractors and sub-

capitated providers. This team meets weekly to discuss submission issues, outstanding rejections, and to track performance, ensuring compliance with the latest Division encounter submission guidelines. This process enables us to manage the accuracy, timeliness, and completeness of the encounter data and strengthens oversight of these subcontracted and sub-capitated services for utilization tracking and financial reporting.

Our detailed review process ensures encounter data submitted contains all required data necessary to meet CMS encounter submission requirements under 42 CFR § 438.242 and Appendix A, Section 16.7. All encounters include allowed amounts and paid amounts; subcontractor paid amounts are excluded from paid amounts on encounter submissions to the Division.

Encounter Data Reconciliation, Triage, and Correction of Errors

Encounters that fail the internal validation process, or that do not pass X12 EDI compliance edits, the Mississippi Medicaid MES/MMIS threshold, or repairable compliance edits by the Division, are managed through the encounters triage and correction workflow. These encounters are tracked to their respective service level agreements within our encounters data warehouse. This tracking process assists with reconciling the non-submitted/Division-rejected encounters to ensure completeness, in accordance with Appendix A, Section 16.7. Operational dashboards provide our encounter teams and leaders with the monitoring necessary to triage and correct submission errors by identifying specific data elements that are invalid or missing. Encounter triage processes include root cause analysis; validation against Companion Guide(s), NUCC, NUBC, NCCI, and internal claims billing; and encounter submission guidelines. Based upon these findings, our team utilizes a combination of error correction processes, including:

- Automated configuration changes
- Claims processing procedure changes
- Pre-adjudication/clearinghouse edits
- Encounters adjustment or voids
- Payment integrity edit/recovery
- Provider outreach and subsequent corrected claim
- Provider data collection

Re-adjudicated claims are extracted to the encounter management system for submission, which generates the appropriate void, replacement, or adjustment records. If claim re-adjudication is unnecessary, the encounter management system executes corrections to allow the resubmission of encounter errors, in accordance with the Division’s encounter correction protocol.

For errors related to subcontractor data submission and claims processing, we notify subcontractors for error correction and resubmission of claims data. We collaborate on all submission issues, outstanding rejections, and encounter errors to resolve and correct. The encounters team cross-references best practices in encounter submission across other Medicaid lines of business to triage and correct encounter errors. Best practices and lessons learned are applied to improve encounter submission accuracy and to minimize rejections, as part of our continuous process improvement protocol.

The use of dashboards, as shown in Figure 4.2.2.8_C, assures ongoing monitoring, while keeping a line of sight on progress and quickly identifying areas to be addressed and action needed.

[redacted]

To ensure compliance with encounter completeness requirements, we employ extensive reporting and monitoring processes and requirements through trend analyses and detailed reports. We ensure providers submit claims for every service rendered. All claim details required for FFS are presented on claims for adjudication and represented on encounters submission to the Division. Our encounters team monitors for unexpected drops in claims and encounter volume, unexpected reductions in medical cost by provider type, and anomalies where low submission rates may indicate a problem with the submission of encounter data. Upon review of those anomalies, a provider representative engages with the provider or subcontractor to review and remediate issues indicating non-submission of encounter data. Based upon the root cause, PRs address these issues through system enhancements or provider education. Our claims intake process, clearinghouses, and encounter management system perform validation of all claims received and encounters submitted for compliance using standard HIPAA guidelines and SNIP levels one through five. Real-time data (Figure 4.2.2.8_D) allows for time-sensitive validations. These validations replicate encounter submission requirements of the Division to ensure inclusion of all claim details on the claims submission to us and encounters submission to the Division.

[redacted]

Claims and encounters data is stored in our encounters data warehouse to reconcile claims-to-encounters for accuracy and completeness of encounter submissions. An Explanation of Benefits (EOB) is issued to MSCAN members for each processed claim. EOBs are available to our members through various channels, including online, email, text, and mail. Members are encouraged to report any suspicion of fraudulent claim activity, including claims for services not provided to the member. The EOB offers multiple ways, including anonymous options, to report suspected fraudulent activity or ask us questions. Our program integrity team thoroughly investigates all reports of potentially fraudulent activity. We investigate any fraud incident, including claims for services not provided, in conjunction with the claims team to re-process those claims, remove payment, and remove the encounter. These processes help ensure proper receipt of all claims data for services rendered to members and submitted as encounters to the Division. These processes also assist in tracking and remediating any claims received for services not provided.

Encounter Data Completeness Reporting

As a critical component of our annual audit compliance monitoring and reporting program, our Mississippi-based data compliance manager compiles required reports, as specified in our Annual Encounter Data Completeness Plan. This plan is reviewed, maintained, and submitted to the Division by our Mississippi-based compliance officer, in accordance with Appendix A, Section 16.7. Our annual plan includes:

- Demonstration that claims and encounters are submitted by providers and subcontractors and are accurate and timely, with denied encounters resolved and/or resubmitted
- Evaluation of provider and subcontractor compliance with contractual reporting requirements

- Demonstration that we employ processes necessary to act upon information from the monitoring program, take appropriate action to ensure full compliance with member encounter data reporting to the Division and submit to the Division an annual Data Completeness Plan for review and approval

All internal audit findings regarding data completeness are reported annually or at the request of the Division. We adhere to all requirements, including submitting any corrective action plans and non-compliance remedies, as applicable, resulting from failure to comply with the encounter claims completeness reporting standards.

4.2.2.8.B.2 Health Information System Data

4.2.2.8.B.2.a. Describe the Contractor's approach to maintaining a health information system that collects, analyzes, integrates, validates, and reports data including but not limited to the following areas:

i. Utilization,

ii. Claims, Grievances and Appeals,

iii. Disenrollment (for other than loss of Medicaid eligibility),

iv. Member Characteristics,

v. Provider Characteristics,

vi. Care Management Utilization,

vii. Clinical Data, and

viii. Population Health.

We built, maintain, and use the modern data platform (MDP), cloud-based data aggregation, and analytics solution that enables us to meet all the requirements in Appendix A, Sections 16.5, 16.6. 16.7, and the MSCAN and CHIP Reporting Manual. Our cloud-based modern data platform facilitates fully integrated data reporting and analytics. All key internal and external data sources are imported, standardized, and validated through automated processes running multiple times daily. This platform provides a sole source of truth for reporting and analytics and enables us to perform analytics across disparate data sources, resulting in a true 360-degree view of our membership. Through seamless automation, we couple population demographic characteristics, disease prevalence, and social determinants of health with members' health care **utilization** history and care management engagement, to identify where opportunities exist and to demonstrate the ways in which we drive outcomes.

When we expose opportunities or risks through these analytics, this integrated data enables us to quickly identify root causes and efficiently mitigate them. A common example is understanding network adequacy and access to care; the modern data platform centralizes all provider data and enables geospatial analytics to visualize the relationship between where members are, their health care and social needs, and what services are readily available to them.

Closing the loop on true **population health** management is the integration of data that establishes MSCAN and CHIP member sentiment, such as **claims, grievances and appeals**, call center topics, and **disenrollment** patterns. This informs optimal product design and improves MSCAN and CHIP member satisfaction and retention. Our approach to data management also facilitates optimal data governance to ensure metrics are produced using consistent definitions. Because these definitions are built into the platform, data consumers do not have to recreate them each time a new report is produced. When a definition or calculation requires updating, it is completed in one place and flows through all reporting.

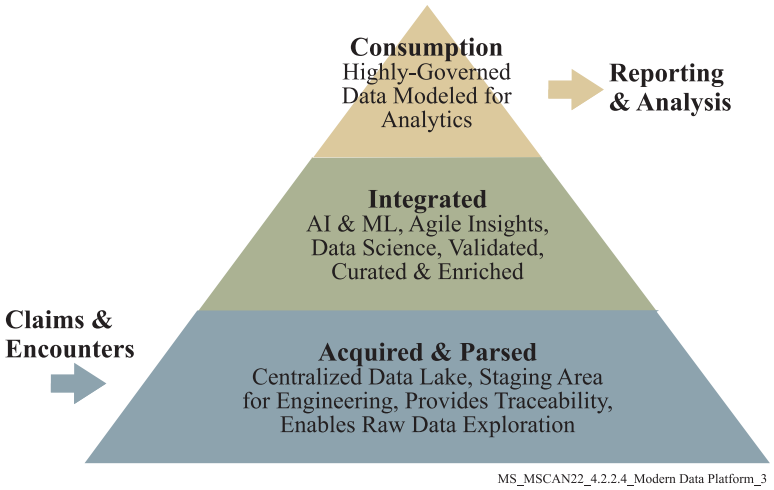
Artificial Intelligence (AI) to Improve Maternal Health Outcomes

Our AI platform identifies high-risk pregnancies by compiling information from multiple sources. Algorithms stratify high-risk pregnancies based upon risk level and the nature of risk, such as previous complications, age, and substance use history, among other elements. This data compilation is fed back into the care management system so that whenever we engage members, information is readily available to ensure timely, appropriate, and effective intervention. As in the lives of the members we serve, timely data readily available is imperative.

The most impactful aspect of our modern data platform (Figure 4.2.2.8_E) is the ability to share data back with the various source systems to enrich the capabilities of those applications, including **utilization; claims; grievances and appeals; disenrollment; MSCAN and CHIP member and provider characteristics; care management utilization; clinical data; and population health in full compliance with Appendix A, Section 16 Reporting Requirements.**

Figure 4.2.2.8_E: Modern Data Platform (MDP) Architecture

Our data management platform ensures the application of consistent definitions.



We have developed artificial intelligence (AI) within the platform that uses algorithms to stratify member high-risk categories, assessing both risk level and the nature of risk. MSCAN and CHIP Member risk level data is fed to the care management system so that when we engage members, the information is readily available for assessment to ensure the most appropriate and effective interventions. Our innovations demonstrate consistent improvement in health outcomes for the areas the Division has designated as priorities.

[END OF RESPONSE]

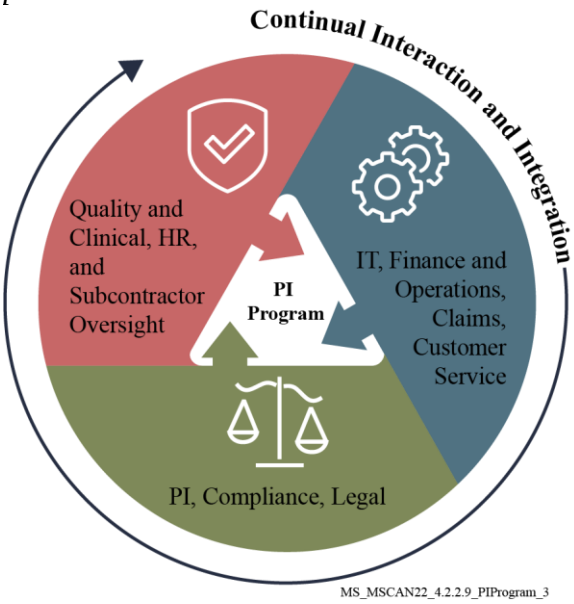
4.2.2.9 PROGRAM INTEGRITY

4.2.2.9.A. Fraud, Waste, and Abuse

4.2.2.9.A.1. Describe the Fraud, Waste, and Abuse program that the Offeror will implement, including:

a. Proactive and reactive fraud, waste and abuse detection methods that will be used, including dollar amount thresholds used for initiating a review, if applicable;
b. Process for acting upon suspected cases of fraud, waste and abuse;
c. Process for complying with federal regulations related to disclosures and exclusion of debarred or suspended Providers;
d. Process for interacting with the Division, including the Office of Program Integrity; and,
e. Other components of the Offeror's fraud, waste, and abuse program.

Figure 4.2.2.9_A: PI Integrated Approach
Through our integrated approach we have improved claims payment accuracy and reduced FWA risks, while decreasing provider abrasion.



We are a coordinated care organization (CCO) committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi. Through our extensive experience administering Medicaid programs, we have built a legacy of providing quality healthcare coverage while protecting against fraud, waste, and abuse (FWA). Our integrated Payment and Program Integrity (PI) Department drives a culture focused on protecting state funds entrusted to us, and all teams play a role in preventing and detecting FWA and supporting the PI purpose. We operate an integrated payment accuracy approach across the claim payment lifecycle, founded on compliance standards, procedures, and best practices with proven techniques that we have implemented across the organization driving meaningful results in early detection and effective prevention of FWA. Figure 4.2.2.9_A depicts our comprehensive and all-encompassing approach to PI. Our structure brings unmatched accountability in protecting the resources entrusted to the Medicaid program so that Mississippians have access to quality cost-effective care. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing state resources and assisting the state in holding wrongdoers who would abuse the system accountable.

Our compliance program, including our FWA program, is based on the Office of Inspector General's Seven Elements of an Effective Compliance Program, and complies with all federal and state requirements regarding FWA, including but not limited to 42 C.F.R. Part 455, Section 1902 (a)(68) of the Social Security Act, 42 C.F.R. § 438.608, as well as Appendix A Section 10 and Attachment G. We strive to exceed those requirements where appropriate with the goal of protecting the Medicaid program and its members. We are not only compliant, but we fully recognize that FWA represents a significant threat to the fiscal health of the Medicaid program. We are committed to ensure we have a program that not only meets the federal sentencing guidelines and other requirements, but that also focuses on doing more than what is required because it benefits everyone, Medicaid, State, beneficiaries, and providers.

FWA Program Approach

Our organizational commitment to compliance, continuous improvement, industry expertise, and innovation supports the success of our FWA program. We prioritize provider education and compliance to avoid violations. Our integrated, enterprise approach leverages experts from across the organization to monitor, with a focus on provider and member aberrant billing behavior and patterns that result in accurate claims payment in accordance

with payment polices and guidelines. We continually monitor and enhance our PI processes to effectively prevent, detect, investigate, and correct suspected FWA. Consistent monitoring and education is crucial.

As experts in the management of Medicaid compliance programs, we maintain our innovative edge with agile delivery and strategic partnerships to shift efforts to prevention while detecting and combating FWA through our fully integrated PI program. This approach encourages open and regular communication between the Special Investigations Unit (SIU) Manager, compliance officer, and all employees. The compliance program intersects with PI through a formal governance structure. Key PI results and effectiveness measures are reported to the Compliance Committee and to the Board.

Enterprise data analytics. Our extensive data repository includes data sources from across the organization such as: authorizations, claims, member, eligibility, quality, appeals and grievances, subcontractor and all other administrative support data. We continually refresh our data repository and analytics by applying state specific requirements to monitor and identify changing trends in member utilization and provider billing patterns using artificial intelligence (AI) and machine learning (ML) capabilities. We also use detailed provider profiling intelligence and sub-contractor data, to continually monitor and identify potential vulnerabilities and system gaps (proactively and reactively). These data analytic activities help ensure ongoing payment accuracy, policy compliance, provider behavior modification through education, and quality outcomes for our members.

- **Influencing PI best practices.** We work collaboratively with internal and external stakeholders to continually identify opportunities to improve PI practices. For example:
  - We have built strong relationships with state PI offices and law enforcement partners to share our best practices related to data analysis and trending, and strategic case reviews to maximize outcomes.
  - We actively innovate and collaboratively share information with external partners, including National Health Care Anti-Fraud Association (NHCAA), Healthcare Fraud Prevention Partnership (HFPP), state PI offices, state attorneys general offices, and Medicaid Fraud Control Units (MFCU). We proactively host information sharing sessions with the HFPP, NHCAA, and other critical stakeholders to share and drive innovative industry ideas and trends to impact best practices.
- **Governance risk compliance platform.** We use a sophisticated enterprise-wide platform to manage risk and maintain compliance through centralized intake, analysis, communication, distribution, and monitoring of all identified risks, and remediation of outcomes.
- **Real-time fraud detection software.** We maintain industry leading detection tools including AI, ML, and robotic process automation that proactively and reactively identify payment anomalies and potential scheme attributes to augment existing FWA lead generation capabilities.
- **Enterprise level provider education programs.** In collaboration with departments, such as claims, customer service, quality, delegation oversight, clinical, finance, and compliance, we use provider profile data to identify provider education needs and provider specific tactics that we execute at the appropriate time to reduce provider abrasion.
- **Enhanced credentialing controls.** We have established mechanisms to identify potential fraud indicators starting at the earliest possible prevention point by using analytics, such as predictive scoring models and anomaly detection during the credentialing processes. We will comply with all provider credentialing recommendations, flag areas of concern, and relay this information back to the state and Credentialing Verification Organization (CVO).
- **Subcontractor Quality Department.** We take full responsibility for subcontractor performance and assure quality outcomes through continual monitoring and auditing, performance management meetings, reporting,

and contractual guarantees. We also ensure all subcontractors are effectively monitoring (proactively and reactively) for FWA and referring all leads for FWA investigations.

Our mature end-to-end payment accuracy programs enable us to apply FWA prevention and detection methodologies starting from the earliest point in the payment cycle and adapt our methodologies to identify FWA vulnerabilities. Our data driven approach is supported by robust operational performance and compliance reporting to include metrics for monitoring overall payment accuracy and identification of and response to an effective FWA program.

a. Proactive and Reactive FWA Detection Methods

We have built our mission driven culture on integrity and our commitment to be good stewards of state funds. This culture creates a shared accountability of all to ensure FWA and questionable practices are reported, investigated, and addressed. Our rigorous execution and monitoring leverages established controls and processes to proactively and reactively detect FWA, and includes a suite of detection tools, industry-leading resources, and extensive reporting and referral mechanisms. **We review all leads as possible indicators of larger issues or emerging concerns, thereby ensuring that our FWA detection methods and investigations are not limited by a dollar threshold.**

Proactive Detection Outcomes

With focused efforts on prevention, our PMPM prevented losses have increased year over year by 30% in another market.

Proactive FWA Detection Method

As described previously, our proactive FWA detection methods address the full continuum of both payment and PI. This approach allows us to proactively identify and address provider claims and billing practices and potential member harm from the earliest possible point in the payment process. Using enterprise data, and industry monitoring information, we look for trends in provider billing behaviors and member utilization to identify and investigate PI risks. Our investment in advanced detection tools and controls demonstrates our commitment to prevent and combat Medicaid FWA. Our proactive FWA controls are comprehensive and include all the elements described in Table 4.2.2.9_A.

Table 4.2.2.9_A: Proactive FWA Detection Controls

Control	Description	Payment Integrity	Program Integrity
Provider and Member Education	We use our years of experience and data analytics to continually enhance our predictive scoring models for detection. We communicate to providers and members in multiple channels such as explanations of benefits (EOBs), handbooks, manuals, website, newsletters, training materials, and outreach. Our educational interventions also use data analytics to identify and target educational opportunities. Using behavioral science, we drive provider behavior modification and member awareness, yielding increased provider and member understanding, with less provider abrasion, and lower administrative cost.	X	X
Claims System Prepay Edits	We use a range of state customized claims pre-pay edits to evaluate claims for accuracy and avoid payment of incorrectly billed claims.	X	
Credentialing, Review and Continuous Monitoring	We will comply with all provided credentialing recommendations but report to the state any areas of concern that we identify through our analytics, such as predictive scoring models and anomaly detection.	X	X
Provider Sanctions Screening	Our provider sanctions database interfaces with our claims payment system, prior authorization systems, and other areas to prevent activity tied to providers that should not be paid due to sanction. This interface allows us to integrate real-time exclusion screening into our claims adjudication and prior authorization processes before payment is made. The database will incorporate the Mississippi Sanctioned Provider List among its sanction sources to ensure providers are not paid and terminated accordingly.	X	X
Pre-Pay Clinical Chart Validation	We utilize state of the art analytics that incorporate machine learning and behavior analytics to help identify pre-pay claims audits that require medical record reviews and administrative reviews that do not require a medical record. These audits include all types of claims, including	X	X

Control	Description	Payment Integrity	Program Integrity
	facility and professional claims for the full range of services (e.g., physical, behavioral, dental, vision, and pharmacy data) Our pre-pay clinical chart validation activities are supported by a dedicated medical director, who is a certified coder, providing oversight of clinical review guideline creation, appeals, and medical necessity reviews.		
Pre-Pay Analytics Tools	Our fraud detection software uses predictive scoring models, that leverage AI and ML, including: ▪ Data algorithms, such as anomaly detection, outliers and spike detection ▪ Code centric payment policy rules ▪ Provider profiling such as: – 360-degree provider performance including: number of audits, error rate, medical record return rate, quality, utilization, and provider billing trends – visualized relationship analysis and identification, including use of geographic mapping – social networking analysis	X	X
Prior Authorization Review and Coordination of Benefits	Our utilization management (UM) approaches that aid in preventing inappropriate payments and help to identify ineffective and inappropriate treatment and care, include: ▪ Member and provider interactions ▪ Claims administrative reviews ▪ Analysis of prior authorization approvals and denials to determine effectiveness of FWA prevention and ensure members receive evidence-based treatment ▪ Audits	X	X
Subcontractor and Provider Contractual Language ensuring Payment and Program Integrity Compliance	Our subcontractor and provider contracts include terms addressing compliance with all applicable federal and state payment and FWA requirements. We not only design our vendor contracts to meet regulatory requirements, but also maintain oversight of our subcontractors to ensure they prevent and detect FWA. We tailor our FWA support, education and monitoring of subcontractors based upon the FWA risks associated with the services they provide. We require subcontractors and providers to complete required FWA and compliance trainings and maintain a robust delegated vendor oversight program to monitor their performance.	X	X
Analytic Performance Monitoring Dashboard	We use real-time monitoring of all analytic activity to ensure accuracy and continuous fraud detection that results in lower provider abrasion, decreased administrative cost, and increased return on investment.	X	X
Lead Generation	We leverage incoming data from all internal and external sources, including identification of suspected FWA during all phases of the claims payment life cycle.	X	X
Provider Profiling	We maintain a data repository to collect all provider intelligence to enable a continuous feedback loop to: ▪ Inform provider management and contracting decisions ▪ Drive development of quality network providers ▪ Identify opportunities to educate or investigate providers ▪ Establish a baseline of normal practice patterns that aid in effective implementation of our FWA program.	X	X
Verification of Services via EOB	Using our robust analytic tools, we identify a targeted and random sample of members to follow-up with and confirm that they received the services the providers billed and were not victims themselves of fraud or identity theft.	X	X
Electronic Visit Verification	We have implemented a program to validate accuracy of services rendered in the home setting by home health aides, personal care aides, occupational therapy, and other nursing services prior to payment.	X	X
Combined Medical and Pharmacy Analytics	We use integrated data sets to create AI based fraud alerts with combined pharmacy and medical claims to find aberrancies such as: ▪ members with high-risk prescriptions cycling between a ring of pharmacies (with common ownership both known and unknown) ▪ policy abuses by a member that includes cycling the billing numbers of other family members, or because the pharmacy is repeatedly split billing a single prescriptions to avoid detection	X	X

Our proactive PI detection tools allow us to more accurately identify when suspect billing practices are likely the result of unintended error versus an indication of potential fraud or abuse. As a result, we more effectively tailor our proactive activities to support providers with correcting unintended errors with minimal abrasion.

FWA Investigative Proactive Analytics in Actions

Our prepay FWA enhanced analytics identified increased FWA activity with substance use disorder (SUD) providers in another market. As a result, through monitoring our spike detection report, we identified a sober living provider as a significant outlier. A search under the Secretary of State business filings revealed the owner was connected to an open investigation and had opened a new addiction counseling center.

We immediately placed the provider on prepay review and compared medical records and services billed prior to claim adjudication. Further investigation revealed cloned treatment plans, overbilling, falsifying medical records, and improper credentialing. We referred the case to the State PI unit, which resulted in a referral to the Medicaid Fraud Control Unit (MFCU) for further investigation. We also we continued to provide updates on evolving behavior discovered during prepay that was suspect to the State PI unit to further support their investigation.

We have designed our proactive detection tools and FWA program to not only comply with the Division and Office of Program Integrity (OPI) requirements, but to ensure that we have a highly effective FWA program that appropriately protects the resources and solvency of the Medicaid program. We obtain required OPI approvals before initiating certain activities, as described in Appendix A, Section 10. As described in Section B.1, we also maintain rigorous monitoring of our claims processing timelines and our PI staff. Our PI processes and staff are aligned with the enterprise operation teams to ensure claims are adjudicated and paid timely.

Reactive FWA Detection Methods

In addition to our proactive FWA detection methods, we also maintain a robust program of reactive payment and PI detection methods to further assure the appropriate use of Medicaid funds. As required in Appendix A, Section 10.3.2.2, we submit a written request and obtain the OPI's approval for all retrospective reviews either we or our subcontractors plan to perform. Our retrospective review lookback period is a minimum of 18 months and maximum of 36 months based on the claim's date of services.

Identifying Member and Provider Fraud Scheme

Through a reactive fraud referral in another market, our PI team identified a member fraud scheme centered around falsification of transportation logs. The transportation provider fraudulently changed the pickup location to a further distance, to obtain a higher mileage reimbursement. After a full SIU investigation, it was determined that two members were conspiring with the provider to split the increased mileage fees. The case led to a provider conviction and order for restitution.

Table 4.2.2.9_B describes our reactive payment and PI detection tools and practices.

Table 4.2.2.9_B: Payment and Program Integrity Reactive Detection Tools and Audits

Tools and Audits	Description	Payment Integrity	Program Integrity
Provider and Member Education	We continually assess and update our educational materials based on trends and findings from across our PI program. These training and interventions include handbooks, manuals, newsletters, EOBs and other letters, telephonic outreach, and webinar-based presentations to drive positive provider behavior modification and improve billing practices.	X	X
Member Eligibility	By using internal referrals, fraud hotline, and member specific analytics, we identify and report member eligibility concerns to the Division.	X	X
Post-Pay Clinical Chart Validation	We use claims audits that require medical record reviews and administrative reviews (data mining) that do not require a medical record to ensure reimbursement accuracy. All claims are interrogated through our detection engines and we audit those claims with risk, including facility and professional claims for the full range of services (ex. physical, behavioral, dental, vision, and pharmacy data). Our audits are supported by dedicated medical director, who is a certified coder, providing oversight of clinical review guideline creation, appeals, and medical necessity reviews.	X	X

Tools and Audits	Description	Payment Integrity	Program Integrity
SIU Case Investigations	We guard against FWA through detecting, monitoring, investigating, and correcting identified deficiencies. We review and process all allegations from our reporting mechanisms throughout a timely investigation process, as appropriate. We assess all FWA tips within 72 hours.		X
Announced and Unannounced Site Visits	We conduct announced and unannounced site visits and perform at least three PI site visits per year as required by Appendix A, Section 10.1.4. Our site visits include PI staff, and onsite visits from other departments including QM, BH, finance, provider services	X	X
Data Analytic Tools	We use a variety of data visualization tools to aid in detecting suspicious patterns including: ▪ Business intelligence data visualization: interaction dashboards ▪ Geo-mapping: Pattern analysis of member and provider behavior used for trending by geographic location ▪ ML analytic software: web portal behavioral monitoring ▪ NHCAA's database providing information sharing on fraud schemes and provider investigations across the U.S. Our post-pay fraud detection software brings together medical and pharmacy data, and numerous reports of provider billing utilization in real-time to provide rules-based, anomaly detection, provider profiling, and predictive modeling. It also includes link analysis, an innovative method of identifying members billed by suspect providers and links to other providers treating the same group of members. Our use of AI and ML capabilities allow us to compare providers to peer groups using CPT codes, payments, and locations to achieve identifications of anomalies and drive more accurate results over time.	X	X
FWA Case Tracking System	Our FWA case tracking system serves as a single repository of all FWA leads, allegations and supporting documentation to ensure compliance, reporting, and tracking.		X

We leverage data and outcomes to inform and determine the continuous refinement of our tools and practices and improve the effectiveness of our program. Through ongoing monitoring, we apply our proactive and reactive PI detection tools, as appropriate across the full spectrum of the payment lifecycle, thus ensuring the comprehensive oversight and effectiveness of our program.

b. Process for Acting Upon Suspected Cases of FWA

We have designed our processes for acting upon suspected cases of FWA to comply with all state requirements and to ensure prompt review, thorough and impartial investigation, and timely reporting and coordination with the OPI and other oversight agencies. We strive to exceed these requirements by building strong relationships with our state partners demonstrated by weekly collaboration status meetings to discuss pertinent case evidence (e.g., information sharing) related to ongoing active law enforcement investigations. **If at any time during the investigative process we identify reasonable cause to suspect fraud or abuse, or a credible allegation of fraud, we immediately report the case to OPI and seek required approval before moving forward with an investigation.**

Our enterprise teams are highly trained to help identify suspect behavior and patterns, and this enables the PI team to multiply its impact and the effectiveness of its investigations, and ultimately translates to a highly effective FWA program. Our Payment and Program Integrity unit has multiple avenues for prevention and detection of FWA, both before and after we pay providers, as outlined in Section 4.2.2.9.A.1.a, as well as reporting via our fraud hotline. These mechanisms detect issues that may trigger an investigation. For example, when a provider exhibits suspicious patterns with claims edit violations, it may trigger a referral to SIU for investigation. Additional examples include identifying providers with continued high error rates in programs such as post pay audits, diagnosis related group (DRG) reviews, and provider upcoding education programs. This continuous feedback loop illustrates our enterprise-wide approach to PI.

To support our investigation process, our PI unit employs automated tools throughout the investigation lifecycle to ensure efficient and quality outcomes of our cases. For example, we use automatic case creation via web forms, automatic data analysis at the provider level when we create a case, and identification of previous

allegations when we load new allegations into our case tracking system. Our PI investigation process includes four primary steps, intake and initial review, triage, full investigation, and reporting and resolution.

- **Intake and Initial Review:** We conduct an initial review of all identified or alleged suspected FWA within 72 hours during the intake process.
- **Triage:** After the initial review, we triage the case, which includes a fraud analyst assessing the allegations, performing research to aid in assessing the validity and risk presented, and determining whether the case should proceed to full investigation. Examples of the triage team's activities include:
  - Performing utilization analysis using fraud detection software to confirm outliers
  - Analyzing peer comparison reports
  - Reviewing applicable billing and coding rules
  - Interviewing relevant individuals
  - Obtaining a sample of medical records, and facilitating a review by clinical advisors/medical coding experts
  - Educating providers and sending notification letters when we identify billing errors that do not present a risk of FWA

Analytics and Interventions Inform our Investigations

Through the use of our industry leading detection software suite of tools in another market, we identified a chemical dependency counselor as an outlier for high dollar to low member count. In collaboration with our Behavioral Health Clinical team and PI workgroup, we identified through further data analysis, a suspicious trend. The investigator and a clinical expert obtained and reviewed medical records, which indicated record cloning. We referred the case to the state PI unit, which led to the MFCU opening an investigation.

- **Full Investigation:** When we validate an allegation, we move the case forward for a full investigation. The investigation team completes a comprehensive review including:
  - data analytics
  - onsite visit, if warranted
  - benefits, system pricing, and contract review
  - consultation with medical directors
  - medical record and coding reviews
  - payment and policy reviews
  - member and provider interviews
  - coordination with law enforcement and state Medicaid agencies

  When we identify errors, opportunities for improvement, or potential FWA, we implement appropriate corrective actions, such as training and education, or instituting pre-payment reviews. We also use the results in a feedback loop to inform our proactive prevention tools and controls, including claims edits. Our goal is prevention of FWA by leveraging our investigative results to enhance our proactive tools in order to stop FWA and eliminate pay and chase.
- **Reporting and Response**: When investigative findings support FWA, we immediately inform the Division of all findings, and proposed actions and remedies. As required by Appendix A, Section 10.3.2, we do not take the following actions without the Division's authorization:
  - Contacting the subject of the investigation about any matters related to suspected or confirmed fraud or abuse
  - Entering or attempting to negotiate a settlement or agreement relating to incidents of suspected or confirmed fraud or abuse
  - Accepting any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with incidents of suspected or confirmed fraud or abuse
  - Indicating to the provider or member that disenrollment from Medicaid will occur if we disenroll a network provider based on our finding of fraud and/or abuse

We understand that, upon approval from the Division, we are responsible for collecting any identified provider overpayments resulting from such investigations and for reporting all overpayment recoveries to the OPI annually. Before initiating any recoupment or withholding PI related funds, we confer with the OPI to ensure the recoupment or withhold is permissible. We do not seek to recoup improperly paid funds or withhold funds potentially due to a provider when:

- The Division or another government oversight agency has already recovered the funds
- The State's recovery audit contractor already identified the improperly paid funds
- The State is already investigating the issues, services, or claims that are the basis of the recoupment or withhold, or the funds are the subject of pending federal or state litigation or investigation or a Mississippi RAC audit

c. Disclosures and exclusion of debarred or suspended Providers

We maintain a robust screening program to assure we are not owned by and do not knowingly hire, or contract with individuals or entities that have been debarred, suspended, or otherwise excluded from participating in federal procurement activities or have employment, consulting or other agreements with debarred individuals or entities for the provision of items and services that are related to our contractual obligations with the State, in accordance with 42 CFR 438.610 and 455.436. We understand and agree the Division does not reimburse us for services rendered by any excluded, debarred, or otherwise prohibited provider, except for emergency services. If we identify a terminated provider under Medicaid, Medicare, or CHIP programs of any other state, we terminate and exclude the provider from participation in our networks.

Our exclusion screening process includes performing provider checks monthly against the System for Award Management (SAM), Death Master File, the List of Excluded Individuals/Entities (LEIE), the Specially Designated Nationals list, and state-initiated exclusions from Medicaid lists, including the Mississippi Sanctioned Provider list. Table 4.2.2.9_C provides additional information regarding how we perform exclusion screening throughout our organization.

Table 4.2.2.9_C: Exclusion Screening and Disclosure Process.

Disclosure and Screening Activity	Description
Initial Provider Disclosure	We capture identifiable information on the owners, agents and managing employees listed on providers' disclosure information in an electronic database.
Monthly and Ongoing Provider Monitoring	Provider Credentialing completes screening of all providers monthly using, a software tool that allows batch or single search exclusion screening and license verification/sanction of our providers both in and out of network. We perform automated screening of all providers as part of our claims adjudication process to reverify provider status at the time of payment. Claims reject edits scan for inactive providers on the Mississippi Medicaid master provider list to ensure payments deny before processing.
Delegated Vendor Screening and Disclosure	Delegated Oversight team collects disclosure reporting information and performs exclusion and sanction screening at time of contracting and conducts monthly screenings. We collect disclosure reporting information at least every three years or more frequently if required.
Subcontractor (non-delegated vendors) Screening and Disclosure	Sourcing department collects disclosure reporting information and performs exclusion and sanction screening at time of contracting and performs monthly screenings. We collect disclosure reporting information at least every three years or more frequently if required.
Human Resources Screening	Human Resources department maintains identifiable information on our owners, agents and managing employees, and screens new and existing workforce members against SAM and LEIE, and any other required sanctions or licensure databases upon hire and monthly thereafter.
Our Ownership and Controlling Interest	Legal department is responsible for making all our entity required disclosures.

Exceeding Requirements Through Our Proactive Sanctioned Provider Database

Our sanctioned provider database automates the collection of state, federal, and internal program integrity data into a single repository that updates as each of the sanction databases updates. The repository interfaces with our claims payment and prior authorization systems, as well as other functional areas, allowing us to integrate exclusion screening into our claims adjudication and prior authorization processes. As a result, in addition to the required monthly screening of our providers, we screen providers prior to paying any claims or authorizing any services.

We will report the results of our monthly screening activities to the Division as required. If we identify an excluded party, we will verify that we have not paid the excluded party with any MSCAN or CHIP funds, report the finding to the Division, and terminate our relationship with the excluded party.

d. Process for interacting with the Division and OPI

We understand the importance of timely reporting, transparency in our communications, and working collaboratively with the Division and OPI, and comply the requirements contained in Appendix A, Section 10, including those specifically addressed in 10.1.2. Additionally, consistent with Appendix A, Section 10.1.5, we cooperate with, and require our subcontractors to cooperate with, all appropriate state and federal agencies, including the Mississippi Attorney General's MFCU, in investigating FWA. We go above and beyond to ensure not only timely but accurately report and proactively communicate with our state and federal agency partners to ensure full transparency.

Collaborating with State Partners

We routinely work closely with State PI departments to develop a CCO data analytic pipeline.

Example of this collaboration includes our participation in the Centers for Medicare and Medicaid Services Healthcare Fraud Prevention Partnership (HFPP) studies of evaluation and management (E&M) services and psychotherapy services.We have provided the state with information and insights related to our participation in this program.

Consistent with Appendix A, Section 10.1.1.8, we will assist the Division in any investigation or prosecution of fraud by providing access to computerized data that we store, including direct access to, and copies of, such information at no charge and in the form requested by the Division. We also require, in our provider agreements, our providers to provide access to any information they possess or maintain relating to services under the MSCAN and CHIP programs that either we or the Division are authorized to access. We exceed these requirements based on our focus of maintaining strong relationships with our state partners demonstrated by ongoing collaboration meetings. We recognize the criticality of these partnerships and information sharing to deliver our highly efficient and effective FWA program.

Our Compliance Officer serves as the primary point of contact and is responsible for making sure all required reports and ad hoc requests for information are thorough, in the correct format, and provided timely. Our Compliance Officer is also responsible for:

- Reporting suspected or identified fraud or abuse by a provider, member, or subcontractor within the required timeframe
- Ensuring timely notification of changes in MSCAN and CHIP members' or providers' circumstances that may affect their eligibility
- Coordinating investigations of alleged or suspected fraud and abuse, including taking steps to pause PI related activities that require prior approval from the Division or OPI
- Ensuring that we, and our subcontractors, timely suspend or re-initiate provider payments, when directed to do so by the OPI
- Reporting all overpayments identified or recovered, including identifying overpayments that were due to potential fraud
- Meeting with the OPI at least quarterly, and more frequently as needed to discuss areas of interest for past, current, and future investigations and to improve the effectiveness of FWA oversight activities
- Coordinating any onsite reviews by the Division and OPI and facilitating the response to requests from the Division to supply documentation and records.

Collaboration with State Agencies to Combat Fraud

In another market, our PI team received a tip from our medical director with concerns related to high utilization of computerized tomography (CT) scans from a rural imaging center. Our investigative activities included an on-site review with our nurse investigator, medical director, and delegated radiology benefit manager. The onsite review revealed the pain management clinic was referring CT scans to an imaging center in which the pain management physician and family had financial interest. Data analysis showed that 92% of all the pain management clinic's patients received one or more CT scans and all patients were referred to the imaging center connected to the pain management clinic. We established evidence of churning CT scans, self-referral, and systematic abuse of patient health. Our investigation and referral to the state and federal law enforcement partners resulted in the provider's 5-year incarceration and court ordered restitution of $2,000,000.00.

e. Other components of the Our FWA Program

Compliance with FWA Program and Plan Requirements

Our compliance program, including our FWA program, is based on the Office of Inspector General's Seven Elements of an Effective Compliance Program, and complies with all federal and state requirements regarding FWA. We require all subcontractors to whom we delegate responsibility for coverage of services or payment of claims to also implement and maintain a compliance program that complies with 42 C.F.R. § 438.608 and the Division's policies and procedures. We view our subcontractors as an extension of organization, and we ensure those supporting our business know we are committed to doing more to prevent FWA and protect the resources entrusted to us. FWA is part of our shared culture. We embed this focus on FWA with our subcontractors and benchmark their performance to drive accountability. Our compliance and PI staffing is appropriate to ensure the effectiveness of our programs, including all required positions described in Appendix A, Section 10.1.3.

We understand and fully cooperate with the OPI's oversight of all our FWA activities, including written direction by the OPI regarding investigations, overpayments, and any other PI related activities and reporting. We use the most current version of the Program Integrity Fraud and Abuse Standard Operating Procedure for referrals and reporting to the Division and OPI and comply with all requirements contained in Appendix A Section 10 Program Integrity. Our written MSCAN and CHIP Compliance Program and Fraud and Abuse Plan addresses all elements outlined in Appendix A, Section 10.1.1 and 10.2.2 respectively. Table 4.2.2.9_D provides a brief summary of how we address the FWA Compliance Plan requirements outlined in Section 10.2.2.

Table 4.2.2.9_D: Overview of Our FWA Compliance Plan

Element	Description
Require reporting of FWA comply with the contract	As described in 4.2.2.9.A.1.d, we maintain clear processes to support required reporting of FWA, in compliance with applicable state policies and the contract.
Perform a risk assessment of FWA and PI processes	As described in detail in the following sections, we perform annual and ongoing risk assessments of our FWA and PI processes, that includes identification of our top three vulnerable areas and associated action plans. We will submit our risk assessment to the Division upon request and immediately after a PI related action is issued on a provider with concerns of FWA.
Outline unique policy and procedures, including specific instruments to be used	Our FWA Compliance Plan addresses FWA specific policies and procedures and describes specific instruments that we use, such as those described in section 4.2.2.9.A.1.a. We have centralized our FWA Compliance Plan and policies in our GRC policy management platform and ensure policies remain up-to-date, and compliant with all federal and state requirements.
Address procedures designed to prevent and detect abuse and fraud in the administration of delivery of services	We structured our FWA compliance plan with multi-layered defenses in FWA prevention and detection. Our assurance functions, including Internal Audit, Compliance and PI, use a risk-based audit approach that we designed to routinely monitor and assess existing and emerging risks. Internal Audit is also responsible for providing independent and reasonable assurances that our internal controls, governance processes and risk management strategies are adequate, and that business functions meet their intended objective.

Element	Description
Describe of the specific controls in place for prevention and detection of potential or suspected FWA	Our FWA plan includes a description of specific controls, such as: ▪ Comprehensive automated pre-payment detection models, code specific analytics, and claims edits ▪ Extensive and continually evolving suite of automated post-payment claims edits to ensure accurate billing and payment ▪ Full spectrum of post-pay review capabilities that include desk audits on post-processing review of claims ▪ Effective surveillance and UM protocols that include prospective, concurrent, and retrospective reviews to safeguard against unnecessary or inappropriate use of Medicaid services and ensure appropriate member care.
List provisions for the investigation and follow-up of any suspected or confirmed FWA, even if already reported, and compliance plan reports	As described in Section 4.2.2.9.A.1.b. and d., our highly effective FWA compliance plan mandates our commitment to verifiable processes ensuring appropriate and timely investigation and follow-up of any suspected or confirmed FWA.
Ensure identities of individuals reporting violations of the Contractor are protected and they protected from retaliation	We have established policies and processes promoting our anonymous reporting mechanisms, including web, mail, and our 24-hour hotline, to ensure the identities of individuals reporting violations to us are protected and not subject to retaliation. Our hotline reporting system allows individuals to report in the method and language they feel most comfortable ensuring integrity and security in the intake process.
Specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating FWA compliance plan violations	We provide a variety of reporting mechanisms, including a fraud hotline; fax, email, and mail reporting options; in-person reporting to our Compliance Officer and SIU staff; and reporting via our claims system. We also offer an external reporting option via a third-party vendor to further support anonymous reporting. We educate our employees, directors, managers, and officers on the reporting mechanisms, through a variety of channels including our website, intranet site, policies and procedures, and trainings.
Specific and detailed internal procedures on how information received from the State regarding providers already under investigation or review is disseminated internally to the appropriate group(s).	Using our regulatory distribution management system, our Regulatory and Compliance department distributes notifications from the State to appropriate departments using automated workflows to track acknowledgement or response. We follow all State approval requirements prior to contacting or investigating a provider.
Require any confirmed or suspected provider FWA under state or federal law be reported to the MFCU and the Division's OPI	As described in Section 4.2.2.9.A.1 d, our Compliance Officer will be responsible for ensuring any confirmed or suspected provider FWA is reported timely to the MFCU and the OPI, consistent with the contract requirements and OPI guidance.
Work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk to ensure services are rendered and billed correctly	We conduct announced and unannounced site visits and field audits of identified high risk providers, such as providers with cycle or auto billing activities, providers offering DME, home health, mental health, and transportation services.
Conduct monthly provider screening and capture identifiable information on the owners, agents and managing employees listed on providers' disclosure information as provided by the Division	As described in Section 4.2.2.9.A.1.c, we exceed requirements to screen providers by performing exclusion and debarment screening monthly and during the claims adjudication and prior authorization processes. Additionally, we maintain processes to capture required disclosure information.
Conduct monthly check for exclusions of their owners, agents and managing employees	As described in Section 4.2.2.9A.1.c, we have established processes to perform require exclusion screening of all employees, owners, agents, and managing employees, at the time of hire and monthly thereafter.
Provides for prompt terminations of inactive providers due to inactivity in the past 12 months, unless the Division directs otherwise.	We have internal monitoring capabilities in place to look for claims system vulnerabilities, such as provider claims inactivity (over 12 months) and will notify the Division prior to terminating the provider unless otherwise approved by the Division to remain contracted.

We will submit our compliance program and fraud and abuse plan, including all relevant policies and procedures, to the OPI for written approval within 90 calendar days of execution of this contract and annually thereafter. We review our compliance and fraud and abuse documents at least annually and submit any revisions

as required or requested to the OPI for written approval at least sixty calendar days prior to the planned implementation date.

We know PI risks and fraud schemes continually evolve, and so does our FWA program. A few examples demonstrating how we assess and maintain an effective PI program include our approach to collaborating with industry partners and pharmacy benefit administrators (PBAs), developing comprehensive risk assessments, educating employees and subcontractors, using provider profiler data, and overseeing subcontractors.

Collaboration and Information Sharing with Industry Partners

Our PI department actively participates in numerous industry information sharing venues, such as HFPP and NHCAA committees and work groups. For example, one of our state plans co-hosted, with the NHCAA and HFPP to discuss shared schemes and suspect providers. The opioid epidemic was a key focus of this meeting with partners sharing several best practices for FWA deterrence. Our experience with these programs provides us with a broader vision of FWA schemes and pain points across the country, bringing a depth of experience we can leverage throughout Mississippi Medicaid operations. We view this as a vital tool for building out and advancing our goal of having a highly effective FWA program. The information sharing allows for earlier identification of suspect behavior. We will partner with our peer plans, state agencies, and law enforcement to help accelerate our FWA program and activities to protect the resources we are entrusted with.

Coordination with State Contracted PBA Entity/Entities

To ensure deterrence of FWA for pharmacy benefits and services, collaboration with the single PBA is critical. We have extensive experience working with a single PBA and integrating pharmacy and medical data to identify FWA. We use pharmacy network and prescription data shared by the PBA to look for prescriber and pharmacy outlier and suspicious trends. Additionally, we monitor external data sources (e.g., Mississippi Board of Pharmacy) to look for potential abuse of pharmacy services. Our goal is to seamlessly couple our detection models with the PBA to ensure we prevent, identify and correct FWA when detected.

We work with the PBA to develop evidence-based algorithms and predictive modeling to identify MSCAN and CHIP members who are at risk or nonadherent to medication guidelines. We believe in using an integrated approach that leverages both our medical and pharmacy directors to support our clinical initiative teams in reviewing members for potential gaps in care or other medication-related concerns. When we identify outlier prescriber behaviors, we use provider education strategies to redirect our network toward appropriate prescribing practices.

Risk Assessment and Work Plan Process

One of the key tools used in identifying potential compliance and fraud risks is our risk assessment process. In collaboration with the enterprise risk management and compliance teams, we routinely complete risk assessments, using a state of the art risk management platform and a governance risk management strategy. Through this process we obtain input from operational and administrative departments across the organization. We assess risks according to the following attributes:

- Member and provider impact, such as access to care, financial payments, interest payments, and clinical quality
- Reputational impact, such as regulator and societal reputation impacts
- Financial impact, assessing the potential for financial implications of deficiency
- Delegate impact, assessing from delegated vendor processes, previous history, and industry knowledge

Our PI/SIU and compliance departments also review data and information from a variety of state, federal and internal sources (e.g., OIG workplans, annual Medicaid FWA reporting, information sharing resources) to further support our risk assessment process and aid in identifying new and emerging risks.

Once we have identified areas of risk, we evaluate and stratify the risks. Our risk stratification process involves departmental subject matter experts rating the maturity and compliance of their processes and detection models on a scale of 1-5 (1=not mature; 5=extremely mature), and the severity of the impact on a scale of 1-5

(1=minor; 5=extreme). Subject matter experts add any areas for FWA identification specific to their department, informing our PI focus areas.

The Enterprise Risk, PI, and Compliance departments compile and prioritize the top risks from each department. We use the results of our risk assessment to develop work plans, including a PI-specific plan, that outline our targeted performance goals, objectives, and planned activities. Once approved by the PI committee, we update the work plan at least quarterly, noting our progress toward identified outcomes. We review and monitor lower risk activities accordingly. We add unforeseen risks (e.g., COVID-19) to the risk assessment and work plan in real-time, with severity rankings assigned according to organizational impact. We report the results of the risk assessment to our state plan, compliance committee and executive leadership. Additionally, we report results to our corporate PI and Compliance departments, who incorporate the results into reports to our corporate risk and audit subcommittees.

Staff and Subcontractor FWA Training and Education

We have developed comprehensive compliance and FWA training for all staff and subcontractors. This training includes information on the False Claims Act, whistleblower protection rights, and other federal and state laws described in Section 1902 of the Act (42 USC 1396a(a)(68), as well as policies and procedures and standards of conduct that articulate our commitment to compliance. We have also developed state specific trainings that address state laws, regulations, and program and contract requirements. We routinely update our training materials to address any changes in regulations. Staff receive scenario-driven training, providing relevant context to compliance and PI requirements. We incorporate testing in the training to evaluate its effectiveness and provide feedback on any opportunities for additional reinforcement of key concepts and requirements.

We require all staff members and vendor staff to complete training upon hire and annually thereafter. The provider manual, member handbook, and our website also have information on FWA and reporting mechanisms. In addition, we provide our delegated entities and subcontractors with information on the FWA program, compliance responsibilities, the False Claims Act, and contact information to report FWA. Delegated entities and subcontractors annually attest to their understanding and compliance with the requirements.

Provider Profiler and Education

Using provider profiler data and peer comparisons of all our provider types and specialties, we monitor and identify aberrant service and billing pattern trends warranting further review or audit. The PI/SIU department’s fraud detection software provides risk scoring, profiles providers, and utilizes peer comparisons to analyze provider behaviors. Our provider risk scoring is based on the provider’s billing and activity compared to his or her peers and known FWA schemes. We also use dashboards for peer comparisons with our dental and vision providers. Our PI team completes ad hoc peer comparisons using business intelligence platforms for use in investigations, pre-pay review, or FWA identification data reviews. We further assess outlier providers to verify there is not a reasonable explanation for the aberrant trends such as providers who have a dual specialty. If we confirm potential FWA, we move the case to an investigation and report appropriately.

We believe an enterprise provider education program is a critical and effective tool in preventing FWA. We use enterprise providers’ billing pattern data to identify outliers compared to peers and offer education to influence or “nudge” the provider to improve billing practices over time to deter FWA. We identify potential provider education opportunities starting at the claims submission gateway through post claims payment history. Our current provider education program includes an extensive code set listing with the ability to create code specific campaigns when trend data suggests the need. As an example, due to the increased utilization of telehealth services during COVID-19, in 2021 we added telehealth services to our provider education program. We use peer comparison data to identify and outreach to providers and communicate information on correct billing practices. We then monitor provider billing for a change in behavior. We assess providers who do not change behavior for referral to the SIU for additional review.

Subcontractor Oversight

As mentioned, we take full responsibility for subcontractor performance and ensure quality outcomes through continual monitoring and auditing, performance management meetings, reporting, and contractual guarantees. The PI department assesses the size and scope of functions performed by the subcontractor. PI creates a specific quality program unique to each subcontractor. We ensure subcontractors have clear understanding of expectations and we implement the appropriate level of monitoring and coordination to ensure accurate and compliant subcontractor deliverables and effective oversight of FWA requirements. These activities include, at minimum, quarterly meetings with "high risk for FWA exposure" delegates. We provide oversight to PI related functions they perform and review PI specific issues, alerts, and risks. We consider a subcontractor at high risk for fraud if they pay claims on our behalf, perform audits or investigations on our behalf, or have two or more FWA related corrective action plans within one calendar year.

Effectively Working with Subcontractors to Identify Provider Fraud

In another market, our dental delegate identified a provider who allegedly billed Medicaid members directly for covered Medicaid services. The dental delegate immediately notified our PI team. The dental provider falsely informed the patients that certain Medicaid covered services were not Medicaid covered. The collaboration with our subcontractor lead to an FWA referral to the state PI Unit. The MFCU subsequently initiated a criminal investigation.

The PI department reviews the vendor's policies and procedures and FWA training materials, upon request by Vendor Risk Management and Oversight. The PI department meets with subcontractors who perform PI related functions on our behalf at least monthly to discuss cases, data analytics, trends, and schemes. We structure these collaborative meetings to ensure process connectivity and compliance with all applicable state, federal and program requirements.

4.2.2.9.B. Claim Denials

4.2.2.9.B.1. Describe the Offeror's proposed Denials Review and Reporting program, including:

a. A description of the Offeror's Denials Management program;

b. A summary/listing of the Offeror's denials criteria/protocol;

c. The Offeror's process for identifying claims and/or claims lines that meet the Offeror's denial criteria;

d. The Offeror's reconsideration process as it relates to claims denials; and

e. The Offeror's process for notifying and educating providers of claims denials.

We believe our members are best served when providers can focus on providing care, which is why we continually work to reduce provider administrative burden. We are committed to changing the trajectory of Mississippi's healthcare system via our fully integrated, transparent service delivery model with the majority of providers using real-time bidirectional data exchanges to bring a new era of provider collaboration to Mississippi. Through our experience working with providers serving Medicaid members, we have developed a balanced claims denial program that ensures we only pay for properly billed services while we collaboratively work with providers to proactively reduce abrasion. Our claims denial management program and practices will fully comply with all MSCAN and CHIP requirements, including those outlined in Appendix A, Section 9.1.4. We will provide the Division with claims denial reports consistent with Appendix A, Section 16.4.2.

a. Description of Our Denials Management Program

Our comprehensive denials management program consists of a wide array of methods and tools, such as data analysis, artificial intelligence and machine learning (AI and ML), governance committee oversight, and our Mississippi provider innovation collaborative and provider escalation unit. We focus on proactive monitoring of patterns of denials both globally and at the provider level to quickly initiate analysis by our teams to minimize issues and unnecessary provider administrative effort.

For 90 days following implementation of any new component of the contract, we proactively monitor any denials that may be associated with changes to identify possible education opportunities for providers through our provider representatives. We go beyond the traditional focus of high-volume claims submitters to identify rejection and denial trends for all providers regardless of size. **As a result, our low volume claims providers and rural providers receive the same level of outreach and customized support as our high-volume claims providers.** Our ability to deliver operational excellence demonstrates that we respect providers and will be a worry-free partner of the Division.

To ensure we provide the proper rigor and controls around our claim's denial program, we use input from multiple governance committees, including UM, clinical policy, and payment policy committees. These cross-functional committees, comprised of delegates from operations, legal, provider services, compliance, and provider innovation (PI) review all new and revised claims policies and actions. Once the committee members approve a modification, we notify providers in advance of configuration and implementation in accordance with contractual obligations. As required by Appendix A, Section 9.1.1.2, we will seek approval from the Division 60 days prior to implementing any changes in our criteria for authorization or denial of payment for services rendered by out-of-network providers.

Provider Innovation Collaborative

To promote a superior model for accountability, data-driven outcomes, and quality care, we have established our provider innovation collaborative that will support our providers' capacity to serve MSCAN and CHIP members.

We understand that providers are diverse in size, staffing, and capacity, and we have developed provider resources to accommodate their broad continuum of needs. We designed our provider innovation collaborative specifically with Mississippi provider needs and Division priorities in mind.

We offer contracted providers a hub of resources, training, and technical assistance that enable providers to operate as fully accountable, quality-driven, innovative care providers.

Our denial management program addresses claims that are either rejected or denied partially or fully, as invalid or requiring additional information. In order to assist providers with managing totally or partially denied claims submissions, we receive the claims and communicate the reason for the denial via a 277CA Rejection, the Explanation of Payment (EOP) or 835 file. This process allows us to rapidly notify providers of the identification of total or partial denial of their claim so they can rectify the cause in a timely fashion, which in turn, promotes faster payment. We evaluate claims for appropriate denials via state of the art clinical and coding editing engines that are integrated in our claims workflow. In some instances, we use Health Insurance Portability and Accountability Act compliant informational denials that convey the requirement for additional information, such as coordination of benefits, consent forms, etc.).

[redacted]

Our claims evaluation process, depicted in Figure 4.2.2.9_B, includes:

- Pre-Adjudication claim level validation (basic demographic review, such as member matching, provider qualifications, etc.).
- Core processing platform claim validation (program and claim specific data, such as benefit maximums, duplicate claims, etc.).
- Pre-payment validation, which includes coding accuracy engines (e.g., National Correct Coding Initiative [NCCI], frequency, high dollar denial reviews) and internally developed macros or scripts to detect scenarios not identified in our pre-payment engines or within the core processing system.
- Retrospective reviews, such as short stay inpatient claims, readmissions, and DRG reviews.

If we identify a systemic denial issue, we inform our providers by posting information about the issue on our Provider Portal and maintain updates with target remediation dates.

Data Driven Monitoring of Denials

We routinely monitor and analyze a variety of denial related data points so we can swiftly identify and take action when needed. These indicators allow us to identify scenarios that may trigger provider abrasion, identify education opportunities, monitor aberrant billing and coding patterns, forecast volumes for potential appeals or adjustments, produce fraud, waste, and abuse (FWA) referrals, and support compliance adherence. We also use denial data and outcomes to inform the evolution of our algorithms, resulting in continuous process improvement and prompt response to new and emerging denial trends.

The denials management program is a part of our overall focus on quality controls to drive claims accuracy. Components of our claims quality control monitoring, depicted in Figure 4.2.2.9_C, include:

- **Prospective Auditing:** As part of our proactive approach to identifying avoidable data entry errors, we perform nightly scans of our technology solutions. These include scan of our automated claims processing, billing, care management, and network management workflow configuration, as well as provider, and member tables.
- **In Process Monitoring and Controls:** We continuously monitor claims during the adjudication process to process them accordingly. We currently execute daily automated reviews of in-process claims for 28 specific scenarios with continual additions and revisions.
- **Retrospective Monitoring:** We continuously monitor finalized claims for identification of anomalies or trends that may be indicative of potential errors. Processes include systematic and manned reviews of the configuration post-production changes, and encounters editing and reject analysis. We have also developed anomaly detection tools using AI/ML algorithms to identify improper denial patterns on claims in process. Additionally, data gathered through the reporting of issues from our provider services call center and our grievances and appeals process is used to augment the analysis to identify trends, patterns or anomalies requiring attention.
- **Retrospective Auditing:** We have developed a multifaceted retrospective audit program to reduce claims errors and support continuous improvement across the functional areas that drive the quality of claim adjudication.

Figure 4.2.2.9_C: Claims Quality Control Monitoring

We are committed to claims accuracy continuous improvement.

The effectiveness of our data driven denial management strategy is reflected in our claim denial trend, depicted in Table 4.2.2.9_E.

[redacted]

b. Summary/Listing of Our Denials Criteria and Protocols

Our claims platform is customized to comply with state specific program requirements and to support comprehensive claims validation. Our processes also make sure we do not make prohibited payments as outlined in Appendix A Section 9.2.6. A summary of our denial criteria and protocols, include:

- Provider eligibility to render the services billed
- Missing, invalid, or mismatched NPIs, CLIA certifications, and/or TINs/EINs
- Duplicate claims, including flagging possible duplicate claims for further review or denial
- Prior authorizations and approvals
- Medical necessity, including validating services are appropriate in amount, duration, and scope as billed
- Covered service under the Contract and eligibility for payment
- Member benefit limits
- Field and general claim edits
- Dates of service
- CPT® codes
- Healthcare Common Procedure Coding System (HCPCS)
- ICD-10 coding
- Age and gender
- NCCI edits

c. Identifying Claims that Meet Our Denial Criteria

Our process for identifying claims and claims lines that meet our denial criteria addresses both pre-adjudication and adjudicated claims. As described previously, we continuously monitor denial patterns to identify and target provider education and supports as described in Section 4.2.2.9.B.1.e. During pre-adjudication we verify the claim meets federal and state claim acceptance criteria in order to proceed to full adjudication. We reject and return claims that fail pre-adjudication review to the provider.

Once we accept the claim our system validates it against our comprehensive and state specific edits, described in Section 4.2.2.9.B.1.b., including member eligibility, provider eligibility and network participation, fee schedules and pricing, and benefit management rules. We use a variety of tools to apply standard and custom clinical and claim billing edits. These tools include pre-payment review tools described in Section 9.2.2.9.A.1.a., such as NCCI edits, diagnosis related group (DRG) reviews, provider sanction screening, and coding rules.

d. Reconsideration Process for Claims Denials

We understand that claims denials can have significant impact on our providers and offer our providers several avenues to submit requests for adjustments or reconsiderations, including submission of a corrected claim, a provider inquiry, a claim dispute, or an appeal. We maintain written policies and procedures, in form and content that are acceptable to the Division, including a process for providers to appeal claims denials.

Our online claim submission tool is available through the provider portal and allows providers to have a convenient, consolidated location to handle their claim submission needs. The tool supports a variety of functions including, but not limited to, submitting corrected claims via paper, portal, or electronic data interchange (EDI); attaching necessary medical record documentation for new or previously submitted claims, viewing claims status, and requesting reconsiderations. We track all inquiries and adjustment requests electronically and investigate, report, and trend them for root cause, aging, and disposition.

To ensure prompt and accurate handling of claims related provider complaints, including reconsideration requests and appeals, we have a dedicated trained unit empowered to research and, if appropriate, adjust claims. If a complaint involves a complex claims issue, a second-tier support team engages with the necessary operational teams through a centralized ticketing system to support appropriate resolution, including offering the provider a clear explanation of any continued denial.

The provider claim dispute process, or reconsideration request, is an administrative process providers may use outside of appeal, or adverse determination process. Providers may use the claim dispute process to challenge any issue related to claim adjudication, including claim denials and underpayments. Providers have 90 calendar days from the date of denial to file a provider claim dispute. Upon completion of an investigation, we notify the provider of the resolution within 30 calendar days of receipt. If a provider needs support from our second-tier support team, our second tier team conducts proactive outreach to keep the provider up-to-date on the status of any open issue. Through active engagement of our claim dispute team and the provider, the tiered support system removes administrative burden and increases provider satisfaction.

e. Process for Notifying and Educating Providers of Claims Denials

We notify our providers of claims denials through a variety of mechanisms including, 277CA Rejection, the EOP, 835 file, and our portal (for systemic issues). Providers can also check and track the status of their claims through our secure provider portal, electronic 276 transaction, or by contacting our provider service center and provider representatives with claim questions. Our provider portal is a piece of our fully integrated, transparent service model which will promote an era of provider collaboration. As required by Appendix A, Section 9.1.4, our denial notifications explicitly address every reason we are or may deny the claim, so providers may address any or all issues with the claim at one time. When we deny a claim, either partially or totally, due to the provider not submitting required information or documentation with the claim, our denial notice identifies all missing information and documentation. We respond to provider inquiries promptly and average 25 days to complete reprocessing for incorrectly paid or incorrectly denied claims. We educate providers about their right to file an appeal during the onboarding process, and via our provider manual and the EOP.

Timely Denial Notification Process

Nationally, we process 98% of claims within 5 days, which expedites notification of provider denials.

We use our denial management process to identify opportunities for provider education tailored to the unique needs of each provider. Our provider representatives use denial reporting tools to review patterns and trends in near real-time, and proactively outreach to providers to offer targeted training and education. We offer training through onsite visits, joint operating committees, and individual meetings. We may also direct providers to prepared trainings and recorded sessions on our provider portal for ongoing education.

We also use our denial reporting results to identify more systemic educational needs, such as offering special trainings, publishing provider notifications, newsletter articles, and updating our provider manual. Our provider innovation collaborative will use our denial management data analytics to support efforts to identify opportunities to further reduce provider administrative burden and reduce provider abrasion.

4.2.2.9.C. National Correct Coding Initiative (MississippiCAN)

4.2.2.9.C.1. Describe the Offeror's process to comply with Medicaid National Correct Coding Initiative (NCCI) for MississippiCAN, to include Offeror's timeline for pulling Medicaid NCCI files, testing, and implementation.

Based on our decades of experience managing Medicaid programs in multiple markets, we have developed our editing platform to support compliance with Federal Medicaid requirements, with easy and fast modification to incorporate State specific requirements and program nuances. Our system ensures we correctly and accurately apply NCCI edits in the processing of claims and rapidly build in exceptions where State policy requires us to adjust or modify an edit. We will submit our policies that address manually priced claims, items, and services for Division approval.

We use an integrated industry-leading claims editing system (CES) to implement standard and custom clinical and claim billing edits. As soon as quarterly updates to the Medicaid NCCI edits are published, the CES integrates the changes into the CES knowledge base files and provides us with recommendations relating to the changes. We promptly review the recommendations and return our decisions to CES, load the updates to CES, perform testing and deploy the updates to our production environment **Over the last five quarters, the average**

time from file release to our receipt of recommendations was nine days, and our average time from receipt of the CES recommendations to production deployment was also nine days across all markets.

We automatically reprocess any claims received between effective date and load date prior to allowing those claims to post for payment/denial. This timeline allows us to implement changes so close to the effective date that the whole process is seamless and invisible to our providers. We currently maintain this level of Medicaid NCCI load compliance across all our Medicaid markets and are readily prepared to expand the process to include MSCAN and CHIP.

[END OF RESPONSE]

4.2.2.10 SUBROGATION AND THIRD-PARTY LIABILITY

4.2.2.10.A. Approach

4.2.2.10.A.1. Describe the Offeror's proposed approach to conducting subrogation and Third-Party Liability activities, including:

As a Medicaid coordinated care organization (CCO) with operations in multiple states, we bring best practices and operational excellence to all our markets, demonstrating streamlined processes to effectively coordinate benefits (COB) and third-party liability (TPL) with other payers. We are a CCO committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence bringing a new era of provider collaboration to Mississippi. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing State resources. In support of the MSCAN and CHIP programs, we maximize cost avoidance by identifying third-party coverage and recoveries through subrogation and other activities. We comply with all relevant sections of the RFQ and Appendix A, Draft Contract, Section 12; Section 1902(a)(25) of the Social Security Act; and 42 C.F.R §433. We maintain standard operating policies and procedures that establish guidelines for processing transactions, monitoring, and auditing claim submissions, and adhering to state and federal payment processing rules. Additionally, we conduct audits focused on payment and financial accuracy, claims entry, adjudication processes, authorizations, COB, and TPL. Our experience reconciling TPL claims and coordinating other benefits with our claims results in optimized cost avoidance and savings across all our markets.

a. Process for capturing Third Party Resource and payment information from the Offeror's claims system for use in reporting cost-avoided dollars and Provider-reported savings to the Division.

We employ automation coupled with manual support to identify legally liable TPL coverage and coordinate benefits with other payers. In compliance with Appendix A, Draft Contract, Sections 12 and 16 requirements, we report cost-avoidance dollars and provider-reported savings to the Division in the required format.

Use of the Division TPL data is critical to providing our members, providers, and Division with the most accurate information. Daily, we ingest the Division's TPL file via secure file transfer protocol (sFTP) or any file transfer process dictated by the Division. It goes through multiple data cleansing processes including but not limited to selecting the most recent validated record in conjunction with other TPL records received from the various vendors used. Once cleansed, we load the file directly to the Eligibility and Enrollment system and immediately update the member records with the most current TPL information. Since the Eligibility and Enrollment system is integrated with the Claims Processing system, updates occur simultaneously. This process allows us to return the most recent TPL roster back to the Division to synchronize data across both entities.

TPL Data Capture Process

We use multiple data sources including the State TPL daily files, claim indicators, enrollment and provider data files, third-party vendors, and the Centers for Medicare and Medicaid (CMS) Open Query allowing real-time access to determine members' Medicare Eligibility. The enrollment COB team employs various methods, including calling other CCOs directly or using web-based validation tools provided by our COB/TPL vendors, to manually research any non-validated information. Our vendors send us pre-validated TPL data, which we load directly into our core system through batch processing. This relationship contributes to coordinated TPL data integration. Information from these data sources is validated using our TPL business partner's portal, TPL payor of record, or third-party consolidators. Our recovery and cost savings management team conducts monthly meetings to review vendor reporting and compliance with regulatory rules.

We also capture COB data from claims data when providers identify a primary payor and submit the resulting COB information for which we did not have TPL on record. Our enrollment COB team specialists validate and enter the claim COB data into our claims processing system. Manual verification of COB information occurs through a real-time COB validation application that provides COB verification to enable prompt TPL updates. In addition, providers can submit COB data through our provider portal to the enrollment COB team. We pay claims received with COB information according to Medicaid and provider specific pricing arrangements, adjusted for the primary payment information.

Upon receipt, we ensure our claims automatically adjudicate against the TPL data in the claims processing system. We have established extensive claims systems edits to ensure payments are not remitted on provider claims for non-covered services. Additional edits automatically deduct any cost-sharing obligation from our provider payment. We ensure our cost avoidance efforts do not prevent a member from receiving medically necessary services and we coordinate benefits with the member's primary insurer to facilitate payments so there is no impact on the member's health. Our automated file load process promotes timely cost avoidance and drives COB efficiency in our operations while our immediate validation process ensures member access to care. We capture final claim payment details, including TPL and COB information, in our claims adjudication system and store it for future reporting.

Reporting Cost Avoidance and Provider Reported Savings
We identify, collect, and report TPL coverage and provider savings data to the Division. On a monthly basis, we query our claims processing system and our financial accounting system to extract all cost avoidance and recovery amounts. Records regarding TPL collections are maintained in our system, and we report the requested information in the format and time frame as designated by the State. We reconcile to encounter claim data and provide the Division with TPL information which includes a change file based on reconciliation with the State Daily File.

b. Process for retrospective post payment recoveries of health-related insurance;

We use two processes to recover claims whenever we identify TPL retroactively for the date of service on a claim. The first process is a programmatic recurring sweep of our denied and paid claims, where the member’s COB information updates retroactively within our claims payment system. We perform this process on a weekly basis for both COB adds (claims paid and now denying/recovering for COB) and COB removal (claims previously denied for COB and now paying). Once identified, we update claims with COB removed that result in an additional payment immediately. Claims identified for recovery due to COB information being added to the member record generate a letter sent to the provider with the information related to the recovery, including the claim information, member information, and primary payer information. If further payment is due, the provider submits an updated claim with the primary payer explanation of benefits (EOB) for payment consideration.

For the second process, we use a third-party vendor to work with other insurance companies to recover claims where there is retroactive identification of COB. Our vendor identifies claims and submits them to the other insurance company, which provides reimbursement for the claims covered. We then update our claim payment system to ensure no claim adjustment occurs after reimbursement from another insurance company.

c. Process for adjudicating claims involving third party coverage;

Our claim processing platform, shown in Figure 4.2.2.10_A, handles third-party coverage processing with the specific objective of adjudicating claims accurately and timely to ensure optimized cost avoidance.

[redacted]

We systematically evaluate submitted claims for the presence of third-party coverage data. If no third-party coverage data is present, the system checks if the member has active TPL on record. After confirming no other coverage exists, we process the claim under primary carrier coverage rules. If our system has an active TPL record and we confirm that the services are not related to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or Title IV, or non-covered by the primary carrier (such as hearing aids for members with Medicare as primary), the claim adjudicates with a denial issued requesting the primary insurer submit the COB information to us for claim reconsideration. The claim system ensures claims only cost-avoid when appropriate and claims with Current Procedural Terminology (CPT) codes such as EPSDT or Title IV-D are not cost avoided. If the claim includes COB data and our member record has an active TPL record, the system adjudicates the claim with the application of the COB data in accordance with COB guidelines. If the claim includes COB data and our member record does not have an active TPL record, our system triggers a report to the TPL Data Management Team and continues to adjudicate the claim with the COB data submitted applied in accordance with COB guidelines. The TPL Data Management Team then verifies the policy information from the claim. If valid, we load the information into the claims platform to support future claims processing and any past claims paid as primary are reprocessed requesting COB information from the submitter.

d. Process for identifying, recouping, and releasing claims;

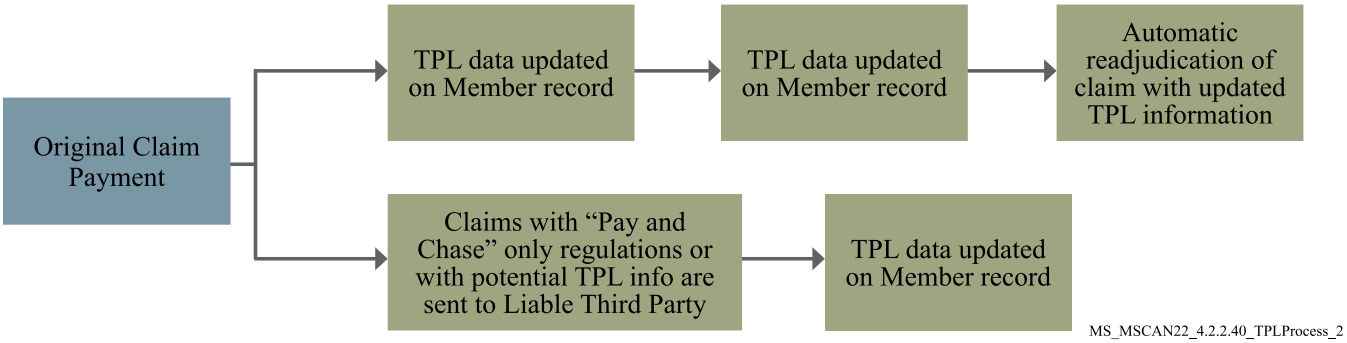
In identifying, recouping, and releasing claims, we retroactively adjust claims systemically on a weekly schedule to ensure proper payment is based upon the primary insurance responsible for the coverage on the date of service. We retroactively adjust claims for primary payment and recovery when TPL information updates. An automated reporting logic programmed to recognize claims with member COB verified after the claim has paid identifies those claims for recovery. The automated reporting uses pre-defined logic to capture only claims eligible for provider recovery. Once a claim is identified for recovery, the claim automatically adjusts, and a programmatic letter is sent to the provider informing the provider of the recovery and the identity of the primary insurance carrier.

We use an independent subcontractor to assist with carrier billing of third-party coverage directly through “Pay and Chase” processes. Claims that are determined to have third-party coverage may be sent through the “Pay and Chase” process directly with the third-party carrier. Claims with CPT codes for EPSDT and Title IV-D

services always fall to the established “Pay and Chase” processes for recovery. Figure 4.2.2.10_B illustrates our retrospective COB claims payment and recovery process.

Figure 4.2.2.10_B: Retrospective COB Claims Payment and Recovery Process

Our automated reporting logic identifies the claims for systematic adjustment.



e. Process for conducting education for the Offeror’s attorneys and insurers about MississippiCAN and CHIP;

We educate our insurers and attorneys about the MSCAN and CHIP programs at the start of any subcontracting arrangement. We will partner with the Mississippi Bar Association to educate members of the Bar regarding our procedures and processes. We create a specific education curriculum integrating an overview of the MSCAN and CHIP programs; Appendix A, Draft Contract, Section 12 requirements; and our relevant policies and procedures. Our education materials also explain that at no point may an insurer or attorney imply that they are representing Medicaid, acting as an Agent of the State, or imply they are settling on behalf of the State or the Division of Medicaid in accordance with the Draft Contract requirements, §12.3.4. Additionally, we educate our attorneys that when handling a subrogation case, all initial letters sent to third parties (i.e., attorneys or insurance companies) must receive Division approval prior to use.

f. Data analytics and informatics used to support the process; and,

Our operational excellence uses data analytics, to ensure TPL claim accuracy through error prevention, rigorous monitoring, auditing, root cause analysis, and quickly acting on feedback. We use a multi-tiered approach to monitor claims processing accuracy and drive continuous improvement through prospective auditing, in process monitoring and controls, retrospective monitoring, and retrospective auditing. When we identify issues, our teams investigate the root cause, evaluate the full impact, remediate, and ultimately review issues and solutions with operations leadership to ensure that the issues are swiftly and thoroughly fixed. This information provides insightful information that allows us to monitor the time it takes to identify TPL coverage after payment of a claim, the accuracy of TPL information when claims adjudicate on the original payment, and trend TPL recoveries by product and provider. The following summarizes our TPL analytic process:

- **Daily Reporting:** We use our system to identify MSCAN and CHIP members for which we have received a claim indicating that the member has primary coverage for which we are unaware. We use multiple channels to validate the submitted information and update the member TPL within our claims processing system.
- **Weekly Indicators:** We run weekly analytics to review changes to our TPL indicators identifying claims that have previously paid to determine if appropriate TPL payment was achieved.
- **Monthly Validation:** We run monthly analytics to validate our entire MSCAN and CHIP membership against CMS eligibility data to obtain highly accurate Medicare coverage.
- **TPL Data Loading Analytics:** We use analytics to evaluate the most recent verified record from multiple data sources to optimize accuracy. Additionally, duplicate evaluation algorithms reduce conflicting record data loads.

We recognize that one objective of the Division is to drive TPL recovery activities to occur within 180 days driving the CCOs to focus on the timeliness of TPL data updates obtained from multiple resources. On

occasion, we obtain data regarding a retrospective policy effective date beyond the 180 days allotted for our opportunity to recover directly. In those cases, to ensure the cost avoidance to the Medicaid program remains optimized, we provide the detailed results of our analysis identifying specific claim opportunities to the State so it may choose to directly recover through its processes.

g. Process for providing supplemental third-party data and files to the Division.

We send daily supplemental third-party data files to the Division. Our advanced analytics allows us to provide all supplemental third-party data and files in the required format, per the established schedule and method to the Division. We accommodate all required fields including Medicaid identification number, MSCAN and CHIP member demographic information, TPL data, all cost avoided claim data, and all data pertaining to recoveries.

h. Process for reconciling third-party liability payments received on an annual basis for submission to the Division's actuaries for rate setting purposes.

We report the TPL payment reconciliation to the State annually. We reconcile our monthly reports on an annual basis to ensure completeness of the data in accordance with §12.3.3 of the Draft Contract. The cost reports, rate survey, and medical loss ratio (MLR) reporting include payments received from the TPL carriers.

4.2.2.10.A.2 Does the Offeror have an internal process in place to benchmark their TPL collections against best practices to ensure that they are optimizing the TPL recoveries on behalf of the Division?

a. If yes, describe the Offeror's process.

We have a process using our normalized internal and external benchmarks and key metrics against our existing Medicaid population on a monthly and annual basis. Our process includes:

- Evaluation of any noticeable standard deviations after considering the differences in membership mix. If standard deviations or variances exist, we initiate an in-depth analysis to determine the underlying cause.
- Working with multiple peer groups and our industry vendors that specialize in this space to assure we stay abreast of best practices to optimize collections.
- Regularly evaluating our processes for opportunities to improve our processes to optimize our collections. Our dedicated TPL data management team works closely with our business owners and vendors to identify and expedite new production processes.

4.2.2.10.B Effectiveness

4.2.2.10.B.1. Describe any innovative approaches the Offeror will take to ensure that its Third-Party Liability program is effective.

We understand that the most effective TPL program ensures that the claims process with all updated TPL policy information is available to minimize efforts required to recover amounts paid erroneously due to the timeliness of the data. To maximize effectiveness and ensure operational excellence we **incorporate several innovative approaches** to ensure our TPL program is efficient and meets the Division's cost avoidance goals. Among these are:

- **Use of Data Analytics Monitoring Payout/Recovery Claims Adjustment Volumes**: We closely monitor trends in adjustments due to updated TPL policy information. The emerging variability of the trend allows us to evaluate the effectiveness of the program. We investigate spikes in trends to determine the root cause and immediately remediate to minimize the continued impact on future claims.
- **Use of CMS Open Query:** CMS's Open Query data allows for real-time identification of Medicare coverage.
- **Vendor Management:** We closely manage our vendor resources to ensure the timeliness and accuracy of the data provided. We track their performance against service line agreements and Draft Contract requirements and work with them on identified opportunities for improvement.
- **Auto-Adjudication:** We use inbound identified COB information to auto adjudicate claims. On claims with COB information for which we do not have TPL data, we process the claim without delay with the COB data provided and programmatically flag the member for validation of TPL. We complete this within 5 calendar

days to ensure correct handling of future claims for the MSCAN and CHIP member, and retrospectively to reprocess claims previously paid incorrectly as primary.

4.2.2.10.B.2. Describe any additional measurements the Offeror will use to measure the efficacy of its Third-Party Liability program.

On a monthly basis, we meet with internal leadership to review the performance of various metrics to see where there are opportunities for improvement. The review performed is critical to identify and mitigate any impact to the Division, members, and providers. We provide the following measurements, along with national results:

- **Overturned Grievance and Appeals Due to TPL:** We review the number of grievances and appeals received pertaining to access to care or claims with incorrect TPL data. A variance of more than 10% in the volume received within a week triggers investigation and remediation efforts to address the cause of the variance. Combined with the other oversight approaches, our Grievances and Appeals due to incorrect TPL data has reduced by 50% in the last 12 months.
- **Claims with TPL Information Not Previously Identified in Our System:** We monitor the volume of claims received with TPL data that are not in our records. Success is measured by the sustained low volume of updates due to the information already existing in our claims system. This method remains a proven TPL collection method that has consistently provided us with new TPL information on 0.25% of our members each month.
- **TPL Vendor Analysis:** We measure and analyze record accuracy from our vendors as well as the receipt timeliness of policy effective and term dates. We meet with the vendor to identify areas of improvement. Vendors are held to a standard of 50% of updates within 30 days of policy effective/term date, 80% within 60 days, and 95% within 90 days.
- **Time to Adjust Claims for TPL Reasons:** We monitor the percentage of claims adjusted within the first 30 days of the original receipt of the claim. Providers understand that delays may happen with TPL data but also expect us to minimize the time to adjust their claims. We have consistently adjusted 50% of incorrectly paid claims due to TPL within 30 days of original payment and 70% within 60 days. We strive to improve that performance by 10% annually.

[END OF RESPONSE]

4.2.2.11 ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

4.2.2.11.A File Management

4.2.2.11.A.1. Describe how the Offeror will use the Division's eligibility and enrollment files to manage membership. Include the process for resolving discrepancies between these files and the Offeror's internal membership records, such as differences in Member addresses.

We recognize that the receipt of the eligibility and enrollment file begins our relationships with the MSCAN and CHIP members, so we ensure it's accurate from the start. Eligibility and enrollment files must be processed timely and accurately for us to ensure a positive MSCAN and CHIP member experience and be a worry-free partner of the Division. Rapid and accurate loading of member eligibility and enrollment allows us to quickly process member material such as ID cards and new member kits, make welcome calls, conduct health risk screenings, assist members with primary care provider (PCP)/patient-centered medical home (PCMH) selection, and support immediate access to all member benefits. Member eligibility and enrollment information is available across all our systems and touchpoints, including member services, care management, member portal, third party liability, and claims processing.

First-Pass Load Rate

Nationally, we have an overall 99.1% automated load of enrollment data within 4 hours, and 100% within 5 days.

We are a coordinated care organization (CCO) committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement, education, community-based coordinated care, and operational excellence. This commitment drives a seamless eligibility and enrollment experience for our providers and members. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources

How we use the Division's eligibility and enrollment files to manage membership: We utilize an advanced core operating system to manage active members. The member eligibility and enrollment module, which is seamlessly integrated into our claims processing system, is our source of truth. Through the automated integration of eligibility and enrollment data into our system, we can ensure accurate data synchronization across the internal application environment and external delegated vendor applications. Data from our core operating system is distributed within four hours of the receipt of the 834 transactions to ensure timely synchronization of member data to be sure we are ready to serve our members.

Reconciling the Division's enrollment data to our enrollment system: There is a daily and monthly reconciliation of the Division's MSCAN and CHIP member eligibility and enrollment data to our member eligibility and enrollment module. We programmatically identify discrepancies between (1) the incoming Division eligibility and enrollment data, (2) our internal eligibility and enrollment data, and (3) the member premium financial accounting system. Data mismatches captured in our exceptions tool include but are not limited to missing member records, eligibility dates, aid categories, names, addresses, phone numbers, birth dates, and genders. The data exceptions tool then initiates a reconciliation process. The reconciliation process involves manually updating our core system to match the eligibility and enrollment file. Found discrepancies are generated into an exception's workflow tool for manual intervention such as reviewing the historic eligibility and enrollment file, checking the Divisions eligibility portal, reviewing claims, conducting member outreach by telephone or email, and communicating with care management and other internal departments to confirm correct information. Following the reconciliation process, we send a report to the Division with the results, including updated information or discrepancy reports advising of unresolvable errors in need of review, such as invalid gender and date of birth errors.

Resolving discrepancies in member addresses and other demographic information: We understand that our membership has the potential to be transient, therefore our core system allows us to store multiple addresses provided by different sources. We have a designated source field for each address, phone, or other demographic

data fields. Any one of these addresses could be flagged as the mailing address. For member mailings (e.g., identification cards), our print vendor compares our mailing address against the most recent US Postal Service National Change of Address (NCOA) data. If the addresses differ, the print vendor uses the NCOA information and sends us the NCOA mailing address for consumption in our database, ensuring we have the most up-to-date member contact information. Our mailroom staff members receive and scan the barcode on returned mailings, which automatically updates to undeliverable address in our core operating system. The flag is visible to all member-facing teams, including member services and care management, ensuring that when they have contact with the member, they are alerted to request an updated address or other missing information and make the correction in the system. We also use a returned mail and member outreach process to obtain current contact information. Our team then follows up with members flagged in the system to obtain a new mailing address. The team uses phone outreach followed by a text or email campaign to attempt to contact the member. We remove the wrong address flag when the Division's eligibility and enrollment file updates the member address, indicating the Division has received a new address; the NCOA file provides a more current address; a member of our team receives an updated address, or the member contacts us. We work with the Division on a file transfer process to update the address information in their system.

4.2.2.11.A.2. Describe the Offeror's process for engaging Members who request to disenroll stay enrolled, including:

a. Process for outreach and engagement of Members

Our members are at the heart of what we do, so we work diligently to address their needs and remove barriers to care. We start by ensuring the member thoroughly understands their benefits and the value we provide through a robust welcome and onboarding process using the communication channel of their choice (call, email, text, live chat). We help them to find and connect with their chosen PCP/PCMH, schedule their first appointment, incentivize the completion of an HRS, and facilitate self-referral to care management. We have ongoing health education campaigns across all our communication channels to ensure MSCAN and CHIP members understand the importance and key components of preventive care, are aware of their MSCAN and CHIP program benefits and are familiar with the additional benefits available to them as our members such as enhanced transportation services and access to our well-being programs. We inform MSCAN and CHIP members of their grievance and appeal rights early on in our relationship, and in the event of a grievance situation, we stay engaged with the member while we research the grievance to ensure the member knows we are actively addressing their concern and working with their providers or others involved to address any gaps or quality of care issues.

If our MSCAN or CHIP members or their approved representatives call and express a desire to disenroll, they are immediately offered a connection with our team of senior level staff to achieve first call resolution, regardless of whether the member is permitted to disenroll per the Division's disenrollment policy. The staff works to inform members of their options, resolve any issues causing member frustration, and serve as a point of contact for that member for future needs.

b. Conducting Disenrollment surveys with Members to determine the reason for Disenrollment. Include how the Offeror will use results from the survey to improve the program

We are continuously improving our members' experience, and disenrollment requests can provide valuable insights into how to better serve our members in the future. If a member ultimately leaves our CCO, we send an email disenrollment survey within five business days of the disenrollment to collect the member's feedback while it is fresh in their mind. The survey assesses why the member requested to be disenrolled. For example, they may have wanted another CCO's benefits or incentives, their preferred doctor or hospital was not in our network, or other reasons. Using data from both our historical interactions with the member and the disenrollment surveys, we trend data for themes and opportunities. Our cross-functional consumer experience team uses the information to develop action plans to address the issues and avoid future

High National Retention

In 2021, 99.9% of our members chose to stay with us.

disenrollment, such as expanding network capacity in a certain region or initiating staff or provider training. We also use these trends to inform further member and provider research, often engaging our member advisory groups.

As a result of survey data analysis, we implemented a proactive approach to prevent disenrollment. Rather than waiting for members to call us, we leverage predictive analytics to understand any potential areas of member dissatisfaction in an effort to proactively improve our members' experience. Our member services team receives an alert based on attributes such as frequent calls, grievances, claim denials, etc. We anticipate these potential areas of concern and reach out to the member using the member's communication channel of choice, fully addressing all member concerns possible before members even consider disenrollment.

c. The Offeror's draft disenrollment survey

We have provided our draft disenrollment survey in Appendix 4.2.2.11.A.2.c-1. We will present a final version to the Division for review and approval at least 30 days prior to use.

4.2.2.11.B Assignment of Members to a Primary Care Provider

4.2.2.11.B.1. Describe the Offeror's proposed process to assign Members to a Primary Care Provider (PCP) within sixty (60) calendar days of Enrollment. Include a discussion of the Offeror's approach to:

a. Assist members when selecting a PCP and selection of a PCP for members who do not make a selection

We believe that a strong connection with a PCP/PCMH is critical to support the Division's goals of improved access to needed medical services and improved quality of care for Mississippians. MSCAN and CHIP members benefit from a consistent, ongoing relationship with a primary healthcare provider who can anticipate care needs and attend to members' overall health and wellbeing. Therefore, we work with MSCAN and CHIP members to select their own provider whenever possible, and we carefully assign one for them if necessary. Within 90 days of contract award, we will submit to the Division our written policies and procedures for enabling members to select a PCP/PCMH, select a new PCP/PCMH, and PCP/PCMH auto-assignment. We also submit a process for ensuring the PCP/PCMH is willing to accept the assignment of a member prior to assigning the member to the PCP/PCMH and a process for tracking data to confirm every member is assigned to a PCP/PCMH. This includes assigning medium and high risk-stratified members to a PCMH and compliance with requirements of Appendix A, Section 6.2.10 regarding Indian Health Services. We will submit any changes to the Division for review and approval at least 30 calendar days prior to implementation.

We engage with members to select a PCP/PCMH within the first 10 days of enrollment. We use multiple channels to connect and help MSCAN and CHIP embers choose a PCP/PCMH, including welcome messages sent via email and text and prominent messaging through our member information packet, website, mobile app, and social media. Using their preferred U.S Mail, digital, or telephonic communication channel, we give encouragement and guidance to new MSCAN and CHIP members about how to choose a PCP/PCMH that aligns with their priorities, along with detailed information on available network primary care providers. We make sure each member has a PCP/PCMH through selection or auto-assignment, including specialist providers where indicated. Through our new member welcome call initiated by member services staff, we take a proactive approach to ensure each member selects from a choice of at least two in-network PCP/PCMHs or is assigned a PCP/PCMH who is responsible for providing an ongoing source of primary care appropriate to the member's needs.

We ensure our MSCAN and CHIP member information packets include information about our respective provider networks in accordance with 42 CFR 438.10(h). MSCAN and CHIP members can access provider network information in print, via phone, and online through our publicly accessible tool for finding a doctor, which conforms with the requirements of 42 C.F.R. § 431.70. Our care management team, including regionally based community health workers (CHWs), and member services call center staff are available to help MSCAN and CHIP members locate a PCP/PCMH provider, schedule appointments, and arrange transportation.

Removing Barriers to Care Across All Markets

In response to member and provider feedback, we have activated a daily monitoring and updating capability with a vendor that has proven success in ensuring the most reliable and current provider information, including capacity to accept new patients, is always available.

We help our members select the best PCP/PCMH to meet their unique healthcare needs. Strong connections between MSCAN and CHIP members and their PCP/PCMH rely on a number of factors including cultural alignment, language, gender, and geographic proximity. In compliance with 42 CFR 438.208, each member has a PCP/PCMH responsible for managing care, coordinating physical and behavioral health care, and making referrals on behalf of the member when the member receives provider services from any provider other than the assigned PCP/PCMH, unless the service is a designated self-referral service.

We encourage MSCAN and CHIP members with special healthcare needs to choose a provider that best meets their needs as a PCP/PCMH. These providers include pediatricians, family, and general practitioners, internists, preventive medicine specialists, obstetricians/gynecologists, nurse practitioners (if they have an agreement with a provider who has admitting privileges at a hospital appropriate for the patient needing admission), physician assistants, specialists who perform primary care functions upon request, or other providers approved by the Division. We do not limit PCP/PCMHs, including those also acting as specialists, from contracting with multiple CCO entities.

Assignment of a PCP/PCMH: We ensure all MSCAN and CHIP members who do not select a PCP/PCMH within 30 days are assigned a network PCP/PCMH within 60 calendar days of the member's enrollment. Our thorough auto-assignment logic promotes member access to high quality providers who are aligned with the member's unique circumstances. We use enrollment and other historical information, such as claims data, to identify member attributes for auto-assignment. These attributes include:

- The member's last known PCP/PCMH
- The family's last known PCP/PCMH
- Geographic proximity based on the member's zip code
- Participation in a PCP/PCMH lock-in program
- Default provider already assigned
- Provider attributes, such as accepting new patients, language, age, and gender

We also use our data and analytics capabilities to identify MSCAN and CHIP members who regularly seek care from a provider other than their PCP/PCMH and implement quality measure monitoring of that provider. A member may be assigned to a provider through auto-assignment or self-selection and is also be attributed to the PCP/PCMH rendering care. For attribution, we review claims history every 18 months, and the member is attributed to the provider they most recently visited. This may also allow a member to be assigned to a non-participating provider if services have been rendered. In this event, we contract with the provider, or the care management team engages with the member to locate an in-network provider and ensure any providers that are part of the treatment plan are available and in-network.

We notify MSCAN and CHIP members of their assigned PCP/PCMH by mail with a member ID card, by phone during a welcome call, and electronically via the member portal. MSCAN and CHIP members have the right to select another PCP/PCMH if they are not satisfied with the automated selection. In our notification, we include information on options for selecting a new PCP/PCMH.

Selecting a new PCP/PCMH: We understand that the need to choose a new PCP/PCMH can be a challenging time for MSCAN and CHIP members, particularly those with special healthcare needs, and so we begin to support them through the process as soon as we become aware that a new PCP/PCMH is needed. Our care managers guide their enrolled members through the PCP/PCMH selection process and answer questions as they arise. We proactively provide all MSCAN and CHIP members with information about options for selecting a new PCP/PCMH when requested by the member, when a PCP/PCMH is noncompliant with provider standards (i.e., quality of care) and

subsequently terminated from our network, or when a PCP/PCMH change is ordered as part of the resolution to a grievance proceeding. MSCAN and CHIP members can self-select a new provider using our online tool for finding a doctor, the member services helpline, and hard copy provider directories. We provide information on access to these tools in the member's written notification of the provider's disenrollment.

We submit all PCP/PCMH network enrollments or disenrollments we receive to the State's fiscal agent through the Division's provider portal within five business days of 1) a termination notification, 2) a termination notification effective date when advance communication was not feasible, or 3) prior to the 24th of each month.

We notify MSCAN and CHIP members when there are provider terminations from the network/directory. For plan-terminated action, we provide notice no later than 30 calendar days prior to the effective date of the termination. For provider-driven terminations, in accordance with 42 CFR 438.10 (f), we provide notice no later than 15 days after receipt of the termination notice. Once identified for termination, we query our records for any member who was treated by the provider during the previous 12 months, and we send a notification letter to the member informing them of the pending termination of their provider from our participating network.

b. Track data to confirm every member is assigned

We track data to ensure every member is assigned. If auto assignment fails to assign a PCP/PCMH to the member, it is addressed by our enrollment operations team, which pulls a weekly list of unassigned members from our member eligibility and enrollment module. The enrollment operations team then manually selects and assigns a PCP/PCMH to each member based on our auto assignment criteria or other criteria as required by the Division.

c. Inform PCPs/PCMHs of their New Member Assignments within the required time frames

Within five business days of receiving the eligibility and enrollment file from the Division, we inform PCPs/PCMHs of new MSCAN and CHIP members assigned to them via U.S. Mail and our secure web-based provider portal. Our secure portal, in addition to tracking the acknowledgement of the member assignment, gives providers an additional source, along with a paper assignment report in regular U.S. Mail, to access this critical information. In addition to their PCP/PCMH member assignment, the secure provider portal enables access to a variety of comprehensive data and member-specific information

d. Confirm that PCPs/PCMHs received the list of assigned Members

To ensure PCPs/PCMHs are in receipt of the list of assigned MSCAN and CHIP members, we deliver assigned member reports via both the secure provider portal and the US Mail. We ask providers to formally acknowledge their members within the portal. Our provider services team has regular contact with our network providers, enabling prompt follow up with any providers to confirm receipt as needed.

4.2.2.11.B.2. Provide a sample of the report the Offeror will use to notify PCPs of their assigned Members.

A sample PCP/PCMH member assignment report is provided at the end of this section.

4.2.2.11.B.3. Describe the Offeror's proposed process to ensure that any new Member has an appointment scheduled with the selected PCP within at least ninety (90) calendar days of Enrollment.

Recognizing the critical role regular primary care plays in overall wellness, we are committed to facilitating well visits for MSCAN and CHIP members. We recognize the initial member onboarding experience, which occurs in the first 90 days of enrollment, is key to engaging members in their own care. As a result, we have a multi-channel approach to ensure MSCAN and CHIP members see their PCP/PCMH within 90 days of enrollment. This approach, which our call center team and care management team leads, starts with putting the member first by using their preferred method of communication as outlined in the following:

- **Call center high touch welcome call:** We outreach to our newly enrolled MSCAN and CHIP members with a welcome call near their enrollment date. During these calls, members receive a comprehensive overview of our plan, and we take this opportunity to ensure the member has an assigned PCP/PCMH. While speaking

with the member, we offer to help schedule a PCP/PCMH appointment for the member immediately and ensure they understand the telehealth options available to them to make the process as simple as possible.

- **Digital welcome engagement:** Not all MSCAN and CHIP members choose to engage in a telephone call with us. As a result, and based on preference, we also send an initial welcome email or text message which communicates the importance of regular visits with their PCP/PCMH and provides links to our member portal, mobile app, and online tool for finding a doctor. These tools allow the member to find their PCP/PCMH contact information to schedule an appointment. We also make click to call and live chat options available at carefully placed points in the member journey so that as MSCAN and CHIP members engage digitally, they know we are always here to help.
- **Care management outreach:** A member of our care management team reaches out to MSCAN and CHIP members stratified by the Health Risk Screening (HRS) or by other member data as medium and high risk. During the call, the care manager also ensures these members have been assigned to a PCMH and assists with scheduling appointments as needed.
- **Member services reminder alerts:** Our member services staff see an alert in the system that displays if there isn't a claim on file for a PCP/PCMH visit within the first 60 days of enrollment. When a member contacts member services we use the opportunity to remind them of the importance of the relationship with their PCP/PCMH, and we offer to help the member in scheduling an appointment.
- **Text messaging campaign:** If a member reaches 60 calendar days of enrollment without a claim being filed for a PCP/PCMH well visit, we send a text message to the member encouraging the initial PCP/PCMH visit and offer support in scheduling, telehealth access, or finding transportation if needed.
- **Enlisting our network PCPs/PCMHs:** We expect all our network primary care practices to be full partners in our MSCAN and CHIP members' care, including proactively outreaching to members newly assigned to them. Our PCMH practices are fully aware of this expectation, understanding that the PMPM payments they receive help to fund this activity.
- **Community Health Workers (CHWs):** We work hand in hand with our practices through our CHWs and peer support staff. They act as additional "feet on the street" with populations needing extra assistance in connecting with their PCP/PCMH, such as MSCAN and CHIP members with serious mental illness, substance use disorder, and youth in foster care.

4.2.2.11.B.4. Describe the Offeror's proposed policies and procedures for designating a Specialist as a PCP/PCMH for Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs.

We understand how critical the specialty provider relationship is for our MSCAN and CHIP members with disabling conditions, chronic illnesses, or children with special health care needs. Given the complex healthcare needs of these members, often the best choice of a PCP is the specialist with whom they have an ongoing relationship and is best able to respond to their unique healthcare needs. Our proposed PCP assignment policy allows a member to choose a specialist when the member and their in-network specialty provider both agree to the arrangement. MSCAN and CHIP members and their representatives or caregivers, providers, and our care managers can all initiate the request for a specialist to act as a PCP. Staff receive the requested document in our electronic documentation system and forward it to our provider services team.

The provider services team member then contacts the specialist to discuss PCP responsibilities and ensure the specialist agrees to act as the member's PCP. The specialist acting as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide specialty medical services consistent with the member's disabling condition, chronic illness, or special health care needs in accordance with our standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, a specialist acting as a PCP must also have admitting privileges at a hospital in our network.

We send notification of the assignment to the new PCP and to the member, who also receives an updated member ID card listing the new PCP.

4.2.2.11.B.5. Describe the Offeror's proposed process for communicating with Members about their PCP/PCMH assignment and encouraging Members to use their assigned PCP/PCMH and keep scheduled appointments.

We are a CCO committed to changing the trajectory of Mississippi's healthcare system and bringing a new era of provider collaboration to Mississippi via our transparent service delivery model which is fully integrated with the majority of our providers through real-time bi-directional data exchange. Our mission is to ensure Mississippians can easily access their benefits, our next generation member engagement and education, and community-based coordinated care to help them lead healthier lives while we prudently manage State resources. We believe that a strong connection with a PCP/PCMH is critical for our MSCAN and CHIP members' health and well-being, therefore we take every opportunity to communicate with members about their PCP/PCMH assignment and encourage them to keep scheduled appointments. This targeted communication begins with our member information packet which includes their member ID card, welcome calls, welcome emails, and text messages. MSCAN and CHIP members who log on to their secure member portal, which is accessed via our website and our mobile app seen in Figure 4.2.2.11_A, can instantly view their member ID card as well as their PCP/PCMH contact information, appointments, and other important health information.

Figure 4.2.2.11_A: Member Welcome Text Message

We invite members to log into their secure portal for instant access to their information.

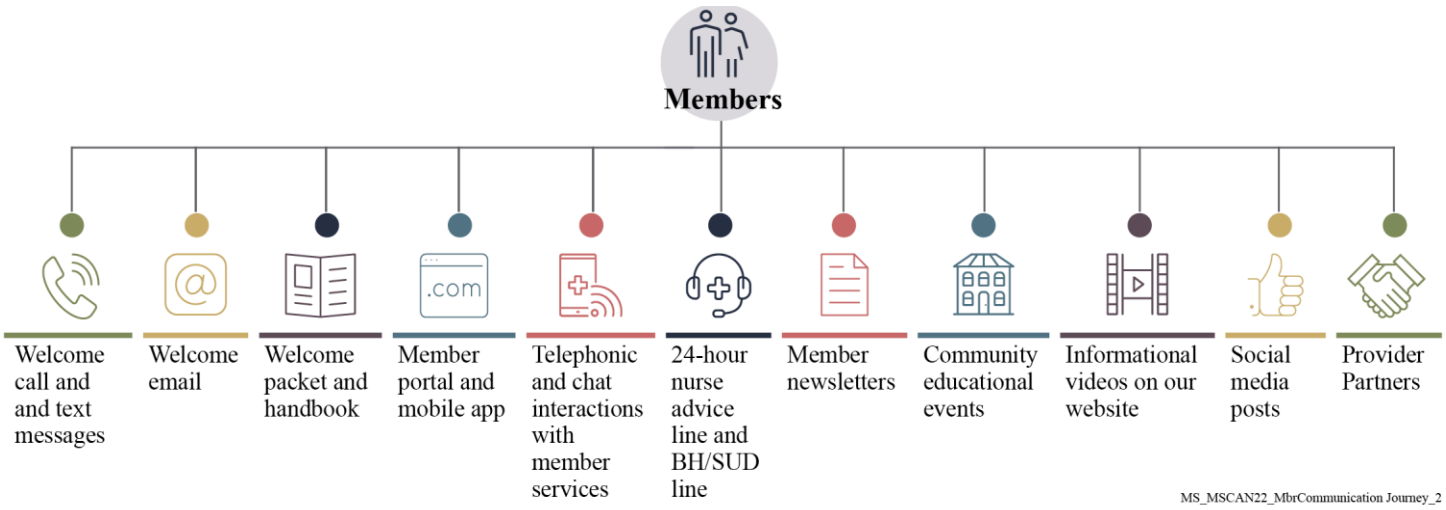
MS_MSCAN22_4.2.2.1_Mobile App Text Message_1

Targeted messaging about primary care and wellness. We address each member's proficiencies, limitations, and preferred language and channels through customized material distribution methods. In our view, meaningful member engagement should facilitate access to care, provide navigation to services, encourage healthy behaviors, and make MSCAN and CHIP members aware of all their health benefits including primary and preventive care. For members with a certain age, gender, and pre-existing condition characteristics, we can set alerts for well-child visits and periodic PCP/PCMH checkups, which generate email and text messages to prompt the member to act. We send targeted fliers to members reminding them of the preventive services they need. As an additional reminder, we send birthday cards to MSCAN and CHIP members each year containing age- and gender-appropriate annual screening information. We also offer member incentives for actions such as keeping Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well child visits.

We will collaborate with local organizations such as Mississippi Head Start, the Community Health Center Association of Mississippi, and the Mississippi Rural Health Association on engaging with our MSCAN and CHIP members about the importance of primary and preventive care. We understand that the people who spend the most time with our members, such as their family, pastors, coaches, and other informal influencers must be included in our communication efforts. Therefore, we employ an empowerment model that focuses on member-centered, community and culturally sensitive wellness promotion, health education, and self-management tools. As seen in Figure 4.2.2.11_B, our local staff, providers, and community-based organization partners are key to delivering face-to-face health education as well as digital messaging and written materials that our MSCAN and CHIP members and the people in their social support systems can keep for later reference.

Figure 4.2.2.11_B: Member Communication Channels

We connect with members via the communication channel of their choice.



4.2.2.11.B.6. Describe the Offeror's proposed process for communicating with Members about PCP/PCMH assignments and assigned PCP/PCMH utilization. Include how the Offeror will monitor, identify, and resolve Member barriers to using assigned PCP/PCMH and keeping appointments.

Even after the initial assignment, we support the member and PCP/PCMH relationship by monitoring utilization and proactively communicating with our members and their PCP/PCMH to remove barriers to care. **Our localized approach leverages the resources of Mississippi providers, our well-being program, and community partnerships to promote best practices of healthy living and health equity**.

Monitoring member barriers to using assigned PCP/PCMH and keeping appointments: We take a proactive approach to support MSCAN and CHIP members by using automated tracking tools to identify when a member has not received the recommended preventive services, including PCP/PCMH appointments. Our tool automatically generates a reminder in the member's preferred communication format when the member has not used preventive services or has not had any claims activity within the last six months after the initial 60 days of enrollment. Our member services call center call tracking software identifies callers and gives our trained staff quick and easy access to that caller's information, including any alerts related to the member and PCP/PCMH visit history. If the member displays gaps in preventive care, the member services call center staff and care managers use system prompts and educational messages developed by our care management team to educate on the importance of primary and preventive care and assist in scheduling an appointment. Care managers may also review their MSCAN and CHIP members' claims data to assess if the member is seeing another provider, using the emergency department, or not accessing care at all. They then engage the member personally, by phone, or other preferred communication methods, and work with the member to remove barriers to making and keeping PCP/PCMH visits.

Identifying member barriers **to using assigned PCP/PCMH and keeping appointments:** We continuously strive to better understand our MSCAN and CHIP members and find ways to remove barriers so they can fully utilize their primary and preventive care benefits. We collaborate with local community advocates, support agencies, public health associations, health departments, and other government agencies who know our communities well, to gather and analyze data and identify systemic barriers to care. We track and trend data sources such as CAHPS surveys and member grievances to help us identify access barriers on the CCO and provider level, and our member-level approach includes our CHWs and peer support staff connecting with our MSCAN and CHIP members through our provider partners and community-based organizations to develop personal relationships with our members to understand their day to day lives and identify each individuals'

barriers to care. We also use our experienced care management staff to identify barriers our MSCAN and CHIP members experience in accessing their chosen PCP/PCMH and other preventive services. For example, our integrated care management team screens members for social needs, including housing, transportation, nutrition, childcare, isolation, and other social determinants of health (SDOH).

[redacted]

We use our real-time, bidirectional data with providers, so they are able to see and act on preventive care gaps experience by their patients by proactively scheduling appointments with the appropriate members. We help our provider partners meet patient care goals by offering incentives for performing preventive services such as EPSDT screenings, mammograms, and HbA1c tests. We use clinical practice and preventive health guidelines and assess provider performance based on these guidelines, and we engage with providers individually to identify strategies for meeting the access needs of their patients, like extended office hours or offering language translation services.

Our member satisfaction history and survey data reveal opportunities to help members access primary and preventive care. We respond to our members' needs and preferences with offerings such as an advanced digital tool for finding a provider; incentivizing the completion of the HRS and preventive screenings; providing decision guides for when to go the emergency department; and offering dynamic interactive health education on primary care and other wellness topics.

4.2.2.11.C Member Information

4.2.2.11.C.1. Describe the Offeror's proposed process for providing Members with information packets, including identification cards, by fourteen days after the Contractor has received notice of the Member's enrollment. Include the following:

We welcome new MSCAN and CHIP members via responsive member information packets designed to provide a comprehensive and easily understood introduction to their benefits. It gives members a roadmap and useful guide about actively engaging in their healthcare journey to improve and maintain good health for themselves and their families.

a. Language alternatives that will be available

We deliver 100% of our member information packets, including the information requirements outlined in Appendix A, Section 3.2.6 within 10 days of a new member's enrollment and upon member request, which is faster than the Division requirement of 14 days. The packet is in English, Spanish, or other preferred languages upon member request or as directed by the Division. We also make information available in Braille, large print, or accessible through verbal explanation. In compliance with section 508 of the Rehabilitation Act, we post information to our website so members and their authorized representatives can view the contents electronically or print them from a remote location. Our website is available in mobile optimized format for ease of use. We submit a copy of the member information packet to the Division for review and approval prior to distribution, annually, and whenever substantial changes are made to the packet.

b. How the Offeror will comply with information requirements listed in Section 3.2.6, Member Information Packet of Appendix A, Draft Contract

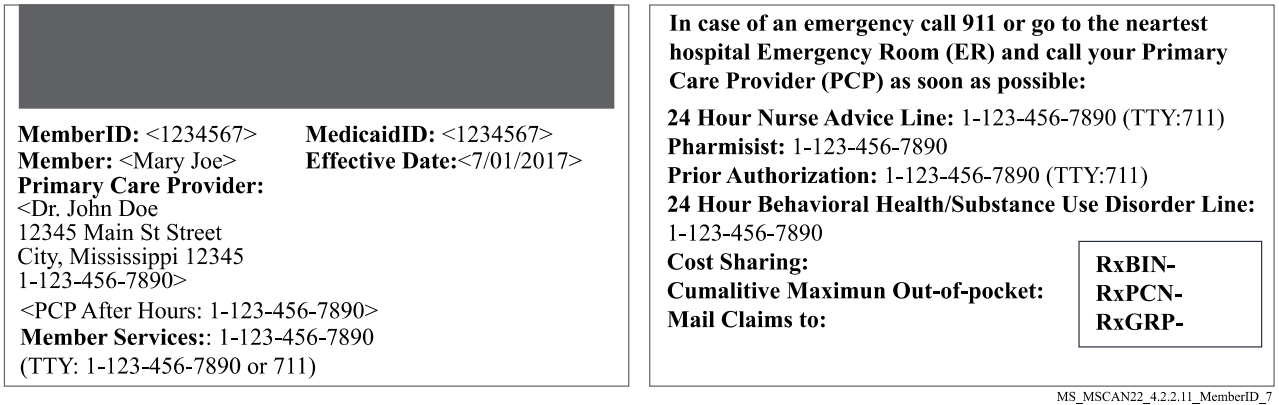
We aim to make each member information packet informative without overwhelming our MSCAN and CHIP members and use this initial outreach opportunity to provide a snapshot of the member handbook. We customize our member information packet to highlight our specific population-based information, and every packet includes the following items.

New Member Welcome Letter: An introduction letter indicating their first effective date of enrollment and explaining that our coverage is more than just health care. As our member, they have many resources available to make their lives a little easier.

Member ID Card: As seen in Figure 4.2.2.11_C, our member ID cards offer valuable information for MSCAN and CHIP members and providers. We include member ID cards in the enrollment packet in an envelope marked “Return Services Requested” and members can access their ID card via our member portal and mobile app. We provide a monthly report to the Division indicating the date and the number of ID cards mailed to new MSCAN and CHIP members each month, as well as the number returned, and methods used to deliver them.

Figure 4.2.2.11_C: Member ID Card

Our member ID cards offer valuable information for members and providers.



Provider Directory: We want our MSCAN and CHIP members to trust the information we provide and feel confident in their knowledge of where to go for health care services. This includes information about our provider network and a reference guide describing our telehealth services. 24-hour BH/SUD line as well, and a brief explanation of when to go to the doctor’s office, care clinics, urgent care, and the emergency department. Our data indicates most of our members use our online tool for finding a doctor, which is updated daily, to view the most up-to-date information about in-network providers. We instruct our MSCAN and CHIP members on how to obtain a provider directory in compliance with 42 C.F.R. § 438.10(f)(6)(h), and we mail printed provider directories to all members upon request.

Quick Start Guide: Using feedback from our members, we developed a quick start guide that helps members navigate through all the information we send them. It directs members to what they need to focus on right away to access their health benefits, including an overview of the member ID card, instructions on how to download and create an account on our member portal and mobile application, and information on how to start earning member rewards and incentives.

Member Handbook: Our member handbook is a key resource for more than just covered benefits. We include a printed copy in the member information packet as well as instructions on where to locate an electronic copy on our website and mobile app.

Benefits At-A-Glance: Prior experience with our member advisory committees in other Medicaid markets revealed that members often are not fully aware of all the available benefits to them. Using that information, we provide members with a summary of their covered benefits in a shortened, one-page brochure.

Important Questions for New Members: We condense critical information by proactively providing the answers to what we anticipate will be the most frequently asked questions by our MSCAN and CHIP members.

Health Risk Screening Form: Our HRS is a valuable tool to identify conditions, needs, and concerns facing new MSCAN and CHIP members. The information obtained from the HRS allows us to recognize member needs and to promptly facilitate and coordinate care. We include a copy of the HRS form with a pre-paid envelope in our mailed enrollment packet, enabling members to complete and return the screening as soon as they are able.

c. The Offeror's proposed methods and creative approaches for obtaining correct Member addresses

During every potential interaction with our member services staff or care manager, we validate contact information to ensure we have the most up-to-date contact information to reach the member. When member services staff cannot reach a member either by phone or mail, we attempt to secure updated contact information for the member in this comprehensive manner:

- Our member services call scripts instruct staff to confirm member contact information with each call or online chat interaction
- If we have a contact phone or email, and we are missing an address, we reach out to the member to update our records.
- If we do not have any contact information, we research member claims for contact information
- We send a postcard to the provider-supplied member addresses requesting the member to contact member services to update their information with us
- Our member app and secure portal prompt MSCAN and CHIP members when they sign on to check and update their address and other contact information
- We use National Change of Address (NCOA) data to inform our mailings
- We partner with providers to share contact information
- We leverage our relationships with community-based organizations to communicate with members and update their contact information
- Care managers regularly update addresses, phone numbers, and other contact and information as needed for their medium and high-risk MSCAN and CHIP members and other members who choose to engage with care management.
- On a bi-annual basis, we reach out to MSCAN and CHIP members with all available digital communication methods to validate and encourage regularly updating their address information.
- If a member logs in to the member portal or mobile app, they are alerted if address information is missing.
- Regularly scheduled social media campaigns to encourage MSCAN and CHIP members to contact us to update their address and other contact information
- We engage with a third party to re-validate MSCAN and CHIP member information on a quarterly basis, which we use to supplement data from the Division and the Mississippi Health Information Network (MS-HIN).
- Analyze pharmacy point of sales claims data for member addresses and other contact information.
- We will also share this information with the Division.

Contacting our Members

In 2021, our monthly percentage of returned mail averaged less than 1% nationally.

d. Process for following up with Members whose information packets or identification cards are returned

We use advanced technology to make sure all members receive their information packets timely. We use barcode technology to identify incorrect member addresses, which enables us to remediate address problems in an expedited manner. Our mailed materials have barcodes that identify the source of the mailing (department specific mailing). If the mailed item is returned to us as undeliverable, we work to identify the correct address by:

- Utilizing National Change of Address (NCOA) data to inform our mailings and validating with the member.
- Suspending mailings to known invalid/insufficient addresses.
- Performing text and email campaigns to notify members to update invalid/insufficient addresses.
- Performing call center outreach to members who cannot be reached by mail, text, or email.
- Analyze pharmacy point of sales claims data to identify address and other contact information and validate by reaching out to member.
- Working with the Division to rectify member data for members who cannot be contacted.

e. Offeror may choose to include sample member materials in excess of the page limit.

Sample member materials are provided in Appendix 4.2.2.11.C.1.e-1.

Our Logo

Member Eligibility by Provider Affiliation

John Doe, MD - #123456789
1234 Street Dr.
Jackson, MS 39211

PCP Name	Affiliation ID	First Name	Last Name	Medicaid ID	Member ID	Program Name	Lang Type	Sex	Birth Date	Case Number	Head of Household	COB	Communication Code	Address Display	Member Telephone	Has New Assessments	Has New Care Plans	Has Updated Care Plans
Doe,John	123456789	Dawn	Smith	1234567	1234567	MSCAN	ENG	F	09/22/1976	123456				1234 Avenue Jackson, MS 39211	(123) 456-7890	False	False	False
Doe,John	123456789	Jon	Smith	1234567	1234567	MSCAN	ENG	M	09/22/1976	123456			103	1234 Avenue Jackson, MS 39211	(123) 456-7890	False	False	False
Doe,John	123456789	Val	Smith	1234567	1234567	MSCAN	ENG	F	09/22/1976	123456	Val Smith	Y		1234 Avenue Jackson, MS 39211	(123) 456-7890	False	False	False
Doe,John	123456789	Tricia	Smith	1234567	1234567	MSCAN	SPA	F	09/22/1976	123456				1234 Avenue Jackson, MS 39211	(123) 456-7890	False	False	False
Doe,John	123456789	Jackie	Smith	1234567	1234567	MSCAN	ENG	F	09/22/1976	123456	Jackie Smith	Y		1234 Avenue Jackson, MS 39211	(123) 456-7890	False	False	False
Doe,John	123456789	Isaac	Smith	1234567	1234567	MSCAN	ENG	M	09/22/1976	123456				1234 Avenue Jackson, MS 39211	(123) 456-7890	False	False	False
Doe,John	123456789	Pat	Smith	1234567	1234567	MSCAN	SPA	M	09/22/1976	123456	Pat Smith	Y	102	1234 Avenue Jackson, MS 39211 1234 Avenue Jackson, MS 39211	(123) 456-7890	False	False	False
Doe,John	123456789	Debby	Smith	1234567	1234567	MSCAN	ENG	F	09/22/1976	123456				1234 Avenue Jackson, MS 39211 1234 Avenue Jackson, MS 39211	(123) 456-7890	False	False	False

Please remember to ask members for all healthcare insurance information at the time of service. You can reference https://portal.com for further details of COB coverage for all members indicated with a 'Y' in the COB column.

All names, dates, and locations are fictitious and for display purposes only.

Communication Needs Types:
100: Vision Impaired **101:** Hearing Impaired **102:** Limited English Proficiency **103:** Limited Reading Proficiency
104: Vision & Hearing Impaired and Limited Reading Proficiency **105:** Hearing Impaired and Limited Reading Proficiency **106:** Vision & Hearing Impaired and Limited English
107: Vision & Hearing Impaired **108:** Vision Impaired and Limited Reading Proficiency This report was printed on 1/31/2022. The data
for this report was last updated on 1/30/2022

LOGO

Subject line: We'd love your opinion!

Dear former CCO NAME member,

We are sorry to learn that you have left CCO NAME. Your feedback is critical to helping us improve our member experience.

We'd really appreciate you taking a few minutes to share your thoughts. The survey will take about **5 minutes** to complete.

Thank you in advance for your feedback!

Regards,

CCO NAME Survey Support Team

Or copy and paste the URL below into your internet browser:
${l://SurveyURL}

Follow the link to opt out of future emails:
${l://OptOutLink?d=Click here to opt out}

CCO NAME complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

Si usted o alguien a quien ayuda tienen preguntas sobre CCO NAME, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

如果您或者您在帮助的人对 CCO NAME **存有疑**问，您有权 **免**费获得以您的语言提供的帮助和信息。 **如果您需要与一 位翻**译交谈，请拨打您的会员 ID **卡上的会**员服务电话号码。

Q1. Why did you decide to leave CCO NAME?

a. Other plan's benefits or incentives [Q1a]
b. Doctor or hospital not in network [Q1b]
c. Recommended by doctor or other person [Q2]
d. Other <open end> [Q2]

Q1a. You said that you left CCO NAME because of another plan's benefits or incentives. Which benefits or incentives from another plan influenced your decision? <Open End>
[Q2]

Q1b. You said that you left CCO NAME because there was a doctor or hospital not in network. Which doctor or hospital was that? <Open End>
[Q2]

Q2. Please rank the CCO NAME **core benefits** listed below in the order of most important to least important to you and your family: [RANDOMIZE LIST ORDER]

a. Has the doctors I need [Q3]
b. Has the hospital and ER coverage I need [Q3]
c. Covers routine check-ups, necessary procedures, and physical therapy [Q3]
d. Covers mental health care [Q3]
e. Covers my prescriptions [Q3]
f. Dental and vision coverage for my kids [Q3]

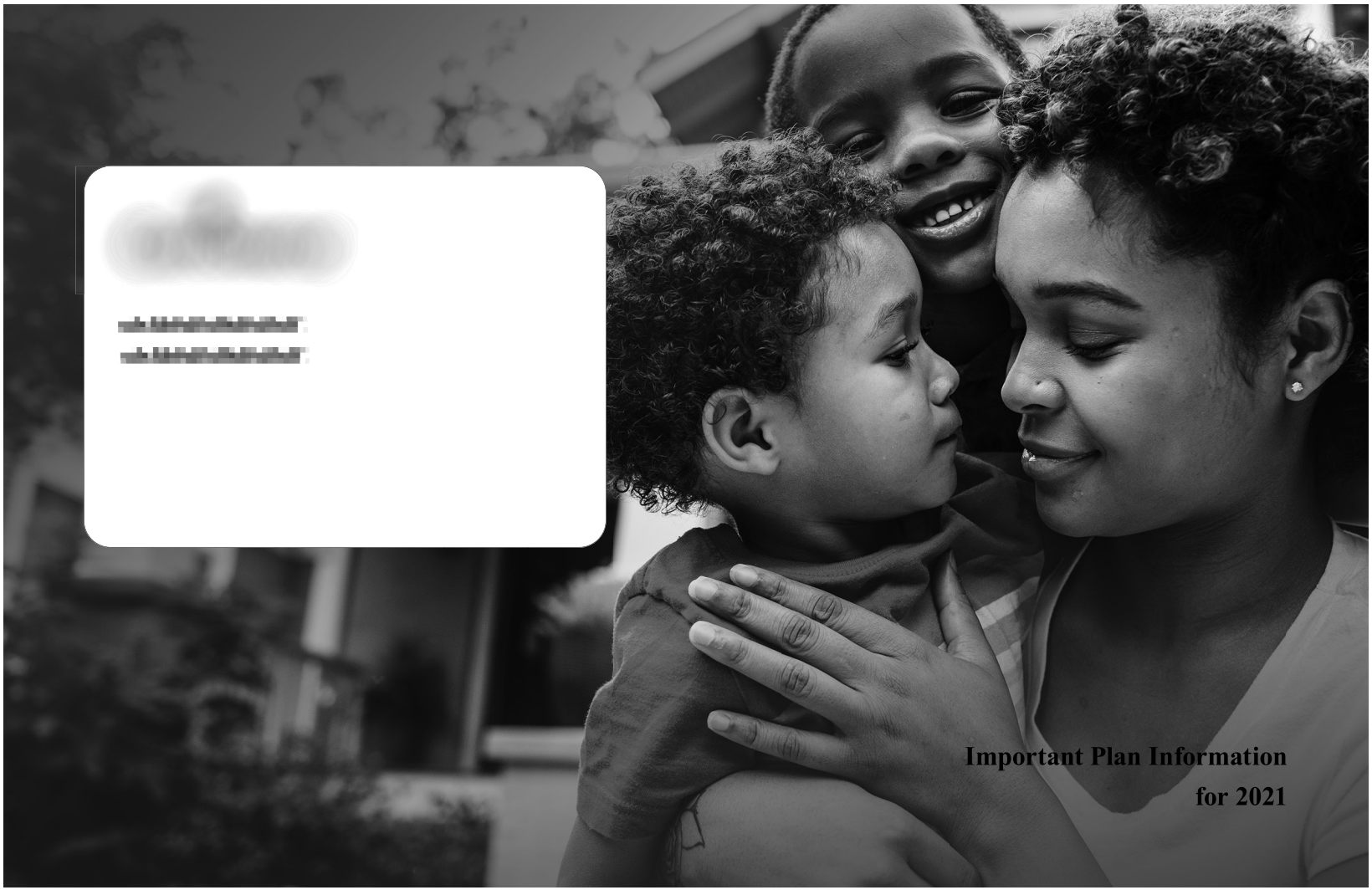
Q3. Please rank the CCO NAME **extra benefits** listed below in the order of most important to least important to you and your family: [RANDOMIZE LIST ORDER]

a. Job assistance and education services [Q4]
b. Dental and vision coverage for me [Q4]
c. Programs for pregnant women and babies [Q4]
d. Convenience care clinics like CVS Minute Clinics [Q4]
e. Transportation to and from doctor appointments [Q4]
f. Earning rewards for healthy activities [Q4]
g. 24-hour nurse care line [Q4]

Q4. Are there any CCO NAME benefits that are currently not included, that you feel you need from a Medicaid plan?

a. Yes [Q4a]
b. No
c. Don't know

Q4a. What additional benefits would you need to receive? <Open End>


Important Plan Information
for 2021

Quick Start Steps

WHAT SHOULD YOU DO FIRST?

1. Get your [redacted] member ID card.

Included with this booklet is your member ID card. Your ID card lists the name and phone number of your primary care provider (PCP). Your PCP will treat you for most of your health care needs.

2. Set up a [redacted] account.

You can use your [redacted] account to change your PCP, ask for a new ID card, view claims and plan details, update your contact information and choose how you would like to hear from us. It's easy to do:

1. Go to [redacted]
2. Click [redacted] at the bottom of the page.
3. Answer the questions.
4. Click [redacted] You're all set!

3. Get the [redacted] Mobile App.

This mobile app lets you manage your [redacted] health plan on the go. The app is free. With the mobile app you can:

- Access your secure [redacted] account
- View your digital [redacted] member ID card
- Find a doctor, hospital, clinic, or urgent care near you through the [redacted] tool
- Call [redacted] our Nurse Advice Line, and speak with a registered nurse 24/7
- Call and speak with Member Services
- Connect with [redacted] and speak with a doctor anywhere, anytime
- And more!

Get the [redacted] mobile app through the App Store® for iPhone® or Google Play® for Android®*.

4. Make sure the providers you plan to use are in the [redacted] network.

Visit [redacted] to view the most up-to-date list of providers in the [redacted] network. You can also use the [redacted] tool on the [redacted] Mobile App. Providers in the [redacted] network are those who accept your [redacted] insurance plan. In most cases, [redacted] does not pay for charges from providers that are not part of our network.

5. Get a printed copy of your Member Handbook or Provider Directory.

You can ask to get either or both the Member Handbook and Provider Directory in paper form at no cost to you. Please follow the directions on the postcard in this booklet to tell us if you would like these mailed to you. There is no postage needed. You can also call Member Services at [redacted] to get these mailed to you.

6. Make Sure Your Prescriptions are on the [redacted] Drug List.

You can use the [redacted] search tool to see what drugs and medical supplies are covered. Just go to [redacted] click [redacted] and then click [redacted]

7. Complete your Health Risk Assessment (HRA).

[redacted] wants you to stay healthy. Using a few questions about your health and lifestyle, [redacted] can help your providers coordinate your care. You can even earn $15 on your [redacted] account when you complete the HRA! You can take the HRA in one of these ways:

- **Phone:** Call [redacted] between 7 a.m. to 6 p.m., Monday - Friday.
- **Online:** Just log into your secure [redacted] account and click on the [redacted]

[redacted]

9

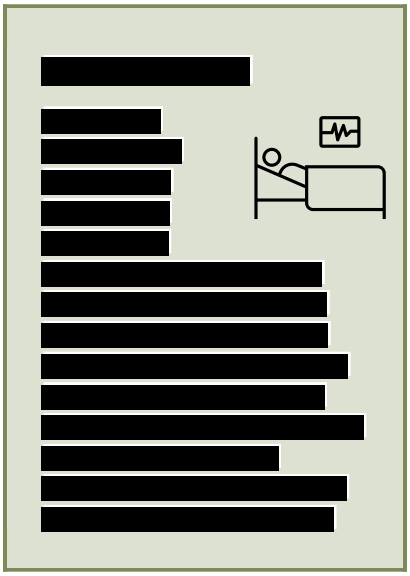
[END OF RESPONSE]

4.2.3.1 VALUE-BASED PURCHASING

The Division intends to develop a Value-Based Purchasing program to improve health outcomes during the next contract cycle. This program will be developed collaboratively, with input from winning offerors,

Division subject matter experts, providers, members, and other stakeholders. The result will be the Mississippi Division of Medicaid Value-Based Purchasing Work Plan, which will be updated as needed to reflect the needs of the Division. More information about this initiative is in Section 8, Quality Management, of Appendix A, Draft Contract.

The Offeror must produce a Value-Based Purchasing proposal for the Division, taking into account the Offeror's knowledge of the needs of the Division, its Members, providers, the state, and the requirements included in Appendix A, Draft Contract. The proposal is meant to be an overview of the Offeror's plan, which the Offeror will have the opportunity to expand upon should the Offeror be chosen as a Contractor.



We are a Coordinated Care Organization (CCO) committed to changing the trajectory of Mississippi's healthcare system and bringing a new era of provider collaboration via our transparent service delivery model, which is fully integrated with most providers through real-time bidirectional data exchange. Our mission is to ensure Mississippians can easily access their benefits, our next generation member engagement and education, and community-based coordinated care to help them lead healthier lives while we prudently manage State resources.

We are committed to partnering with the Division, other CCOs, and other key stakeholders to achieve the quality strategy aims, goals, and objectives in the development of a uniformly applicable Mississippi Division of Medicaid value-based purchasing (VBP) work plan. Fundamentally, a VBP program should include primary care transformation and the integration of physical and behavioral health while promoting payment reform, such as episodic payments. Core to our development of VBP models is the ability to leverage an integrated real-time bidirectional data exchange and connection between key providers. These features are key components of our VBP approach resulting in our record of successfully improving health outcomes for our members. We look forward to sharing our processes and scaling those efforts collaboratively with the Division, other Contractors, and stakeholders in developing a VBP work plan. We acknowledge the work plan may be updated post-implementation to reflect changing needs of the Division, members, and providers. We also understand that VBP may affect enrollment and that if multiple contractors meet the proximity standard, assignment may occur based on Division-defined VBP performance measures. We will comply with the Division's final model, understanding that reports are produced and disseminated in accordance with MSCAN and CHIP reporting models.

We understand the positive impact that well-designed incentive programs have on member health outcomes. Core to our thinking in developing VBP models is the effect they have on provider behavior. We use the lessons of behavioral economics in the design of our models. Health care literature shows that incentives have minimal effect if not designed well, but that we can enhance the effectiveness of incentives by improving program design. It is critical to be aligned with providers to drive the best outcomes, quality, and efficiency. Incentives that are too small or do not motivate providers to undertake the appropriate behaviors can actually undermine the intended effect. This perspective shapes our models, and with this in mind, the principles we consider when building incentive programs include:

- Inclusion of specific, measurable, achievable quality goals
- Timeliness of incentive payment distribution
- Pay for performance and incentive payments that are separate from usual reimbursement.
- Incremental incentives aligned to tiered quality outcomes for multiple opportunities to earn incentive payments
- Consideration of an administrative attributed member PMPM to facilitate dedicated staffing

Our flexible and scalable enterprise wide VBP program proposal will improve health outcomes for members and clinical and financial performance within Mississippi. Value-based care is mission-driven and supported at the highest levels of our organization. We share a commitment to accelerating the transition to effective VBP models to achieve improved member experience, access, health outcomes, health equity, quality, appropriateness, and affordability. Our VBP models consider these factors, while also ensuring the most efficient use of health care resources.

Leveraging our relationship with key providers in Mississippi, combined with our experience and knowledge of the Division's needs, MSCAN and CHIP members, the State, and the requirements included in Appendix A of the Draft Contract, we propose the implementation of a comprehensive integrated primary care (IPC) VBP program that incents primary care providers (PCPs) to collaborate with behavioral health (BH) and other specialty medical and community–based providers. This collaboration along with a sophisticated bidirectional real-time data exchange, facilitated by closed loop community-based referrals to address social gaps will improve the quality of preventive care and the delivery of care to members with chronic conditions.

Our detailed IPC VBP proposal is built on a foundation of actionable, real-time information in a secure online connection for providers who are participating. Our proposed program is designed to improve member care and help IPC providers who are patient-centered medical homes (PCMHs) become more successful in value-based payment models. The data enables a provider to view when a member accesses services such as admissions, discharges, and emergency department (ED) visits, and allows them to improve care coordination. Additionally, this approach can also identify and close care gaps, address targeted quality measures and manage member risk level. Driving IPC transformation must include the integration of physical and behavioral health as well as aligning behavioral health providers to the same goals of the VBP program. Our VBP program also assists providers in achieving PCMH status through practice transformation, financial incentives, and a per member/per month (PMPM) payment, enabling practices to invest in infrastructure to improve the delivery of quality care.

Bidirectional Data Connectivity Platform

Our unique integrated bidirectional data connectivity platform is **already established** and we commit to making real-time data available to any other participants in the program so that we have a consistent framework among all CCOs that will result in a final uniform VBP model.

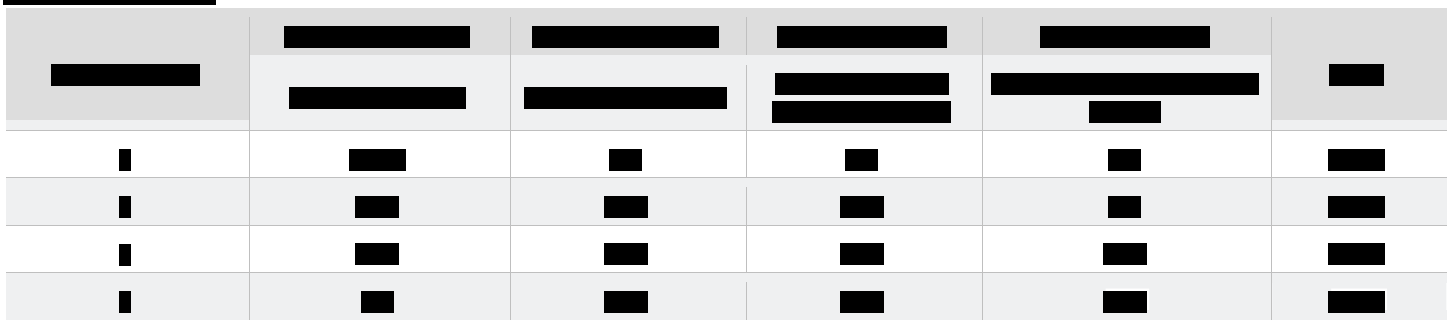
Building on this framework, we propose the design and implementation of core quality and efficiency metrics to support the program. The utilized metrics and corresponding incentives must drive the behaviors of PCMH and behavioral health providers, the foundation of integrated primary care, on a sustained basis to capture the Division's priorities and improve member outcomes.

The final step to a successful VBP program that incorporates real-time data as well as incentive metrics is to introduce alternative payment models (APMs) such as payments for episodes of care. Episodes of care are designed to transform the way healthcare services are delivered by incenting high-quality, cost-effective care based upon evidence-based clinical pathways and encouraging integrated care coordination between providers.

Our final VBP proposal will be submitted to the Division within 90 calendar days of award and includes information regarding provider recruitment, reimbursement methodology, how utilization review informs our VBP program development, implementation, timeframes, and anticipated challenges.

Table 4.2.3.1_A shows our projected percent of MSCAN and CHIP providers participating in our VBP programs across the value-based continuum by contract year.

[redacted]



Impacting Health Equity Through VBP Collaboration

In an effort to assess the overall health status of the MSCAN and CHIP members and uncover health disparities, we completed a comprehensive epidemiological analysis of the state population demographics, held focus groups in the State to collect member and provider feedback, and reviewed state health priorities, HEDIS® results, quarterly regulatory reports, review of VBP programs and provider incentives, social driver data, and other public data sources and national surveillance systems such as the March of Dimes Report Card and America's Health Rankings.

Our analysis yielded significant opportunities to tailor targeted interventions by race and ethnicity, as well as by geography (both rural and urban), in five key areas:

- Health equity and social drivers by addressing health disparities through addressing social driver needs delivering a member-centered approach that incorporates the perspective of members and their families into all aspects of their care.
- Chronic disease management by helping MSCAN and CHIP members reduce the risk of and manage chronic conditions.
- Maternal and child health by eliminating health disparities, improving birth outcomes, and enhancing the health of women and children across Mississippi.
- Prevention of substance use disorder (SUD) by treating the entire member, including physical symptoms and behavioral triggers, while leveraging the knowledge and skillset of their support structure to protect their health and safety and increase their quality of life.
- Preventive care through member, provider, and community engagements, combined with cost-effective and sustainable interventions.

As part of our ongoing quality improvement, we continuously develop targeted goals that are achievable and interventions to measurably improve health equity. Given our extensive experience, we see many forms of disparities in our other markets. Mississippi has the highest percentage of residents that live in maternal health deserts and has an infant mortality rate nearly twice as high for Black infants as it is for White infants (11.1 compared to 6.6 statewide). To help address this striking health disparity, we will promote targeted interventions, such as Nurse Family Partnership evidenced-based national nurse home visiting model, Mississippi Pregnancy Engagement Program and Count the Kicks, as well as new provider incentive for OBs around prenatal and postpartum care. We are providing women in more rural areas of Mississippi, where many of the maternal health deserts are located, with access to a telehealth platform for OB providers and smart phones with unlimited data plans for members identified as high risk.

Our VBP Philosophy and Approach

We recognize the Department intends to develop a VBP program to improve health and is looking for input and collaboration from CCOs to shape the program. As we present our proposed design, we also want to share our holistic approach to how we support VBP programs in our CCO.

Through our VBP collaborative governance structure, our approach supports value-based initiatives on an enterprise-wide basis:

- Develops an operating model that provides a VBP Program enterprise infrastructure
- Evaluates VBP capabilities across key functional areas of the organization
- Designs a cross-functional VBP operating model with clear roles, responsibilities, and integration points
- Incorporates national and regional competitive trends/best practices
- Includes provider enablement into the enterprise VBP approach

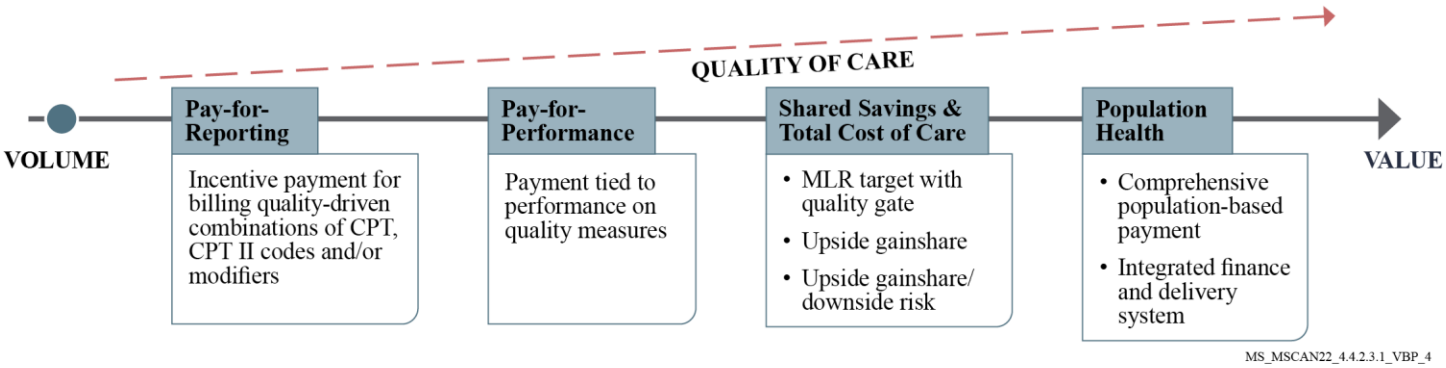
On the local market level, our approach integrates our VBP approach by:

- Creating an optimal market process for VBP entry, adoption, and maintenance
- Developing parameters for VBP contracting purposes
- Creating an "easy to do business with" approach

We employ a **path to value** approach in the design and implementation of value-based programs, as depicted in Figure 4.2.3.1_A. This path elevates and supports providers along a stepped continuum and includes an array of models departing from the traditional fee-for-service (FFS) architecture and graduating in financial risk and reward toward the most complex integrated delivery system structure. Our comprehensive VBP program includes provider incentives to support practice-level process improvement and to achieve improved health outcomes for our members. VBP arrangements are not one-size-fits-all. Program development requires provider feedback on the construct of VBP programs from our Physician Advisory Committee (PAC), provider associations, and individual provider offices as well as our Member Advisory groups. This approach strengthens our provider relationships by reducing administrative burden and provider burnout. We will partner with providers from the outset to assess their capabilities and readiness to enter a VBP agreements to support their full engagement in quality and total cost of care initiatives and programs.

Figure 4.2.3.1_A: VBP Continuum Model

Based on the proven HCP-LAN framework and provider feedback, our VBP continuum enables providers at any level of engagement readiness to participate in a VBP arrangement. At all levels of engagement, and in partnership with providers, we will improve the quality of care and health outcomes for our members.



Pay for Reporting

The **Pay for Reporting (P4R)** program is at the beginning of the continuum and provides an entry point for providers into VBP arrangements. The P4R program is available to all PCPs, including FQHCs, RHCs, and behavioral health and OB/GYN providers. There is no membership threshold required to participate in the P4R program, enabling even small rural practices to engage. This incentive does not impede FQHC or RHC eligibility for wraparound payments.

Our P4R program drives the provision of high-value services by focusing incentive offerings on specific quality measures. Completing services that help to achieve these quality measures and submitting supporting CPT, CPT-II codes or modifiers using standard claims submission processes initiates a P4R payment. Our entire primary care network can participate in VBP through our P4R program.

Pay for Performance

The second step on our Path to Value is our **Pay for Performance (P4P) Program** that helps address the complex needs of our members through a coordinated system of care. While eligible practices do not need to be NCQA certified as a Patient-Centered Medical Home (PCMH), the Pay for Performance Program supports the PCMH philosophy of a team-based approach to health care delivery. The Pay for Performance Program compensates practices for obtaining maximized health outcomes through a coordinated system of care that includes comprehensive primary care, referral to specialty care, acute care, behavioral health integration and referral to community resources.

Our P4P Program uses the following payment model:

- Fee-for-service payments
- Per-member-per-month (PMPM) Care Coordination Transformation fee (CCT) practice infrastructure payment to support transitioning from volume performance to quality-centric population health management.
- Quality incentives based on clinical outcomes measures. Providers are incented for each metric-related service for which they meet or exceed the established target.

Our P4P Program offers providers multi-level opportunities to earn incentive payments on quality measures. Quality measures are tied to one or more target achievement levels. With this tiered structure, providers have multiple opportunities to earn incentive payments – the higher the tier achieved, the higher the corresponding incentive payment. Timely and actionable reports are available to give providers regular insight into determining which care and referral decisions contribute to optimum results for quality, outcomes, and value.

Shared Savings and Total Cost of Care

Advancing further along the VBP continuum are our Shared Savings and Total Cost of Care programs. Shared savings is structured to afford providers an opportunity to earn financial incentives if they achieve an overall medical loss ratio (MLR) reduction target (based on historical data) and meet quality metrics tied to provider performance. Shared savings programs may include upside only (share of savings achieved) or upside and downside risk (share of savings, penalties for exceeding MLR targets).

In a total cost of care relationship, providers may earn an additional payment if spending for attributed members on a normalized basis is lower than the benchmark cost target for the performance year. The total cost of care benchmark reflects average spending under a wide range of health services and settings, including inpatient, outpatient, laboratory, radiology, and pharmaceuticals. This projected cost estimate is then compared to actual spending to assess whether the provider generated savings or incurred losses during the performance year. Total cost of care payouts are also contingent upon quality performance. By tying payment to a quality gate, we ensure the delivery of needed care is not impacted by a desire to retain savings.

Population Health

Our **Population Health** model resides at the most advanced end of the continuum and links financial performance with achievement of quality outcomes. Contracted with full risk agreements, providers are responsible for managing the total cost of care for eligible members and can earn a percentage of their capitated premium for eligible members who meet specific quality metrics and quality gates. For example, we implemented a state-wide pediatric Accountable Care Organization (ACO), in collaboration with a children's health system, in one of our other markets. The ACO supports nearly 670,000 pediatric members and links them with high quality local providers. This model includes delegation of care management, disease management, and utilization management components to support and strengthen success at the point of care. Understanding

the impact of the family and social environment on a child's well-being, these factors encompass our model, coupled with clinical treatment. For example, the agreement requires ACO practices to screen for social risk factors and facilitate connections with community resources upon identification. This approach, together with medical and behavioral care, helps ensure we address all aspects of health. Our care management programs are critical to the success of this model, with locally based provider representatives who engage in frequent interactions with practices and maintain strong relationships with providers. Their extensive knowledge of integrated care, community resources, and experience in addressing social challenges that impact health drive successful outcomes for our members. Another driver of our successful population health model is system interoperability, with providers afforded access to all our member services programs and resources. Exchanging member health information in a bidirectional manner, securely and quickly, is key to facilitating coordinated care delivery and achieving clinical integration.

Proposed VBP Programs

Patient Centered Medical Homes (PCMH)

Our proposed **PCMH** VBP is driven by our commitment to supporting and growing the PCMH model in Mississippi. To incent adoption and commitment among providers, we feel any uniform VBP program includes this as part of the design. [redacted]

For this component, we recommend a set of performance metrics used for qualified PCMH providers that result in enhanced and bonus reimbursement for meeting and exceeding targets in alignment with the State's Comprehensive Quality Strategy. The key to developing the metrics is coalescing on the types of behaviors and outcomes that are important. NCQA HEDIS® measures to be considered for inclusion in the Division's model may include the following:

- Effectiveness of care
  - Immunizations
  - Comprehensive diabetes care
  - Breast cancer screening
  - Colorectal cancer screening
  - Asthma medication ratio
  - Anti-depressant medication management
- Access/Availability of Care
  - Timeliness of prenatal care
  - Postpartum care
- Utilization
  - Child and adolescent well-care visits
- Efficiency metrics such as ER cost reduction or readmission rates
- Patient Experience such as CAHPS surveys

This VBP model develops targets for the PCMH providers based on baseline rates for their members and provides bonus payments for improvements to the targets. We recommend tiered payment levels with greater achievement resulting in higher payments. We recommend a PMPM payment based on attributed members as well as a combination of both rates of improvement to their attributed members and overall market or industry targets for a particular measure. Investing in a PCMH program and working with providers who deliver primary care, will result in improved integration of care, better clinical outcomes, improved wellness and member experience, and lower costs.

Integrated Primary Care

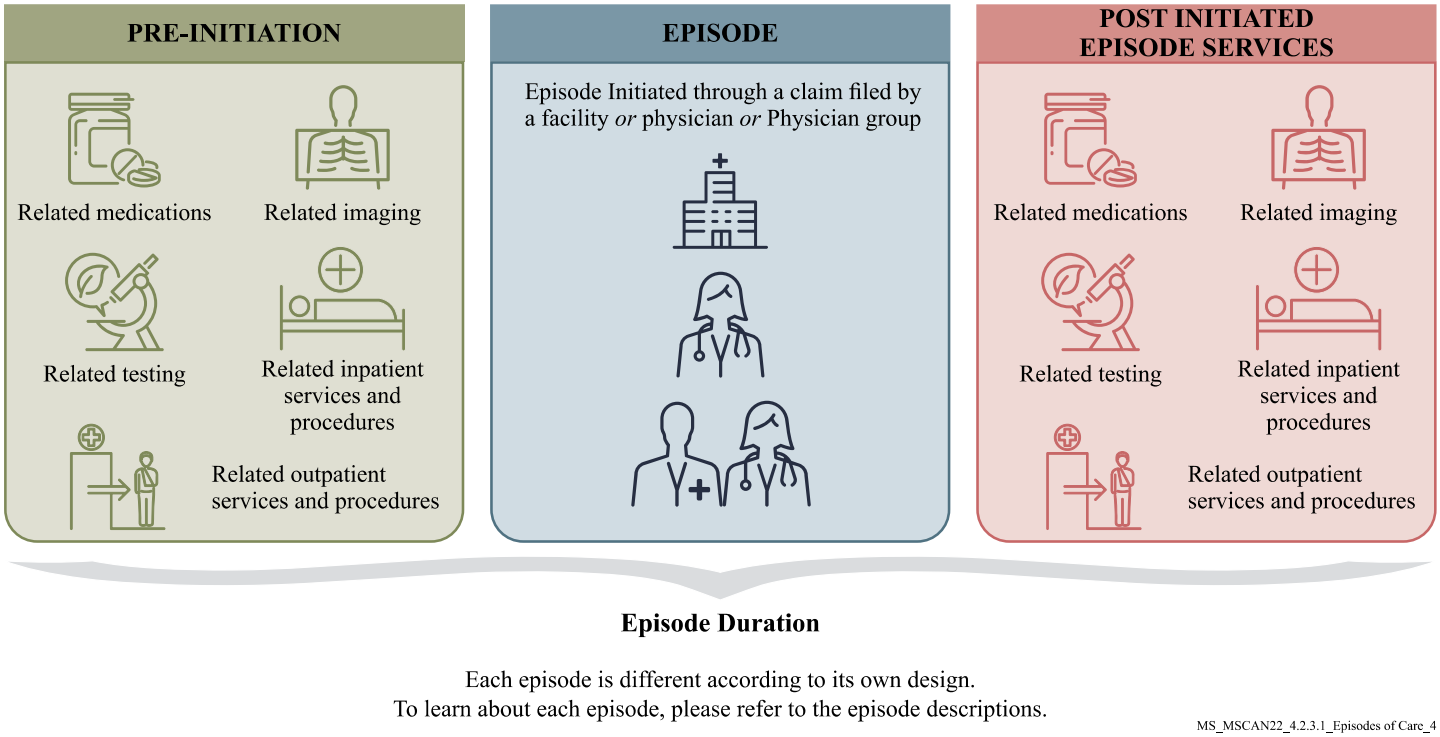
Integration of physical health and BH is critical to improved outcomes and wellness. Coordination between primary care and BH providers is fundamental to supporting this aim. Many times, the BH provider acts as the medical home for the member. At a minimum, member attribution is shared between a primary care and BH provider for members with a primary or secondary serious mental illness (SMI) and/or substance use disorder (SUD) condition. Additionally, our experience has also shown that BH capacity and access is an issue in the health care delivery system. Mississippi is not different, and for this reason is a priority for the Division. For this reason, we propose a BH component to a VBP program.

Like the PCMH program described previously, the Integrated Primary Care program uses measures that are important to driving the outcomes that support members BH conditions (i.e., follow-up after BH admission, medication adherence). It is offered to providers including the network of community mental health providers who are integral to the execution of physical and BH care coordination.

Episodes of Care (Episodic Payment)

We propose an VBP model incorporating episodic/bundled payments for specific care pathways. These payments would be available to hospitals and providers across specific episodes of care. The mechanism used would determine the total cost of care for selected conditions as the target from the pre-initiating and post 90 days service period. With improved coordination and focus for these episodes, providers can drive better outcomes at lower cost relative to historical outcomes.

Figure 4.2.3.1_B: Episodes of Care



Supporting Provider Success in VBP

We will support providers of all capabilities and readiness levels through all VBP categories. Our Mississippi quality and provider services teams include provider representatives and market quality improvement specialists (MQIS) dedicated to proactively guiding providers in VBP engagement. Our Mississippi quality and provider services teams will offer guidance and assistance with in-person and online education related to our VBP models. We also offer direct electronic health record (EHR) data sharing with select large health systems and PCMH providers. Communication occurs directly with the provider's EHR vendor to tailor a solution for data sharing. This platform is used for bidirectional feeds; electronic medical records data from the EHR system to us, and to deliver gaps in care including gaps closed at other provider locations as frequently as desired by both parties. This data exchange allows us to share member information and gaps in care directly into the provider's EHR. We leverage sophisticated analytics and member experiences to quickly identify barriers that impact access to care and magnify disparities. For example, we used our high-risk pregnancy predictive model, a machine learning algorithm, which looks for patterns in historical high-risk pregnancies and identifies clinical, behavioral, and social drivers that enable the prediction of potential adverse outcomes for current pregnancies. Attributes include social determinants of health, age, race, ethnicity, chronic disease, behavioral health conditions, and past pregnancy outcomes. Our model focuses on the following birth outcomes: sick newborn,

premature delivery, neonatal abstinence syndrome, failure to thrive, low birth weight, NICU admission, and stillbirth. Our valid, reliable predictive analytics model accurately identifies members who are predisposed for high-risk pregnancy, allowing rapid stratification and care management prioritization.

We also support providers with quality improvement, clinical practice guidelines, and cross-training for person-centered care. After a provider signs a VBP contract, our local contracting team completes a warm transfer to our locally based, regionally assigned provider representative and MQIS team member. Our provider representative and MQIS team members work closely with providers to identify members with gaps in care and to encourage them to provide or direct members to preventive health services. Provider representative and MQIS team members review practice-level performance reporting information with provider office staff and suggest enhancements to clinical processes to drive performance improvement. Our provider representatives routinely meet with providers to share gaps in care reporting and to educate them on VBP support tools available on our secure provider portal. Targeted supports to increase provider practice capabilities to participate in VBP arrangements include:

Bidirectional real-time data feeds: Data-sharing and reporting are key to successful VBP implementation. In all three of our proposed VBP models outlined previously, actionable data is integral to the providers being successful and empowered. For example, bidirectional data allows providers to view when an attributed member accesses services at the point of care, such as admission, discharge, or transfer from a hospital, an emergency room visit or fills a script to improve care coordination. The data also identifies and tracks the closure of gaps in care linked to quality measures. Additionally, it allows providers to view member panels and manage the level of risk that a member represents, which facilitates provider outreach to members with higher likelihoods of adverse health events. While we commit to meeting our providers where they are in terms of interoperable data exchange, we provide ongoing support to assist in the adoption and implementation of interoperable data systems throughout our network to ensure appropriate communication with providers and follow-up care for our members.

This level of integration has already been completed and we will work with the Division to make this information available to other CCOs as appropriate.

Comprehensive suite of provider tools and data analytics: Our provider services team members will meet regularly with their assigned providers to review quality and financial progress and deliver timely and actionable data and reports. Providers will track performance through one of the dynamic, interactive tools available on our secure provider portal, such as:

- Provider Performance Dashboard: This dashboard offers a single, consolidated scorecard view of provider performance in value-based programs, as shown in Figure 4.2.3.1_C. It offers self-service tools for providers to monitor their performance and includes real-time access to claims information to assist in tracking performance on cost of care metrics.
- Clinical practice registry (CPR): The CPR is a proactive online tool emphasizing preventive care by identifying and prioritizing health care services and screenings for our members. This tool is available to all PCPs with attributed members. Key benefits for providers include quick and easy filtering of data to manage populations, color coding to identify targeted members quickly, and health care services and screenings highlighted when needed or past due.
- Member profile: The member profile report provides a comprehensive view of a member’s medical and pharmacy data. It helps providers determine an accurate diagnosis and reduces duplicate services and unnecessary diagnostic tests.
- Diagnostic verification program: This program uses advanced risk analytics to evaluate members for confirmed existing conditions and those expected to exist, based upon clinical understanding of chronic conditions. The results empower providers to close gaps in care through targeted interventions. Each completed risk verification form submitted to us from the practice is eligible for a payment to the office and reimbursement for the visit submitted on a claim.

[redacted]

[END OF RESPONSE]

4.2.3.2 PATIENT-CENTERED MEDICAL HOME

The Offeror must produce a PCMH proposal for the Division, including how it will have PCMHs interact with other elements of its programs to Members' benefit, with an emphasis on the mechanisms through which PCMHs will be able to coordinate with Care Management, any incentive programs used to recruit and retain PCMHs, and methods for measuring success of PCMHs both individually and as a system

We are a CCO committed to changing the trajectory of Mississippi's healthcare system and bringing a new era of provider collaboration via our transparent service delivery model, which is fully integrated with the majority of providers through real-time bidirectional data exchange. Our mission is to ensure Mississippians can easily access their benefits, our next generation member engagement and education, and community-based coordinated care to help them lead healthier lives while we prudently manage State resources.

We support provider groups in multiple markets throughout their journeys to attain and maintain recognition as Patient-Centered Medical Homes (PCMHs). We support provider groups in multiple markets throughout their journeys to attain and maintain recognition as Patient-Centered Medical Homes (PCMHs). [redacted]

Our innovative PCMH program has been proven to improve health outcomes in the Division's priority areas, including maternal/child health and the integration of behavioral health. We believe PCMHs are fundamental to our value-based programs outlined in 4.2.3.1. For the new contract period, we will submit our PCMH proposal meeting and exceeding all requirements outlined in Appendix A, Section 6.2.5 to the Division within 90 days of contract award. Further, to improve health outcomes for MSCAN and CHIP members we will collaborate with the Division and other CCOs to establish and implement a statewide PCMH strategy which sets aggressive and attainable goals for the number of medium and high-risk members receiving services from highly connected and coordinated PCMHs.

We have identified current Mississippi recognized PCMH providers and geographic regions of high need to focus contracting and practice transformation efforts to ensure coverage and access for our members. Priority areas for provider engagement include the Delta, Golden Triangle, and East Central regions, where we know there are high health needs and few PCMHs. We will offer network contracts and PCMH recognition support to provider practices throughout the state to ensure our medium and high-risk members have access to enhanced support intrinsic in the PCMH model. We are aware some Mississippi providers have PCMH certification from The Joint Commission (TJC), and we will work with these providers to adopt the National Committee for Quality Assurance (NCQA) model. Upon award we will assist practices in the adoption and maintenance of the NCQA PCMH model of care through the following strategies:

- Provide direct, on-site education, coaching, and guidance for NCQA recognition through practice transformation coaches assigned to network provider groups agreeing to serve as PCMHs for our members
- Break down financial barriers to attaining and maintaining NCQA recognition by:
  - Offering enhanced payments and other pay-for-performance payment models
  - Providing grants for up to 20 rural health providers in underserved areas to accelerate their capacity to achieve and maintain NCQA recognition
  - Working with PCMHs to generate cost savings while improving outcomes, quality of care, and enhancing member experience
  - Optimizing member assignment
  - Focusing on maternal/infant health outcomes
- Provide existing and prospective PCMHs with timely, practice-specific, actionable data (including NCQA HEDIS measures and population health data) and transformation coaches who collaborate with them and utilize data to improve performance, identify disparities, and close gaps in care

- Prevent duplication when a member receives care outside of the provider group by utilizing our real-time bidirectional data feed which will include PCMH electronic medical record data and identify open and closed care gaps, providing unparalleled transparency into the health and service utilization of their patients
- Establish a Mississippi provider learning collaborative to share ideas and learn about PCMH relevant topics, such as change management and ideation to meet standards

Attaining PCMH recognition is an arduous and costly process for providers, taking up to nine months of concentrated effort to complete. We are committed to minimizing the impact on practices by covering the cost for providers as well as walking alongside them in their transformation journey with expertise and practical, real-time intensive supports. Further, we will collaborate with the Division to develop and implement a statewide integrated primary care value-based purchasing model to support PCMH in alignment with the 2021 Comprehensive Quality Strategy, including exploring the State's willingness to review and reform the provider reimbursement structure for PCMHs.

Patient-Centered Medical Home Proposal

PCMH supports meaningful access to care, patient-centered partnerships, mitigation of health disparities, enhanced member health literacy, and improved member health outcomes. Our efforts to promote PCMH adoption benefit not only MSCAN and CHIP members, but every patient receiving care from these transformed practices. We use our fully integrated, transparent service delivery model to work in tandem with provider groups to coordinate and manage care while supporting their quality improvement initiatives. Informed by our experience building medical home models in other states, our Mississippi PCMH proposal is guided by these main goals:

Meaningful access to high value care: We will monitor PCMH locations to ensure our contracting efforts support the access needs of our membership. We will target low PCMH provider volume areas and/or new practices for PCMH engagement initiatives through geospatial mapping to prioritize both contracting and support efforts.

Support of patient-centered partnerships: We will reward PCMH providers by optimizing our member assignment process to drive membership toward PCMH recognized practices. We will ensure ease of access for our members by highlighting PCMH status in provider directories, providing transportation for appointments, and offering closed-loop referrals.

Increased provider engagement in PCMH care models: We will support practice transformation through financial incentives to providers who are participating in a PCMH recognized care model and provide onsite support to practices actively working in a PCMH environment or interested in transitioning to the PCMH care model, including current TJC certified practices.

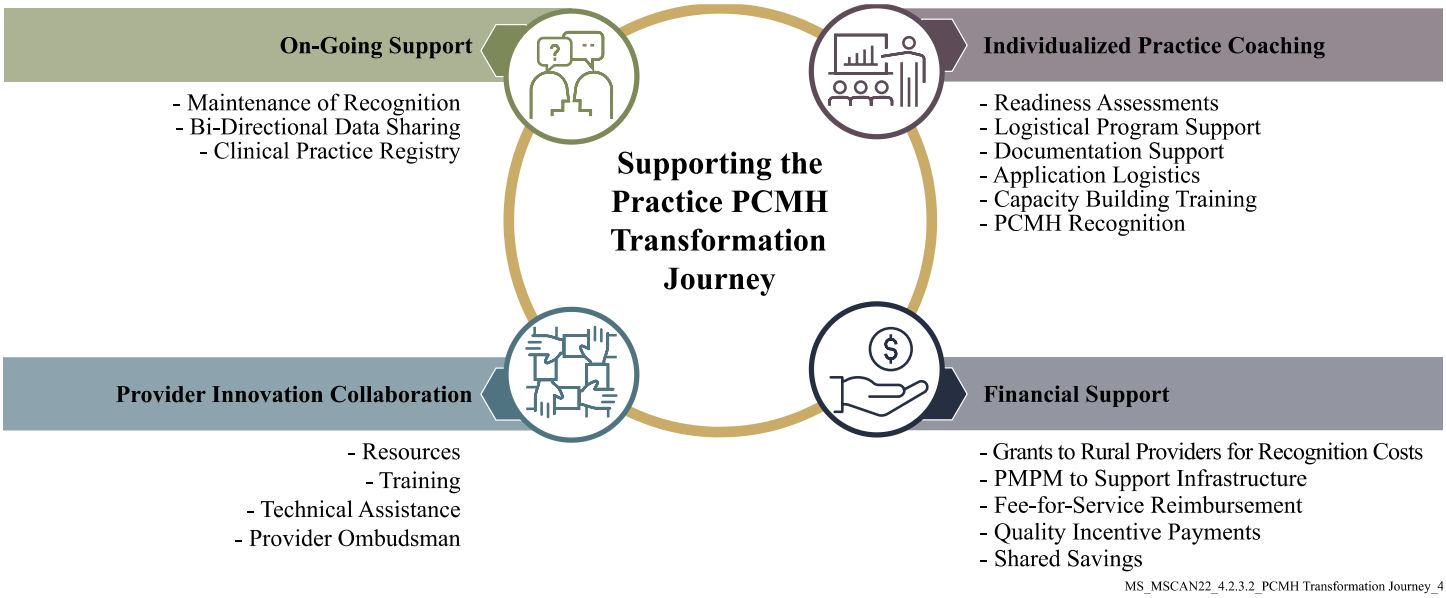
Improved outcomes: We will use NCQA HEDIS measure specifications to monitor quality and identify gaps in care. This data is also used to determine improvement initiatives specific to each market/region based on the needs of the identified demographic. Providers have access to our Clinical Practice Registry to identify and prioritize services, screenings, tests, and gaps in care to holistically address patient care and improve clinical outcomes. Our value-based contracts with providers consider both medical costs/utilization and quality measures. Additionally, we will conduct ongoing joint development operating committee meetings with larger, high-volume providers and health systems, and regional learning collaboratives/provider forums to ensure all practices have opportunities to fully engage in these efforts. Specific metrics are outlined in the "Measuring Success" part of this response.

Activities to Support PCMH Transformation

We drive transformation of the healthcare system to a quality based, patient-centered care model by providing wraparound, comprehensive, and ongoing support to our providers as shown in Figure 4.2.3.2_A.

Figure 4.2.3.2_A: Supporting Practices Through Their PCMH Journey

We work side-by-side with our providers to identify and break down barriers for practices who have made the significant commitment to become primary care medical homes.



Our comprehensive approach to practice transformation starts with the PCMH assessment phase by gathering information from the provider group to understand operational infrastructure, staffing dynamics, and details about populations served to ensure a tailored experience for practices to maximize efficiency and impact. We meet with the provider group to determine PCMH readiness, electronic capabilities, staff satisfaction, and conduct a gap analysis. Our PCMH certified coaches provide technical support on strategies, complex points, resource requests, documentation questions, and interpretation of medical home standards and guidelines. We provide webinar trainings for provider groups to build expertise in NCQA PCMH required areas, such as team-based care, population management, evidence-based guidelines, care management, performance monitoring, patient-centered access, care coordination, and medical home responsibilities.

While participating in our PCMH transformation program, provider groups have full access to our medical home documentation library as well as expert documentation reviewers. Based on our experience with PCMH transformation, we understand the NCQA application platform for PCMH may seem daunting for providers, so we help them complete the application properly and conduct virtual mock check-ins prior to the NCQA evaluation. Our goal is to provide practitioners with the level of support needed to focus and complete key concepts, identify opportunities for operational cooperation, and build the infrastructure to sustain positive gains. Our PCMH certified coaches continue to work with practices after they attain recognition to ensure continual monitoring and guidance for sustained success.

PCMH Interactions with Programs to Benefit Members

Our PCMH model is embedded within all aspects of care for medium-and high-risk members and is integrated not only within care management and disease management programs, but throughout our quality, utilization management, well-being program, pharmacy, provider relations, and member incentive programs. Our fully integrated, transparent service delivery model uses next generation member engagement education, community-based coordinated care, and operational excellence to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources. For example:

- Our internal pharmacy program supports PCMH members through the medication therapy management program in which a licensed pharmacist conducts an annual review of member medications to reduce the risk of negative drug interactions and/or prescribing unnecessary medications.
- We incentivize members for healthy behaviors (e.g., well-child, prenatal, and postpartum visits) and support them in accessing preventive and acute care from their PCMHs by providing solutions to SDOH barriers such as lack of transportation, stable housing, and access to healthy food. We work with our PCMH providers to ensure they are providing culturally competent care and streamline processes for making referrals into our care management program to holistically support our members.
- To enhance access to care for members, we will support PCMHs in using telehealth as an adjunct to in-person visits by providing a telehealth platform for practices who do not have this capacity. This is especially important in rural areas where our members face significant access challenges due to lack of transportation or other social barriers. We encourage members to first seek telehealth services from their PCMHs to maintain continuity of care and treatment before offering telehealth services from other providers.

In another market we generated significant improvements in operational efficiency across programs to benefit members, as shown in Figure 4.2.3.2_B.

[redacted]

Examples of Patient-Centered Medical Home Practice Competencies:

TBC: Organizes and trains staff to work to the top of their licensure
PM: Has an implemented provision of culturally and linguistically appropriate services
CM: Identifies patient needs at the individual and population levels to effectively plan
AC: Patients/families/caregivers have 24/7 access to clinical advice appropriate care facilitated
CC: Systematically tracks tests, referrals and care transitions
QI: Establishes a culture of data-driven performance improvement and engages staff and patients in quality improvement activities.

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PCMH Coordination with Care Management

As partners in care, we and our PCMHs have shared roles and responsibilities in ensuring appropriate plan/provider communication to support and affirm members receive comprehensive, coordinated, and non-duplicative care. With our support and based on member needs and preferences, we facilitate PCMHs engaging with other treating providers and community-based organizations to ensure our members receive culturally competent care and all necessary medical, behavioral, and social services to improve their health outcomes and experiences. **We recognize the unique value providers bring through their trusted relationships with our members, and we will partner with PCMH providers to engage them in member care planning, interdisciplinary care teams, and supporting members through transitions of care.**

We will ensure our PCMHs are fully informed about our care management services during their comprehensive new provider orientation within 30 days of their contract effectiveness date and through ongoing education and outreach programs. Our coaches provide technical assistance for all services, including our model of care and how to connect to care management. Our integrated care management (ICM) staff attend provider visits with transformation coaches to encourage collaboration and assist with care coordination, medication, transportation, and SDOH needs. Our training reinforces the importance of the PCMH role in member interdisciplinary care teams (ICT) and care planning. To facilitate knowledge-driven care and continuous learning, we provide annual refresher training and education through the provider manual, provider newsletter, and the provider training website. For larger groups, we will provide regular training and education during joint operating committee meetings.

Our collaboration in care management brings value to providers by helping them manage their most complex members. We ensure our PCMHs have access to evidence-based tools and decision-making supports to inform clinically appropriate treatment and follow-up care for chronic condition management. We educate providers on disease management, care management, and SDOH services they can refer members to within our plan to comprehensively cover member bio-psycho-social needs. Upon award we will connect to statewide health information exchanges, electronic medical records of FQHCs, other PCMHs, and hospitals for real-time data exchange of clinical information and admissions, discharges, and transfers. We promote and support providers connecting to statewide HIEs. Our real-time data will help providers transition from reactive care to proactive care. For example, we include member screening/assessment results, care management enrollment and disenrollment notifications, care management rosters, and member assessments and care plans in member records in our provider portal. This information supports PCMHs to fully participate in integrated care management efforts that facilitate coordinated, whole-person care across providers and care settings.

The provider services section of our website includes toolkits PCMHs can use to access validated screening and assessment tools and informational resources for a range of medical and BH conditions including but not limited to, attention-deficit hyperactivity disorder, depression, opioid/substance use disorders, and suicide prevention. In addition, our psychiatrists are available to consult with PCMH providers on the management of patients with low to moderate behavioral health conditions.

Our Clinical Practice Registry, shown in Figure 4.2.3.2_C, streamlines this information within our provider portal for easy and efficient access.

Figure 4.2.3.2_C: Our Clinical Practice Registry

Providers can use our registry as a one-stop resource to identify care gaps and prioritize services, screenings, and tests.

													Diabetes					Well Baby		
Member Name	Member ID	DOB	Sex	State	Plan	LOB	Adult Access	Beta Blocker	Breast Cancer	Cervical Cancer	Colorectal Cancer	Chlamydia	Eye Exam	A1C	Kidney Function	ER	Lead	# of Visits	DOS	WellCare
XX	X	X	F	ST	Plan													1	11/5 2016	
XX	X	X	F	ST	Plan		12/29 2016			12/22 2014	4/30 2014									
XX	X	X	F	ST	Plan		11/18 2016			8/18 2014			2/5 2016	9/26 2016	10/6 2016					
XX	X	X	F	ST	Plan		10/18 2016													
XX	X	X	F	ST	Plan		3/25 2016													
XX	X	X	F	ST	Plan		12/21 2016			4/6 2015			10/15 2015	7/29 2016	11/13 2015					
XX	X	X	F	ST	Plan		11/1 2016		4/27 2015											
XX	X	X	F	ST	Plan		12/28 2016					10/19 2016								11/28 2016
XX	X	X	F	ST	Plan															11/22 2016
XX	X	X	F	ST	Plan												6/1 2016			12/26 2016

The registry is color-coded, so you can easily identify areas of focus for your patients:

Service was rendered | Service needed | Service past due | Service not applicable

MS_MSCAN22_Clinical Practice Registry_1

Our statewide regional integrated care management system is a key innovation that delivers regionally tailored education to PCMH and other network providers focusing on closing care gaps and improving coordination of care. Additionally, our regional approach ensures we consider existing resources and infrastructure in each locality, bringing together community providers, community- and faith-based organizations, state entities, and other partners to serve members in their own communities. Our care management approach facilitates stronger and more effective collaboration across PCMH, behavioral health, and specialty providers to help members avoid unnecessary ED visits and preventable inpatient admissions while working with hospitals and other inpatient facilities to improve discharge planning activities, post discharge follow-up, and medication adherence to reduce avoidable readmissions in concert with the Division's Quality Incentive Payment Program (QIPP). Further, in the coming contract period, we will embed care management staff in high volume providers, including hospitals and FQHCs (many of which are PCMHs), across the state to support and coordinate care management and transitions of care activities.

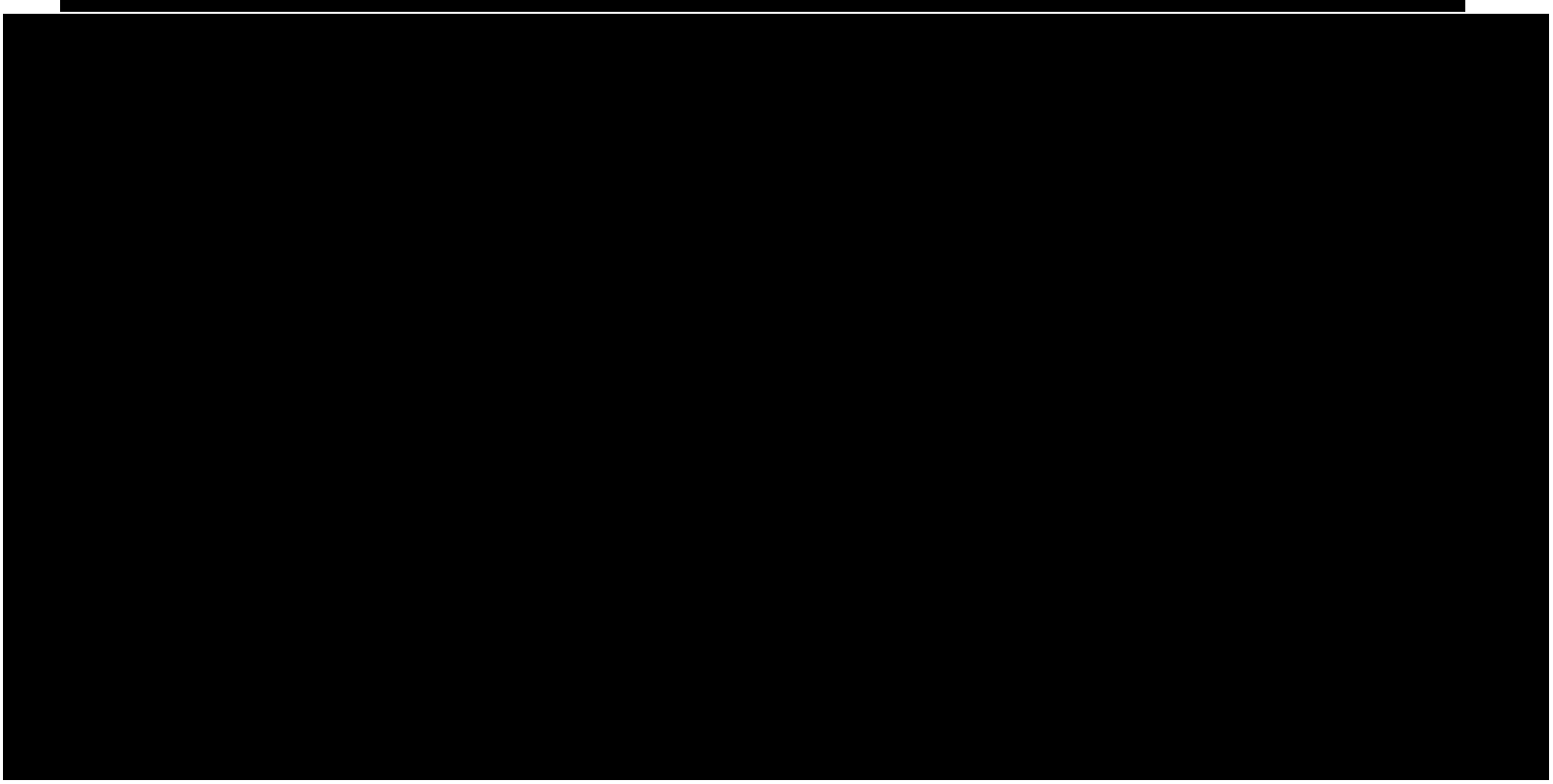
Sharing Data with PCMHs: Effective bidirectional communication is critically important to our collective success in identifying and addressing members' physical, behavioral, and social care needs holistically. Upon award, our unparalleled access to real-time data through connection to a statewide HIE and interoperability with our providers' EHRs will improve coordination of care, resulting in improved health outcomes and decreased avoidable high-cost utilization.

Real-time data-sharing and reporting are key to effective PCMH performance, and actionable data is integral to PCMH success. For example, real-time bidirectional data notifies providers when an attributed member

accesses services at the point of care, such as admission, discharge, and transfer (ADT) data from a hospital or emergency room visit. The data also identifies and tracks the closure of gaps in care linked to quality measures, such as attending perinatal appointments and getting required vaccinations and screenings. Additionally, it allows providers to view member panels and manage members appropriately for their levels of risk, which facilitates provider outreach to members with higher likelihoods of adverse health events. Continuity of care features can augment the HIE and ensure the HIE product is not simply resting data, but actionable data for the providers to use to coordinate care and improve outcomes.

As part of our overall population health strategy, our clinical, quality, pharmacy, network, operations, and analytics teams collaborate to develop and deliver timely and actionable data and reports to our providers. We offer continuous training and support to help providers interpret and apply the data in their practices. We inform providers of how to engage us in these efforts through provider orientation activities, the provider manual, network notification alerts posted on the provider portal or delivered via email, site visits, and our quarterly provider newsletter. Providers may contact their assigned provider representative, transformation coach, or our provider services call center with questions or concerns.

While we commit to meeting our providers where they are in terms of interoperable data exchange, we provide ongoing support to assist in the adoption and implementation of interoperable data systems throughout our network to ensure appropriate communication with PCMHs and follow-up care for our members. Our value-based payment (VBP) program assists providers in achieving PCMH status through practice transformation, financial incentives, and a per member/per month (PMPM) payment, enabling practices to invest in infrastructure to improve the delivery of quality care. These investments improve provider capacity and readiness to participate in PCMH recognition and value-based care delivery, and payment reforms incentivize providers to offer higher quality member care. Our VBP software provides visibility into quality metrics, cost, utilization, and compensation, as shown in the de-identified example in Figure 4.2.3.2_D.

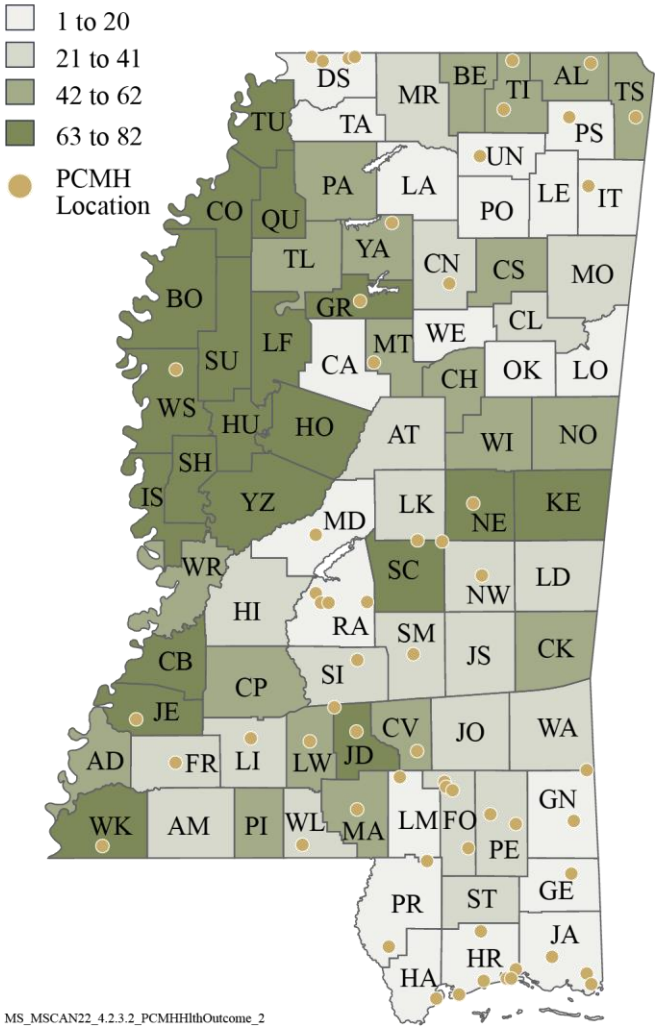


Recruiting and Retaining PCMH providers

A strong primary care system is the backbone of a strong healthcare system. A statewide PCMH delivery care system will reduce costs while improving patient health outcomes. We also acknowledge that required enhanced data/technology capacity and coordination of care results in additional administrative costs to PCMH partners, which can hinder a provider's ability to attain PCMH accreditation. We are committed to working with our providers to mitigate these additional burdens. We will pursue NCQA Partner in Quality (PIQ) recognition in Mississippi to promote the PCMH framework which will enable discounted recognition rates for our providers. We will engage Mississippi federally qualified health centers (FQHCs) to help them attain/maintain PCMH recognition and assist them in applying for funding from the federal Health Resources and Services Administration. We will collaborate with providers across Mississippi to access practices ready for PCMH transformation. We know that the success of this program is rooted in meeting provider needs, and we are committed to walking with providers on the PCMH transformation journey.

Figure 4.2.3.2_E: Current PCMH Locations and County Health Outcome Ranks

We will use county health outcome data to decide where to focus PCMH practice recognition for maximum impact.



Identifying Practices for Potential PCMH Adoption: We will routinely review volume, claims, utilization, and performance data of our network primary care providers to identify practices who might be appropriate for pursuing PCMH recognition, particularly those providers serving areas with high unmet health needs (see Figure 4.2.3.2_E). We will prioritize localities having poor health outcomes currently served by few or no PCMHs. As an example, increasing the number of PCMHs serving members in the Delta, where preterm birth, low birth weight, and infant mortality are significantly higher than the rest of the state should improve maternal and child health outcomes in these under resourced communities.

Once practices are identified, practice representatives will reach out to gauge the practice's interest and readiness for transformation. We understand the significant commitment required to provide PCMH services, and we make sure providers are aware of the supports we offer to assist them in addressing issues of access (e.g., telehealth support and services) and SDOH needs (e.g., transportation, housing, food) for our members.

We will discuss the array of transformation supports available to them throughout their PCMH transformation journey (e.g., coaching, training, value-based payments) and point out that the financial viability of successfully providing PCMH services increases by serving members from multiple CCOs.

Provider Services Organization: In addition to transformation coaches, our provider-centric program will support providers (especially PCMHs and practices moving toward PCMH status) through regionally assigned provider representatives who live in and are actively engaged with the Mississippi communities they serve. They will have knowledge from firsthand experience augmented by robust training on regional health needs, provider accessibility, and resource availability in both rural and urban areas within their assigned territories. Every provider in our network will have access to a single point of contact who works collaboratively with them

to learn the provider's business model, identify practice needs, and resolve issues in real-time to ease administrative load and improve provider satisfaction.

Attribution Model: Upon award we will take a member-focused approach to optimize our attribution model by refining the methodology used to construct and model utilization patterns. Our current attribution model allows for linkages between health partners and members through the retrospective examination of claims to determine how members engage in care. To fulfill requirements of the new contracting period, we will develop a new model that will allow preferential assignment to PCMH recognized providers. Our goal is to create a PCMH attribution model which provides a holistic view of the member's engagement with health partners.

Value-Based Program: Our value-based program is designed to promote and support the adoption of the PCMH model among our network providers. Our proposed PCMH program, including value-based payment (VBP) models, is driven by our commitment to supporting and growing the PCMH model in Mississippi. We recommend a set of performance metrics for qualified PCMH providers that will result in enhanced and bonus reimbursement for meeting and exceeding targets in alignment with the State's Comprehensive Quality Strategy. The key to developing the metrics is coalescing on desired behaviors and outcomes, including:

- **Effectiveness of Care** (immunizations, comprehensive diabetes care, breast/colorectal cancer screenings, asthma medication ratio, anti-depressant medication management)
- **Utilization** (child/adolescent well-care visits)
- **Patient Experience** (CAHPS surveys)
- **Access/Availability of Care** (timeliness of prenatal/postpartum care)
- **Efficiency Metrics** (ED cost reduction, readmission rates)

The incentive design will develop targets for the PCMH providers based on baseline rates for their members and provide bonus payments for improvements to their targets. We recommend tiered levels of payments which would mean greater achievement would result in higher payments. We also recommend a PMPM payment based on attributed members and a combination of rates of improvement to their attributed members as well as overall market or industry targets for a particular measure.

Measuring Success

We measure success of our PCMH program and performance of individual PCMH practice groups on an ongoing basis. We have adopted continuous improvement methodologies, such as Six Sigma, Lean, and IHI's Plan Do Study Act (PDSA), to assist providers in PCMH transformation and sustainment. We are committed to decreasing health disparities and improving health literacy of our members at the population health level by analyzing utilization, health outcomes, and access for various populations and geographic regions, which we share with providers to provide context for better understanding the needs of their patients. We utilize NCQA HEDIS measure specifications to monitor quality and identify gaps in care at the practice level. This data is available to our providers on-demand through the clinical practice registry tool located on our provider portal. This data is also utilized to determine improvement initiatives specific to each market/region based on the needs of the specifically identified demographic.

We strategically choose quality measures to align with the needs of our members and Division priorities, including improved health outcomes for children, maternal health, preventive care, and reduction in cost of care. In the coming contract we will track PCMH performance on a variety of quality of care and pay-for-performance measures, including:

- Follow-Up Care for Children Prescribed ADHD Medication
- Closing the Referral Loop
- Controlling High Blood Pressure
- Diabetes Eye Exam
- Appropriate Treatment for Upper Respiratory Infection
- Pneumococcal Vaccination Status for Older Adults
- Cervical Cancer Screening
- Breast Cancer Screening
- Tobacco Use: Screening and Cessation Intervention
- Timeliness of Prenatal Care
- Postpartum Care
- Screening for Depression and Follow-Up Plan
- Documentation of Current Medications in the Medical Record
- Diabetes HbA1c Poor Control (>9%)
- Appropriate Testing for Pharyngitis
- Influenza Immunization
- Childhood Immunization Status: Combination 10
- Infant Mortality
- Colorectal Cancer Screening
- Body Mass Index Screening and Follow-Up Plan

We are committed to continuously building our knowledge of PCMH best practices, and in the next contract, we will establish a PCMH learning collaborative in Mississippi for providers to share best practices. We will scan healthcare and political landscapes that may impact the program and analyze data on a continuous basis to measure success and identify opportunities for improvement of the program. These opportunities will be reviewed, evaluated, and considered for incorporation into the PCMH program by our quality improvement committee and shared with the Division.

Investing in a PCMH program and working with providers who deliver primary care will result in improved coordination, better clinical outcomes, improved wellness and member experience, and lower costs. **Our ability to delivery operational excellence ensures we will be a worry-free partner to the Division and providers as we work together to transform care into a patient-centered medical home model for MSCAN and CHIP members.**

[END OF RESPONSE]

4.2.3.3 SOCIAL DETERMINANTS OF HEALTH

The Division requires Contractors to devote at least 0.5% of its Capitation Payment to efforts to improve Social Determinants of Health during the next contract cycle. The Offeror must produce a proposed SDOH Strategy that addresses the following questions:

Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing state resources. Addressing social determinants of health (SDOH) through targeted and effective investments is our fundamental strategy to improve health and outcomes of MSCAN and CHIP members. Research on the impact of SDOH is clear, with barriers to healthy food, safe housing and environment, economic opportunity, social engagement, and transportation contributing as much as 40% of factors that lead to overall health and well-being. Our integrated SDOH strategy will address social factors through local community partnerships fully embedded into our system of care. We achieve strong results by integrating SDOH and other non-clinical factors into every interaction with our members and proactively engaging members and communities to address barriers. As an Offeror, **we will devote more than 0.5% of our capitation payment to programs and community-based supports to improve SDOH for MSCAN and CHIP members.** We welcome and encourage the Division to raise this target for contractors at any point during the life of the contract.

We address SDOH at the systemic, population, and individual member levels. Our localized approach will leverage the resources of Mississippi healthcare providers, patient-centered medical homes (PCMHs), and strategic community and faith-based organization partnerships to promote member and community healthy living and health equity. We use a whole-person care approach that integrates the member's clinical, behavioral, and socioeconomic needs, and we bring care to the member in alternative and community-based settings to increase engagement. We will have dedicated SDOH staff based in Mississippi. A Director of Health Equity will be responsible for providing leadership and oversight of all health equity activities. The Director of SDOH and Community Partnerships will be responsible for providing leadership and oversight of all SDOH activities, strategic partnerships, and SDOH staff, including four Life Coaches, a Housing Strategy Lead, a Community Partner Strategy Lead, and an Employer Specialist. These positions are listed in Appendix E, Section 4.3.3.2, Job Descriptions. There are five key components to our strategy to address SDOH:

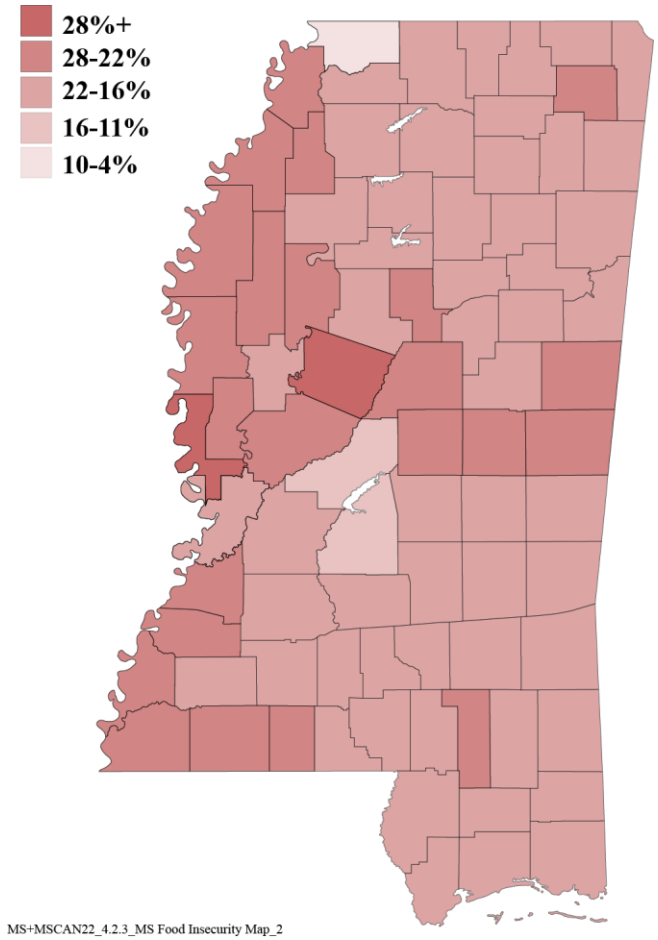
1. **Executive Commitment:** Our chief executive officer and executive leadership are committed to addressing SDOH and health equity and providing fully integrated, transparent service delivery, ensuring the incorporation of SDOH into everything we do to serve our members. Our executive leadership will commit to volunterring service hours with organizations engaged in supporting the social needs of their communities.
2. **Member Focus:** SDOH is integrated into every aspect of the member journey, including assessment of social needs and barriers, proactive coaching and integration into the care plan, and connection with community-based organizations (CBOs) to provide coordinated care and improve outcomes.
3. **Healthcare Provider Network Partnerships:** We will engage bidirectionally with our provider partners to ensure that care delivery organizations have the resources and data required to support the holistic needs of members, and that members experience fully integrated care across the continuum. We will collaborate actively with providers to share real-time data on member needs, and develop strategies to address SDOH including training, aligned incentives, and access to resources such as our referral management platform.
4. **Community Partnerships:** We will contract and partner with local CBOs and connect members with community-based resources to provide members with SDOH supports and comprehensive social care. We will implement innovative payment arrangements to invest much-needed resources into these organizations and ensure sustainabilty of services.
5. **Robust Analytic Tools:** Data drives all our planning and decisions about how to decrease the impact of SDOH, improve health equity and outcomes, and reduce the overall cost of care. We will use bidirectional data sharing with our network providers and PCMH, community-based health care (CBHC), and CBO partners to maximize the impact of our approach and sophisticated tools to measure outcomes. We will also provide data insights to the Division in agreed upon formats.

Our locally based Medical Director and our Director of SDOH and Community Partnerships will direct our local SDOH program, along with the support of our market enterprise leadership team. Staff members have access to the top decision makers in the organization to ensure SDOH program implementation issues and challenges are escalated in a timely and effective manner. Our population health management committee will include SDOH and health equity subcommittees. The SDOH committee will have cross-departmental representatives, including our Director of SDOH and Community Partnerships, Director of Care Management, Director of Utilization Management, and Director of Health Equity. The committee will also include healthcare provider, CBO, and member representatives.

1. Describe the Offeror's approach to and experience with collecting data on non-medical risk factors for targeted Medicaid populations, the types of domains and metrics collected, standardized screening tools that are utilized, and methods used to analyze and act on the data.

Proactive identification and analysis of SDOH factors enable our population health and community-based interventions to improve member outcomes. First and foremost, we talk with our members and their providers to listen to what their needs are. Secondly, we continually assess all available data sources to identify member and community needs, including 1) analysis of community and systemic barriers that contribute to members' opportunity; 2) proactive assessment of risk factors and likelihood to experience unmet social needs; and 3) engagement with members to understand and address their barriers to accessing care and optimize health and quality of life. These data collection and analysis tools will enable us to respond to the needs of each MSCAN and CHIP member and their families and implement effective strategies to mitigate the impact of SDOH in Mississippi communities.

Figure 4.2.3.3_A: Food Insecurity-Mississippi



Approach to Collecting Data

We will use the following approach to collect data on non-medical risk factors for targeted Medicaid populations:

- **Analysis of community and systemic barriers:** Building strategies to address SDOH requires understanding systemic and community-based resources and gaps. Statewide SDOH are well documented, including persistent poverty and lack of access to care. We will leverage community health needs assessments from our hospital providers as well as census tract, neighborhood stress scores, and other publicly available data sources to refine our understanding of specific challenges likely to impact member outcomes, significant disparities in access to community resources, and precise opportunities for improvement at the community level. For example, we assess food deserts (Figure 4.2.3.3_A) where members need to drive more than 30 minutes to access healthy foods in full-service grocery stores, and we identify regions where housing stock is oldest and most likely to contribute environmental risk factors to health. We validate information from the analysis of community and systemic barriers with providers and community stakeholders, and then we prioritize investments and programs for members. In addition, care managers can access the information through our fully integrated medical records and use it when engaging members and determining specific needs.

- **Predictive analytics to anticipate member risk factors:** Predictive analytics are a powerful tool to understand member risk factors to enable stratification of member needs and proactive mitigation efforts. Our predictive analytics software leverages two main domains of data: individual member factors and population level aggregate data. On the individual level, our population health platform incorporates important SDOH data sources such as demographic and community data; health risk screenings (HRS), and SDOH assessments such as the Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) tool; information available on the health information exchange (HIE); z-codes billed as a part of provider encounters; and medical record information from providers, to augment our clinical predictive analytics process and reflect social needs. We generate a risk profile or index value for each member for five domains: economic stability, education, community, environment, and healthcare. We combine these index values with other member level attributes to provide a more complete picture of member and population characteristics. Using this information, we identify members with the highest risks and match them with an appropriate level support within our care management and life skills programs.

We will collect predictive analytics, clinical, and social needs data through our enterprise data warehouse and display information through an analytics dashboard. The dashboard will also integrate predictive models including those that identify high risk pregnant members, members at highest risk of adverse COVID-19 outcomes, and members at risk of homelessness. We will create real-time bidirectional data feeds with health partners, PCMHs, CBHC, CBOs, and faith-based organizations alerting them to member needs.

Experience Collection Data

Our care manager and life coaches assess members for individual SDOH needs through the HRS and use the PRAPARE tool to support our collection of SDOH data. PRAPARE is a nationally recognized standardized SDOH assessment tool used to better understand and address basic social needs as well as other key domains such as migrant worker status, access to basic utilities, maternal security including potential domestic violence or intimate partner violence, transportation, social integration and support, and other factors. We document the information from the screening tools in our fully integrated medical record and incorporate it into specific member goals and predictive analytics analysis. Furthermore, when a member completes the PRAPARE screening at their provider's office or FQHC, we will receive information through the HIE and incorporate it into the integrated medical record. Care managers, life coaches, and our provider partners will use the HRS and assessment information to make connections between members and social supports using our closed loop CBO referral system.

Supporting Mississippi PCMHs

We will support Mississippi PCMHs through training and incentives to complete a PRAPARE social needs screening with our shared members. Our support will:

- Help providers become comfortable assessing SDOH needs
- Help us gain a comprehensive understanding of member needs
- Assure more members have access to vital support services.

Our robust three-part data collection and analysis strategy will enable us to proactively identify community and member needs and respond in a way that mitigates risks and improves member lives and the health of their communities. For example, in one of our Medicaid markets we recently had success leveraging our data analysis processes to improve maternal health outcomes. We examined census tract data to identify a region with the highest rate of infant mortality, driven by systemic barriers, a high rate of pre-term births, and low birth weight. Looking more closely at our member data, we identified a group of women at higher risk for pre-term delivery because of homelessness, so we developed a targeted intervention for this community in collaboration with the infant mortality task force, city and county leaders, metropolitan housing authority, faith-based community center, and health partners to impact housing resources. After four years of the program, we demonstrated that women in the program who received a housing subsidy from the collaboration partners, in addition to housing support and maternal health care had significantly better birth outcomes. [redacted]

[redacted]

2. In the Offeror's view, what are the greatest SDOH challenges facing the MSCAN and CHIP populations?

The scale of unmet SDOH in Mississippi communities is well documented in local community needs assessments[1] and national statistics related to poverty, economic opportunity, and food insecurity. We anticipate focusing on four key challenges that we believe impact members most acutely: **economic opportunity, food insecurity, housing insecurity, and access to supports in rural areas**, as well as the statewide infrastructure to support linkages to social services (Table 4.2.3.3_A). It is critical to appropriately identify important challenges and specific opportunities to make the largest impact on communities and member outcomes through targeted programs and investment in proven, community-based partners. To refine our SDOH strategy for Mississippi communities, we will examine statewide priorities through Governor Reeves' policy statements and meet with the Division, other state agencies, and local organizations and universities. We will also conduct focus groups and survey our provider partners to understand what they know about communities and how social factors and need impact populations and health outcomes. Finally, we will meet with MSCAN members to understand what would be most helpful and relevant to them. This input guides us in identifying the greatest challenges facing the MSCAN and CHIP populations and implementing targeted investments to achieve improvements.

Table 4.2.3.3_A: Greatest SDOH Challenges in Mississippi

Employment, Education and Economic Opportunity
Economic Opportunity: Although Mississippi's unemployment rate is near historical lows, The Bureau of Labor Statistics (BLS) data shows that Mississippi's labor force participation rate is hovering around 55%. Promoting available jobs and increasing the labor force is essential.
Educational Attainment: Mississippi's graduation rate is improving; however, many Mississippians did not attain a high school degree or a post-secondary degree. Education attainment is linked to poverty and poverty to health outcomes. Workforce training can lift people out of poverty.
Food Insecurity
Food Insecurity: According to Feeding America, food insecurity was projected to have risen from 18% in 2018 to 23% in 2020; similarly, child food insecurity rose from 23% in 2019 to a projected 31% in 2020.
Food Deserts: According to Feeding America, Mississippi counties are predicted to have among the greatest rates of food insecurities post pandemic. 70% of SNAP eligible households across the state must travel more than 30 miles to reach a supermarket.
Housing Insecurity
Unaffordable Housing: 31% of all Mississippi renters are low income and 63% of this population experiences renter burden (paying more than 50% of income on rent). A renter in Jackson, Mississippi would need to make $10 more than the minimum wage to afford an apartment in that city.
Unhealthy Housing: Poor housing quality has a direct impact on health outcomes. According to America's Health Rankings, Mississippi ranks 48th in water quality with a high number of communities having serious drinking water violations.
Rural Disparities and Access
Insufficient Access to Care/Care Deserts: Over 54% of Mississippi's population is rural. Over half of Mississippi doctors practice in four urban areas; most of Mississippi is medically underserved.
Insufficient Access to Transportation: According to rural health access report, 24% of households in Mississippi have access to one car or less**.**
Limited Broadband Access: Mississippi State Extension Office found in May 2020 that 27% of Mississippi residents in rural counties lack broadband access

[1] UMMC Community Health Needs Assessments, 2018 and 2019: https://www.umc.edu/UMMC/UMMC-Community-Health-Needs-Assessment.html

In addition to documented social needs, Mississippi lacks a robust, statewide system for coordinating social service providers or tracking referrals. In our experience, development of shared systems between providers, payers, individuals, and local community-based organizations contributes meaningfully to promoting access to appropriate supports across the continuum.

3. What approaches will the Offeror take to address these challenges?

Making progress on core challenges to improve member outcomes and community resilience will require concerted action and strategic investments in partnerships with local trusted organizations. Our approach to addressing member SDOH includes community reinvestment exceeding 0.5% of our capitation payment. Our approach relies on solid partnerships with local CBOs including contractual incentives to encourage collaboration and coordination of efforts in addressing SDOH challenges. Table 4.2.3.3_B details anticipated partnerships. We will seek Division approval of our SDOH plan and projects prior to implementation.

Table 4.2.3.3_B: Summary of SDOH Investments by Core Challenge

Challenge	Strategy, Programs & Partnerships	Expected Outcomes
Employment	▪ Proven workforce development and employment program for all MSCAN and CHIP members over the age of 16 interested in pursuing education and employment goals ▪ Potential Partners: Goodwill Industries, community colleges/universities	▪ Increase in graduation rates and completed educational programs ▪ Increase in number of members and parents/caregivers employed ▪ Decrease emergency department utilization
Food Insecurity	▪ Support to address food insecurity through collaboration with food pantries and home delivered meals ▪ Potential Partners: Mississippi Food Network, Urban League, grocery stores	▪ Decrease 30-day readmission ▪ Increase member engagement ▪ Decrease gaps in care
Housing	▪ Support to locate and connect to housing resources and increase the number of units of affordable housing in Mississippi ▪ Potential Partners: Mississippi Home Corp., Housing Authorities, Homeless Shelters	▪ Decrease in homelessness among member population ▪ Decrease emergency department visits for asthma attributed to environmental triggers ▪ Increase in affordable housing units
Rural Access	▪ Ensure that our members in rural Mississippi have equal access to health providers, PCMHs, CBHC and social services through strategic partnerships and value-added benefits ▪ [redacted]	▪ Increase completion of HRS ▪ Increase member engagement in care management, behavioral health, and SDOH programming ▪ Decrease gaps in care

[redacted]

Employment, Education and Economic Opportunity. Our investment strategy to improve economic opportunity for members throughout Mississippi communities will feature strong partnerships with established educational and community-based organizations supported by care navigation supports to help members be successful. Our employment support program is recognized for assisting members to increase employment, increase wages, and reduce dependence on governmental services. Specific programs will include:

- **Jobs for America's Graduates:** We will partner with the Mississippi branch of this national nonprofit organization working in 22 school districts to enhance the opportunity and achievement of middle- and

high-school students. We will collaborate with this partner to expand their reach into the school districts that where our teen members live.

- **Goodwill Industries of Mississippi** (GIM): We will partner with GIM to provide training courses, case management support, and employment support services to our members. In addition to the support directly to members, GIM will offer workforce development training classes to our other community partners to increase their footprint and expand their current services into the rural parts of Mississippi. GIM is one of 10 Goodwill organizations in the country selected by Accenture in 2020 that has access to virtual reality (VR) employment search and exploration. This state-of the-art VR technology allows students to explore over 200 different career fields and gain insights into career paths.
- **Hinds Community College, Jackson State University, and Mississippi State University** We will partner with schools to support members who need high school equivalency courses or are interested in certification or degree programs. We will support these partners with scholarships for students in internship and Allied Health programs. In our other Medicaid markets, we have assisted over 1,700 members with increasing their education and employment levels through similar programs.

For many members, access to employment support and education opportunities will not be sufficient to improve outcomes, so we also provide members with care navigation and support to develop life skills. MSCAN and CHIP members, or the parents/guardians of members, will be able to voluntarily enroll in our life skills coaching program to work with a life coach for up to two years. The life coach will provide individual coaching sessions telephonically or in person, help with resume building, support to achieve their GED and individualized assistance with job searching, and interviewing techniques. All members will be encouraged to enroll in the Mississippi Works and Mississippi Department of Employment Security portal. [redacted] Once a member enrolls in an employment support program, begins working with a life coach and a relationship is established, the life coach is able to educate and guide the member into more proactive utilization and healthy living.

We understand that alleviating the core challenge of diminished economic opportunity in many Mississippi communities is an important long-term priority and we are committed to investing for future success. We have begun working to invest in **Innovate Mississippi**, a local nonprofit organization whose mission is to strengthen and grow the culture and innovation in Mississippi. Our support will be targeted to support local startup entrepreneurs with diverse founders who seek to improve health outcomes, promote health equity, and to generate positive social impact. [redacted]

Food Insecurity Support. Food insecurity remains a pressing challenge for many low-income families in Mississippi; [redacted] Addressing food insecurity requires a multi-pronged strategy including promoting access to immediate food supports, increasing members' longer-term food access, and providing members with nutrition education to improve health outcomes. We will screen all members for food insecurity as part of our HRS and incent our health partners and PMCHs to screen patients. We will assist members with enrolling in food and nutrition programs, as we have seen a reduced readmission of members with healthier food options. We will also align our value-added benefits, such as transportation to grocery stores, food banks, and farmers markets, and we will offer member incentives that help families fill food insecurity gaps.

We will partner with diverse local organizations to support our MSCAN and CHIP members and their families to reduce food insecurity, especially for those members with recent inpatient admissions:

- **MS Food Network (MFN):** As a statewide organization, MFN provided more than 1.8 million individuals with food in 2021 through their network of 430 local food pantries throughout Mississippi. Through our investment in MFN, we will expand school-based food pantries and enhance the weekend backpack program for students in

low-income school districts. We will also integrate our member supports with MFN locations enabling us to leverage the community locations to help us outreach to members, provide health equity campaigns, screen members for SDOH needs, and encourage members to enroll in member benefit programs.

- **College-based food pantry supports:** We will invest in the launch of new college-based food pantries. Mississippi has a disproportionate number of college students who experience food insecurity, and we will target these members specifically to support accessible options for food security.
- **Nutrition support for healthy eating:** To support members with longer-term skills development to support food security and healthy eating, we will partner with the Mississippi Urban League, a CBO dedicated to achieving health equity and building healthy eating habits among under-served populations.
- **Home-based meal delivery to promote recovery:** Members recently discharged from the hospital often have acute needs for nutritional supports to promote recovery in resource-constrained environments. Members have told us that they had difficulty focusing on healing and recovery while also having to grocery shop and prepare meals. We will provide members the opportunity to access up to 14 days of home delivered meals after being discharged from the hospital. [redacted] Once a member begins working with a life coach and a relationship is established, the life coach is able to guide the member into more proactive utilization by educating and focusing on healthy living with the member.
- **Extending SNAP benefits:** We will partner with grocery stores, farmer's markets, and other United States Department of Agriculture (USDA) sponsored programs like **"Double Up Food Bucks."** These programs will allow our members to stretch their SNAP benefits for healthy produce purchases. Our care management and life skills coaches will play an active navigation role to assure members who receive SNAP benefits are able to access grocery stores through our non-medical transportation value-added benefit.

Housing Insecurity Support. We have a multi-pronged housing strategy that we will implement through formal partnerships to address housing instability among members and expand affordable housing options.

- **Member supports for locating appropriate housing:** We will establish a partnership with the **Mississippi Home Corporation** to launch a statewide housing locator platform. This platform provides professional housing location and listing services for members who are experiencing housing instability or homelessness. The **housing locator platform** will allow our community-based team, health partners, PCMHs, and CBOs to assist members who are at risk for housing insecurity to find new housing and offer waiting list opening support. The service is a powerful platform for identifying critically needed, affordable, accessible, and special needs housing. Our housing locator is integrated into our single member view care management system to pinpoint housing units for members based upon their unique circumstances. **We will work with the Division to expand this capability to all CCOs as an innovative collaboration as a part of our community reinvestment commitment plan.** [redacted]

In addition to these community-based SDOH programs, our plan-based care management and SDOH staff will collaborate with members to achieve housing stability. We will hire housing experts in Mississippi who bring experience navigating the complexities of the housing system, housing programs, and housing finance to offer our members the most accurate information available. [redacted]

Rural Access to Care Support. In Mississippi, 50% of the population lives in rural areas and more than 80% of all doctors practice in just four urban areas. This disparity in access to care and services has significant impact on

health outcomes, as well as economic and social opportunity. The burden of unmet social needs is high among these communities. Working closely with partner organizations, we will invest in programs that close the service gaps and enable participation in CCO-sponsored health and wellness programs among members in rural areas, including, for example:

- [redacted]
- **CSpire for Digital Technology Support:** We will collaborate with CSpire, a well-respected Mississippi technology company and an early telehealth partner in Mississippi, to reduce the deficit of access to broadband technology and digital health resources for our members in rural areas. CSpire will provide Smart Wi-Fi Network and Chromebooks to residents in 900 Section-8 housing units in rural areas. We will also provide member education on how to use the technology, set up email accounts, access telehealth platforms and access member portal and apps. The educational component is critically important to increase access and a way for us to keep members connected to their care plans, life coaches, and care managers, telehealth services and use our self-service tools and member incentive programs.
- Another way we ensure health equity for our rural members is to provide enhanced **non-emergency transportation (NET) value-added benefits**, which allow members to use our transportation vendors for increased access to grocery stores and county offices for enrollment and eligibility appointment. We will also provide transportation to high school equivalency programming, job training, and even assist in the first month of employment while the life coaches work with members on a long-term transportation plan. Other transportation support will include assisting members in getting their driver's license, connecting with legal support for members with suspended licenses, and helping members through our member assistance fund to make minor repairs to existing transportation.
- [redacted]

4. How will the Offeror address Health Equity through its SDOH programs?

The key to addressing health equity is to ensure our SDOH interventions are **tailored and responsive** to the needs of our membership, including refining strategies to lift barriers experienced by diverse subpopulations and communities. We recognize that different populations in Mississippi have economic, geographic, and cultural distinctions that shape how interventions are received and define the impact. In addition, individual members and communities have different experiences and barriers that influence behavior and access and are impacted differently by systematic determinants of health. For example, as noted previously, members in rural areas often experience barriers to care and support services because of their geographic separation and limited broadband access. Our director of health equity will collaborate with our director of SDOH and community partnerships to ensure that program designs reflect the diversity of our membership and health equity is incorporated into all SDOH strategies.

When we stratify data on SDOH needs by race, disability, age, educational attainment, and geography in the population health model, we identify a subset of members that are at even greater risk for poor health outcomes and need specialized and enhanced services to ensure they have social needs met and equitable access to care. Based on our member stratification, we make strategic decisions about our member programs, location of services, our community partners, our value-added benefits, and our member incentive programs. This data helps us identify prioritized investments and partnerships, as well as potential systemic determinants of health and barriers likely to be encountered by members. We fully adhere to all federal regulations, including, 42 CFR 438.206, 42 CFR 438.204, and the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS). We address health equity through our SDOH programs by:

- Maintaining a comprehensive, multi-faceted health equity plan and ensuring all services are delivered through a health equity lens; this includes health equity representatives, cross departmental leadership, care management, community-based staff, and life coaches involved in SDOH initiatives that reduce disparities
- Obtaining input from Medicaid insured members and families, CBOs, and healthcare providers regarding SDOH challenges and opportunities to reduce adverse health outcomes among our members.
- Developing targeted SDOH interventions, measures, and key community-based partners to assist us in addressing the disparity through quality initiatives and health equity campaigns.
- Extending our SDOH services and engagement efforts to include providing services in **alternative and community-based settings**, including shelters and food banks.
- Ensuring cultural competency principles are incorporated into SDOH programs to promote engagement.
- Collecting and analyzing data to track progress in disparity reduction efforts related to SDOH.
- Continuing to get feedback from stakeholders, including members, providers, and community leaders to refine and monitor effectiveness of programs.

5. How will the Offeror integrate SDOH evaluation into other programs (i.e., Care Management, Quality Management)?

Continuous monitoring of our SDOH program and outcomes at the member and community levels is an important component of our overall strategy, and the best way to assure accountability and operational excellence across our programs. Our medical director and director of SDOH and community partnerships share oversight of the SDOH programs, and report quarterly on SDOH and health equity data and outcomes to our Quality Committee. The committee reviews data from our care management record, provider and member feedback, SDOH program reporting, and cost and quality outcome data to determine effectiveness of our programs and opportunities for improvement.

In addition to the oversight of the Quality Committee, we incorporate analysis of SDOH outcomes into ongoing evaluations of structures across our system of care to assure integration and optimal outcomes:

Measuring Program Impacts on Total Cost of Care: Since 2019, we have worked with an external evaluator to determine the effectiveness of our SDOH programs. The evaluation includes assessment of process metrics, such as the number of members enrolled, in addition to positive outcomes and behavior change among members as shown in utilization data and cost of care. We track clinical measures for all members engaged in SDOH life skills coaching and SDOH referral programs on our integrated care management platform, including engagement in preventive care and closing gaps, performance on HEDIS quality measures, medication adherence, utilization of the emergency department and 30-day readmissions. Trends in utilization for members receiving SDOH services are compared to members receiving care management or other supports to fully understand the impact of the programs. As shown in Table 4.2.3.3_C, in one Medicaid market, members engaged in SDOH coaching supports had significant changes in utilization resulting in cost savings and improved outcomes.

[redacted]

Provider and Member Feedback: Receiving feedback from our providers and members is a critical means of evaluating the value of SDOH interventions and the sustainability of those investments. We collect qualitative information directly from our providers and members through surveys and focus groups and evolve our program offerings to best fit member needs. For example, member feedback about barriers to engagement led us to add a virtual coaching platform and texting capability so members could more easily access their life coach, facilitate better member engagement, and strengthen member relationships.

Incentives for Network Providers and Social Service Partners: For our strategic CBO partners and those who are a part of our community reinvestment programs, we will establish specific metrics with support of the Division. Our incentive structure ensures our community partners help us drive better health outcomes for our members and are appropriately rewarded for progress on shared goals. Our current CBO value-based payment arrangements include metrics on member engagement, care management engagement, and overall changes in utilization and cost of care. We will also assess changes in the gaps in care among members engaged with CBO partners to capture any broader impacts on engagement. We will work with the Division and our CBO strategic partners to establish realistic benchmarks and measures that will drive overall improvements.

[redacted]

Taken together, this measurement strategy will give the Division and us insights into the effectiveness of our programs and strategies to impact social needs among members and communities.

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

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

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

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

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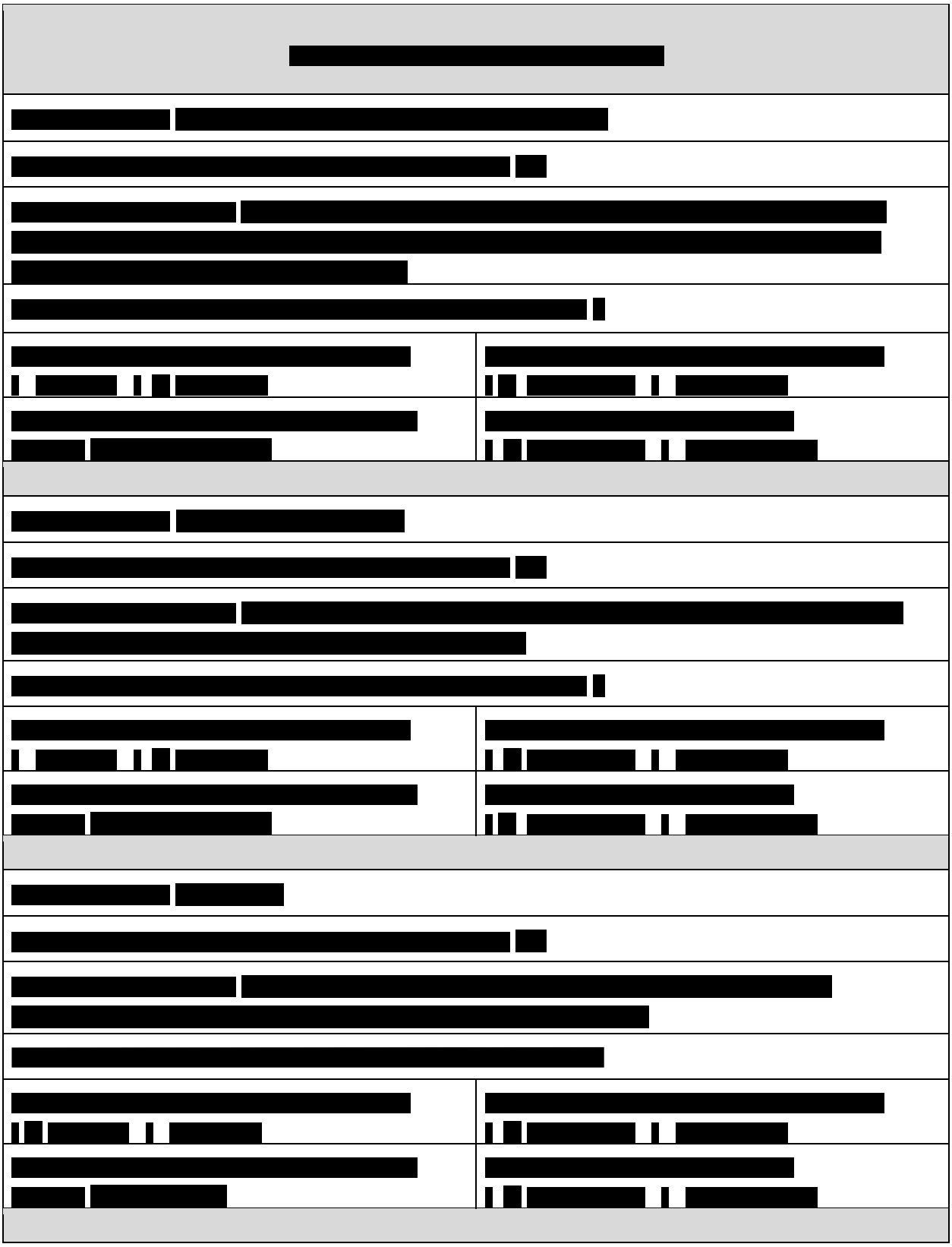

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[END OF RESPONSE]

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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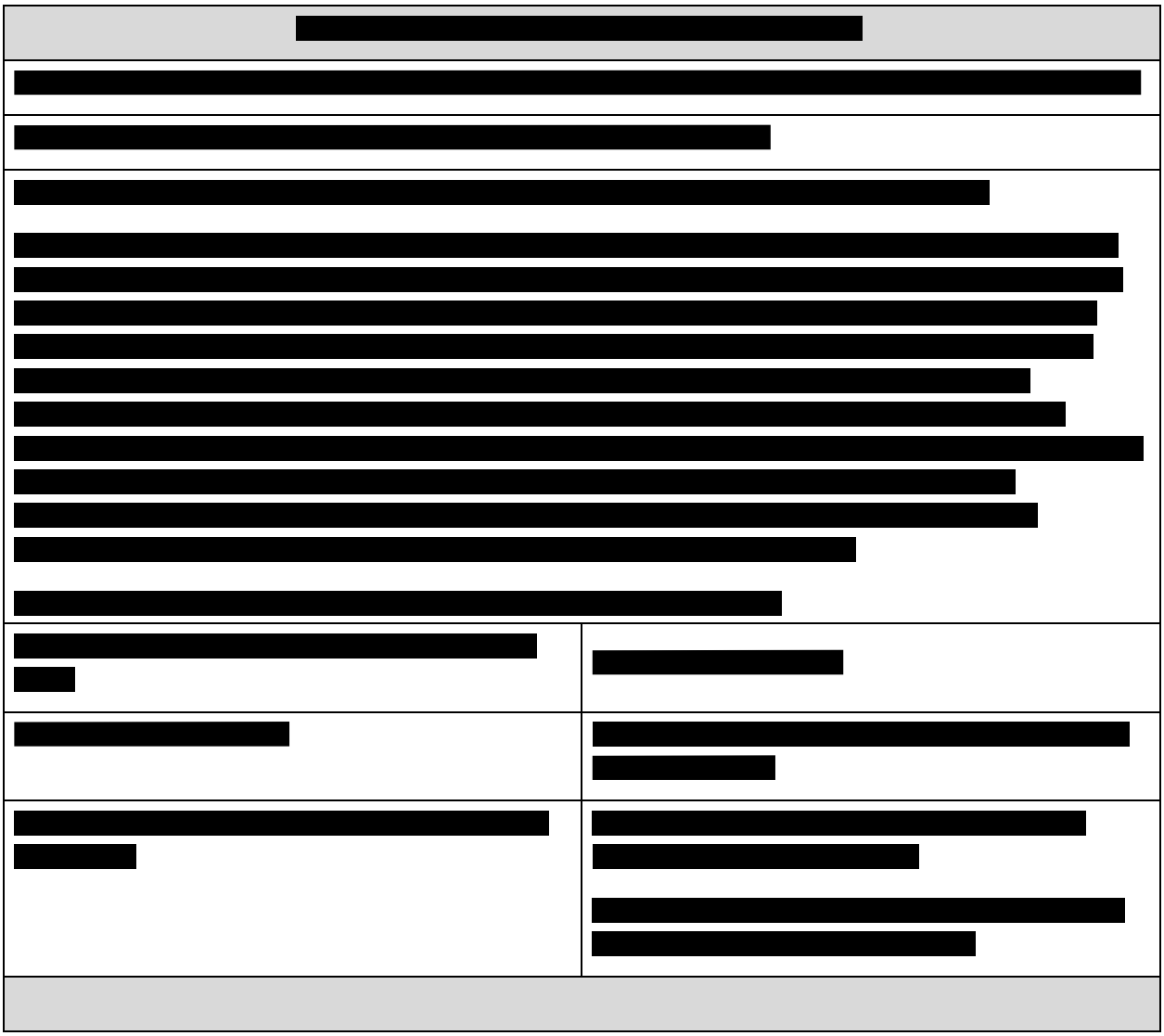

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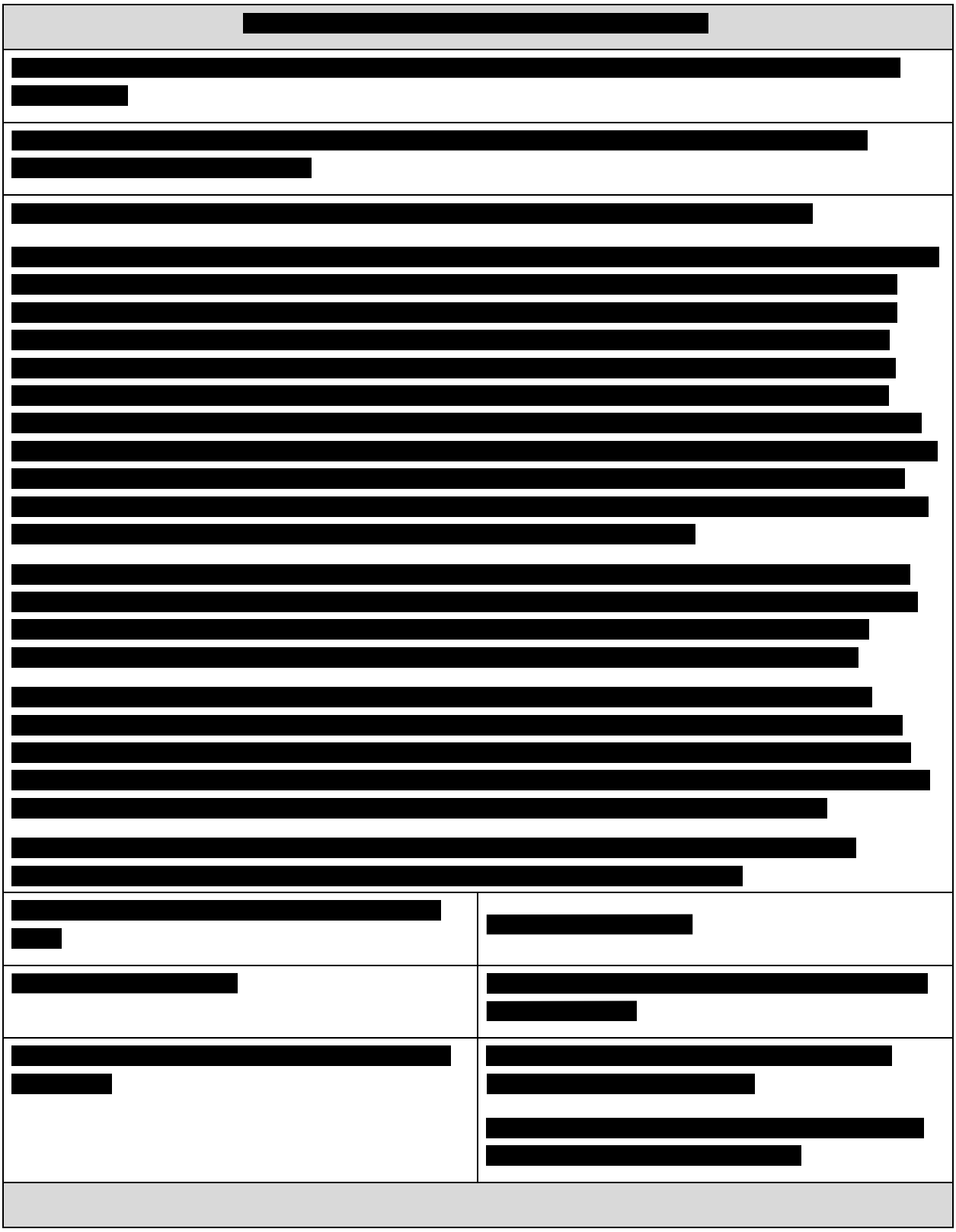

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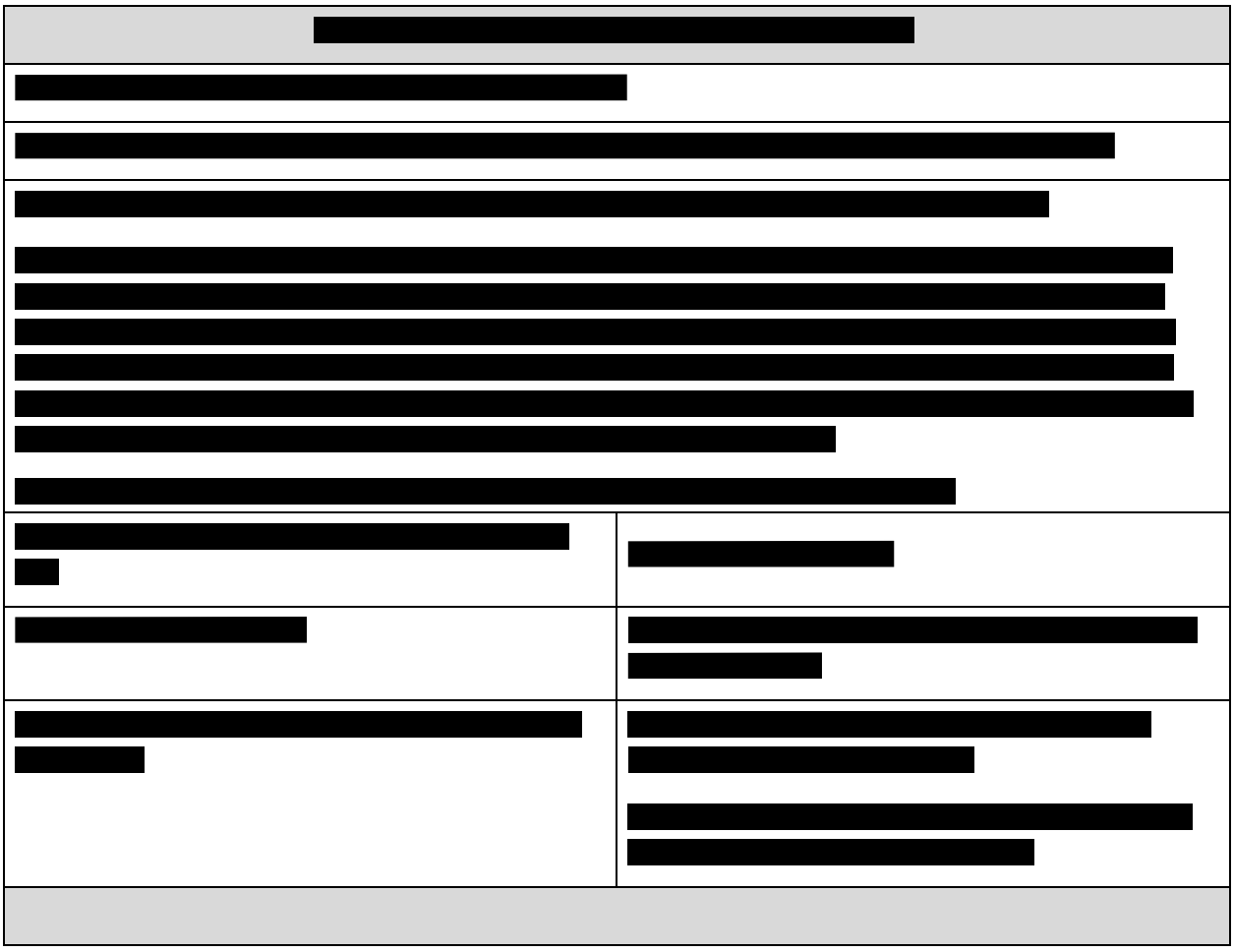

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[END OF RESPONSE]

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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[END OF RESPONSE]

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.

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Health Literacy Campaign: Summary Chart
Campaign Title: Building Blocks for Healthy Kids
Target Beneficiary Population(s): Child and adolescent members and their caregivers, members who are pregnant and their support networks
Overview of Campaign Strategy and Goals: Multi-modal campaign to increase use of EPSDT services. Goal: Increase understanding of the importance of preventive screenings which help to identify health issues early to address and mitigate negative effects on the overall health and wellness of members as they age. ▪ Objective: Increase parent/caregiver knowledge the importance of EPSDT services ▪ Objective: Increase the number of members who receive EPSDT services from childhood through adolescence. ▪ Objective: Identify and address barriers to receiving EPSDT services Strategy: Convene peer focus group to identify barriers and develop and test messaging Strategy: Develop innovative traditional and social media campaigns emphasizing EPSDT is key to ensuring children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services Strategy: Complete individual outreach with members Strategy: Provide early childhood bags to mothers of young children containing learning toys which improve early childhood language and coordination skills, and educate caregivers on the importance of scheduled care Strategy: Incentivize members/families to utilize EPSDT services through cumulative family-based incentives Strategy: Develop EPSDT messaging kits for parents and screening tools for early childhood educators with the help of childhood development departments at colleges across Mississippi
Reason for choosing this Campaign: CMS data demonstrates only 58% of eligible children in Mississippi received EPSDT screening services in 2020; the number of children receiving EPSDT services in Mississippi declines dramatically after two years of age: 43% of Medicaid members aged 20 and under received only one recommended well-child screenings in this timeframe.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): ▪ Email reminders/interactive text messages using (intelligent apps present timely member-relevant information) for information and reminders of well-baby and well-child visits ▪ Public service announcement with athletes from a Mississippi university ▪ Regularly scheduled alerts and notices on the member portal and member mobile app ▪ Short video on importance of regular well-child visits and getting immunizations by CCO medical director ▪ Targeted messages reinforced by organic social media contact (e.g., vaccinations, well child) ▪ EPSDT member web pages and online microsites with tailored content for parents ▪ Ongoing multi-modal communications/telephone contact to promote preventive health education/facilitate appointments and follow-up care; inform members of incentives for well-baby and well-child visits ▪ Distribution of EPSDT messaging kits for parents/caregivers through early childcare centers/programs and schools; CBOs and faith-based organizations; mobile clinics offering EPSDT education and services ▪ Welcome materials/personal contact highlighting EPSDT in English and Spanish at member enrollment ▪ Mail quarterly member newsletters/other materials promoting EPSDT and addressing barriers to care
Tools for measuring engagement: ▪ Volume and contact rates for individual contact where member was actively engaged ▪ Total number of letters, texts, and emails sent to members; use of member portal to access materials/programs ▪ Number of early childhood bags distributed to members ▪ Impressions/interactions for materials on website, mobile apps, social media
Tools for measuring impact: ▪ Closure of HEDIS and EPSDT gaps in care ▪ Annual EPSDT participation report
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: Baby – It's all about YOU!

Target Beneficiary Population(s): Members who are pregnant/their partners/support networks/general public

Overview of Campaign Strategy and Goals: Multi-modal approach to increase health literacy about pregnancy enabling members and their support networks to make healthy decisions to improve maternal/infant health outcomes.
Goal: Improve birth outcomes and decrease infant mortality

- Objective: Increase knowledge of self-care during/after pregnancy
- Objective: Increase utilization of prenatal and postpartum care
- Objective: Learn to identify signs of danger during pregnancy, delivery, and postpartum
- Objective: Build skills to obtain, understand, and use family planning tools
- Objective: Increase rates of breastfeeding
- Objective: Improve caregiver knowledge about infant development, health and well-being, safety, home preparation

Strategy: Convene a member prenatal focus group to develop and test messaging
Strategy: Complete individual contact (e.g., mobile apps, social media, texts, emails, telephone calls, in-person visits)
Strategy: Conduct peer group activities on perinatal/infant care, breastfeeding, safe sleep (face-to-face/virtual)
Strategy: Develop traditional/social media campaigns to increase awareness of good perinatal and infant care practices
Strategy: Incentivize members to engage in prenatal/postpartum and well-child visits; offer welcome baby baskets
Strategy: Partner with community-based organizations (CBOs) to host group activities
Strategy: Offer educational materials about breastfeeding, perinatal/infant care, safe sleep, family planning, C-sections, vaginal tears (online, mailed, OBGYN offices)

Reason for choosing this Campaign: Mississippi mothers experience the highest rates of premature births, low birth weight babies, and the lowest breastfeeding rates in the nation: greater odds of preterm birth, small size for gestational age, low Apgar scores at delivery, and low birth weight; greater odds of C-section and major vaginal tears

Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.):

- In-person visits (e.g., hand-delivered welcome baby baskets), mail, email, text, and web portal for all program offerings, including schedules for group activities
- Text messages (using intelligent apps to present information relevant to the member at that moment)
- Interactive group prenatal sessions weekly with a consistent group of members (e.g., childbirth, BH, nutrition, parenting, breastfeeding, and infant CPR) for peer-to-peer learning and accountability
- Prenatal, postpartum, infant health, BH educational materials/appointment reminders mailed, emailed to members; available on our website/mobile apps (e.g., audio and SMS); print materials distributed to OBGYN offices
- Billboards/public service announcements with general healthy perinatal/infant awareness messaging
- Social media (e.g., TikTok, YouTube, Facebook)
- Reinforced messaging through CBO partners involved with members

Tools for measuring engagement:

- Number of members participating in group course for at least one session
- Number of members sent education materials via mail; number of members sent materials electronically
- Number of members who engage with care management services
- Impressions/interactions for materials on website, mobile apps, social media

Tools for measuring impact:

- Survey of all participations which evaluates satisfaction with program/materials or reasons for not participating
- Breastfeeding adoption
- Analyze health outcomes for actively participating members/infants (e.g., perinatal visits, birth weights, full term births, C-sections, vaginal tears)

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: Be Your Healthiest YOU!
Target Beneficiary Population(s): Child and adolescent members diagnosed as obese with a body mass index (BMI) at or above the 95th percentile and their families
Overview of Campaign Strategy and Goals: Weight management campaign focused on the family, encouraging parent/caregiver involvement for all family members to achieve and maintain healthy weight and live healthier lives. Goal: Instill healthy lifelong habits in weight management, nutrition, physical activity, and emotions/behaviors for obese children and adolescents and their families and reduce obesity-related chronic diseases. ▪ Objective: Increase understanding of nutrition and exercise on weight for children and families ▪ Objective: Learn to mitigate the emotional aspects and family dynamics affecting obesity ▪ Objective: Learn ways to shop, cook, and eat healthy foods on a budget Strategy: Offer age-appropriate, readable, actionable materials emailed/mailed digital and print materials Strategy: Offer telephonic one-on-one health coaching with children and parents Strategy: Offer interactive age-appropriate online activities Strategy: Using a registered dietician (RD), teach families meal planning, grocery selection, and how to create healthy meals form foods on hand in their pantry and how to make healthy menu selections when eating out Strategy: Incentivize members for improved A1c control, reduced BMI targets and use of blood pressure monitors (how/when to use them); fund weight reduction program fees and exercise fees Strategy: Increase access to safe, community-based locations which promote exercise and physical activity; partner with early childhood centers, schools, and community centers to reinforce messaging
Reason for choosing this Campaign: Mississippi ranked second highest in the nation with 23.3% of children ages 10-17 diagnosed with obesity; Children/youth who are obese are at higher risk for high blood pressure, high cholesterol, Type 2 diabetes, coronary artery disease, osteoarthritis, sleep apnea, depressions, and anxiety; Demonstrated plan success with campaign in other markets: from Jan 2020-Dec 2021, 2,184 members expressed interest and 982 completed a weight management assessment, for a 44.96% rate of continued engagement.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): ▪ Direct contact via mail, email, text, and telephone to identified members and their families ▪ Easy to understand evidence-based information materials and graphically appealing, mailed to members/families, includes modules on weight management/nutrition/physical activity/emotions/behaviors ▪ Minimum of six health coaching sessions over 12 months after enrollment; health coaches document contact, coaching sessions, and family-completed assessments in our clinical platform ▪ Unlimited online activities include interactive learning focused on healthy nutrition and physical activity and printable family-oriented education materials ▪ Personalized registered dietician family consults for healthy cooking and eating out ▪ Reinforced messaging through education/programs at early childhood centers, schools, and community centers
Tools for measuring engagement: ▪ Quarterly reports of member engagement: assessment of nutrition, physical habits, emotions/behaviors; pre and post height and weight; statistics for ongoing participation in coaching and follow-up calls ▪ Pre- and post-testing of behavioral changes ▪ Number of dietician consults ▪ Sign-in sheets at early childhood centers, schools, and community center partners
Tools for measuring impact: ▪ Analyze obesity-related claims analysis of all participants (e.g., diabetes, sleep apnea, dental) to measure long-term impact ▪ Self-reported pre- and post- height and weight at coaching sessions and 6- and 12-month follow-up calls ▪ Routine review of program components to assess program success, identify barriers, and opportunities ▪ Participant pre-and post-knowledge testing
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: There is HOPE and There is HELP
Target Beneficiary Population(s): Adolescent members/families/network supports, general public
Overview of Campaign Strategy and Goals: Multi-modal campaign to support adolescents in mental health self-care, accessing resources when needed, and preventing escalation and suicide. Goal: Increase youth and family awareness of mental health hygiene to prevent escalation and suicide ▪ Objective: Increase youth and family knowledge of mental health behaviors ▪ Objective: Increase youth and family awareness of mental health resources and self-care ▪ Objective: Learn to identify signs of risk and escalation and access resources which mitigate risk Strategy: Form a council of youth to develop and test teen-centric messaging and communication modalities Strategy: Develop traditional and social media campaigns to reinforce messaging with celebrity spokesperson/champion Strategy: Complete 1:1 contact (e.g., mobile apps, social media, texts, emails, telephone calls, in-person visits) Strategy: Offer personal interventions (e.g., real-time access to BH/SUD line, interactive mobile apps, crisis texting); connecting to NAMI peer-to-peer and family-to-family support groups Strategy: Offer online Suicide Prevention Toolkit with printable materials (e.g., safety plan, warning signs wallet card) Strategy: Offer educational materials on mental health hygiene, SUD, BH resources, self-care Strategy: Innovative partnerships with first responders, schools/educators, community centers, churches/youth pastors, sports teams/coaches on Mental Health First Aid, trauma-informed care, and adverse childhood experiences (ACEs) training/education to reinforce messaging
Reason for choosing this Campaign: We are committed to next generation member engagement and education. Our data across our markets indicates 15% of the children and adolescents we serve have an identified BH diagnosis and 3% have an identified SUD; suicide is the 3rd leading cause of death for Mississippi youth and young adults ages 15-34.
Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.): ▪ Teen-centric mobile application with bidirectional text-based coaching and connection to services, digital reminders for medication adherence (e.g., antidepressants, antipsychotics) ▪ Social media (e.g., TikTok, YouTube, Facebook) ▪ Reinforced messaging through mental health first aid, trauma-informed care, ACES training and educational materials for first responders, schools, CBOs, churches, sports teams ▪ First responders deploy trauma-informed training to de-escalate and refer to appropriate resources ▪ Mail cards of care and concern to members who experience suicidal ideation ▪ Personal outreach by care management for at-risk adolescents ▪ On-demand education and resource materials on website ▪ Mailed member newsletters about signs, symptoms, and resources of depression and anxiety ▪ 24-hr nurse advice line, BH crisis line, and SUD line promote education and program resources and referrals ▪ Reinforced messaging through partnerships with school-based health service clinics/co-location of BH services ▪ Printed materials promoted to members identified with a BH condition or at-risk after an event by care managers
Tools for measuring engagement: ▪ Member requests for materials filled ▪ Tracking of BH and suicide alert calls to 24-hour nurse advice line, BH crisis line, SUD line ▪ Impressions/interactions for materials on website, mobile apps, social media
Tools for measuring impact: ▪ Antidepressant medication adherence ▪ Youth engaged in BH services ▪ Member pre- and post-program surveys
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	
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[END OF RESPONSE]

4.2.3.7 TELEHEALTH

Telehealth has grown immensely during the COVID-19 pandemic. The Division is seeking innovative proposals from Offerors about their ability to support and ensure the most efficient use of telehealth for Members and Providers, especially considering the rural nature of much of the MississippiCAN and CHIP populations. The Offeror should be specific about methods of technical assistance it plans to provide to Members and Providers. For more information, see Section 4, Covered Services and Benefits, of Appendix A, Draft Contract.

Building on our success, we will support the most efficient use of telehealth within an integrated system of care for our members and providers to improve health outcomes and increase access to services, especially in rural and underserved areas of Mississippi. In alignment with the **Governor's goal to make telemedicine as commonplace as in-person visits, our telehealth program brings tangible value to the Division and MSCAN and CHIP members** by removing barriers to access to care, empowering members to seek care at times and places of their choice, maintaining high quality care, decreasing the rates of appointment no shows, and reducing avoidable emergency department (ED) visits and hospital readmissions. We are committed to making telehealth solutions available to providers throughout the State for use with all their patients.

Our ability to deliver operational excellence shows our respect for members and providers and demonstrates we will be a worry-free partner of the Division in expanding efficient telehealth services throughout the State. In two of our 2021 NCQA accreditation surveys, the surveyors recognized our exceptional success in telehealth, calling out "application of telehealth during COVID for members with behavioral health needs" and "inclusion of telehealth services to obtain care after business hours." As our nation recovers from the COVID public health emergency, we are committed to sharing our expertise and vision for how telehealth is best utilized over the long term, refining the use of telehealth when it is the best solution for care, and recognizing when member needs are best served through in person services.

Our Telehealth Proposal

We are committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model. Our experience providing telehealth services (more than four million claims in the past 12 months in multiple markets) has informed development of comprehensive telehealth policies, procedures, and processes for our MSCAN and CHIP members incorporating the following strategies:

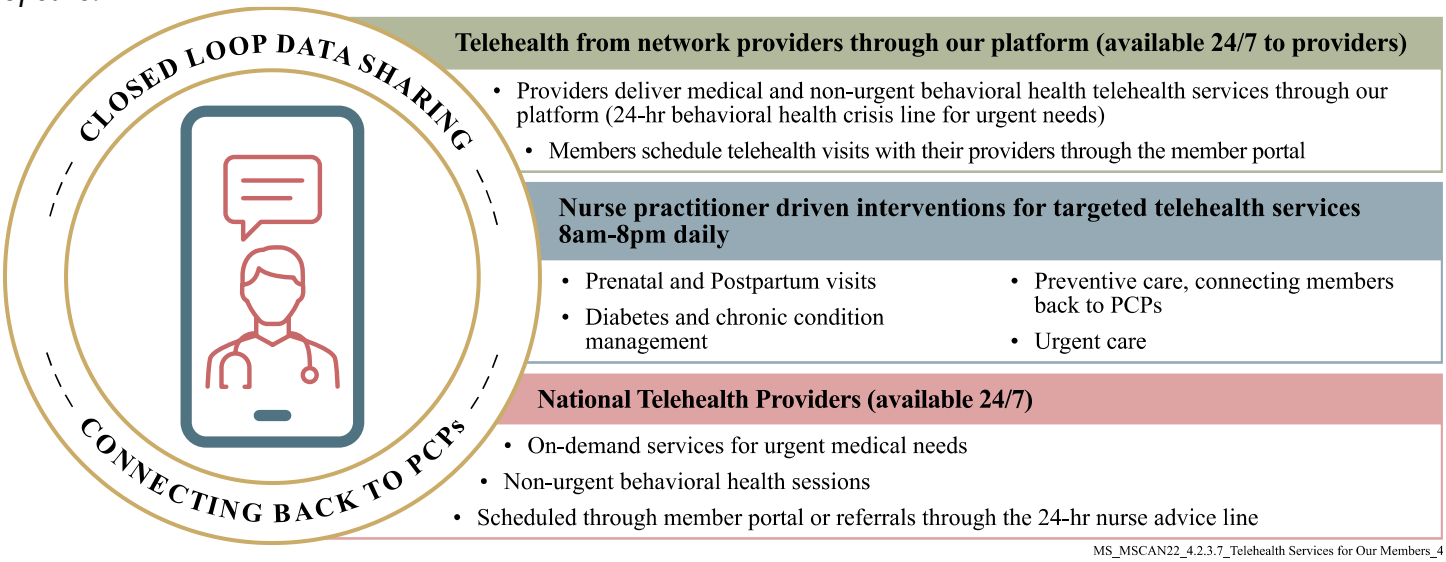
- Supporting members and providers with technical and access assistance to extend primary care beyond the walls of offices and clinics and increase the reach of behavioral health (BH) and specialty care providers to individuals and communities that may otherwise go unserved, especially in rural communities
- Providing access to a free telehealth platform and technical assistance to operationalize telehealth services to network primary care and specialty care providers lacking technical telehealth capacity (with priority for rural providers) to schedule and conduct telehealth visits with all their patients
- Enhancing provider capacity through virtual learning collaboratives, tele-mentoring programs, and our psychiatric consultation service for primary care providers (to serve members with low to moderate BH needs) mitigates the severe shortage of Mississippi psychiatrists
- Our internal nurse practitioners (NPs) and contracted telehealth vendor providers, working in collaboration with Mississippi licensed physicians will deliver plan-directed on-demand or scheduled telehealth (video-chat) for preventive, primary care, BH, and urgent care services to members
- We will partner with Mississippi-based telecommunications vendor CSpire to offer free network/data services and Internet-enabled devices to our members for telehealth services and access to rich resources on our member portal
- Vigilant monitoring of telehealth services to ensure quality of care standards are met and to identify and address potential fraud, waste, and abuse (FWA) issues

Supporting Member Use of Telehealth Services

We have woven telehealth services into an integrated, person-centered, and coordinated system of care as a key innovation as a result of the pandemic. We support member use of telehealth through multiple tiers to ensure all members have efficient access to telehealth services, as shown in Figure 4.2.3.7_A.

Figure 4.2.3.7_A: Telehealth Services

Our members have 24-hour access to scheduled and on-demand telehealth services within a coordinated system of care.



Our member website and printed materials, 24-hour nurse line staff, and care management and member services teams encourage members to seek telehealth services from their primary care providers (PCPs)/patient centered medical homes (PCMHs), and other network providers to maintain continuity of care and treatment. Our internal NPs, working in collaboration with Mississippi licensed physicians, and contracted telehealth vendor providers cover preventive health, well-care, urgent care, BH, maternal health, and chronic and/or complex conditions for our members, preventing the need for unnecessary hospital readmissions and ED visits. Our NPs assist members in scheduling follow-up appointments with the member's PCP/PCMH during telehealth calls, and we notify the member's PCP/PCMH of all telehealth visits.

COVID isolation and social restrictions had a significant impact on the utilization of telehealth services across the nation.

The pandemic provided an opportunity for us to identify critical needs and enhance the way we support telehealth for our Medicaid members and providers. Across our Medicaid markets, telehealth services closed quality gaps for our members living in rural, urban, and suburban areas. Our telehealth utilization over the past 12 months has seen an average increase of 119% over the previous year, where claims for behavioral health sessions represent the majority of services. Nonetheless, as an overall proportion, telehealth services provided for medical needs of our members increased more than one hundredfold during this same period, which demonstrates brisk utilization which might otherwise have resulted in the delay of necessary care and services. **Notably, through telehealth visits for members referred to our nurse practitioners, we closed 65% of gaps in postpartum care via telehealth, including confirmation of scheduling the baby's wellness visit with a pediatrician and conducting depression screening for the mother.**

Telehealth Services for Members

We offer efficient, convenient, private, and flexible telehealth services to address member needs, including:

- **Telehealth Visits with Network PCPs/PCMHs, BH Providers, and Other Providers:** Many network providers offer telehealth services currently, and we support their efforts through value-based payments (VBPs), training, and telehealth platform accessibility. We work with all network providers, including PCPs/PCMHs and BH providers, to encourage and support them in offering telehealth as an adjunct to office

visits for appropriate acute, chronic, and preventive services while reinforcing the importance of in person visits. Members schedule telehealth visits with their providers in the same way they schedule in-person visits, including online scheduling through the member portal. For members who are engaged in care management services or our well-being program, we can provide tablets or other Internet-ready devices through our member assistance fund. When Internet access is an issue, we help our members find alternative locations and/or approach access systemically through our digital equity initiatives, including **offering free network/data services and Internet enabled devices to members**.

- **Alternative Telehealth Services:** In coordination with providers that do not offer telehealth (frequently providers serving rural populations), we provide multiple telehealth alternatives to members for enhanced access and notify their providers of telehealth encounters for follow-up care. We have established relationships with nationally recognized telehealth vendors for medical and behavioral telehealth care. We oversee telehealth vendor performance by tracking HEDIS outcome measures and member satisfaction, verifying documentation of diagnoses with care of conditions in claims, and monitoring for FWA.

Alternative telehealth services include:

- **Nurse Practitioner Telehealth Program:** Our NP telehealth program, in collaboration with Mississippi licensed physicians, will be available every day from 8:00 am – 8:00 pm, increases access to care for acute telehealth services to close gaps in care (e.g., timely postpartum care and depression screening, preventive care for appropriate populations, and follow-up care for chronic care conditions) and member understanding of and adherence to medication plans and appropriate medication refills. NPs monitor labs through our integrated clinical platform, enhance member knowledge of disease processes, and connect the member back to their PCP/PCMH as part of every visit. We monitor and target at- risk sub populations for opportunities to support and ensure continuity of care in alignment with their PCP. Our Mississippi-licensed NPs can view the member's record (including outreach attempts, assessments, care plans, PCP assignment, and progress notes) in our integrated clinical platform and document information, such as updated member contacts, within the member's record.
- **24-Hour Nurse Advice Line:** Members can directly call or be transferred to our 24-hour nurse line which provides immediate consultation via telephone to answer member questions about health concerns and conditions anytime night or day. If the member needs further assistance, our nurses conduct a seamless warm handoff to our nationally recognized telehealth vendors or our 24-hour behavioral health/substance use disorder line when circumstances warrant. When needs are not urgent, nurses encourage members to schedule an appointment with their PCP/PCMH and provide information to the member about how they can schedule an appointment with our NPs or telehealth services provided by our vendors.

Julia | Telehealth Assistance with Complications from COVID-19

Julia (not her real name) is a 27-year-old member who was not engaged in care management when she called our nurse advice line. She had been diagnosed with COVID-19 ten days earlier and had been feeling somewhat better but was experiencing the feeling of phlegm that she could not "seem to get out." Julia had a history of asthma, but her inhaler had expired, and she was unable to get a same-day appointment with her primary care provider.

Our triage nurse immediately connected Julia to telehealth for treatment, and she referred her to care management to follow up with Julia to see if she had any unresolved or emerging needs related to managing her asthma, such as refilling her medications. The next month, Julia enrolled in our integrated care management program and received referrals for providers, mental health visits, and medication. Her case manager also helped her set goals, and Julia now has a plan for getting and staying healthy.

- **Telehealth Services:** We will partner with nationally recognized telehealth vendors to provide comprehensive telehealth services, including general medical and BH for urgent care, complex and chronic care, mental health, perinatal health, and specialty care provided by specialists, nurses, and therapists. Appointments are

available on-demand (in urgent situations) or by appointment. Members can see a physician or other health care professional anywhere using their phone, mobile app, or computer for treatment of symptoms/illnesses when they cannot see their PCP. To ensure continuity of care, we send an automated alert to the provider notifying them of the visit and directing them to the provider portal for details so they can follow up with their patients. We also help the member connect with their PCP/PCMH to schedule follow-up appointments.

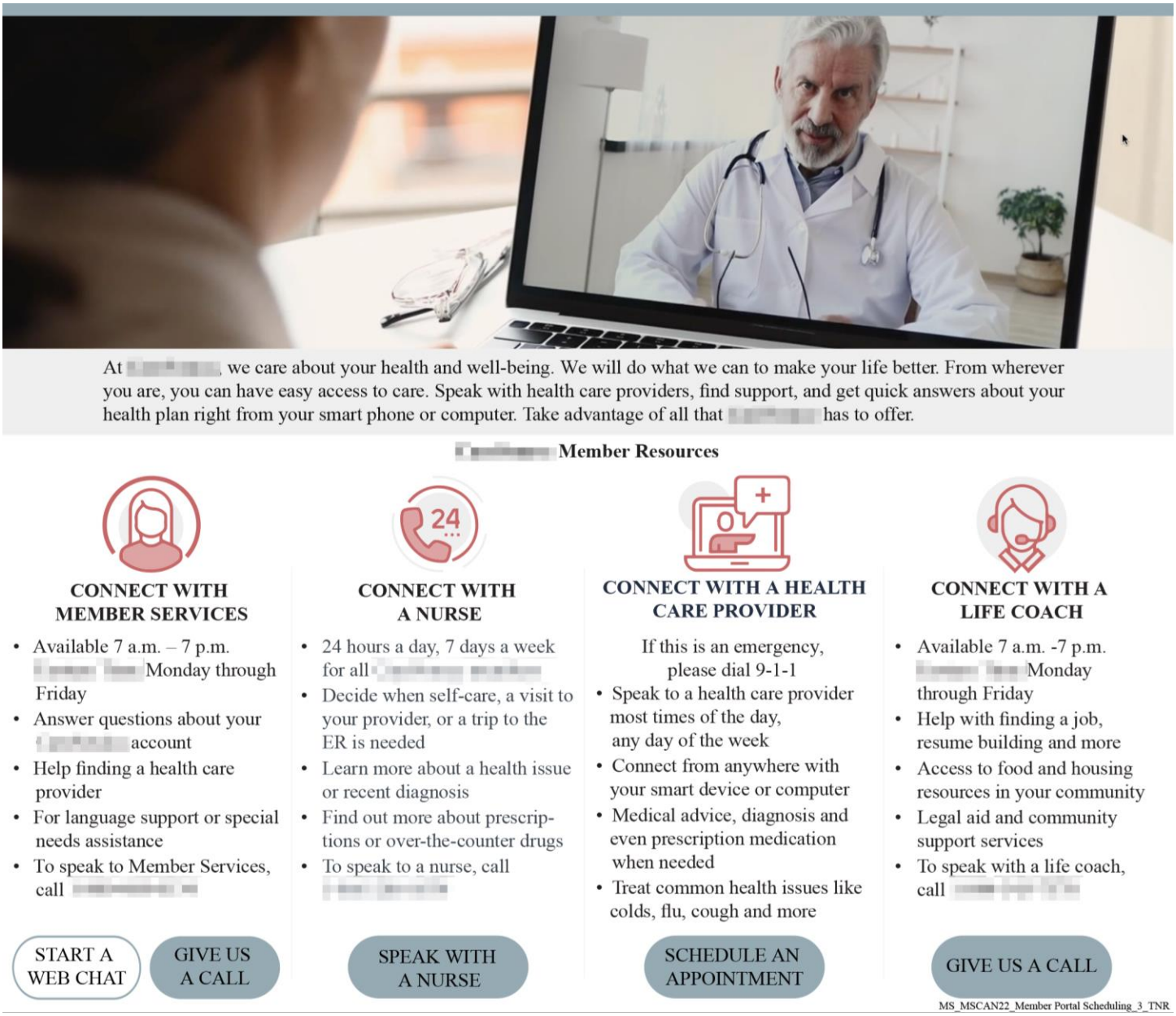
Connecting Members to Telehealth

Before COVID, many Americans were unfamiliar with telehealth and how to use it as an alternative to in person care settings. Today we have begun to view telehealth as an extension of the provider office by bringing virtual health care visits directly into our homes and community settings. In 2020, across all our markets, 63% of psychotherapy sessions with our members were conducted through telehealth. We are committed to next member engagement and education. We inform members of the availability of telehealth as a covered benefit through our member handbook, the member portal, our website, and through interactions with our member services and care management teams. We recognize providing information about the service is not enough, and we assist members with using technology and have developed processes to encourage members to use telehealth efficiently. We include services supported by telehealth in our member incentive programs to the extent clinically possible based on clinical guidelines and continue to examine opportunities to enhance these incentives for our MSCAN and CHIP members.

Making Access Easy: Members schedule telehealth appointments with NPs working with Mississippi licensed physicians through the member portal on our website, care management and member services teams, and the 24-hour nurse advice line. Our telehealth platform, which we make available at no cost to non-telehealth enabled providers in rural areas, includes on-demand video-chat and scheduling capabilities they can use for all their patients. Our members can select from a comprehensive network of medical and BH providers, including their own PCPs and other network providers (when providers make their schedules available to us) or telehealth vendor providers to schedule an appointment through the member portal. Figure 4.2.3.7_B shows the window in our member portal illustrating the ways members can connect to care, including scheduling telehealth appointments.

Figure 4.2.3.7_B: Member Portal

Connecting to care through our member portal is easy and efficient.



Enhancing Access to Preventive Care: We are committed to ensuring Mississippians can easily access their benefits to live healthier lives. Nurse practitioners reach out to members identified as high risk or having gaps in care to schedule telehealth and in-home appointments to address barriers to care. We provide postpartum telehealth visits with a NP working in collaboration with a Mississippi licensed physician based on analysis of member delivery claims. During those visits we assess maternal and infant well-being and facilitate referral/scheduling with the primary OB/GYN or pediatric provider for urgent issues identified during the visit, which is scheduled between delivery and the provider postpartum visit. We provide education on birth-spacing and contraceptive options (including long-acting reversible contraceptives), breastfeeding, infant care, and safe sleep. The NP shares results with the member's provider and helps the member in scheduling follow-up visits with her established provider. Our experience across markets demonstrates that the NP program successfully closed 65% of gaps in care of members referred to telehealth during the postpartum period, meeting HEDIS requirements and ensuring continuity of care for the mother and infant. Comprehensive services in the

telehealth visit include postpartum depression screens, making appropriate referrals for community-based services, and ensuring scheduled follow-up appointments are in place with the OBGYN and the baby's pediatrician.

We also offer disease management-focused telehealth visits with NPs to augment the care they receive from their providers, address preventive health needs and clinical concerns, and ensure the member schedules (and attends) visits with their PCP/PCMH. We document visits in the member's record, notify the PCP of the telehealth encounter, and share the after-visit summary with the member's PCP/PCMH and other providers through the provider portal.

Connecting Members 24/7: Nurses in our 24-hour nurse advice line connect members to telehealth services that provide immediate or scheduled access to medical and BH providers over secure interactive audio or video. The physicians consult, diagnose, and (if needed) prescribe medicine for common and acute illnesses. Our national data demonstrates that access to these resources and educating members about the availability of telehealth reduced ED utilization by 21% in calendar year (CY) 2021, an improvement over reductions in CY 2020 (14.5%) and CY 2019 (13.1%).

Building Digital Equity

Access to digital health for our members relies on high-speed Internet connections. Woking with community leaders in a digital equity initiative in another market, we provided high speed Wi-Fi access and Chromebook devices to residents in 900 low-income housing units.

As of December 2021, over 3,100 individuals were registered and approved for the service, with 92% being our Medicaid membership. These members used 166,730 sessions of Wi-Fi access and over 250,000 hours of service. They accessed our member platforms and member portal over 2,000 times.

Crossing the Digital Divide

Access to technology and connectivity is another area in which we see disparities among our members in Mississippi. In the Kids Count 2020 report, the state ranked 49th in the country for access to broadband services, with only 47.6% of households having consistent connections and access. We will establish a digital equity partnership with CSpire, a national telecommunication provider based in Mississippi, to prioritize providing fiber connections for communities and schools where our members live, focusing on rural areas where shortages of primary or specialty care exist. By partnering with CSpire in the coming contract, we will replicate our innovative solution from another state where we provided high speed Internet access, digital devices (e.g., Chromebooks), and member education on how to use the technology, set up email accounts, access our member portal and apps, and connect to telehealth platforms for virtual care.

Enhancing Access to Care through Schools

We are committed to next generation member engagement and education. In the coming contract, we will collaborate with schools through our partner, Schoolcare, to establish connections with electronic health records (EHRs) in school-based health centers. Access to these EHRs supports visibility to gaps in care and timely connection to services through our nurse practitioners who reach out to parents/guardians of children with gaps to connect them to primary care.

In another market we collaborated with a Title I elementary school to fund telehealth equipment and services that enable school health professionals to connect students to medical doctors without leaving school. The equipment facilitates real-time videoconferencing, store and forward high-resolution imaging, and other diagnostic technology to support member engagement with providers of preventive health care and screenings. **We will commit to funding similar programs in Mississippi schools to facilitate member access and relieve parents from missing work**.

Supporting Members in Telehealth Use

We escalated our support of telehealth services with our providers before and during the COVID pandemic and are committed to continuing our support when the pandemic ends. We will collaborate closely with the Community Health Center Association of Mississippi, the Mississippi Rural Health Association, and the Mississippi Association of Community Mental Health Centers to understand the needs of providers. We will discuss a range of topics and have identified ways to support efficient use of telehealth, including providing

education, training, and clinical support to help providers expand their telehealth capacity. Our strategies support providers in a variety of ways according to their specific needs.

Telehealth Platform Access for Providers

We are committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model. We give our providers access to a telehealth platform if they do not already have access to one. **The telehealth platform, which providers can use for our members and their other patients, supports on demand video-chat and scheduling capability, expands access, specifically to behavioral health and rural health practices.** We proactively drive the expansion of network provider telehealth utilization by using claims data and information gathered by our provider representatives to identify providers who are underutilizing telehealth compared to their peer groups and reach out to make them aware of the supports available to them.

Listening to Providers

At the onset of the COVID pandemic, we recognized we had a critical role to play in stepping up to serve our providers and members during the public health crisis. We organized behavioral health provider listening sessions to generate innovative ideas for dealing with the challenges of the pandemic in another market.

The listening sessions led to identifying themes (operations, timelines, delivery modalities, HIPAA considerations, SUD services, and health disparities) which informed innovations in our person- and community-centered telehealth programs.

Value-Based Provider Arrangements Supporting Telehealth

Our demonstrated record of performance in other markets tells us that incorporating telehealth into VBP will work in Mississippi too. We offer enhanced reimbursement to PCPs and BH providers who offer extended member access through telehealth.

The provider partners we will work with in Mississippi are already excelling in offering telehealth services and we aim to support and expand their current programs through VBP arrangements. St. Dominic Health System, Baptist Memorial Health System, North Mississippi Health Services, Forrest Health Systems and the University of Mississippi offer connectivity to rural hospitals through tele-emergency, tele-stroke and other telehealth services to provide access to care.

We will also incentivize providers to make appointments available to pregnant members during their first trimester and for using telehealth to close postpartum care gaps. Additional incentives include a performance-based payment tied to meeting quality and outcome targets.

Telehealth for Virtual Provider Education and Support

Another important aspect of telehealth is its use to provide education, training, and clinical support to providers, especially PCPs/PCMHs practicing in rural areas with limited specialty and BH providers. We support all network providers in expanding their capacity to serve our members through telehealth to reduce avoidable ED and inpatient readmissions and overall costs of care in the following ways:

Our **provider services organization** helps providers enhance their capacity to serve MSCAN and CHIP members through various means, including telehealth. Our provider representatives and full-service hotline offer dedicated support for timely resolution of issues related to telehealth. We provide access to national, multidisciplinary team of experts for consultation on cases for which providers need additional expertise.

Our **psychiatrists offer consultation to primary care providers** via telephone to discuss BH prescribing and treatment to support managing mild to moderate mental illness in their adult patients. We will make our pediatric providers aware of the Child Access to Mental Health and Psychiatry Services (CHAMP) resource through the Mississippi Department of Mental Health and the University of Mississippi Medical Center (UMMC). The service supports PCPs individually by answering questions about mental health care, such as diagnostic clarification, medication adjustment, and treatment planning to increase PCP confidence in their ability to treat mental health issues for children. Recognizing this service is funded by a federal grant from the Federal Health Resources and Services Administration, we will work with the State and UMMC to explore more sustainable funding scenarios.

In the new contract period, we will leverage our experience with tele-mentoring programs in other states to support UMMC's Project ECHO and our providers who wish to participate. We will review UMMC's teleclinics and share information with providers to increase their awareness and participation. Additionally, we will work with UMMC to identify opportunities to offer new teleclinics for all Mississippi providers.

Addressing Sickle Cell Disease Provider Capacity

Mississippi has the highest SCD prevalence in Medicaid beneficiaries in the country, yet there are fewer than 50 adult hematologists in the State and only a small set of those providers see SCD patients. As a result, the majority of SCD treatment statewide is episodic interventions in emergency departments with little follow up, preventive care, or care management.

In the coming contract, to increase the capacity of providers to treat SCD, we will collaborate with UMMC to develop and fund a SCD training and ongoing support system for community PCPs, PCMHs, and our care managers within the existing UMMC Project ECHO framework. Training programs include preconception counseling, pain management, clinical hub-and-spoke knowledge sharing, and prevention of infections, cardiovascular, renal, and cerebrovascular diseases. We will invite all Mississippi CCOs to engage in ongoing SCD ECHO efforts through the Mississippi Association of Health Plans, the Mississippi Academy of Family Physicians, and the Mississippi Medical and Surgical Society to establish statewide SCD Primary Care Medical Homes in community PCP/PCMH practices.

Enhanced Oversight of Telehealth Services

We are committed to changing the landscape of Mississippi's healthcare system via a fully integrated, transparent service delivery model while prudently managing State resources. We monitor telehealth services delivered to our Mississippi members and insure balance between quality of care and potential misuse of these services. We will enhance our FWA program to take telehealth innovations into account and monitor for misuse of resources. For example, during the drastic increase in telehealth services during COVID-19, we quickly formed workgroups to implement monitoring for potential fraud during the public health emergency. Through these workgroups, we developed a provider education program that utilizes peer comparison data analytics, proactive outreach measures, and education on correct billing practices to support appropriate billing. We have applied this provider education model to telehealth services as a FWA prevention workplan initiative due to increased utilization and an industry wide focus on telehealth services.

Supporting the Division's Telehealth Initiatives

Building on valuable lessons learned over the past few years during COVID and our experience developing statewide unified telehealth policies, we will provide a sounding board and thought partnership with the Division in its efforts to expand the use of telehealth to provide access to medical and behavioral health services for MSCAN and CHIP members. We will work with the Division to ensure expanded access to telehealth is delivered within a system of care that drives optimal health outcomes for our members.

We will collaborate with the Division on goals to optimize telehealth services for MSCAN and CHIP members statewide and will submit our telehealth proposal within 60 days of contract award. Our broad and comprehensive telehealth program complies with all requirements of Appendix A, Section 4, Mississippi Administrative Code, Mississippi DOM State Plan, and relevant communications issued by the Division to ensure our members have access to telehealth services as needed.

[END OF RESPONSE]

4.2.3.8 USE OF TECHNOLOGY

The Division is aware that Offerors have access to numerous technologies that could be used to the benefit of the Division. The Offeror is asked to describe how it can leverage its technology to give the Division more insight in the following areas and any other areas the Offeror has technology that may normally be underutilized by state Medicaid programs:

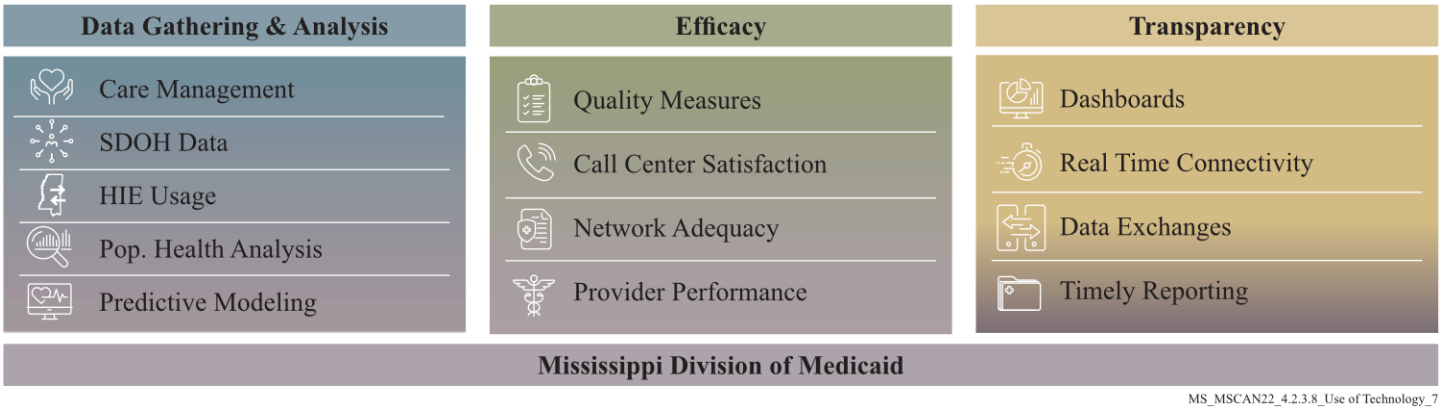
1. Data gathering and analysis 2. Efficacy of initiatives and programs 3. Transparency

We are a CCO committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through **real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi**. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing state resources.

Our commitment to and continued investment in modern and innovative technology is foundational to providing to the Division visibility into our gathering and analysis of data, evaluation of the efficacy of initiatives and programs, and transparency in the sharing of actionable outcomes and findings. The **integrated nature of our service delivery model** is what distinguishes our model from all others. We acquire a diverse set of data in near real-time, which will afford the Division a holistic view of insights, performance, and outcomes driven by member, provider, national, and regional data. **Our centralized modern data platform (MDP) will serve as a single source of truth** for both our organization and the Division. The MDP uses artificial intelligence (AI), machine learning (ML), and predictive analytics capabilities to provide insights and actions. Our data governance and other internal teams validate**,** analyze, and use data to evaluate the impact on member outcomes, resulting in the **creation of targeted clinical interventions and innovative programs and services proven to consistently improve health outcomes for the Division's priority areas**. We will share transformational, actionable, reliable data with the Division through our **essential indicators dashboard,** which provides insight on population health, health information exchange (HIE) use, social determinants of health (SDOH), network and provider performance, regional health disparities, and the efficacy of care management and value-based purchasing (VBP) programs, to name a few. Figure 4.2.3.8_A provides examples of the areas in which we utilize technology to provide insight to the Division in support of moving from volume to value, from quantity to quality, and from quality assurance to quality improvement.

Figure 4.2.3.8_A: Use of Technology to Provide Insight to the Division

We use technology in a myriad of ways to afford the Division insight into data gathering and analysis, efficacy of programs and initiatives, and transparency.



From the outset, we will actively collaborate with the Division to ensure the provision of accurate and usable required data and reporting, ad hoc requests, and a customized essential indicators dashboard with data points that are beneficial to the Division but that do not inundate the Division with superfluous reports and data. In addition to offering the Division resources from our actuary, medical analytics, Care Management, and Quality Management (QM) teams, our **data liaison** will serve as a point of contact for the Division. This individual will collaborate on the Division's data analytics needs and facilitates additional insight and orientation on the use and interpretation of the data we provide. Our data liaison can meet quarterly with the Division to formally discuss its priorities and needs and is available on an ad hoc basis to answer questions or to provide assistance. Additionally, many of our organization's leaders actively participate in workgroups, committees, information technology (IT) and HIE advisory boards, and strategic initiatives across our many data-sharing partnerships, to ensure we continuously learn, grow, and evolve in this area. Our engagement in these groups, which dates back nearly a decade, demonstrates our longstanding commitment to partnering with state Medicaid agencies. Using this engagement, we will invest in our partnership with the Division, sharing our depth of experience, technical assistance, and diverse ability to unlock additional value from technology and interoperability initiatives to support the Division in achieving its priorities.

Collaboration to Ensure Accuracy of Data

During a rate adjustment phase in another market, we discovered discrepant (outdated) data between our plan and the Medicaid agency. We partnered with the Medicaid agency to update its data and, as a result, strengthened the collaboration and transparent communication in our relationship with the Medicaid agency to foster accuracy of data going forward.We now have monthly meetings with their Reimbursement Director.

Data Gathering and Analysis

Our fully integrated MDP currently supports data gathering for all business functions programs, including utilization management (UM), grievances and appeals, enrollment and disenrollment, member and provider call centers, authorizations, claims management and benefit administration, care management, quality management, customer service, network, provider performance, finance and accounting, and integration and electronic data interchange capabilities, such as pharmacy. Within the MDP, we ingest raw data and then process and enrich it into a consumable form. Each layer of the MDP's architecture supports business-driven operational and analytical use cases. **We will use data to inform a fully integrated, transparent service delivery model with the majority of its providers that will be in a real-time bidirectional data exchange.** Our data is not simply harvested and stored; it is cultivated and made actionable to inform and support our plan, our partners, and to ultimately improve outcomes for our members.

We also govern and optimize our MDP to support the data and reporting needs of the organization, external partners, and regulatory agencies. The MDP leverages business-centric data structures, with breadth, depth, and ease of use as a core principle. We employ a dedicated Enterprise Analytics team that provides vision, insight, and expertise to both internal and external stakeholders; this team will also collaborate closely with our data liaison. To facilitate efficient and actionable analysis, team members specialize in key areas, such as population health analytics, medical economics, clinical informatics, data science and predictive analytics, provider network and VBP, and operational analytics. We also incorporate an extensive catalog of self-service reporting and dashboards that empowers data-driven decision-making on demand. This catalog uses the MDP, with integrated data from systems and sources across the enterprise to deliver comprehensive and in-depth perspective into the most critical aspects of serving our members. Our dedicated team of data scientists uses a suite of models and algorithms, built with AI, ML, natural language processing (NLP), and predictive analytics capabilities, to provide practical solutions to real health care issues. For example, our high-risk pregnancy predictive model applies ML techniques to identify these members and to categorize them according to the key drivers of risk for a more targeted intervention. We also employ ML to identify claims payment anomalies, which results in more timely and accurate reimbursement and increased provider satisfaction.

Use of data analytics and reporting is paramount to the successful operation of Medicaid programs and to transforming the support and delivery of optimal, transparent care to our members. **We will provide the Division insight into member health conditions, areas of risk, and social needs by sharing data analysis via our customized essential indicators dashboard in key areas such as care management, SDOH, HIE, geospatial analysis of population health, and predictive modeling**. As a result, the Division will have greater visibility to emerging member needs, trends, and health disparities, facilitating the Division's ability to provide oversight and guidance to all plans regarding new clinical interventions. In addition, our plan chief executive officer (CEO) will meet with the Division to discuss new trends, issues, and insights to create a true partnership with the Division and ensure our services result in positive health outcomes for our members and meet the quality, value, and cost effectiveness expectations of the Division.

Care Management

Our fully integrated clinical platform serves as the central repository for gathering all relevant care coordination data and provides our Care Management team one-stop access to all member information. This platform contains core modules that include member demographics, utilization management, care management, SDOH, appeals and grievances, and analytics. The platform also supports the aggregation and normalization of utilization data (e.g., claims, pharmacy, and labs) collected from interoperable electronic health records and HIEs, based upon national standards, including HL7 and Fast Health Interoperability Resources (FHIR). It uses branching logic in comprehensive assessment protocols to include additional tools, such as condition-specific elements, PRAPARE, and behavioral health assessments such as the PHQ9. Additionally, our platform integrates with providers' electronic health records, inclusive of PCMHs, to provide closed-loop connectivity and collaboration. Together, the platform provides a 360-degree, single view of members' health information for all internal partners and allowable providers. This information and data exchange improves our collective ability to identify and address members' care needs.

We leverage a variety of data and methodologies to identify and prioritize members in need of care management. Starting with industry standard tools, we establish an initial risk stratification for all members. Risk levels are then enhanced using predictive analytics and additional data sources such as health risk assessments, SDOH, and other data collected through the health information exchange. This approach allows for a refined segmentation of the population within risk levels and a more targeted approach to care management. Specifically, we are able to explicitly associate risk with actionable health concerns like chronic disease, episodic events, behavioral health issues, and socioeconomic factors. Our Care Management staff uses their clinical expertise along with this enhanced risk stratification to deliver programs, interventions, and community-based coordinated care tailored to the needs of our members. Ultimately, this leads to more effective engagement, greater member satisfaction, and better health outcomes.

We intend to provide insight into our care management data gathering and analysis by sharing the following data analytics elements with the Division:

- Number of members engaged in care management
- Number of, and outcome status regarding, efforts to outreach and engage members in care management
- Member preferences for language, religion, and preferred outreach method
- Risk stratification percentages
- Regions/populations for which care management is more successful, as defined by:

National Care Management Leader

Nationally, our success with care management is evidenced by perfect scores received during five NCQA surveys in 2021.

ED Intervention

Nationally, we have saved more than $12 million dollars through our ED intervention program, which connects members with a medical and dental home.

- Increased member engagement in active care management programs
- Improved control in chronic conditions, such as diabetes, hypertension, increased medication adherence
- Reduced avoidable ED and hospital utilization
- Consistent closure of preventive health gaps in care, and
- High member satisfaction in care coordination; currently, 85% of members across all our markets report satisfaction with our Care Management team

Social Determinants of Health Data

Because regional SDOH are key drivers of health care access, utilization, and outcomes, addressing SDOH at the community level is essential to the effective treatment of members' physical and behavioral health challenges. We collect SDOH data through our MDP and make it available to staff members through our single member view care management clinical record. Our Population Health Analytics team monitors all relevant sources of data from the MDP, including member health risk assessments, SDOH assessments, claims, Z-codes, and member clinical assessments. All data points capture SDOH risk, which is juxtaposed against health outcomes and member demographics, such as race, ethnicity, and geographic location (zip code).

We have refined our collection of SDOH indices to simplify the application of these factors in identifying at-risk members and populations. The platform captures SDOH data and assigns a high, medium, or low index value to individual members. The index value is assigned for five domains, including economic stability, education, community, environment, and health care. These index values are combined with other member-level attributes to provide a more complete view of member and population characteristics. Our Care Management team incorporates SDOH data to assess, identify, and address needs to create a person-centered individualized care plan with targeted interventions to ensure we resolve unmet needs. Having readily available real-time data that provides a 360-degree view of a member increases the responsiveness of our team to connect with our member and their family to be the solution in their time of need. These insights allow us to spend time with our members, focusing on their needs.

[redacted]

We will provide the Division an analysis of regional SDOH prevalence data, monthly regional SDOH referral outcomes reports, data regarding risk for homelessness, involvement with the child welfare system, and other social risk factors.

Health Information Exchange and Interoperability

We currently participate in HIEs in all markets where the State has established them and will establish partnerships to do so in Mississippi. We partner closely with each state's Medicaid administrations to provide real-time admission, discharge, and transfer (ADT) notifications and other important HIE features. We partner with multiple leading population health technology companies, which provide plan-to-provider bidirectional information sharing and data-driven reporting and analytics. In multiple states, we have developed bidirectional electronic information sharing between Federally Qualified Health Centers (FQHCs) and our plan. FQHCs in these markets serve on average one in five members and are a vital primary care delivery network within the covered programs. This innovative partnership will advance health equity and well-being solutions for those we mutually serve. Through this arrangement, we will provide member-specific gaps in care to the FQHCs. In turn, the FQHCs will share information about appointments, encounters, member records, and SDOH data.

Our HIE experience in other markets enables the successful implementation of our partnership with statewide HIEs in Mississippi. These HIEs will provide ADT notifications and offer a comprehensive view of needed preventive and follow-up procedures, as well as an aggregate, practice-level view that enables providers to better plan and manage care for their members. Because HIEs provide an avenue for improved provider collaboration, it is important to

achieve high levels of provider interaction with the HIEs and to promote their use with Value Based Programs. We proactively promote providers' use of the HIE via review of its benefits and the process to gain HIE access during provider orientation, provider meetings, and through our provider portal and newsletter. We emphasize the benefits of HIE use in discussion with PCPs and PCMHs in particular. Additionally, we will help smaller providers' adoption of the HIE by offsetting the cost of HIE participation in some cases.

We will share with the Division an analysis of providers connected to and using the HIE, usage volume, and growth over time of providers' use of the HIE.

Population Health Analysis

In addition to multiple other technologies, we use geospatial mapping as part of our broader population health analysis to assess and localize health disparities and implement clinical interventions that address the needs of our members. We use this technology to guide care management staffing decisions and hire staff in areas of the state with high needs. In one market, we used these maps to identify regions having the highest concentration of pregnant members diagnosed with substance use disorder and hired RN care managers living in those areas to support this population. We have also used geospatial analysis to identify regional disparities related to infant mortality and diabetes. Understanding the needs of our population in each area facilitates hiring qualified, regionally based staff who can connect members to local providers. Additionally, we use geospatial intelligence to illustrate the neighborhoods with the lowest vaccinations rates and identify apartment complexes in those neighborhoods where we provide mobile COVID-19 vaccination units and door-to-door vaccine awareness campaigns. All of our population health data analysis activities comply with Appendix A, section 16.5.2.

We intend to share with the Division insights gained through geospatial analysis regarding regional vaccination rates and health disparities.

Predictive Modeling

Our predictive modeling approach sheds light on all aspects of the member experience and fully integrates different systems to predict elements, such as gaps in care, provider competencies, and high-risk populations who may need long-term services and supports in the future. Our care management teams use this information to identify member needs and address them in the least restrictive settings early enough to prevent exacerbation or worsening of conditions. Our dynamic predictive modeling tools identify the disproportionate impact of chronic disease for members with complex physical or behavioral health needs such as members with serious mental illness (SMI), substance use disorder (SUD), or intellectual or developmental disabilities (IDD) and incorporate ML models to stratify high-risk pregnancies and members at risk for becoming homeless. Our tool also predicts readmission events and likelihood of an avoidable emergency department encounter within the next 90 days, and identifies members who are inpatient with high acuity to help prioritize safe and efficient transitions of care. Additionally, our predictive modeling tools:

- Collect over 400 SDOH elements for our entire adult population and incorporate these into many of our predictive algorithms
- Use a set of socioeconomic indices that group hundreds of SDOH elements into intuitive and measurable risk factors
- Include algorithms that leverage the SDOH of parents and relates those to dependent children, as it is often difficult to obtain SDOH elements for children and their whole household
- Ensure accurate claims payment and identify potential fraud, waste, and abuse to help minimize disruption and inefficiency in the delivery of medical services

We will share our predictive modeling findings, such as the percent of the population at risk for homelessness or high-risk pregnancy, and trends regarding health disparities for members with SMI, SUD, or IDD with the Division.

Efficacy of Initiatives and Programs

It is critical that we continually measure the effectiveness of our programs and initiatives to ensure our services result in positive health outcomes for our members and meet the quality, value, and cost effectiveness expectations of the Division. **We will share information with the Division regarding program and initiative effectiveness to enable it to identify areas that may require system-level performance improvements, or to highlight best practices.** Several examples of the evaluative processes we use to assess the impact of our initiatives and programs, and the data elements we will share with the Division regarding the efficacy of our programs and initiatives include:

Quality Measures

We participate in HEDIS® data collection and reporting across existing markets each year using National Committee for Quality Assurance (NCQA) certified Healthcare Effectiveness Data and Information Set (HEDIS®) software. We collect, analyze, evaluate, and compare data to regional and national benchmarks. Based on the results, comparison data, and Quality team analysis, we identify and structure improvement initiatives. An internal relational database stores all incoming data. We authenticate accurate data aggregation by performing integration and regression testing, volume, and data quality validation. Our Population Health Analytics team will monitor comprehensive sources of data from our MDP, including claims, member assessments, and member health risk screenings, along with integrated data feeds from external sources, including HIEs, data feeds from our lab partners, and providers. We will combine this data with our business intelligence platform and HEDIS® analytics software tools to create dashboards that provide more accurate reporting and population-based detail on demographics (e.g., race and ethnicity). Using this integrated data, we identify racial and ethnic disparities, geographic regions with access issues, outlying providers, overutilization of ED for non-emergent conditions, excessive cost, and program participation process data. We further analyze these findings from a health equity perspective to distinguish areas and members with greatest burden needing assistance and/or improvement. This approach is used to target market level performance improvement projects. In one market, our interventions in a pregnancy engagement initiative were useful in identifying the highest risk mothers in the state, allowing us to implement interventions that improve birth outcomes and reduce the risk of infant mortality. We adapt our systems and processes to include future quality improvement activities requested by the Division.

We drive quality improvement and boost network engagement across all populations through our end-to-end QM, AI/ML-based advanced analytics, automated workflows, and coordinated approach protocols, which elevate our efforts to drive equitable health care and reduce administrative burden on providers and the Division. Through this technology**,** we offer pre-built, configurable analytics tools, dashboards, and rich visualizations, including HEDIS, gaps-in-care, 360-degree member and 360-degree provider views that quickly drive quality improvement. The technology includes built-in data driven capabilities to predict measure denominator qualification and compliance rate, and to identify focused member lists for outreach. Additional flexibility is available to add custom reports or modify the existing user interface.

We profile quality of care and clinical practice compliance data in a scorecard and share that with the provider and practice quarterly. This tool assists with education and recommendations for practices. The technology provides a powerful, intuitive, and easy-to-use tool for report creation, along with customized scoring to provide a holistic view of providers, members, and measures, with rate benchmarking, rate-trending, rate traceability, member details, and provider scorecards. The platform comes with a library of self-service tools to further empower our provider community to drive improvements independently. By aggregating this information for our network providers, we reduce the time and effort to find and execute cost savings and quality improvement initiatives, while increasing the speed of information sharing.

This platform ensures providers understand the full scope of their performance. Provider performance scoring is consolidated into flexible hierarchies, which enables performance analysis through a variety of criteria and scales, thus driving multi-level network engagement and clear communication of goals, while eliminating ambiguity and

abrasion. The AI/ML library contains comprehensive provider performance features, such as panel size, performance history location, member accessibility, communication, and others, for scoring and segmentation of provider network efficiency. This tool helps providers remain targeted and focused on their own improvement opportunities through strategies of varied intensity. It also provides performance scoring for HEDIS measures and scoring related to providers' performance against VBP goals for applicable providers. Figure 4.2.3.8_B provides an example of a dashboard reflecting VBP performance.

Along with required quality management deliverables, we will provide the Division direct access to our QM platform tools, dashboards, and visualizations.

Member Satisfaction with Call Center Interactions

Technology is used to evaluate and improve the member experience, with every call serving as a potential opportunity to close a broader experience gap. We use NLP and AI to mine call data for key words and elements of information across our calls and members to identify factors leading to success or failure of the call, emotion analysis, call time insights, cross-departmental opportunities, and more. We share speech analytics insights and findings across the organization to clearly convey the voice of members who contact our call center. Regular partnership occurs across the organization to review contact reasons to proactively identify opportunities to address root causes of sub-optimal interactions and improve how we deliver services to our members. Each call is an opportunity to build a relationship with our member and improve health outcomes. Based upon our call mining data, we will provide the Division with information regarding members' reasons for contacting our call center and any opportunities to improve member communication or offer self-service solutions.

Network Adequacy

We utilize geo-mapping and other data sources, including member surveys, provider appointment availability surveys, HEDIS® requirements, and primary care provider (PCP) panel reports to evaluate whether our network meets all Division network adequacy requirements and enables members' easy access to timely services.

We will provide the Division with network adequacy and appointment access data, insights regarding network gaps, and our efforts to remediate these gaps.

Provider Performance

In addition to the quality and VBP measures related to provider performance previously described, we create and use several reports to evaluate provider performance, including:

- PCP profile to provide insights on cost, quality, and performance for members attributed to PCPs and to identify provider patterns to address outlier behavior and improve care quality
- Behavioral health profile and comparison tool to assess the impact of the behavioral health network on complex members and to educate providers on how they compare against their peers; efforts in one Medicaid market resulted in a 30% decrease in opioid prescriptions written across providers in the state
- Hospital performance report to evaluate volume, service, and member demographics, and to support strategic planning and maintenance for optimal network performance

Our data liaison will collaborate with the Division to determine provider performance data they would like us to share.

Transparency

We will provide the Division a customized essential indicators dashboard to offer insight and **actionable data** related to data-gathering, analysis, and program efficacy elements described earlier in the response. Our MDP affords the Division rapid and transparent data exchanges, along with required and ad hoc reporting deliverables. We are committed to data-sharing processes, which prioritize ease of access and timely adherence to required and ad hoc data and reporting requests. Our **data liaison** will partner with the Division in the creation and review of the customized essential indicators dashboard, as well as in the review and discussion of required reporting and ad hoc requests.

Supporting Medicaid Agencies with Data

Our Medicaid administrator in one market used our data, dashboards, and recommendations to determine how to re-allocate membership.

Dashboards

Our data-gathering and analytics activities result in the output of numerous dashboards, which we use to evaluate the success of our programs. Our dashboards aggregate data from external and internal data sources (e.g., medical claims, pharmacy claims, HIE, authorizations, etc.) to create a complete, standardized view of what is occurring within the populations we serve. These dashboards visually represent information to allow interactive analysis of various performance metrics. We review and discuss the reports in-depth during cross-functional forums to decide how resources, initiatives, and priorities must shift based on the needs of our members at the point in time. For example, we use our leading indicators dashboard to monitor areas, such as pharmacy utilization, inpatient admissions, and lab testing. We utilize our population risk dashboard to track demographics, behavioral health needs, SDOH, and population health risks to map members by location to identify disparities and gaps in care and implement targeted interventions.

We will provide the Division a customized essential indicators dashboard with the ability to filter for region, gender, CM status, and Patient Centered Medical Home assignment where applicable. Our data liaison will collaborate with the Division regarding which data elements to include in this dashboard. At minimum, it will include the following elements, as referenced earlier in this section:

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Figure 4.2.3.8_C provides an example of the proposed essential indicators dashboard we would provide to the Division.

[redacted]

Transparent and Timely Access to Our Systems and Data

We consistently work with our Medicaid agency partners to provide solutions for access to member and provider information and data. We comply with all regulatory rules when transmitting, storing, and receiving information, and adhere to Division-required formats. We have the technology capability to share information with state Medicaid agencies in several ways, including these preferred methods:

- Exchange of information via industry standard data transmission methodologies
- Creation of custom extracts transmitted to the State for consumption and use in the State's IT systems
- Provision of role-based access to business systems that enable the delivery of Medicaid managed care to members
- Development of a custom view of our data for Medicaid agency staff

We provide to Division-authorized staff real-time, read-only connectivity to our systems and data through our complete integrated care management platform. Within this platform, the Division can securely access our systems to view member data, provider data, care plans, authorizations, encounters, grievance and appeals, SDOH, utilization management, health risk assessments, and risk stratification information. We offer training and documentation on the platform to enable the Division to effectively use and access our members' information, and audit and track staff access to our system.

We can also provide additional enhanced data extracts shared using the Division's secure file transfer protocol (SFTP) connectivity. These data extracts include data and information on member enrollment, prior authorizations, care plans, service plans, assessments, encounters, and other activities compiled as part of our managed care programs. These additional file exchanges enable the Division to consume this data into its platform and query operational data and information relevant to members' ongoing and historical care. As part of the overall solution, the Division can receive file layouts, schemas, and data definitions for each data element to use and interpret. As our data liaison collaborates with the Division to identify and add more capabilities around interoperability standards, we can enable the extension of these data sources as real-time FHIR endpoints with the Division and the broader health care information community.

Data is also collected from our subcontractors who provide services for our members' care through encounter reporting, financial reconciliation, and operational processes. Division staff can access data structures within our MDP, with subcontractor data available as an additional data feed and with the same granularity, quality, and timeliness as data that originates with our plan.

[END OF RESPONSE]

4.2.3.9: Potential Partnerships (Unmarked): 10 points available

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

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

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

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Potential Partnership: Summary Chart

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Potential Partnership: Summary Chart

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Potential Partnership: Summary Chart	
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Care Management Potential Partnerships: Summary Chart	
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Care Management Potential Partnerships: Summary Chart	
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[END OF RESPONSE]

RFQ # 20211210

Management Qualification

TrueCare™

TRUECARE™

4.3: MANAGEMENT FACTORS TABLE OF CONTENTS

4.3 MANAGEMENT FACTORS

4.3.1 Corporate Background and Experience

The Corporate Background and Experience Section shall include for the Offeror details of the background of the company, its size and resources, and details of corporate experience relevant to the proposed Contract including all current or recent MississippiCAN, CHIP, or related projects.

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.

Our response can be found in Appendix F 4.3.1.1, immediately following this section.

Biographical Information					
General Background Information					
Date Business was Established: June 8, 2015					
Legal Business Name as Reported to the Internal Revenue Service: Mississippi True					
Doing Business As Name (if applicable): TrueCare	**Tax Identification Number (required):** 81-3739211				
Ownership Type (public company, partnership, subsidiary, etc.): Mississippi True is a Mississippi membership not-for-profit corporation formed for the purposes of operating a not-for-profit health plan as described pursuant to Mississippi Code Ann. Section 83-5-601, et seq.					
Number of Personnel Currently Engaged in Operations: [redacted]	**Total Number of Employees:** Mississippi True is hiring a full-time, Mississippi-based, CEO/Project Manager, CCO, MD, CFO, Medical Director and COO. Additionally, TrueCare will have 9 part-time employees serving on various committees and a 3rd party auditor on retainer to perform numerous audits throughout the year. [redacted]				
Professional accreditations pertinent to the services provided by this RFQ: Mississippi True holds Mississippi Health Maintenance Organization Certificate of Authority and is certified as a Provider-Sponsored Health Plan.					
Location of the Principal Place of Business					
Address Line 1 (Street Name and Number): 116 Woodgreen Crossing					
Address Line 2 (Suite, Room, etc.): N/A					
City: Madison	**State:** MS	**Zip Code:** 39110	**County:** Madison		
Mailing Address (P.O. Box): N/A	**City:** N/A	**State:** N/A	**Zip Code:** N/A	**County:** N/A	
Location of place of performance of the proposed Contract					
Address Line 1: 382 Galleria Pkwy					

[redacted]

Address Line 2: Sorrento II, Suite 105			
City: Madison	**State:** MS	**Zip Code:** 39110	**County:** Madison
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.**			

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Biographical Information				
General Background Information				
Date Business was Established: CareSource was established in 1989.				
Legal Business Name as Reported to the Internal Revenue Service: CareSource Management Services LLC				
Doing Business As Name (if applicable): N/A	**Tax Identification Number (required):** 31-1703371			
Ownership Type (public company, partnership, subsidiary, etc.): CareSourece Management Services, LLC is an Ohio LLC.				
Number of Personnel Currently Engaged in Operations: There are over 4,500 employees at CareSource.	**Total Number of Employees:** There are over 4,500 employees at CareSource.			
Professional accreditations pertinent to the services provided by this RFQ: We currently maintain NCQA Accreditation for all Medicaid and Marketplace lines of business in the states in which we operate.				
Location of the Principal Place of Business				
Address Line 1 (Street Name and Number): 230 N. Main St.				
Address Line 2 (Suite, Room, etc.): N/A				
City: Dayton	**State:** OH	**Zip Code:** 45402	**County:** Montgomery	
Mailing Address (P.O. Box): PO box 8730	**City:** Dayton	**State:** OH	**Zip Code:** 45401	**County:** Montgomery
Location of place of performance of the proposed Contract				
Address Line 1: 382 Galleria Pkwy				
Address Line 2: Sorrento II, Suite 105				
City: Madison	**State:** MS	**Zip Code:** 39110	**County:** Madison	
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.**				

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4.3.1.1 CORPORATE BACKGROUND

4.3.1.1.2 Corporate Resources

The Offeror may answer the following questions using narratives, charts, and lists as appropriate.
Describe the Offeror's Computer and Technological Resources
Describe the Offeror's Current Products and Services
Describe the Offeror's Intangible Assets
Describe any unique and/or innovative resources in which the Offeror specializes
Describe additional resources of the Offeror

Introduction

Introducing TrueCare, a New Mississippi Medicaid Plan with the Power to Improve the Health of Mississippians and Transform the Delivery of Healthcare in Mississippi

TrueCare represents the Mississippi-focused collaboration between two industry-leading healthcare organizations: Mississippi True and CareSource. Mississippi True is a not-for-profit Mississippi health maintenance organization that was formed by a coalition of Mississippi's most well-established hospitals and health systems to serve as Mississippi's one and only provider-sponsored health plan. CareSource Management Services, LLC (**CareSource**) is a nationally recognized managed care organization with more than 30 years of Medicaid managed-care experience, a not-for-profit mission,[1] a unique member-centric focus, and an established reputation as a leader in quality and operational excellence. As a result, this allows TrueCare to be a worry-free partner to the Division.

TrueCare will harness the synergy between CareSource's unique strengths and Mississippi True's capacity as Mississippi's only provider-sponsored health plan with responsibility as the license holder; however, CareSource will serve as the plan's managed-care program administrator running the day-to-day operations and ensuring fiscal responsibility. By combining CareSource's extensive experience in Medicaid health-plan operations with Mississippi True's deep and longstanding relationship to the Mississippi provider community, **TrueCare offers significant advantages over the typical Medicaid CCO plan** and has the power to improve the health of Mississippians to transform the delivery of healthcare in Mississippi.

For example, TrueCare brings to Mississippi a fully integrated, transparent service delivery model where providers have access to real-time, bidirectional data exchange, next generation member engagement, and education and training with a true focus on health equity. TrueCare will also leverage local physician experience to inform decision-making, align incentives, and reduce friction between the delivery and financing of health care, thereby ushering in a new era of provider collaboration to Mississippi. With these and other industry-leading solutions, TrueCare will empower Mississippians to easily access their benefits and live healthier lives, all while prudently managing the State's resources.

Furthermore, as Mississippi's only truly aligned provider plan model, we are the only Offeror positioned to *"*encourage and facilitate collaboration between Mississippi Medicaid providers and managed care entities to align incentives in support of integrated and coordinated health care delivery, and to encourage the development of appropriate population or community health strategies to better serve Medicaid beneficiaries and the state's health care delivery system as a whole*"* (see Miss. Code Ann. § 83-5-601(1)). Moreover, as a local, not-for-profit, TrueCare offers substantial value by ***keeping Mississippi's money in Mississippi***.

The History and Experience of Mississippi True and CareSource

Mississippi True is Founded as State's Only Provider-Sponsored Health Plan

To create Mississippi's first fully integrated payer-provider organization, 65 Mississippi hospitals and health systems formed Mississippi True, a not-for-profit health plan licensed as a Mississippi health maintenance organization with payer-provider health plan certification (refer to Figure 4.3.1.1_A). These founders chose to

[1] CareSource Management Services, LLC is the subsidiary of CareSource, a not-for-profit. All CareSource family companies share the same not-for-profit mission.

invest in Mississippi True because they believe in the power of the payer-provider integrated model to truly transform Medicaid in the State, both in terms of the delivery of services to members and the management of taxpayer dollars. The investment further commits Mississippi hospitals to taking financial risk as a partner of the Division with the goal of improving the lives of Mississippians.

The hospitals and health systems that founded Mississippi True have been part of the fabric of Mississippians' lives for over a century, all the while ensuring that Mississippians have a better quality of life. They are deeply rooted in Mississippi's communities, are trusted by Medicaid members, and have been serving Medicaid patients since the program's inception. Mississippi True's member hospitals and health systems are committed to improving outcomes for all Mississippians. **Together, the founding members employ more than 30,000 Mississippians, including thousands of Mississippi physicians.**

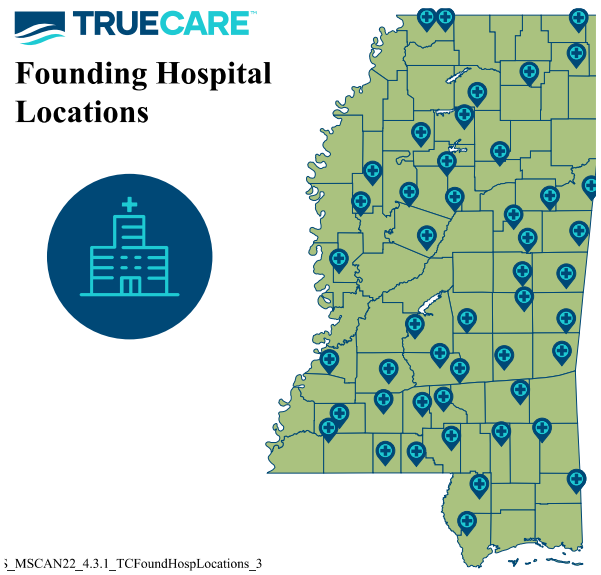
Mississippi True Chooses CareSource to Power TrueCare

To identify the best managed-care program administrator, Mississippi True conducted an exhaustive, nationwide search to partner with a management care organization with the experience, capacity, shared not-for-profit mission and values in improving lives by caring for medically vulnerable individuals, and commitment to investing in Mississippi. Mississippi True recognized the importance of fulfilling the State's objective in enacting the PSHP legislation, which was to align provider and CCO incentives to improve integration and coordinated health care delivery for all Mississippians. Consequently, Mississippi True looked for a partner with deep government programs experience evidenced by successful implementations and positive government-client feedback to support its payer-provider model.

Of all the organizations that Mississippi True evaluated, CareSource most decidedly met and exceeded all qualifications needed to support TrueCare's goal of transforming the delivery of Medicaid services for MSCAN and CHIP members. CareSource's extensive qualifications include, among other things, the following:

Figure 4.3.1.1_A: TrueCare Hospital Locations[2]

Mississippi True's founding hospitals cover the state of Mississippi, giving us unparalleled knowledge of local communities' strengths and needs.



- CareSource puts **people over profits.** Without shareholders to satisfy, and with a not-for-profit mission, CareSource will allow TrueCare to optimize the State's funds for enhanced member services and value-based purchasing (**VBP**) incentives. This ultimately means TrueCare will direct more health care dollars to member care than for-profit CCOs will.

As evidenced in its other markets, CareSource has a deep commitment to the communities it serves through reinvestment in the community. CareSource far exceeds the social determinant of health (**SDOH**) resources other CCOs make available to Medicaid members. As described throughout this section, CareSource has a **national reputation as a leader in SDOH services** for Medicaid members, effectively using SDOH programs to reduce health care costs, increase quality of life, and increase health equity across multiple Medicaid markets.

> We are excited about CareSource's comprehensive focus on addressing social determinants of health in Mississippi. This is much needed in communities across the state.
>
> **- Ira E. Murray, PhD, President & CEO, United Way of the Capital Area**

[2] Graphic identifier number included at the bottom of graphic is used for internal tracking purposes.

- CareSource is dedicated to serving members in vulnerable communities. Indeed, CareSource **is the only national managed care organization that focuses on helping members move off Medicaid and CHIP and into competitive and gainful employment** by providing unique employment supports through the CareSource JobConnect™ program.
- CareSource has a demonstrated history of working to improve the lives of all Medicaid beneficiaries in the markets it serves, and not just for its own members. Consequently, the government programs that it participates in are improved by CareSource's collaborative spirit and desire to better the lives of the states it serves. For example, in Indiana, CareSource's "Justice Involved Reentry Program" is available to members of any Medicaid plan (not just CareSource's plan), which demonstrates how **CareSource creates innovative programs to benefit Medicaid and CHIP beneficiaries—no matter which Medicaid or CHIP health plan in which they are enrolled.**
- The CareSource family of companies has over 30 years of expertise in Medicaid managed care and is **wholly dedicated to government health care programs** in its markets, including Arkansas, Georgia, Indiana, Kentucky, Ohio, and West Virginia, where CareSource serves almost 2.3 million members in government programs.
- Through all programs, including Medicaid, Medicare, Dual Eligible Special Needs Plans, and Marketplace products, CareSource serves members though all stages of their lives.
- CareSource brings the support of its national organization's **vast resources to support the delivery of Mississippi's MSCAN and CHIP programs**, including the tested and proven innovations and products and services currently supporting Medicaid members in other markets. This includes a demonstrated history of operational excellence in the areas of claims payment, timely authorization, and reporting, among others.
- CareSource demonstrates its commitment to the markets it operates in through the CareSource Foundation, which makes **meaningful contributions to develop the capacity of local, community-based organizations.**
- CareSource has the **capability to customize and scale** its programs and services to the meet the unique needs of Mississippians.
- CareSource has a proven reputation for **prudently and effectively harnessing both public and private resources** to improve the lives of medically vulnerable beneficiaries.

For these reasons, CareSource was determined to be the best partner to serve as TrueCare's managed-care program administrator, and TrueCare is confident that CareSource's extensive experience, innovative solutions, and collaborative approach will empower TrueCare to transform the health and lives of MSCAN and CHIP beneficiaries in Mississippi through its day-to-day operation of TrueCare. Recognizing the opportunity for change created by our alliance with CareSource, Mississippi True branded itself as TrueCare.

TrueCare will Change the Trajectory of Medicaid and CHIP in Mississippi

TrueCare brings a next generation Medicaid model along with health information technology, operational capabilities, and programs and services that can meaningfully improve the wellbeing and quality of life of Mississippi Medicaid beneficiaries. We offer an industry-leading model, bringing the first real-time, bidirectional, data-exchange capabilities to MSCAN and CHIP programs through our unique IntelliTrue connection to hospitals, community mental health centers, patient centered medical homes, federally qualified health centers, and rural health centers. We will encourage all CCOs to replicate TrueCare's level of data connectivity, thereby changing the trajectory of Mississippi healthcare through the exchange of actionable data that eases provider burden and facilitates timely coordination of care for members. TrueCare's next-generation member engagement and education, community-based coordinated care, and operational excellence will usher in a new era of provider collaboration for Mississippi. Figure 4.3.1.1_B summarizes TrueCare's core differentiating capabilities:

Figure 4.3.1.1_B: TrueCare's Differentiators Align with Division Priorities

MS_MSCAN22_Win Themes Marked_2

TrueCare's Corporate Resources

As demonstrated, TrueCare is well-positioned to serve as an accountable partner to the Division, bringing innovative Medicaid programs and sophisticated IT systems to MSCAN and CHIP members. With a firm commitment to the delivery of services through a localized approach, we will leverage our close relationships with network providers, Community Based Organizations (CBOs), the Division, and other stakeholders, and we will dedicate a local team of Mississippians to enhancing member engagement and improving health outcomes.

[redacted]

In the following, we detail the resources, programs, and services TrueCare will bring to Mississippi, which are **tried and tested** in other markets and **will have a direct impact on bettering the lives of Mississippians**.

TrueCare's Computer and Technological Resources

Bidirectional Data Sharing with Providers

Our data connectivity with Mississippi providers is one of our most powerful resources. It will enhance Mississippi providers capabilities to practice medicine and the way members receive and manage their care. This resource is comprised of multiple components, which are detailed in the following subsections:

[redacted]

GuidingCare

Our integrated clinical platform, GuidingCare, provides real-time, bidirectional sharing of clinical data and supports electronic health record (EHR) integration. It tailors reporting to enable successful administration for Division programs. We will use Guiding Care to support our population health approach, thereby improving the health of those Mississippi members experiencing health disparities to mitigate the impact of health inequity and unmet social needs. Specifically related to data sharing, GuidingCare:

- Allows providers and external case managers (e.g., Mississippi Department of Child Protection Services) to view member care plans and authorizations
- Exchanges data in compliance with HIPAA standards for electronic exchange, national provider identifier (NPI), and privacy and security requirements (e.g., 45 CFR 162 and 164), and Appendix A, Section 16.5
- Manages provider grievances and appeals related to clinical issues
- Supports making all collected data available to the Division, CMS, the Mississippi Department of Insurance, and other oversight agencies
- Allows for bidirectional communication between providers and care managers via the provider portal

IntelliTrue

TrueCare is dedicated to supporting the Division's vision to develop interoperability and data-sharing among the Mississippi health care community. TrueCare has access to the Mississippi Hospital Association's (MHA) statewide health information exchange (HIE): IntelliTrue. This innovative approach to data-sharing was recently noted in the Division's 2021 Comprehensive Quality Strategy as being well positioned to positively impact healthcare outcomes by providing hospitals, providers, commercial insurers, and appropriate State agencies improved access to clinical data.

Our Commitment to Accountability

As of February 2022, more than 85 of the largest hospitals, behavioral health hospitals, Community Mental Health Centers (CMHCs), and accountable care organizations (ACOs) are participating in IntelliTrue, covering 80% of the discharges across the state.

TrueCare is the only CCO proposing to use IntelliTrue, a one-stop, real-time data platform designed to house member data across longitudinal plans of care. We will incorporate this data into our care plans and workflows. IntelliTrue provides a significant advantage that goes beyond simply sharing ADT data. It has the unique ability to identify, ingest, and share patient data surrounding SDOH, care gaps, medication adherence, and more. IntelliTrue uses dashboards and workflows providing real-time notification of each data point collected. IntelliTrue also serves as a workflow engine that allows uses to both share and edit information. Dashboards are provided for real-time actionable data such as post-acute scheduling. IntelliTrue eases appointment scheduling by finding and communicating with providers based on a specific mile radius, specialty, and availability.

The platform is electronic medical record (EMR) agnostic and has integrated with Epic, Cerner, and Allscripts. IntelliTrue drives quality of care across all domains, and it will be a common denominator in elevating the health of all Mississippians.

Azara

To help members see their primary care physicians at federally qualified health centers (FQHCs) and rural health clinics (RHCs), we contract with Azara, a centralized data reporting and analytics solution that facilitates care transformation, drives quality improvement, aids in cost reduction, and simplifies mandated reporting. Specifically, Azara provides quality reporting to assist in member scheduling and report gaps in care. Benefits of Azara include the ability to accurately determine FQHC and RHC incentives and generate reports for the State that detail the amount of direct reimbursement paid to an FQHC or RHC.

i2i

As part of our agreement with i2i, we can communicate directly with our providers' EHR vendors (such as Epic, Cerner, and eClinicalworks) to tailor solutions for data sharing. i2i's Population Health Technology platform is used for bidirectional feeds of electronic medical records data from the EHR system to TrueCare and to communicate gaps in care. This data exchange not only allows us to share member information and gaps in care directly to the provider's EHR, but also eliminates the administrative burden associated with chart review requests.

Medicaid Management Information System (MMIS)

In support of the Division's ongoing efforts to enhance the use of health care data to improve quality, transparency, and outcomes, TrueCare will leverage CareSource's HIPAA-compliant MMIS to ensure the effective administration plan benefits. Our MMIS will be HITRUST-certified before the initiation of the new contract period. This fully integrated MMIS supports all business functions described in the RFQ, including utilization, grievances and appeals, enrollment and disenrollment, authorizations, claims management and benefit administration, care management, customer service, finance and accounting, and interoperability and electronic data exchange capabilities. Our MMIS is compliant with functional requirements as stated in 42 CFR 438.242, including performing data receipt, transmission, integration, management, assessment, and system analysis tasks described in Section 1.12 of the Appendix A.

Our MMIS fully aligns with and supports the Division's health information technology initiatives, offering interoperability and data exchange capabilities with Mississippi Medicaid providers and their clinical systems. For example, our MMIS uses sophisticated tools to aggregate, analyze, and share provider-based clinical data across the clinical landscape, supporting advanced population health and quality measurement initiatives. Our MMIS leverages best-in-class applications like Facets, Edifecs, GuidingCare, and SAP, and it is compliant with all federal privacy and security requirements, including 45 CFR 162 and 164 and Appendix A.

Components of our MMIS

Table 4.3.1.1_A outlines the major components of our MMIS and the core functions they play in supporting the MSCAN and CHIP programs:

Our Commitment to Health Information Technology

Since 2018, CareSource has invested more than $500 million to ensure a secure, stable, and scalable MMIS and infrastructure.

Our Commitment to Security

A HIPAA Security Risk Analysis performed by ecfirst in 2020 confirmed that our MMIS was fully compliant with all HIPAA security, privacy, and breach notification requirements.

Table 4.3.1.1_A: Major Components of our HIT

Systems	Functional Description
Member Enrollment	
Facets® Core Administration Platform	Enrollment and disenrollment management; provides direct integration with GuidingCare, our integrated clinical platform
Edifecs EDI Manager	Facilitates the loading and processing of 834 enrollment files, maintains enrollee data and attributes
Member Services	
Microsoft Dynamics	Member portal, member mobile application, social media, interactive voice response (IVR), video and message chat
Care Connect	A member focused digital engagement page that is leveraged to promote the service options that are available to members, such as: ▪ Engaging with members services via live chat or phone ▪ Speaking with a nurse through our 24-hour Nurse Advice Line and 24-hour behavioral health substance use support line ▪ Scheduling and conducting video telehealth appointments for both same day needs and future appointments ▪ Receiving assistance with SDOH needs through Life Services

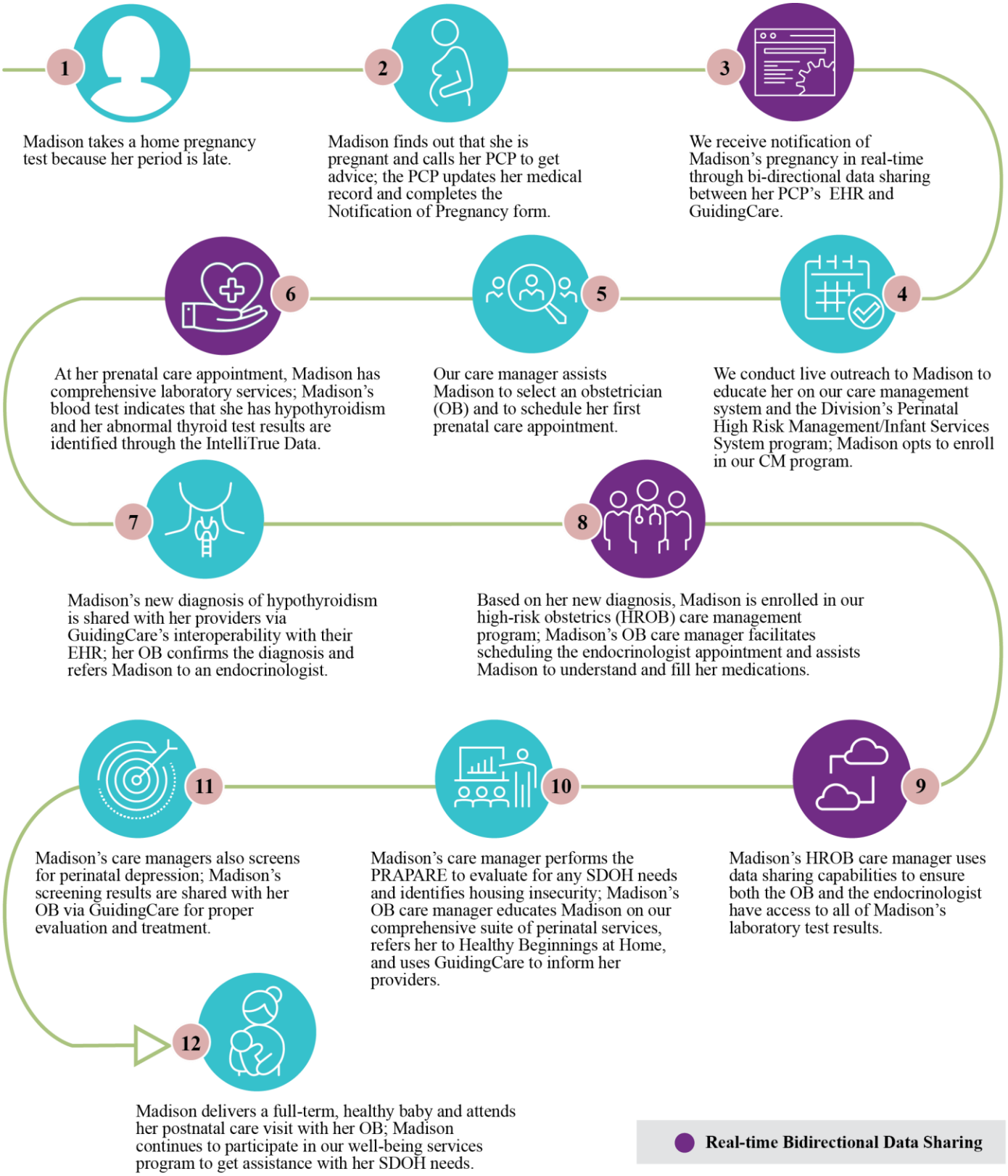
Care and Utilization Management	
GuidingCare®	Integrated clinical platform delivering a 360-degree view of each member. Core modules included: ▪ Utilization management (UM) (e.g., authorizations) ▪ Care management (e.g., assessments, care plans, bidirectional communication with providers) ▪ Social determinants of health ▪ Appeals and grievances ▪ Analytics (e.g., predictive modeling)
MCG CareWeb	Evidence-based care guidelines to support clinical decision-making, transitions between care settings, and documentation
MCG Transparency Portal	Allows providers to view all MCG Guidelines TrueCare uses
Indicia	Evidence-based clinical decision support for providers
Care Web QI	Evidence-based clinical guidelines for payers
Cite® AutoAuth	Payer and provider automated evidence-based system to facilitate prior authorization processes
Collaborative Care	Payer and provider ability to communicate via EHR and collaborate on evidence-based criteria, currently for inpatient admission
Clinical Practice Registry	Online tool available to providers to identify and prioritize needed health care services, screenings, and tests for TrueCare members. The tool supports: ▪ Identifying gaps in care ▪ Holistically addressing member care ▪ Improving clinical outcomes
Data Management	
Facets® Core Administration platform	Provider enrollment and network management
I-Network	Next generation provider data management system that enables us to manage master provider file processing
Choreo	Library of contract component templates to build uniformed provider contracts
NetworX Modeler	Analysis of provider contracts and do “what if” scenarios based on historical claims data from Facets
I-Network	A provider management software that standardizes and streamlines the ability to track, centralize, and manage provider information
IntelliTrue	A one stop, real-time data platform designed to house member data across longitudinal plans of care
Provider Services	
Microsoft Dynamics	Provider portal, telehealth, IVR, video and message chat
Call Centers	
Cisco Unified Contac Center Enterprise w/ Nuance Iteractive Voice Response	Multi-channel, natural language, self-service comunication platform. Enables customer interactions supporting automated routing and self-service functionality including: ▪ Explanation of Member Benefits ▪ Member Eligibility Lookup ▪ Member Claims Status ▪ Provider Claims Information and Status ▪ Replacement of Member ID Card ▪ Select a new PCP
Claims Processing and Payment Management	
Facets Core Administration platform	Claims and payment processing, third party liability, and coordination of benefits
OPTUM Claims Editing System (CES)	Applies added logic when processing claims for payment
Health Cost Guidelines Grouper	EasyGroup – Manages prospective payment systems (PPS); Compares and contrasts cost across regions
Payment Integrity Manager	Identification and avoidance of improper payments, overpayment recovery, fraud detection and prevention, validation and compliance with regulations, and resulting cost savings efficiencies
Encounter Management	
Edifecs Encounter Platform	Comprehensive encounter management system that provides integrity, security and streamlines encounter management according to state specific submission guidelines

Financial Management	
SAP®	Financial accounting and reporting, member billing and collections, and provider payments
Reporting and Analytics	
▪ **Synapse Analytics** ▪ **Power BI** ▪ **SSRS**	Our data analytics and reporting capabilities enable our business operations to improve health outcomes, reduce medical costs, manage administrative costs, increase the ability to respond to market disruptors, expand value to members, and efficiently react to State and Federal changes: ▪ Regulatory reporting required for state and federal entities ▪ Operational reporting to monitor service levels, contract compliance, and performance ▪ Analytical reporting to manage care, services, and outcomes
Clinical Data Exchange/Interoperability	
Healthshare	Provides clinical data sharing and electronic health record (EHR) integration. Our modernized technology platform enables data sharing capabilities for interoperability and cloud-based integration. These capabilities allow near real-time data integration between our operational systems with other entities that have similar capabilities. This provides a bidirectional exchange of claims, member eligibility, care plans, and other data.
Core Identity and Access Management	Core identity and access management technology includes enterprise identity and access management (Sailpoint), privileged identity management (Thycotic), multi-factor authentication, single sign-on, and customer identity and access management (OKTA).
Palo Alto	Scalable perimeter defense is provided by machine learning powered next generation firewalls, which also includes intrusion prevention, advanced threat protection, and application control
Security	
Remote Access Control	Remote access is controlled by Cisco virtual private networking (VPN) appliances and VMWare Virtual Desktop Infrastructure (VDI) technologies that require multi-factor authentication for access
Detection and Response	Detection and response technologies include a security information and event manager (Splunk) for log aggregation and alerting, a user and entity behavioral analytics (Exabeam) tool for detecting anomalous activities, and security orchestration, automation, and response (Palo Alto SOAR) solution that enables rapid detection and response to potential cybersecurity attacks and insider threats
ProofPoint	Advanced email security and threat protection
EndGame	Leverages machine learning technology to provide robust protection against evolving threats such as ransomware and previously unknown attacks
Symantec Data Loss Protection (DLP)	Provides robust email, network, and endpoint protection against loss of protected health information (PHI) and other sensitive information. Our email exchange is configured to use a minimum of TLS 1.2 for all email exchanged and can enforce minimum TLS 1.2 or greater encryption. Any email that contains PHI uses Zix secure email gateway. Zix supports modern encryption protocols, such as TLS 1.2 and TLS 1.3

Figure 4.3.1.1_C illustrates how our real-time, bidirectional, data-sharing capabilities facilitate the healthcare journey of a fictional TrueCare member, “Madison.”

Figure 4.3.1.1_C: Madison's Journey to a Healthy Delivery: Supported by Interoperability and Data Sharing

TrueCare's real-time, bidirectional, data-sharing capabilities support the timely and effective delivery of care.



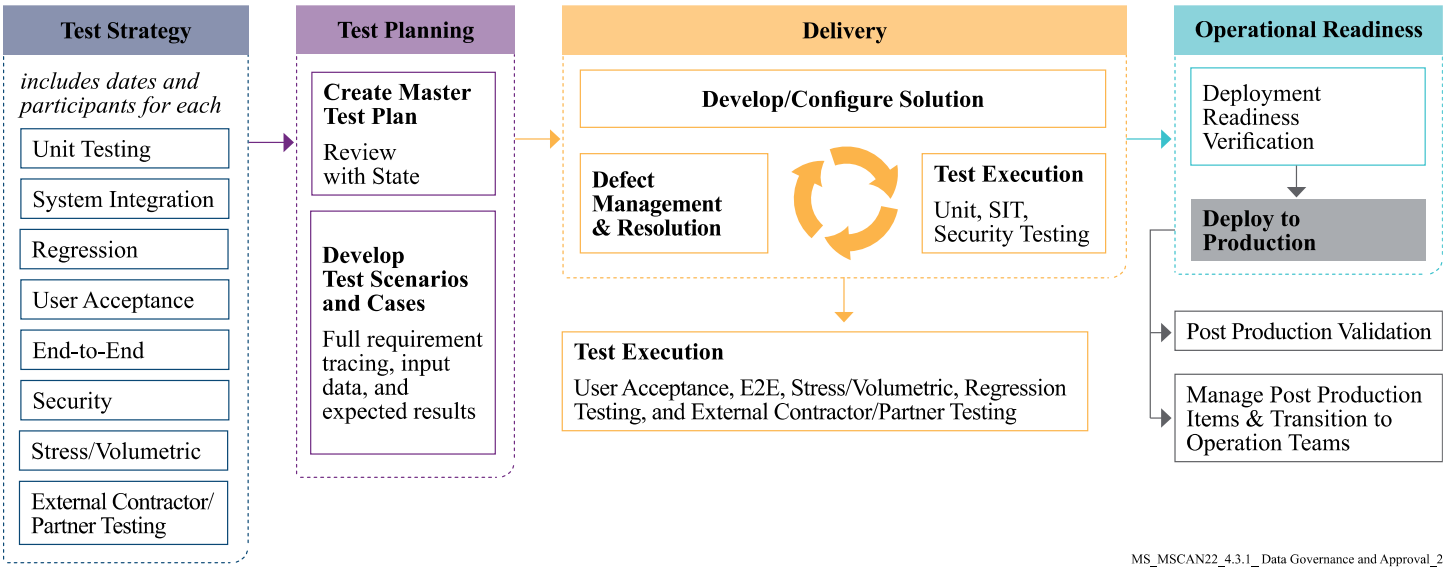
Data Governance and Approval

In compliance with the RFQ and Appendix A, TrueCare will practice strict change control, quality, testing, and release management practices to identify, evaluate, and address any potential business impacts from planned system changes in collaboration with Division IT counterparts. We will maintain a technology roadmap that defines key objectives for our MMIS and includes milestones for upgrades, releases, and enhancements. We will achieve application availability and stability through a disciplined strategy of applying updates and software releases transparently and with rigorous quality and testing controls (see Figure 4.3.1.1_D). We also will conduct annual benchmarking and process maturity assessments, not only to evaluate our performance but also to identify continuous improvement goals so that we consistently outperform targeted industry benchmarks.

Our IT strategy and governance processes will provide oversight and direction to the timing and sequencing of all IT projects, including those requested by the State as part of the initial contract or amendment. We will work responsively and collaboratively with the Division on any new requirements and will use a disciplined process to keep constituents informed of any TrueCare-initiated technical changes that may affect the State, vendors, or contractors. Our release management process includes mechanisms for communicating minor and major system changes in the timeframes specified in the contract. The level of rigor and cross-team collaboration we will apply to testing management reflects our dedication to delivering high quality solutions to our partners and their constituents. All system upgrades and enhancements will include plans, timelines, milestones, and descriptions of each testing component prior to implementation. We provide these to the Division upon request.

Figure 4.3.1.1_D: TrueCare's Technology Roadmap for Upgrades, Releases, Enhancements

Our rigorous data governance strategy and processes ensure all updates to our applicable business applications and systems are implemented successfully



Resources Supporting Business Continuity and Disaster Recovery

TrueCare's digital ecosystem will run on highly secure, resilient, and scalable infrastructure that consistently meets application and network availability targets of 99.99%. Our information systems and related infrastructure are built on geographic resiliency, network carrier diversity, and near real-time failover. All key systems (server, database, network, power, and cooling) are fully redundant. Our physical data centers connect through a redundant, high-speed network forming a single, logical data center that allows critical systems to be active in all data centers at the same time. This includes physical servers in multiple locations for Tier 1 and Tier 2 applications that support mission critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, provider enrollment, and encounter data

management. Should data loss occur due to unforeseen circumstances, we are able to immediately restore the data from either a replicated location or from the offsite media.

TrueCare's Products and Services

The products and services that TrueCare will bring to Mississippi are powered by CareSource's expertise and experience managing Medicaid health plan operations and have been proven effective in other markets. This includes claims payment and encounters, population health and health equity programming, utilization management, quality management, grievances and appeals, program integrity, and all other operational requirements outlined in Appendix A. We are committed to harnessing CareSource's experience in each of these programs while also tailoring them to meet the unique needs of Mississippi's MSCAN and CHIP programs. We will also leverage the programs, products, and services of the hospitals and health systems participating in our fully integrated payer-provider model as described in the "Additional Resources" section.

TrueCare's Clinical Products and Services

We will offer a variety of clinical products and services, including those detailed in Table 4.3.1.1_B:

Table 4.3.1.1_B: Clinical Products and Services

Care Management	
Integrated Care Management System	Our Integrated Care Management (ICM) system holistically addresses members' physical, behavioral, and social needs. It includes services and supports to promote evidence-based health education and disease management and prevention, continuity of care, transition of care, and discharge planning. It promotes timely access and delivery of health care and services and coordination of care, including physical, behavioral, and substance use disorder (SUD) services. Working with community-based organizations, we will identify socioeconomic disparities and challenges specific to Mississippi communities, address social determinants of health using closed-loop referrals, and implement creative initiatives to engage difficult-to-reach members. We will staff our ICM system with regionally based teams equipped to provide population-based services. We will embed our staff members in key provider locations (e.g., high volume hospitals and emergency departments (EDs), FQHCs, RHCs, and PCMHs), community-based organizations, faith-based organizations, and State agencies. Our care managers will be specially trained to provide targeted services to high-risk populations, such as foster children, high-risk maternity, NICU, behavioral health (BH)/SUD, Native Americans, and members of all mandatory populations described in Section 3.1.1.2 of Appendix A. **John | Meeting Member's Behavioral Medical, Behavioral, and SDOH Needs** The effectiveness of our ICM system is illustrated by CareSource's use of the same system in another market to assist "John,"[4] a CareSource member who lives with alcoholism, anxiety, atrial fibrillation, substance use, congestive heart failure, pleural effusion, and malignant neoplasm of the lung. He was living in his van, while receiving chemotherapy treatments, and was involved in a serious car accident that left him with numerous broken ribs. John's goal was to find housing, obtain food stamps, and gain access to necessary care for the treatment of his cancer. Lisa, who is John's care manager, located a secure, newly remodeled subsidized apartment, where he is only required to pay 30% of his income. To accomplish John's housing goals, Lisa contacted a local volunteer Catholic organization that paid his apartment deposit and another faith-based organization that furnished his home. Lisa then worked to help John gain access to food stamps. John now attends his routine medical appointments and chemotherapy and has expressed on several occasions how much he appreciates the support and services he has received from Lisa.
Transition of Care Program	Our Transition of Care (TOC) program will promote timely, coordinated, and safe transition between health care settings to help prevent unnecessary emergency department use and readmission. Our approach is grounded in the evidence-based Coleman Model, which includes medication adherence, signs and symptoms of worsening conditions, follow-up with PCPs/PCMHs, and the use of personal health records. In addition, we will use advance care planning that specifically

[4] The member's name has been changed in this Qualification to protect his identity.

	addresses the functional needs of the member and SDOH. TOC care managers will work with member-assigned care managers and providers to facilitate seamless coordination of care. Across three other Medicaid markets, CareSource used the same TOC program to drive average 7-day and 30-day all-cause readmissions rates to 7.5%, which is significantly lower than the national average of 13.7%.
Maternal and Child Health	
Pregnancy and High-Risk Pregnancy Care Management Program	Our pregnancy and high-risk pregnancy care management program consists of cross-functional teams, including a maternity and high-risk pregnancy care management team, a neo-natal intensive care unit care management team, a Pregnancy Engagement Initiative team, and a Women's and Children's Health Outcomes team. Working in an integrated manner, these teams will provide support related to the physical, behavioral, and social needs of all pregnant TrueCare members. This includes screening members for risk, conducting the health needs screening, planning with members for proactive decision-making and access to family planning options, and completing additional trimester assessments, including prenatal and postpartum depression screening for those members that are at risk. Through this program and our predictive analytics, we will identify early pregnancy and provide effective care management and complex case management. Using the same program, CareSource has achieved favorable results in other markets, including the following: ▪ Indiana Medicaid Members: From 2017 to 2019, 38% increase in timeliness of prenatal care and 40% increase in postpartum visits ▪ Georgia Medicaid members: From February to August 2021, a targeted, multi-channel outreach campaign contributed to a 49% increase in the percent of women receiving post-partum care
Pregnancy Engagement Initiative	Our Pregnancy Engagement Initiative is designed to reduce infant mortality by supporting pregnant members residing in areas with poor access to maternal care who use tobacco, have a high body mass index, or are diagnosed with gestational diabetes, with a focus on addressing health disparities for Black women. Life Coaches, Peer Support Specialists, and Community Health Workers support women with in-person visits, making sure they receive needed screenings, are connected to care management, and receive all medical, behavioral, and social services they need to meet their whole-person and family needs. CareSource used the same initiative in Indiana, where it has an 81% engagement rate. Of engaged members: ▪ 67% attended an in-person meeting with the Life Coach ▪ 77% (of those without a Life Coach meeting) completed a health screening ▪ 85% enrolled in care management ▪ 100% of the women identified as tobacco users were referred to tobacco Quitline and/or were given tobacco cessation education resources ▪ 100% of women engaged during their pregnancy had a live birth
High Risk Maternity Center of Distinction	Our High-Risk Maternity Center of Distinction, which we will implement in partnership with Baptist Memorial DeSoto, Baptist Memorial Golden Triangle, and Baptist Memorial North Mississippi, will use telehealth for rural, high-risk pregnant members through text, audio, and video-based communication. Care will be provided during pregnancy, post-partum, and neonatal periods, including one-on-one primary care, midwife care, nutritional therapy, and behavioral health care. It also will include group prenatal care facilitated by midwives trained in the Centering Pregnancy group model of care, with a focus on co-morbid conditions and risk factors. This telehealth solution will include close coordination with hospital discharge planners and pediatric care providers for all infants (including those with a NICU stay) and will provide immediate tele-neonatology post-NICU discharge to prevent emergency department utilization and hospital readmissions, in close collaboration with OB/GYNs who serve as members' primary, prenatal providers. Bidirectional referrals and clinical note-sharing affords continuity of care across in-office prenatal care, enhanced primary care, and group prenatal care programs. This collaboration also ensures prenatal care providers are aware of our management of shared members and provides an option for prenatal care providers to refer their members with additional clinical or social needs for support beyond what can be addressed in typical prenatal care office visits. For infants admitted to the NICU, services assist families in preparing for discharge and continue for one year of infant life to support successful care at home, including remote monitoring, if needed. This coordination also helps families prepare their homes (e.g., car seat, safe sleep environment, CPR training, etc.) and provides access to telehealth services for post-partum care, including mental health and lactation counseling, infant urgent care, and home care for babies born with jaundice and other newborn conditions.
Women's and Children's Health Outcomes Program	Our Women's and Children's Health Outcomes Program is comprised of a locally based team of nurses with backgrounds in obstetrics and pediatrics who partner with key local community stakeholders that provide valuable services and resources to pregnant and new mothers to improve coordination of care, promote awareness, conduct education, and build initiatives to improve outcomes. We will identify local, community-based organizations to co-host events that support our members and all mothers in the community who are interested in whole-person, integrated, pre-conception, pregnancy, and postpartum services.

Healthy Beginnings at Home	According to the Centers for Disease Control and Prevention, Mississippi's infant mortality is the highest in the nation, with 9.1 deaths for every 1,000 live births in 2019.[5] We believe our Healthy Beginnings at Home program can help improve this statistic through outreach and initiatives focused on combating the high rate of infant mortality faced by our members, including lack of appropriate prenatal care and SDOH factors such as food and housing insecurity. Indeed, we have already established a partnership with Sisters in Birth to implement the program in Hinds County with a focus on combatting low birth weight births. CareSource has achieved success through the same Healthy Beginnings at Home program in Franklin County, Ohio, where members participating in the program had a 15% reduction in emergency hospital stays prior to delivery, a 60% reduction in NICU utilization, a 72% reduction in the NICU average duration of stay (8 days compared to 29 days), and reduced readmission rates. **Kayla | Supporting Pregnancy and Birth Outcomes through Healthy Beginnings at Home** The effectiveness of our Healthy Beginnings at Home program is illustrated by CareSource's use of the same program in another market to assist "Kayla,"[6] a 34-year-old mother of five with 10 prior pregnancies. She previously gave birth to six premature infants, one of whom later died in a sleep-related incident. With the support of our Health Beginnings at Home program, providing rental subsidies for pregnant women facing housing insecurity, coupled with Kayla's own determination, Kayla gave birth to her sixth child, a full-term healthy baby girl, who recently celebrated her first birthday and who resides in a safe and loving home with her mother and her five siblings.
Postpartum Care via Nurse Practitioner Telehealth	Through our Postpartum Care program, nurse practitioners close gaps in care and offer coordinated care with providers for targeted populations, thereby reducing costs and improving access to care. Our Mississippi program goal is to close care gaps for postpartum women, preventing complications and reducing unnecessary cost by delivering appropriate care and linkage to ongoing services. We will identify targeted populations using claims and gaps-in-care data. Nurse practitioners, with oversight of a medical director, will complete outreach and schedule members for virtual visits using our advanced technology platform. Nurse practitioners will have access to our integrated care management documentation system, which includes outreach information, assessments, and care plans. Members can connect to TrueCare nurses in a virtual appointment environment using smartphones, tablets, or computers. Nurse practitioners will address medication plans, monitor labs and vitals, and provide education on preventive health care (such as well-child visits) using evidence-based guidelines. As part of every visit, the nurse practitioner will connect each member with their primary care or OB/GYN provider and assist with scheduling the next appointment. We will evaluate program outcomes annually and identify activities and goals that improve member engagement and experience through our Quality Enterprise Committee. Using the same program in 2021, CareSource was able to close gaps in care for 54% of women identified as needing a postpartum visit. TrueCare will provide members with a postpartum telehealth visit with a nurse practitioner based on analysis of their delivery claims. We will assess maternal and infant well-being and facilitate referral/scheduling with the primary OB or pediatric provider for urgent issues identified during the visit, which visit will be scheduled between delivery and the provider postpartum visit. We will provide education on birth-spacing and contraceptive options (including long-acting reversible contraceptives), breastfeeding, infant care, and safe sleep. The nurse practitioner will share results with the member's primary medical provider/OB and help the member in scheduling follow-up visits with her established provider. We also will offer telehealth visits for mothers and children over two years of age to augment the care they receive from their providers and address preventive health needs and clinical concerns.
No Cost Maternal and Child Health Education	Where appropriate, we will connect members to The Rush Family Birth Center, which offers many no-cost classes, including childbirth, breastfeeding, and taking care of a newborn. Rush designed and implemented the Baby Application, which offers convenient access to information such as a kick counter, contraction timer, personal journal, feeding log, immunization log, and information about delivering a baby at Rush Hospital.
Behavioral Health and Substance Use Disorder	
SUD Medical Home Recovery Support	[redacted]

[5] https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm

[6] The member's name has been changed in this Qualification to protect her identity.

	[redacted]
TrueCare Command Center	The "Command Center" is TrueCare's rapid response unit of care managers, care coordinators, life coaches, and peer supports that can be dispatched in real-time to support members identified as at risk of a BH crisis. The Command Center relies on advanced data analytics to predictively identify members at increased risk of unplanned hospital admission and dispatches resources to connect with the member and their identified natural and provider supports to create a robust person-centered plan, inclusive of a crisis plan. The Command Center team focuses on individual member needs and goals, strategic and coordinated planning to address opportunities to coach on ambulatory care options, access to care issues/SDOH opportunities, and geospatial/health disparity analysis to develop strategies to address needs and provider availability to enhance member and population-level outcomes. The team is supported by clinical pharmacy, provider relations representatives, member services, analytics, physical health and behavioral health directors, and UM to ensure a robust response to the member's needs.
Collaboration with Local Providers to Increase Access for TrueCare Members	TrueCare will co-locate community health workers and peer support specialist to assist members at a variety of settings including but not limited to: **Outpatient Behavioral Health Services:** ▪ Baptist Memorial Health Care offers comprehensive counseling, education, and treatment for children, adolescents, and families in Booneville, Southaven, and Columbus for a wide variety of BH conditions. Services are provided in a day treatment environment, allowing children to remain in the home. ▪ South Central Regional Medical Center offers outpatient BH services for children over 5 years old. The team of experienced professionals includes physicians, psychiatric nurse practitioners, licensed professional counselors, social workers, nurses, behavioral health technicians, and an activity director. ▪ Forrest Health Systems offers outpatient BH services for children and adolescents at their state-of-the-art facility in Pine Grove. Services include psychiatric, SUD, eating disorder, and sexual disorder. **Inpatient Behavioral Health Services** ▪ Forrest Health Systems offers inpatient BH services for children and adolescents including psychiatric, SUD, eating disorder, and sexual disorder. Pine Grove coordinates with schools to ensure children receive continuity of school education while inpatient. ▪ Inpatient Behavioral Health services offered at Brentwood, Parkwood and Gulfport Behavioral Health are key providers in more populated areas
School-based Services	TrueCare will collaborate with St. Dominic Health Services nurses to provide services to children with BH conditions at elementary and middle schools in the Madison County School District and will expand outreach programs like those underway at Velma Jackson High School.
Suicide Prevention	As a result of its 2016 community health needs assessment, Pine Grove developed targeted goals to address suicide prevention for children and adolescents. Services include a Suicide Awareness and Response team, which coordinates with schools and assist educators in understanding suicide risks. They also offer a link on their website with resources related to suicide prevention. TrueCare will expand on these efforts by deploying a statewide Suicide Prevention health literacy campaign through a multi-modal campaign to support adolescents in mental health self-care, assessing resources when needed and preventing escalation and suicide.
be me HEALTH	To increase Mississippi teen access to and engagement with appropriate behavioral health services, TrueCare will offer "be me HEALTH," a teen-centric behavioral health platform designed to improve the mental health and emotional well-being of our adolescent members. It serves as an early intervention program to reduce the need for crisis intervention and to help teens engage in outpatient behavioral health services. The platform has compelling and age-appropriate content about adolescent behavioral health issues, as well as the capability for teens to receive texts with tailored, pertinent content from behavioral health coaches and licensed clinicians to support them with their own emotional concerns.
Medication Management	
Medication Therapy Management Platform	Based on CareSource's experience working with pharmacy benefit administrator carve-out programs in other markets, TrueCare will employ proven processes to ensure seamless service to our members and network providers. In collaboration with pharmacists and prescribers, we will work to reduce adverse events and improve medication adherence. Our medication therapy management platform enables pharmacies to receive reimbursement for their consultative services, provides critical information for HEDIS measures, and addresses existing targeted conditions. We will continue to develop additional

	interventions aimed at the new targeted conditions for Mississippi, including sickle cell disease, asthma, chronic obstructive pulmonary disease, hypertension, and more. Use of our platform assures all partners are member-focused, with the overarching goal of improving medication use through monitoring, education, and resolution of drug therapy issues. We have also revitalized our approach to traditional drug therapy issues with the implementation of direct-to-prescriber targeted medication reviews, which are in addition to those triggered to pharmacists at the point of service. While the market uses approximately 400 drug therapy issue recommendations, we have access to a library of nearly 2,500 therapy gaps, which also provides critical lab values to pharmacies to aid in their clinical decision-making. We also will offer comprehensive medication reviews that include member consultations, written summaries in the required CMS format, and sharing of information with our Care Management team. We will contact providers by phone or fax with recommendations to resolve medication-related issues or opportunities to optimize targeted members' medication use.
Rx Solutions Center	We will use an Rx Solutions Center Services team, composed of pharmacists and certified pharmacy technicians, to lead our clinical pharmacy intervention initiatives and outreach to members and providers. This team will use medical and pharmacy data to identify opportunities to improve medication adherence and close medication gaps in care to improve quality and reduce costs. Capabilities include outreach phone calls, text messages, mailed letters, and emails. Whenever members begin a targeted medication (e.g., Metformin), they will receive a medication adherence kit, which includes a weekly pill box, welcome letter, medication list template, and a white board to track doses and medical appointments. CareSource's experience with this program in other markets shows that members who receive these kits have a 14.26% improvement in a consistent proportion of days covered (a widely accepted measure of medication adherence) across various disease states. Members will receive push notifications through a mobile app or online portal whenever a medication is nearing refill (90% depletion), with follow-up notifications to remind them of missed refills. The Rx Solutions Center Services team also will focus on closing gaps in care and engaging members and providers whenever opportunities are identified. For example, our clinical team will identify and contact members at highest risk for heart attacks and strokes (in accordance with HEDIS technical standards and clinical guidelines) who qualify for statin therapy, based upon diabetes and/or cardiovascular diseases. In 2021, CareSource's eligible members showed a compliance rate of 87%, which reflects a 3% improvement compared to 2020 performance.
Combatting Diabetes	
Collaborating with Local Providers to Offer Member No Cost Diabetes Education Classes	TrueCare will provide transportation to diabetes education classes, including the following: ▪ Simpson General Hospital offers no-cost, diabetes-education classes, including information related to healthy eating habits, for members in Simpson and Smith County. ▪ Greenwood Leflore Hospital offers diabetes-management and preventive-education programs to primary care providers and specialists in the Delta through their Diabetic Center of Distinction. Specialists are educated on specific care coordination protocols to facilitate effective communication with members and other physicians, which reduces the amount of, and related cost associated with, end stage conditions. Primary care providers are educated on symptoms that might suggest diabetes, ordering and interpreting tests, medication protocols, and conducting effective weight control counseling. ▪ Anderson Regional Medical Center offers a complete diabetes treatment and education program accredited by the American Diabetes Association. Their health team of experts includes certified diabetes care and education specialists, registered nurses and dieticians, social services workers, pharmacists, exercise physiologists, and medical directors. Services and supports include diabetes self-management, nutrition and meal planning, blood glucose monitoring, stress management, individualized exercise plans, and education related to healthy lifestyles. ▪ Rush Health Systems offers members access to team-based, comprehensive diabetes education that emphasizes self-management to improve control and prevent complications. ▪ Baptist Memorial Health Care offers members comprehensive diabetes management, counseling, and education services in Booneville and Southaven. Topics include self-management and nutrition support targeted to children, adolescents, and pregnant women.
No Cost Diabetic Care Packages	TrueCare will join Baptist Diabetes Education Center and Baptist DeSoto in partnering with the Mid-South Food Bank to provide Diabetic Care Packages for newly diagnosed diabetic members. Packages include a three- to four-day supply of shelf-stable, non-perishable foods appropriate for diabetes patients. We will work with food banks statewide to assist members in accessing healthy food.
Combatting Obesity	
Mobile Outreach and Health Screenings	TrueCare will provide volunteers and staff to assist St. Dominic Health Services in offering mobile health screening using their Care-A-Van, a 42-foot bus that travels through central Mississippi conducting health screenings and education programs for school-aged children and elderly. Each year, the Care-A-Van records over 12,000 direct contacts for those at-risk.
Providing Access to Wellness Programs	TrueCare will provide transportation for our members to Get Fit Wellness Programs: Baptist Memorial Health Care Get Fit First Grade, a six-week program held at local schools for first graders focused on exercise and nutrition. Club Get Fit is a ten-week program for first through fifth grade children that offers health and exercise education and connects individuals in need to no cost, nutritional counseling.

	Greenwood Leflore Hospital's The Wellness Center, a local, state-of-the-art exercise facility that Greenwood Leflore owns and operates, where Mississippians can take advantage of quality programming and educational offerings. Experts in successfully blending traditional fitness with preventive care, all aspect of their programs are aimed at helping people achieve a healthy and fit lifestyle that can last a lifetime. The Wellness Center offers the latest exercise equipment and amenities in an atmosphere of family fitness and motivation. Programs are designed to help overcome the everyday obstacles that stand in the way of attaining health and fitness goals. South Central Regional Medical Center's personalized member nutritional care, outpatient consultation, and fitness programs where registered dietitians also provide specialized nutrition support, diet modification support, and nutrition counseling. Anderson Regional Medical Center's personalized nutritional services provided by certified clinicians who specialize in chronic disease management, diabetes education, and the nutritional needs of children and adolescents. The Anderson Health and Fitness Center offers the only health club experience of its kind in the region, including a comprehensive, medically integrated environment focused on total well-being. Health educators and fitness specialists offer services such as daily health maintenance, weight loss programs, and special medical and clinical programs.
Personalized Nutritional Care	TrueCare will offer members personalized nutritional care including: ▪ Outpatient consultation, and fitness programs through South Central Regional Medical Center. Registered dietitians also provide specialized nutrition support, diet modification support, and nutrition counseling. ▪ Personalized nutritional services at Anderson Regional Medical Center provided by certified clinicians who specialize in chronic disease management, diabetes education, and the nutritional needs of children and adolescents.
Virtual Exercise Programs	TrueCare members will have access to Baptist Memorial Health Care's no-cost, eight-week virtual wellness program designed to help participants adopt healthy behaviors. The program includes health education and virtual exercise sessions and inspires participants to make changes in eating and exercise habits to lose weight and develop healthier lifestyle choices.
Telehealth Services	
St. Dominic's TeleStroke Program	TrueCare will collaborate with St. Dominic's TeleStroke program, the only Comprehensive Stroke Center in Mississippi to provide TeleStroke services to our members. St. Dominic's TeleStroke program has received the Gold Plus Achievement and Target Stroke Elite Awards from the American Health Association, five stars in Health Grades, and the 2015 Stroke Care Excellence Award.
Remote Patient Monitoring	We will offer remote patient monitoring to help members manage chronic conditions. Members can connect to the member portal for synchronized feeds of their biometrics and track progress with their self-paced, care-plan activities. They also have access to self-paced learnings and can access telehealth for video consults with the care team. Our remote patient monitoring program is an extension of the clinical care team that offers surveillance and early intervention with members to promote optimal outcomes. The remote monitoring technology allows for compliance tools, individualized modules, self-care protocols, patient teach back, nutritional support, and synchronized ICT data feeds and communication. In addition, TrueCare will deploy Baptist Telehealth Centers TeleGuardian eICU, a remote monitoring technology that quickly identifies changes in an in-home patient's condition. Using TeleGuardian eICU, nurses can monitor patients virtually, in real-time, 24/7/365. They work collaboratively with other ICU staff to ensure patients receive the same level of care in their home that they would otherwise receive in the ICU. TeleGuardian eICU also provides physician oversight when hospital physicians are not available, expanding access to care.
[redacted]	[redacted]
Project ECHO	Project ECHO (Extension for Community Healthcare Outcomes) is an innovative telementoring program designed to create virtual communities of learners by bringing together healthcare providers and subject matter experts to share clinical challenges and learning via videoconferencing. Upon award, TrueCare will provide additional grant funding to the University of Mississippi Medical Center's Center for Telehealth to launch a new Project ECHO series specific to office-based opioid treatment.
Enhanced Oversight of	TrueCare will apply technology, staffing, and program design in creative ways to expand existing resources throughout the State. We will enhance our fraud, waste, and abuse (FWA) program to take these innovations into account and monitor for misuse of resources in these programs, including in areas such as telehealth use and pharmacy spending. For example, TrueCare will leverage

Telehealth Services	the ongoing efforts of CareSource's Program Integrity Department to combat telehealth related FWA, including a provider education program that leverages peer comparison data analytics, proactive outreach measures, and education on correct billing practices to create a change in billing behavior. TrueCare will apply this provider-education model to telehealth services as a FWA prevention workplan initiative due to increased utilization and an industry-wide focus on telehealth services.

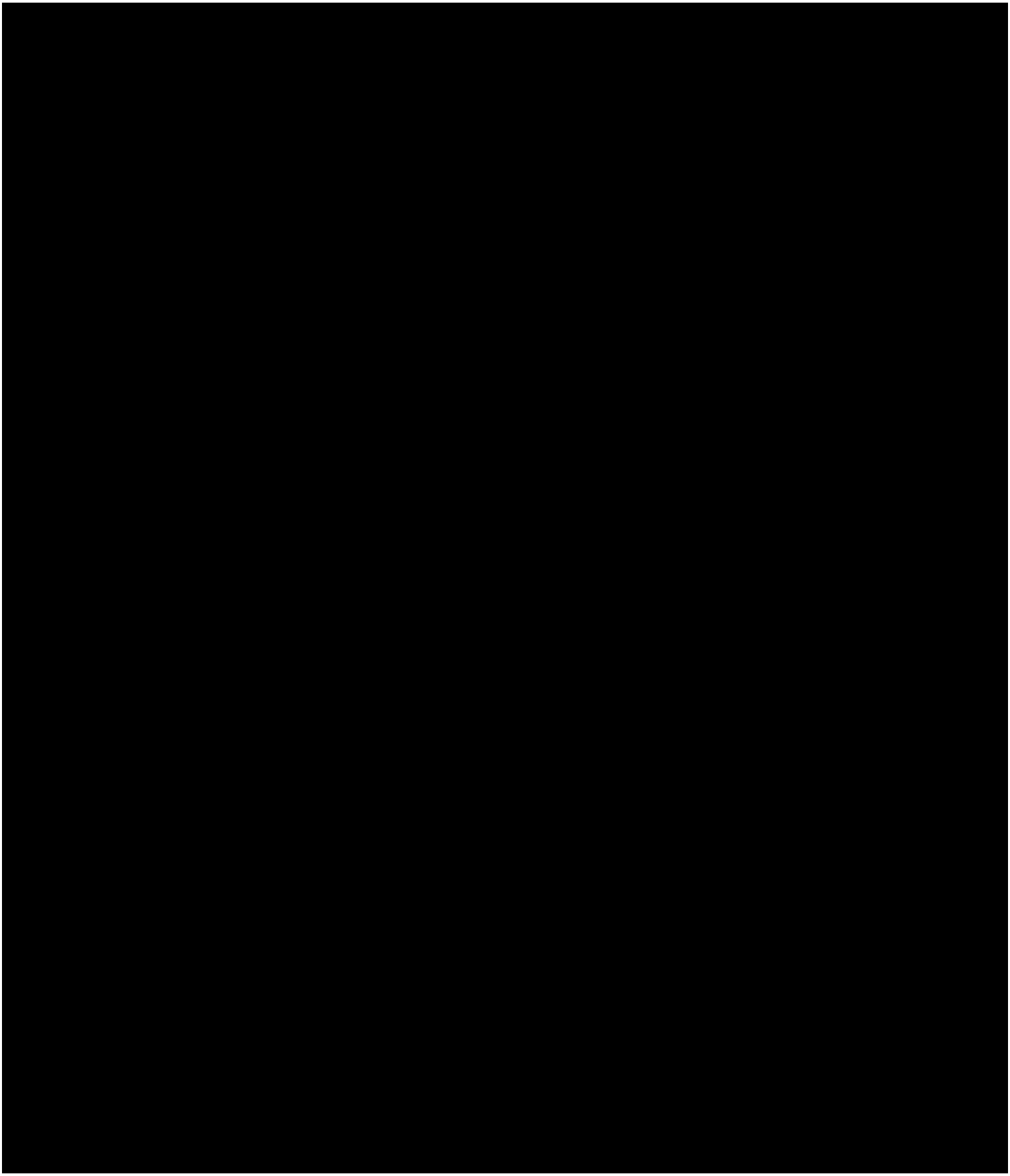
TrueCare's Member-Facing Products and Services

We also will offer a variety of member-facing products and services (Table 4.3.1.1_C)

Table 4.3.1.1_C: Member-facing Products and Services

[redacted]

[7] The member's name has been changed in this Qualification to protect her identity.



> TrueCare is exactly the kind of managed care entity we need for the state of Mississippi - passionate about improving the lives of its members and the community, committed to working collaboratively with community partners across sectors to reimagine health beyond just healthcare services and willing to lead, investing in what some may consider simple solutions – like a coat, but are much needed in the communities we serve.
>
> **- Linda Keys, Founder and CEO, MS Coats 4 Kidz**

TrueCare's Provider-Facing Products and Services

We will offer provider-facing products and services (Table 4.3.1.1_D).

Table 4.3.1.1_D: Provider-facing Products and Services

Provider Services	
Provider Innovation Collaborative	Through a unique Provider Innovation Collaborative and Provider Services staff, we will offer high-level customer service for providers, coupled with a hub of resources, training, and technical assistance, which enables them to operate as fully accountable, quality-driven, innovative care partners who can adopt and scale evidence-based practices and participate in value-based payment programs. This Collaborative is further detailed in the Unique and Innovative Resources section.
Provider Resolution Unit	TrueCare will use an internal Provider Resolution Unit (PRU) dedicated to resolving complex provider issues and concerns about managed care (e.g., claims, credentialing, grievances and appeals, etc.) that require additional internal escalation. The

	PRU will be comprised of manager- and director-level staff who provide ombudsman-like services and serve as an additional level of support for our providers if they encounter delays receiving timely or complete resolution through routine issue resolution processes.
PCMH Practice Transformation	TrueCare recognizes practices often need significant capital to transform their services to participate in value-based care, such as tier two P4P and tier three Shared Savings and Total Cost of Care programs. We will offer financial support to such practices through prospective, per-member-per-month payments to help defray costs related to the adoption of the Patient-Centered Medical Home model and the associated NCQA accreditation. Providers can also use practice transformation funds for technology investments that allow for data sharing between us and the provider.
Providing Telehealth Platform Access to Providers	TrueCare will give the provider community access to a telehealth platform if they do not already have access to one through their own network. Our intent is to allow members expanded access, specifically to behavioral health and rural health providers. The platform helps to improve access in rural areas by supporting on-demand video chat and scheduling capability for non-telehealth-enabled providers, especially those with members in rural areas. Additionally, TrueCare will provide funding to providers to attain necessary telehealth equipment.
Claims Payment Solutions	
Programmatic Auto-Adjudication of Claims	To achieve higher programmatic auto-adjudication rates for claims payment, TrueCare will: ▪ Develop proprietary algorithms that uniquely identify attributes and flag root causes of claims that pend for manual processing ▪ Use advanced analytics to isolate opportunities for automation ▪ Develop proprietary scripts, integrating capabilities of Facets adjudication ▪ Develop proprietary rules for Robotic Process Automation tools Using the same strategy and tools, in other markets, CareSource increased its combined Medicaid programmatic auto-adjudication rate from 92.9% at the start of 2019 to the current level of 98.2%.
Real-time Claims Payment	TrueCare will use a real-time claims payment feature, which will allow our provider portal and EDI claim transactions to complete payment without the typical delay of batch processes. This is an innovative tool focused on driving increased access to care and improved outcomes for our members residing in rural areas. Using the real-time claims feature, providers can submit specific procedure codes for immediate processing and receive payment within two minutes on average.
Value-Based Purchasing (VBP)	
VBP Programs	To drive optimal health outcomes, quality of care, and efficiency, TrueCare will implement an alternative payment model framework that moves providers along the value-based contracting continuum with specific strategies based upon provider preferences and willingness to participate. We will leverage our deep understanding of Mississippi providers to meet them where they are in terms of readiness and support them along the continuum of alternative payment models.
VBP Analytics and Reporting	To effectively educate our VBP providers on how they are performing relative to their peers for quality (e.g., HEDIS), cost, and utilization measures, our Analytics team will use automated, peer-comparison tools to deliver a custom provider profile. These custom provider profiles, combined with comparative data visualizations, outlier analyses, and self-service Power BI solutions, will allow us to actively identify opportunities and manage providers against statistically meaningful benchmarks to improve outcomes and value. For example, we will create and run algorithms that cohort providers into peer group clusters and risk adjust the utilization, cost, and quality metrics to create a 360-degree view of each provider's performance against their peer group benchmark.

TrueCare's Member Outreach, Engagement, Education and Self-Management Products and Services

TrueCare will offer member outreach, engagement, education, and self-management products and services (Table 4.3.1.1_E).

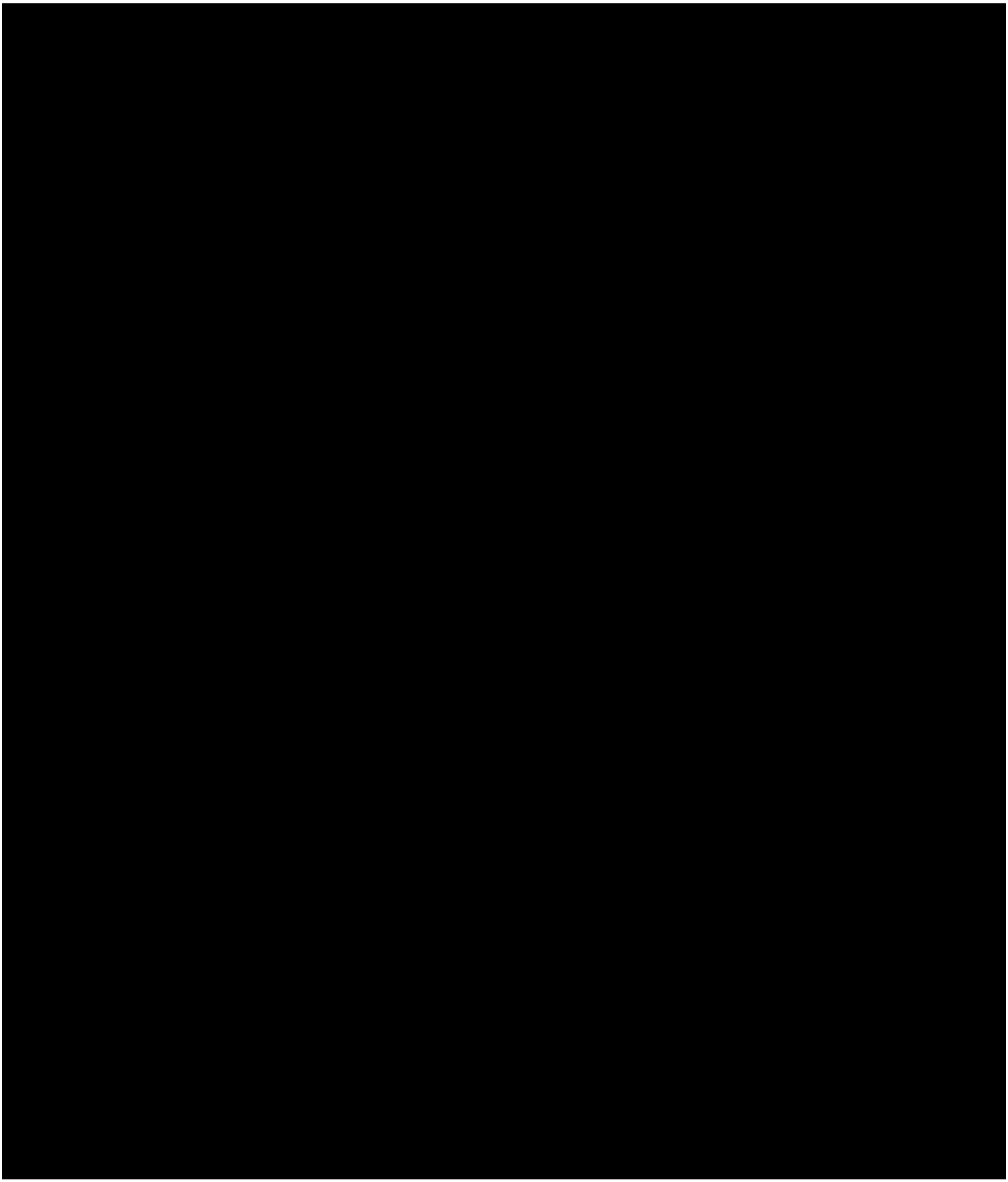
Table 4.3.1.1_E: Member Outreach, Engagement, Education, and Self-management Products and Services

Member Outreach and Engagement	
Member Web Portal	Members will always have access to our secure member portal, which they can access through multiple browsers (e.g., Internet Explorer, Chrome) as well as their smartphones. It is user friendly, interactive, and compatible with both Android and Apple devices. Members can request a new primary care provider, view a copy of their ID card, request a new ID card, review claims, make payments, see plan details, and update their contact information. They can also use our "Tell Us" form (which we respond to within 24 hours) to communicate questions and concerns, submit a grievance or appeal, update their address, or report other insurance information. There is also a live chat feature that saves a record of all conversations for future reference.
Mobile Application	Our intuitive mobile application offers information members need to be healthy today and in the future. Our intelligent app presents customized information upon log-in, so members see high-value information immediately upon entry. Through the app, members can find a provider, view gaps in care, see available incentives, and have instant access to a digital ID card. The app also connects members to customized healthy living information and provides access to other enhanced benefits like transportation. Our mobile app prioritizes a simple, intuitive interface so that members can see immediately what they need to live longer, healthier lives.

Secure email	We will communicate with our members via a secure email platform (non-confidential information only) and help members create a free email account if needed.
Advanced Text Messaging Capabilities	TrueCare will use data analytics to design advanced text-message campaigns that reach members with the appropriate message to motivate them act for their health and wellness. Using a similar campaign in partnership with a provider health system in a very rural area in another market, CareSource used texts to target members requiring follow-up breast screening exams. Members received a text message with a link that allowed them to be immediately connected with an accessible, in-network provider. The provider reported a 70% increase in call volume to schedule screenings immediately following completion of the text campaign.
Social Media Communities	TrueCare will engage members early to determine their individual communication preferences and to ensure a personalized member experience. Based upon member preferences, we will engage through social media (e.g., Facebook, Twitter, Instagram) to proactively connect with members in a manner convenient to them. Harnessing social communities, we will provide two-way communication when, where, and however members choose to engage. This includes a streamlined path to telehealth services and access to immediate online assistance. We will be available 24 hours per day, seven days per week, to direct members through social media on how to find care, access ID cards, and address other high priority needs. By meeting members where they are, we will deliver faster, more effective care and streamline member access to services, such as telehealth, our nurse-advice line, care-management services, and other enhanced benefits. Since implementing the use of similar social media communities in 2019, CareSource saw a 3,200% increase in members seeking care on social media.
Voice Application	TrueCare is breaking ground in secure member communications by offering a voice-activated smart device to help our members engage with us, particularly those with limited mobility. We have HIPAA certification to use the voice-activated smart devices to receive and communicate health information with our members. Members can interact with the device in a secure channel and connect with customer service, call their case manager, ask questions about their coverage, and get a reminder about prescription refills. By placing this technology in the homes of some of our most at-risk members, we mitigate health disparities related to a lack of technology and mobility and positively impact self-management.
Member Education and Self-Management	
Healthy Body, Healthy Me™	This program encourages healthy eating and active living to assist adult members with managing their weight. The program consists of four monthly education packets and four health-coaching calls covering one of four topics: weight management, nutrition, physical activity, or emotions and behaviors. In addition, there are two follow-up calls, the first at six months and the second at one year. Some of the topics covered in the program include goal setting, reading food labels, moving more, dealing with emotions, and behaviors that contribute to weight gain.
Baby & Me Tobacco Free™	We will offer the Baby & Me Tobacco Free™ program, which is a national, evidenced-based smoking cessation program that offers counseling support and resources to reduce the use of tobacco products by pregnant and postpartum members. Pregnant members attend four prenatal counseling cessation sessions, which can be accessed using telehealth to support members regardless of geographic location. We will offer members diaper vouchers as an incentive to participate in the program and use a carbon monoxide breath test to verify compliance.
Kids' Wellness Program	Our Kids' Wellness program will help combat childhood obesity in members aged 3 through 18 who have been diagnosed as obese with a body mass index at or above the 95th percentile. The program offers interventions to support children, including healthy weight-management habits, nutritional choices, physical activity, and effectively dealing with emotions/behaviors resulting from being obese. This program stresses family participation because outcomes improve when the entire family is involved. Educational materials include information on making healthier food choices, energy balance (energy in and energy out), non-food rewards, getting kids in the kitchen, and tips on recreational activities.
myStrength	myStrength is an online resource tool that we will make available to our members 24 hours per day. It is an evidence-based tool incorporating Cognitive Behavioral Therapy and Mindfulness techniques to improve emotional regulation and well-being. It offers features such as a mood tracker, daily inspirational quotes, and educational videos about depression, anxiety, SUD, and other behavioral health conditions.

TrueCare's Value-Added Benefits

TrueCare recognizes that, to achieve optimal health, some members may need additional services. For this reason, we intend to offer the following value-added benefits to assist our members (Table 4.3.1.1_F).



TrueCare was created to address the needs of Mississippi healthcare through collaboration between Mississippi Medicaid providers and a managed care entity. Indeed, TrueCare presents **the first team effort** between providers and a health plan to change the trajectory of Mississippi healthcare. TrueCare's intangible assets include, but are not limited to, our local alliance with CareSource national expertise; our deep community roots, our local and national and reputation, our Medicaid thought leadership, our history of member satisfaction, and our financial strength.

TrueCare's Local Knowledge and CareSource's Medicaid Expertise

TrueCare brings to the Division a partner that was born in Mississippi to address the key drivers of access to care and health outcomes in the state. Our health plan is operated and governed by Mississippi residents who know the state and its resources and are committed to positively impacting the local economy through job growth, workforce development, and community reinvestment. The Mississippi-based TrueCare Board of Directors, executive team, and committees will ensure CareSource shares the same Mississippi vision and that CareSource's operations are tailored to meet the intricacies of Mississippi healthcare.

Further, TrueCare will be supported by a robust enterprise workforce that will support our MSCAN and CHIP programs. This table details the number of employees and contractors, consultants, and independent professionals, by functional area, responsible for supporting MSCAN and CHIP members, providers, and the Division (Table 4.3.1.1_G).

Table 4.3.1.1_G: Enterprise Workforce Supporting MSCAN and CHIP

Enterprise Area	Total Workforce
Information Technology	1,242
Operations	2,111

Enterprise Area	Total Workforce
Clinical	718
National Market Support (e.g., pharmacy, sales, network management, etc.)	374
Complex Health	35
Enterprise (e.g., legal, compliance, marketing, communications, finance, etc.)	435
TOTAL	**4,915**

TrueCare's Community Roots and Partnerships

Mississippi and its citizens require a **health plan partner** that understands its needs and priorities while demonstrating in-depth understanding of the State's cultural preferences and differences, along with its regional variations in access to care and health outcomes. TrueCare's founding hospitals and systems have been part of the fabric of Mississippians' lives for over a century. TrueCare's founding members have been providing Medicaid eligible Mississippians their healthcare since Medicaid's inception. TrueCare's founding hospitals and health systems with the longest history of services in Mississippi are shown in Table 4.3.1.1_H. Together, TrueCare's founding hospitals and health systems employ more than 30,000 Mississippi residents, including more than 3,000 Mississippi physicians.

Table 4.3.1.1_H: TrueCare's Founding Hospitals with the Longest History in Mississippi

Founding Organization	Location	Date Established
Greenwood Leflore Hospital	Greenwood, MS	1906
King's Daughters Medical Center	Brookhaven, MS	1914
Rush Health Systems	Meridian, MS	1915
Anderson Regional Medical Center	Meridian, MS	1928
Saint Dominic Hospital	Jackson, MS	1946
Forrest Health	Hattiesburg, MS	1952
Delta Regional Medical Center	Greenville, MS	1953
University of Mississippi Medical Center	Jackson, MS	1955

TrueCare has developed relationships with a wide array of CBOs to bring innovative programs to serve Mississippians in their community, to address the Division priorities, and to impact issues of health care access, SDOH, and health equity for MSCAN and CHIP members, their families, and all citizens of the state.

[redacted] For example, we plan to partner with the:

- **Mississippi Food Network:** Addressing food insecurity, health care access, nutritional education
- **Hope Enterprise Corporation and Hope Credit Union:** Housing investments, banking access and financial literacy
- **Mississippi Home Corporation:** Combatting homelessness and housing insecurity; developing affordable units
- **Goodwill Industries**: A workforce development partner offering virtual employment resources to members in rural areas.

> As you know Goodwill works to enhance people's dignity and quality of life by strengthening their communities, eliminating their barriers to opportunity, and helping them reach their full potential through learning and the power of work. After meeting with CareSource and MS True it's evident our partnership is aligned with the same mission and collaborative efforts with your Life Service team will help MSCAN members find employment and reach their personal life goals."
>
> **- Vicki Burton, Vice President of Workforce Development at Goodwill Industries of Mississippi Inc**

- [redacted]
- **CarePortal:** Providing a technological platform to link children and families involved with the child welfare system to family, faith-based, and community supports
- [redacted]
- **CSpire:** Offering smart Wi-Fi access and Chromebooks at schools in Mississippi
- **Mississippi State University Extension Service:** Developing programs to support workforce development, food access, transportation, Mental Health First Aid training, etc., especially in rural areas
- **Jackson State University:** Developing programs to support early childhood education and workforce development
- **Hinds Community College:** Developing programs to support workforce development, and health education
- **Head Start Association:** Collaborating to improve early child education, health access, parental involvement, and health literacy
- **Double Up Food Bucks:** Increasing access to healthy food by expanding supporting local grocery stores and expanding the program's footprint across Mississippi
- **Stewpot:** Supporting urban children through summer camps, food pantry location, and tutoring services
- **Hattiesburg Diabetes Center:** Collaborating to establish the Hattiesburg Diabetes Center for Excellence
- **My Brother's Keeper Clinic and Community Programs:** Working together to improve health equity and minority health access
- **Urban League:** Developing programs to improve health equity, maternal health, children's programs, food access, and our Healthy Beginnings at Home program

> We are delighted and proud to have CareSource and now TrueCare as a partner. As you know, we have many issues here in our state. However, those issues can be overcome with the right efforts in place, and we're optimistic that we're helping to create and bolster those efforts through key partnerships like ours.
>
> **- Portia Espy, Executive Director, Mississippi Urban League**

Mississippi True's Local and CareSource's National Reputation for Excellence

CareSource brings a national reputation for leadership, innovation, and excellence across a range of areas such as health information technology, social determinant of health programs, quality, and fostering a positive workplace environment. The following table provides a summary of recent CareSource awards and accolades which demonstrate CareSource's sustained commitment to excellence in government programs managed care and evidence the type of partnership CareSource will bring to TrueCare (Table 4.3.1.1_I).

Table 4.3.1.1_I: CareSource Awards

Area	CareSource's Awards or Recognitions
Health Information Technology	▪ Outstanding Technology Team, Technology First, 2021 ▪ Chief Information Officer, Modern Health Women Leaders to Watch List, 2021 ▪ Senior Vice President of Data, CDO Global Data Power Women's List, 2021

Area	CareSource's Awards or Recognitions
	▪ Senior Vice President of Data, CDO Global Health Insurance List of Data Leaders, 2021 ▪ Healthcare Excellence Award, Cognizant 2020 ▪ Excellence in Operations, Cognizant, 2018 ▪ Excellence in Innovation, Cognizant, 2016
Social Determinants of Health	▪ Secretary's Award for Public-Philanthropic Partnerships. U.S. Department of Housing and Urban Development, 2021 ▪ Pinnacle Award for the Dayton-Montgomery County Digital Equity Initiative, Ohio Association of Health Plans (OAHP), 2021 ▪ Housing Partner of the Year, Ohio Capital Corporation, – 2021 ▪ Partner Award for Collaboration, KVC Health System, 2020 ▪ Pinnacle Award for the CareSource LifeServices program, OAHP, 2016
NCQA	▪ NCQA Accredited Medicaid Health Plan: Georgia, Indiana, and Ohio
Workplace Environment	▪ Best Place to Work Healthcare, Modern Healthcare Magazine, 5-time awardee by ▪ LearningElite Award Program, Chief Learning Office Magazine, 2020

In addition, TrueCare's member hospitals and health systems bring a strong reputation for providing high-quality health care to Mississippians (Table 4.3.1.1_J).

Table 4.3.1.1_J: TrueCare Founding Member Hospitals Awards[8]

TrueCare Member Hospital/Health System	TrueCare Member Hospital/Health System Awards and Recognitions
Anderson Regional Medical Center	▪ NCDR Chest Pain – Mississippi Registry Platinum Performance Achievement Award - American College of Cardiology's, 2019 and 2020
Baptist Memorial Health Care Corporation	▪ Hospital Outcomes Award – Mississippi Rural Health Association, 2021 ▪ Hospital Quality Award – Mississippi Rural Health Association, 2021 ▪ Baby Friendly® hospital designation, 2020 ▪ "A" Ratings – Leapfrog Hospital Safety Grade, 2020 ▪ QUEST Award for High-Value Health Care – Premiere Inc., 2020
Delta Regional Medical Center	▪ Women's Choice Award for Best Hospitals™ ▪ Healthiest Workplace Finalist – Mississippi Business Journal and Mississippi Business Group on Health, 2019
Forrest Health	▪ Best Hospital/Medical Center in the Pine Belt – Signature Magazine, 2020 ▪ NCDR Chest Pain – MI Registry Platinum Performance Achievement Award -American College of Cardiology's, 2020 ▪ Mission: Lifeline® Gold Plus Receiving Quality Achievement Award ▪ Get With the Guidelines® Stroke Gold Plus Quality Achievement Award – American Heart Association, 2020 ▪ 2020 - Lifetime Achievement Award for Women & Children's Services – Sales & Marketing Professionals Pine Belt, 2020
Greenwood Leflore Hospital	▪ Get With the Guidelines® Stroke Gold Plus Quality Achievement Award – American Heart Association, 2020
Magnolia Regional Health Center	▪ NCDR Chest Pain−MI Registry Platinum Performance Achievement Award – American College of Cardiology's, 2019 and 2020
Rush Health Systems	▪ Patient Satisfaction Award and Clinical Distinction Award for the Wound Care Center – Restorix Health, 2021 ▪ Testing Accreditation for Vascular Institute at Rush Earns Vascular – Intersocietal Accreditation Commission, 2020
Simpson General Hospital	▪ Hospital Quality Award – Mississippi Rural Health Association, 2021
South Central Regional Medical Center	▪ Patriot Award from Employer Support of the Guard and Reserve, 2021 ▪ Get With the Guidelines® Stroke Gold Plus Quality Achievement Award – American Heart Association, 2020 ▪ National Award for Caregiver Satisfaction for Comfort Care Hospice – Strategic Healthcare Programs, 2020

[8]The following list is not an exhaustive list of all awards won by our founding hospitals; it is intended to give the reader a sample of the recognition which our members have received

TrueCare Member Hospital/Health System	TrueCare Member Hospital/Health System Awards and Recognitions
South Sunflower County Hospital	▪ Hospital Outcomes Award – Mississippi Rural Health Association, 2021
Southwest Mississippi Regional Medical Center	▪ Designation as a COVID-19 Center of Distinction for their commitment to COVID-19 response in their communities, by the Mississippi State Department of Health
St. Dominic Health Services	▪ Top 100 Ranking Nationally for Consumer Loyalty – NRC Health, 2019

Thought Leadership

TrueCare will benefit from and leverage CareSource's significant thought leadership, especially in the areas of solutions for Medicaid beneficiaries with complex health needs. Table 4.3.1.1_K lists some of the local, regional, and national organizations CareSource participates to bring innovative solutions to issues facing Medicaid beneficiaries which allow TrueCare to offer better solutions to Mississippians.

Table 4.3.1.1_K: Examples of Local, Regional, and National Thought Leadership

Organization Name		
▪ State and Regional Housing Development Organization Boards and Affordable Housing Coalitions ▪ Atlanta Regional Collaborative for Health Improvement ▪ Health Policy Equity Advisory Group, Health Policy Institute of Ohio ▪ Workforce Development Board of Central Ohio ▪ Lead Safe Cleveland ▪ Subcommittee on Children's Mental Health, Kansas Governor's Office ▪ American Health Insurance Plans HIT and Interoperability Workgroup	▪ Task Force on Criminal Justice and Behavioral Health Steering Committee, Ohio Attorney General ▪ Steering Committee, Stepping Up Ohio ▪ Health Policy Equity Advisory Group, Health Policy Institute of Ohio ▪ Policy Board Member, National MLTSS Health Plans Association ▪ Member, U.S. Department of Labor Office of Disability Employment Policy's DSP Workforce Development Experts Panel ▪ Founder, Coalition for Children's Health ▪ The NCQA Learning Collaborative ▪ Root Cause Coalition	▪ Founding Member, Aligning for Health ▪ SDOH Learning Cohort, and Center for SDOH Founder's Circle, Association for Community Affiliated Plans ▪ America's Health Insurance Plans Project Link Learning Collaborative on SDOH ▪ SDOH Committee, Institute of Medicaid Innovations ▪ Partnership to Align Social Care (a Robert Wood Johnson funded national coalition) ▪ Opportunity Starts at Home (Housing Collaborative) ▪ The Adult Immunization Measurement Advisory Panel

Member Satisfaction

CareSource brings a history of exemplary member satisfaction to TrueCare, demonstrating TrueCare's ability to deliver on its mission to empower Mississippians so they can easily access their benefits and live healthier lives.

TrueCare members will benefit from CareSource's experiences in other markets where CareSource members quickly learn that CareSource cares about them as a person, in addition to their health. For example, CareSource helps members become actively involved in their health and well-being by providing a life coach to every member who wants one at no cost through Life Services. Life coaches offer support and guidance for critical conditions that impact health such as education, finding a job, or housing insecurity. In 2021, CareSource was the number one selected Medicaid plan in Georgia, as well as Ohio, the nation's seventh largest national Medicaid population, which is predominantly driven by voluntary enrollment. In Georgia, in 2021, 36.2% of Medicaid members, more than any other plan, voluntarily selected CareSource as their preferred plan. In Ohio, 57.7% of members, over three times the nearest competitor, selected CareSource as their preferred plan in 2021. Once members choose or are assigned to CareSource, they stay with CareSource. In Ohio and Georgia, 99.9% of CareSource members stay with CareSource.

Financial Strength

CareSource is a responsible steward of Medicaid managed care funds and, as a TrueCare alliance partner, is at risk for the performance of TrueCare. CareSource optimizes the State's funds for enhanced member services and value-based purchasing incentives and will bring this financial discipline to Mississippi. CareSource uses a

local operational model for critical member and provider-facing activities, with corporate support for shared services where scale produces more efficient service. CareSource's not-for-profit mission allows it to serve as a responsible fiduciary agent, optimizing the State's funds for enhanced member services and VBP provider incentives.

As of December 2021, CareSource maintained capital and surplus of $2.0 billion compared to a risk-based capital (RBC) requirement of $0.8 billion. The resulting 497% enterprise RBC ratio demonstrates a strong capital position and limits any insolvency risk.

At full scale, TrueCare is one of the ten largest Mississippi-based corporations in terms of revenue, and the second largest non-profit organization based in Mississippi. Mississippi True exceeds the minimum statutory requirements per §83-19-31 and will surpass all RBC requirements through capitalization by its member hospital systems.

TrueCare's Unique and/or Innovative Resources

In addition to the resources, products and other intangibles discussed previously, TrueCare will bring Mississippi other unique and innovative resources that will be tailored for the State with the goal of changing the trajectory of Mississippi healthcare through new ideas and practices, surpassing the status quo.

TrueCare Will Bring Proprietary Predictive Models and Algorithms that Will Transform Mississippi Healthcare

Our dedicated team of data scientists uses a suite of proprietary models and algorithms, built with artificial intelligence (AI), machine learning (ML), natural language processing (NLP) and predictive analytics capabilities, to provide practical solutions to real healthcare issues. Table 4.3.1.1_L describes the proprietary predictive models and algorithms TrueCare will leverage to support members and providers in Mississippi.

Table 4.3.1.1_L: Predictive Models and Algorithms

Model	Purpose
Identification and stratification of high-risk pregnancies	This algorithm leverages medical history, clinical attributes, demographics, and SDOH to identify high risk pregnancy as early as in the first trimester of pregnancy, providing opportunity for early intervention and prevention of complications. The algorithm also specifically segments cases by the primary risk factors to inform the most appropriate intervention.
Prediction of readmissions	This model establishes the risk of readmission based on demographics, SDOH, clinical diagnosis, medical history, and the industry standard LACE (Length of Stay, Acuity, Comorbidities, and Emergent) index. Members with behavioral health and other complex conditions are isolated to help understand the specific challenges that might escalate their readmission risk.
Member-specific SDOH indices	This algorithm assigns a high, medium, and low index value to individual members with respect to each of the following five domains: economic stability, education, community, health care, and environment. There is also a sixth blended index to reflect overall social risk. Because some attributes are more difficult to obtain for children, we have developed algorithms that can infer the SDOH attributes of the parent to understand the social risk to children.
Disease/comorbidity identification and risk stratification	We employ several data resources to develop our three levels of risk stratification to guide our care management activities. Starting with the Chronic Illness and Disability Payment System, Johns Hopkins ACG model, SDOH data, and State and internal claims data to perform an initial stratification of all members. We then layer a combination of clinical assessments and determinations along with proprietary population segmentation models to establish the most appropriate risk level of a member for a clinical programs and member centric culturally competent interventions to improve outcomes for each member.
Identification of members at risk for homelessness	This algorithm identifies members who are most likely to experience homelessness soon, using an extensive set of variables including the historical medical and pharmacy utilization, demographics, various social risks, current housing data, and historical address changes.
Automated identification of billing and payment anomalies	To avoid provider abrasion and reduce appeals, we have developed a proprietary machine learning algorithm to proactively identify anomalies in claims denials process. The algorithm calculates weighted anomaly scores based on unexpected patterns versus a historical baseline. The results are used by the Claims department to improve payment accuracy.

Model	Purpose
Prediction of member sentiment and satisfaction to mitigate disenrollment	We have a suite of predictive models to help understand the drivers of member satisfaction and voluntary disenrollment. These models leverage a wide range of data including member demographics, SDOH, medical history and NLP of call center data.
COVID-19 composite risk scoring	Very early in the onset of the COVID-19 pandemic, we developed a risk model that identifies the members who are the greatest risk of an adverse outcome in the vent that they also contracted COVID-19. This model is primarily based on the presence of chronic conditions that are known to drive hospitalizations when combined with a COVID-19 diagnosis.
Inpatient large case predictive model	This model evaluates active inpatient cases and predicts which are likely to result in an unusually long length of stay or adverse post-acute outcome. We use this tool to actively case manage these admissions and to more accurately reserve costs.

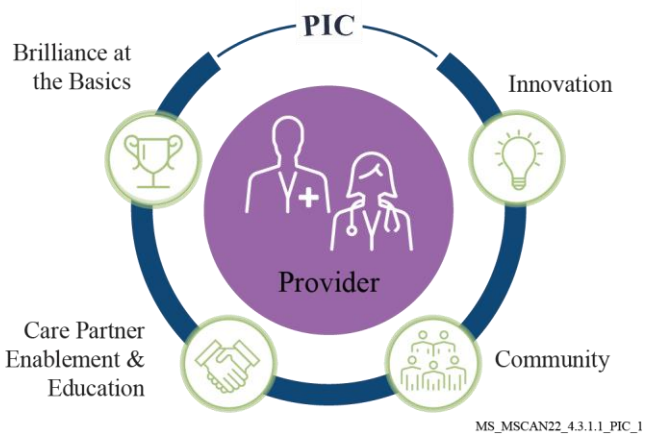
TrueCare Will Bring Provider Support and Services That Will Increase Provider Collaboration and Member Healthcare Experiences

Provider Innovation Collaborative (PIC)

To promote a superior model for accountability, data-driven outcomes, and quality care, TrueCare has established our PIC, which supports our providers' capacity to serve MSCAN and CHIP members. At TrueCare, we meet providers where they are and provide opportunities for true transformation. We understand that providers are diverse in size, staffing, and capacity, and we have developed provider resources to accommodate their broad continuum of needs.

Figure 4.3.1.1_E: PIC

TrueCare's PIC offers tailored programs and services to Mississippi providers to build on their strengths, support their needs, and address priority issues in the state.



The PIC is an advisory council of Mississippi providers and stakeholders to inform the creation and deployment of PIC programs and services. We designed our PIC specifically with Mississippi provider needs and Division priorities in mind (Figure 4.3.1.1_E). We offer contracted providers a hub of resources, training, and technical assistance that enable providers to operate as fully accountable, quality-driven, innovative care partners, adopt and scale evidence-based practices, and participate value-based payment models, depending on the provider's unique strengths and needs.

Table 4.3.1.1_M includes the types of support the PIC will provide to Mississippi providers.

Table 4.3.1.1_M: PIC Support for Mississippi Providers

Category of Support	General Description	Examples of Programs and Services
Brilliance at the Basics	Supporting providers with basic provider functions and daily operations, such as claims questions and issues	▪ Proactive calls to providers to offer support based on evaluation of key measures (e.g., denial volumes and rates) ▪ Full-service hotline, offering dedicated and expert support timely and complete resolve issues, including regional provider ombudsmen ▪ Specialized service desk to ensure excellent customer service for key providers identified high volume of service or high performance
Care Partner Empowerment and Education	Providing a full suite of programs, resources, and services to enable providers to improve care for Mississippians	▪ Provider education events, such as in person and virtual training and education series, such as 'Lunch and Learns' with national leaders and experts, and weekly open office hours with the Provider Relations team

Category of Support	General Description	Examples of Programs and Services
		▪ Operational capacity supports, such as providing access to shared office and meeting space for smaller providers to encourage collaboration, access to a telehealth platform, and a membership to support bulk purchasing power ▪ 'Clinical Excellence Command Center' providing access to a national, multi-disciplinary team of experts for consultation on cases for which they need additional expertise ▪ 'Data for Value' analytical support for providers in value-based arrangements to offer peer-to-peer support to improve provider use of clinical and quality reports
Innovative Solutions	Increasing opportunities for providers to develop and implement innovative solutions to identified issues in their practice or community	▪ 'Innovation Incubator' events allowing providers to make proposals to both self- and TrueCare identified priorities, with funding allocated to support winning solutions ▪ 'Collaboration Hub' to offer consultation ▪ [redacted]
Community	Encouraging providers to be involved and engaged partners with TrueCare and Mississippi communities	▪ Exclusive benefits for providers, such as access to CareSource LifeServices and select value-added benefits for their families, discounts with local vendors and dining, etc.

Medical Director Bioethics Seminars

Since 2016, nationally recognized medical ethics experts have facilitated seminars for CareSource physicians, nurses, and social workers. Our clinical seminars pair industry-leading, managed care approaches with cutting edge, evidence-based research in a case consultation format for clinical providers working directly with MSCAN and CHIP members. Participants earn continued medical education units. Seminar topics include managed care perspectives, healthcare policy issues, and ethical dilemmas in managed care determinations and coverage. In Mississippi, seminars will be held four to five times per year in a virtual environment and include provider-led, case consultation with facilitators.

[redacted]

[redacted]

> Prevention and Relational Health are key to creating change and we believe that partnering with CareSource in this effort will help to both strengthen families and improve relational health for children and families involved with child welfare in Mississippi.
>
> **- Jennifer Jacobs, PHD, CEO and Co-founder of Connect Our Kids**

TrueCare Will Bring a Foster Care Model of Care That Will Keep More Children with Their Families

TrueCare's foster care model of care focuses on supportive services to families to prevent the need for foster care. Family caregivers and parents face an array of challenges; including, navigating the health and foster care systems; identifying and accessing social supports; managing medication administration, provider appointments and high stress and personal health issues. We take a multigenerational approach; helping caregivers find employment, childcare when needed to gain employment, and addressing other SDOH needs of the family. Caregiver support is essential to prevent the need for foster care, and aid caregivers caring for children in foster care. We will use CareSource's **Caregiver Connect**, a program, which targets the highest risk members and those that care for them. Services provided include additional transportation to the grocery store two times per month; assistance with food access; assessment to identify stress and burnout and referral to resources or support groups; home assessments and minor modifications to ensure safety; medication review to ensure adherence; coaching to address and manage caregiver chronic conditions; homemaker and personal support services; life coaching; post discharge visits; and technology support to have access to web-based information and support including, MyHealth, MyResources, and MyStrength.

TrueCare will also provide a short-term in-home respite value-added benefit to support families with children diagnosed with a serious emotional disturbance. Finally, our package of comprehensive mental health benefits includes 24 hour per day BH crisis support to meet the needs of families any time of the day or night.

TrueCare's programs and initiatives that also support children in foster care, their caregivers, and families, include:

Child and Family Health Training Institute

We will bring to Mississippi a Child and Family Health Training Institute to create, maintain, and provide a menu of training and professional development opportunities that our partners can use free of charge to enhance their work without members. All training is culturally sensitive, trauma-informed, and relate back to our goals of enhancing family and community wellbeing, preventing the need for foster care, providing innovative and best in class services to those experiencing foster care and all our members. All training is focused on person-centered care, using lived experience to integrate into our work, and emphasizes that healing happens in the context of loving relationships, using a relational health focus.

The Child and Family Health Training Institute provides an opportunity for our partner agencies to participate in relevant trainings with our staff to help establish strong working relationships and cohesive experiences for multisystem involved families.

Potential trainings topics include:

- ACEs and PCE (positive childhood experiences)
- Diversity equity and inclusion training for anyone, specifically child welfare system staff
- Community advocacy to strengthen families
- Family Seeing – an evidence-supported framework that supports strengthening families and reducing avoiding placements for children with people outside of their family

- HEERO (Helping Everyone/Each Other Reach Out) workshops – training sessions designed to strengthen peer relations and skills adolescents needs to build supportive relationships
- Mental health first aid
- Pax tools training – the Pax Institute offers tools and training for teachers, human services, professionals, and communities to support health interactions with children in a trauma informed model
- Adoption Competency Training for Child welfare staff and mental health providers
- Parent Peer Leadership and Parent Peer Certification training
- Be Strong Families Training and Parent Café training – to reinforce and strengthen the parent engagement strategies of agencies that seek to integrate the evidence-based practice Strengthening Families Protective Factors framework and cutting-edge family leadership practice.

Healthy Outcomes from Positive Experiences

Healthy Outcomes from Positive Experiences (**HOPE**) represents a paradigm shift in the ways in which we view and discuss positive experiences **that support children's growth and development**. HOPE supports children and families to improve their health, empathy, and respect for human dignity. The HOPE Innovation Network (HIN) comprises child and family services organizations in diverse communities that implement the HOPE framework. In partnership with the HOPE team, we are shifting the paradigm from deficits-based services to strengths-based supports to mitigate ACE outcomes, reduce health inequities, and to connect families with needed services. This enables us to further build and foster family and community relationships to advance positive childhood experience and to facilitate the development of additional tools and best practices. Through participation in the HIN, we will engage in a six-month HOPE implementation process, followed by a six-month evaluation period. We will focus on internally implementing our own HOPE-informed process, along with reviewing forms, policies, staff trainings, family engagements, and more.

Stronger Together Initiative

TrueCare will also offer the Stronger Together Initiative in Mississippi. The goal of our Stronger Together Initiative is to **keep children with their parents** and prevent the child's entry into foster care. Secondary goals include reducing behavioral health spend (ED, acute care, and residential care utilization), and address family SDOH needs. CareSource implemented this program in Georgia, focusing on family preservation and strengthening supports and service to families who have children living with severe emotional disturbance (SED). To determine the target population, CareSource used data on diagnosis and specific utilization patterns including inpatient admissions and ED utilization. The identified population has a low engagement in care management and while their overall spend was higher than youth without a SED diagnosis, they had limited spending on BH services. TrueCare is excited to offer this in Mississippi as the initiative that will support families with wrap around supports such as peer support, respite, in home services, and care management/coordination, which can prevent out of home placements and keep children in their communities.

TrueCare's Additional Resources

In addition to TrueCare's computer and technological resources, current products and services, intangible assets, and unique and/or Innovative Services, TrueCare will bring Mississippi, or continue to offer through its member hospitals, the following additional resources that will enhance member engagement and improve health outcomes:

- **TrueCare Member Hospital's Existing Programs and Resources:** As described in the "TrueCare's Products and Services" section prior, TrueCare's member hospitals and health systems have deep roots in their communities and already have a full array of respected, high quality medical and non-medical programs and resources available to support the whole person needs of MSCAN and CHIP members.

  Additional Resources Available to TrueCare Members and Providers Through Collaboration with Our Member Hospitals:

- **Care Management Co-location:** TrueCare will co-locate care management staff, including community health workers (CHWs) and discharge planners, at Delta Regional Medical Center, Forrest General, Baptist Memorial Golden Triangle, Baptist Memorial DeSoto, King's Daughters-Brookhaven, along with other high-volume founding member facilities such as the University of Mississippi based on geo-mapping analysis of where members many utilize the most services. Co-located care managers can optimize health outcomes through the following services:
  - Arranging for health care services, such as follow-up appointments, disease management, home care, durable medical equipment, condition-specific testing, etc.
  - Supporting triage of members from the ED to an on-site urgent care, when appropriate and with the consent of the members
  - Coordinating referrals to specialists and to services to address SDOH
  - Enrolling members in our care management system
  - Coordinating claims with other benefit plans
  - Conducting telephonic outreach to a member before, during, and after specific health care interventions
  - Negotiating case rates for nonparticipating health care provider services
  - Recommending and approving coverage exceptions when appropriate
- **Convenient Afterhours Appointments:** TrueCare member hospitals and systems will offer afterhours appointment times to increase access to providers.
- **Inclusion on Committees, Boards, and Workgroups:** TrueCare commits to increasing the participation of Mississippi providers and associations on our Provider Advisory Council and other committees, boards, and workgroups. We will offer a position on the Provider Advisory Council to the Association of Community Mental Health Centers and Mississippi Chapter of American Academy of Pediatrics, among other local, regional, and statewide provider associations. (Our specialized committees, boards, and workgroups follow).
- **Collaborating on Training for Cultural Competency and Health Equity:** TrueCare will convene Mississippi leaders to drive important work to increase health equity and health outcomes. We will convene providers and key stakeholders throughout the state to take meaningful action to identify and close health equity gaps and health literacy through our Health Equity Collaborative. The pandemic highlighted that there is much work to be done; we are enthusiastic about tackling health inequity head on in partnership with other community leaders.
- **Collaboration with Community Mental Health Centers (CMHC) on Training Providers:** TrueCare will collaborate with CMHCs to train all TrueCare member providers on ACEs and trauma informed care and will offer continuing education units (CEUs) and continuing medical education (CME).
- **Coordinating Educational Events and Health Literacy Campaigns:** TrueCare will work with our member hospitals to co-design and implement events bringing health education and health literacy campaigns to Mississippi.

TrueCare will Offer Additional Resources CareSource has Successfully Deployed in Other Markets:

- **Incarcerated Member Re-entry Program:** Although outside of program requirements, TrueCare proposes to offer an innovative Re-entry Program, which addresses the disproportionate chronic health needs, complex behavioral health needs, and significant SDOH needs for individuals leaving incarceration, from pre-release up to 90 days post release.

CareSource Re-entry Program™ Outcomes

For Indiana CareSource Reentry Program participants who had an inpatient visit in a 12-month period of re-entry, 60% completed their 7-day follow up visit compared to 28.5% of non-participating members.

In doing so, TrueCare will replicate the successful CareSource Re-entry Program™. This program was developed to address the disproportionate prevalence of SMI and SUD diagnosis among individuals who are incarcerated and eligible for Medicaid coverage in Indiana. Nearly 22% of returning citizens have a diagnosed SMI and over 60% have a history of SUD. Without transitional supports, re-entering members with a history of mental illness or SUD are 12.5 times more likely to die in the first two weeks post incarceration than individuals not transitioning from incarceration. CareSource collaborated with the Indiana Department of Correction and the Indiana Family and Social Services Administration to engage returning citizens during and after release from incarceration to address critical resource needs during transition. CareSource embedded a dedicated reentry team of criminal justice liaisons and CHWs in every Indiana prison. They engage members prior to release to explain benefits, assess needs, and make referrals to appropriate services including community mental health centers, SUD providers and FQHCs. Following release, CareSource assesses individuals for education and employment interest and makes referrals to our CareSource JobConnect™ program, when appropriate. CareSource developed an entire employer network in Indiana willing to hire these reentering members.

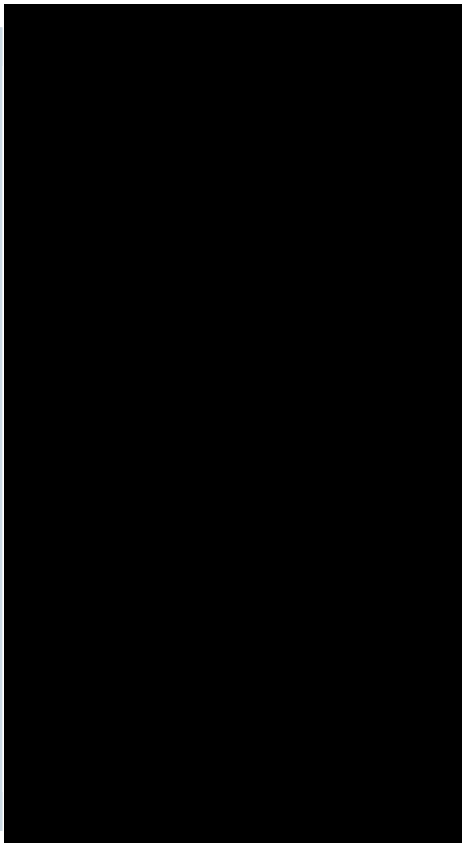
As of 2020, Mississippi has the second highest incarceration rate of any state. The incarceration rate in Mississippi indicates a need for a tailored re-entry program to address the whole person needs of returning citizens to address unmet social needs, the complex health conditions of individuals with SMI and SUD and reduce the likelihood of recidivism. TrueCare, leveraging CareSource's nationally recognized, proven Re-entry Program model, with approval from the Division will collaborate with the Mississippi Department of Correction to co-locate criminal justice liaisons and CHWs in Mississippi facilities, with a focus on supporting pregnant members and mothers of children enrolled in MSCAN or CHIP and juveniles involved with the justice system. Like CareSource did in Indiana, TrueCare will build a robust network of second chance employers for our Mississippi members.

- **TrueCare Care Vans:** Our Care Vans will arrive in communities across Mississippi and provide easily accessible services including vaccines, health needs screenings, food assistance, haircuts, employment assistance, high school equivalency education resources, and interview training. Each Care Van is equipped with GPS capabilities, allowing members to track the van's location online. CareSource has effectively utilized similar vans in its other markets and have been successful in assisting hundreds of people throughout the communities we serve. We post schedules on our member website and our social media pages. Additionally, members can sign up for text alerts, or mobile app alerts to receive a push notification whenever the Care Van is in their area. **Our Care Van can also serve as a mobile hotspot for members with limited internet connectivity.**

- **The CareSource Foundation:** Like CareSource's Foundation in its other markets, TrueCare will establish a Foundation and invest in innovative programs and partnerships in Mississippi that eliminate poverty, provide much-needed services to low-and moderate-income families, develop innovative approaches to address critical health issues, and enhance the lives MSCAN and CHIP members. [redacted]

The CareSource Foundation focuses on improving health equity, health outcomes, and health literacy in local communities where our members reside; and creating vibrant communities by driving economic growth and helping residents lead healthy lives. To accomplish these goals, the CareSource Foundation's priorities include:

- Supporting health education and promoting healthy habits
- Improving maternal, infant, and child health
- Investing in transformative programs and partnerships that support building vibrant neighborhoods
- Investing in innovative programs and initiatives that prepare and cultivate the next generation and foster a high-quality, diverse workforce



- Since 2006, the CareSource Foundation has **invested more than $25 million to support scalable and replicable projects** that encourage and promote healthy communities and support these goals, such as:
  - **Improving Maternal Health Outcomes**: The CareSource Foundation has partnered with the Nurse Family Partnership (**NFP**) in Georgia and Indiana to address infant mortality and improve maternal health in several markets and will in Mississippi as well. NFP is a program of prenatal and infancy home visiting for low-income, first-time mothers and their families. Nurses and moms discuss a wide range of issues that affect prenatal health — from smoking cessation to healthy diets — to information on how to access proper healthcare professionals. Research on the national replication of NFP finds that mothers who received NFP services had 18% fewer preterm births, 21% more mothers breastfed at 6 months, and 19% more infants were immunized at 6 months compared to a similar reference group of low-income women nationally.
  - **Diversity, Equity & Inclusion in Health Care –** The CareSource Foundation partners with a national non-profit organization to develop and implement a cultural consciousness pathway for nurses to create a client-centered care pathway that acknowledges the negative impacts of racism, implicit bias, and discrimination on the health and wellbeing of populations living with adversity—particularly Black and Indigenous people of color (**BIPOC**). This training is used by all nurses in other CareSource markets and will be offered to all TrueCare staff and health partners in Mississippi.
- **Broadband Access** – CareSource co-developed a Digital Equity Initiative paring Foundation investment, in-kind donations, and volunteers to provide digital access to care, jobs, and education in our markets. By providing broadband access and Chrome books for families through this unique partnership, we were able to increase health literacy and improve access to resources. CareSource used this partnership to send out health literacy info and in a recent COVID vaccination campaign and had a 41% open and click rate to mobile phones. TrueCare will replicate this initiative in Mississippi through partnership with CSpire and in communities where our members live and lack access to broadband.
- **School-based Mental Health** – CareSource has invested in the development of an online community, positive.ly, to meet teens where they are online. TrueCare will bring this online app to Mississippi and create online communities that fosters resilience by giving teens a safe space to share their mental health stories and access mental health resources.
- **Health and Childhood Literacy** – CareSource has seen firsthand the value of reading and education in our youngest members. That is, in part, why CareSource has partnered with the Dolly Parton Imagination Library, a national program that sends one book per month to children from birth to five years old. According to a

recent study from Case Western Reserve University, there is a positive correlation between enrollment in the Imagination Library and kindergarten readiness assessment scores, with a greater impact in zip codes with the highest poverty rates. TrueCare will use the Dolly Parton Imagination Library for children in Mississippi with a special focus on rural and hard to reach areas, as well as Mississippi's most populated county, Hinds County.

TrueCare will Offer Providers Additional Resources and Collaboration Through Specialized Committees, Boards, and Workgroups:

- **TrueCare's Population Health Management Committee.** Our Population Health Management Committee is led by our Medical Director and is tasked with ensuring all parts of our population health program are working in unison to achieve MSCAN and CHIP program goals. It includes two subcommittees: one focused on healthy equity, and the other focused on special populations and SDOH. Our population health management committee reports to our quality management committee at least quarterly.
- Our **Health Equity Subcommittee** is charged with fostering the health and well-being of members who experience health disparities due to race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, zip code, or other socially determined circumstances. This subcommittee is composed of multiple health equity representatives, including our health equity officer, and our health equity lead.
- Our **Special Populations Subcommittee** provides input on ways to ensure person-centered, community-based care for members with complex medical conditions including members with physical disabilities or serious behavioral health needs, or members in foster care. Functions of this Subcommittee include assessing gaps and identifying strategies for improving access to shared living, crisis stabilization, integrated care coordination, community transition from hospitals, psychiatric residential facilities, and other care facilities. We offer opportunities for members and their families, caregivers, guardians, providers, and community stakeholders to participate on this Subcommittee. To assure the equitable representation of plan members who identify as part of one or more of the target populations, we ensure at least 50% of the Subcommittee's participants are TrueCare members. Subcommittee meetings are held at various regional locations, as well as virtually, to assure maximum participation. The Subcommittee is co-chaired by a plan member and a provider or stakeholder with expertise in the provision of evidence-based practices within one or more of the focus areas. The co-chairs report directly to the TrueCare Board of Directors and share and disseminate findings and recommendations with the MAC and the QMIC.
- **Ministerial Advisory Board**. TrueCare's Mississippi Ministerial Advisory Board is tasked with providing evidence-informed advice on current and emerging issues, and on challenges and opportunities affecting the lives of MSCAN and CHIP members within their congregation. Input from the Ministerial Advisory Board provides valuable insight to TrueCare's member outreach, provider engagement, community investments, and overall operations strategies. Careful consideration is given to diverse membership participation from groups such as the Cooperative Baptist Fellowship of Mississippi and Delta Hands for Hope, who can contribute a wide range of perspectives and advice on the health needs of families served under MSCAN and CHIP.

[redacted]

- **Member Experience Workgroup.** Our Member Experience Workgroup serves as part of a broader organizational initiative focused on ensuring our members from different regions have high quality interactions with us across all platforms and services to ensure we address disparities and health equity. This means imagining all health plan services to exceed our members' expectations and implementing technology to improve every member touchpoint.

- **Provider Experience Workgroup.** Our Provider Experience Workgroup is tasked with providing information on systems and innovations that will affect providers, including new incentives, ways to reduce administrative burden, and methods to improve quality of care. We believe this workgroup is vital to improving the overall experience of our network providers and the care our members receive.

TrueCare's Governance and Oversight of CareSource

To satisfy Appendix A, Section 13 delegation oversight requirements, TrueCare has a robust oversight structure of CareSource's services. TrueCare is led by a Board of Directors comprised of respected leaders from the Mississippi healthcare industry, including a dedicated seat for a physician representative. Our Board of Directors takes an active role in the operations of our health plan and provides operational oversight to ensure cost effective, high-quality care for MSCAN and CHIP members.

In compliance with Appendix A, Section 1.13.1.1 and Section 13, most of the Key Personnel are full-time, Mississippi based, TrueCare employees who will be the Division's point of contact for all topics regarding the Draft Contract. These include the TrueCare Chief Executive Officer (**CEO**)/Project Manager, who reports directly to the Board of Directors, and the TrueCare Chief Compliance Officer (**CCO**), Chief Operating Officer (**COO**), Chief Financial Officer (**CFO**), and Medical Director (**MD**), all which will report to the CEO and oversee the respective CareSource services related to their respective position. CareSource will employ the Chief Information Officer, the Perinatal Health Director, the Behavioral Health Director, and the positions required by Appendix A, Sections 1.13.1.2 and 1.13.2. The TrueCare executive team is reinforced by the following TrueCare Committees (Table 4.3.1.1_N):

Table 4.3.1.1_N: TrueCare Committees Supporting the TrueCare Executive Team

TrueCare Committee	Role
Operations and Information Committee	This committee will oversee TrueCare's operational performance, the performance of TrueCare's information technology systems, and the accuracy and timing of encounter data. The committee will oversee operations and information technology and report any findings or suggestions to the TrueCare CEO, COO and CCO. This committee will meet at least monthly and the COO or an approved executive designee must attend all committee meetings. Three external members will serve on the committee and must have at least the following qualifications: (1) located in Mississippi, (2) have managed care experience, (3) have experience in operations and healthcare claims payment.
Finance Committee	This committee will oversee and be accountable for TrueCare's financial-related functions. The committee will oversee financial performance and report any findings or suggestions to the TrueCare CEO, CCO and CFO. The Committee will meet at least monthly and the CFO or an approved Finance executive must attend all Committee meetings. Three members shall serve on the Committee and must have at least the following qualifications: (1) located in Mississippi; (2) have managed care experience; and (3) have a healthcare finance background.
Clinical Committee	This committee will oversee CareSource's clinical decision-making, provision of covered services, and other clinical issues. The committee will report any findings or suggestions to the TrueCare CEO, CCO and MD. The committee will meet at least monthly and the TrueCare MD and the CareSource Perinatal Health Director and Behavioral Health Director or an approved clinician of similar training and experience must attend all meetings. Three external members shall serve on the committee and must have at least the following qualifications: (1) located in Mississippi; (2) have managed care experience; and (3) served as a Mississippi-licensed physician.
Third-Party Auditing Consultant	In addition to the audits required by the State contract, TrueCare will engage a third-party auditing consultant to perform performance oversight audits of CareSource and other delegated functions. At least biannually, the Third-Party Auditing Consultant shall perform comprehensive audits of CareSource's operations, compliance, finances, clinical performance, information and technology, and accuracy and quality of the submissions to the State of Mississippi to include, but not be limited to, encounters. These reports will be produced to the CEO, CCO, and applicable TrueCare committees. The CEO, CCO, or committees may also request other ad hoc audits.

The TrueCare Board of Directors, executive team, and committees will manage and oversee the implementation and adherence to Appendix A. CareSource shall run the day-to-day operations of TrueCare.

[END OF RESPONSE]

4.3.1.2 CORPORATE EXPERIENCE

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

If the information requested above is not available, the Offeror must provide an explanation. Acceptance of the explanation provided is at the discretion of the Division.

Our response can be found in Appendix F:4.3.1.2, immediately following this section.

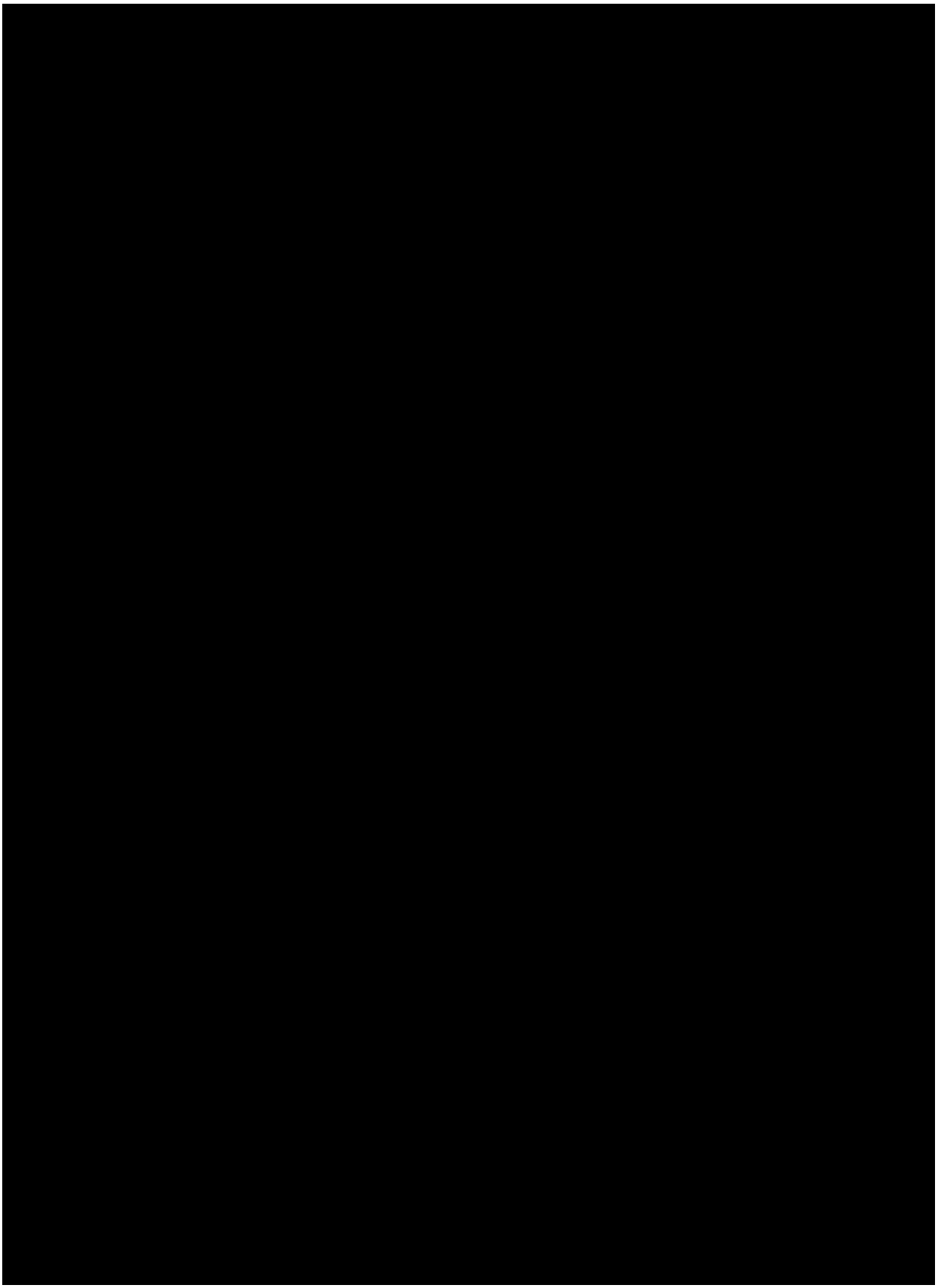
4.3.1.2 Use the following form to provide information for any states that the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.

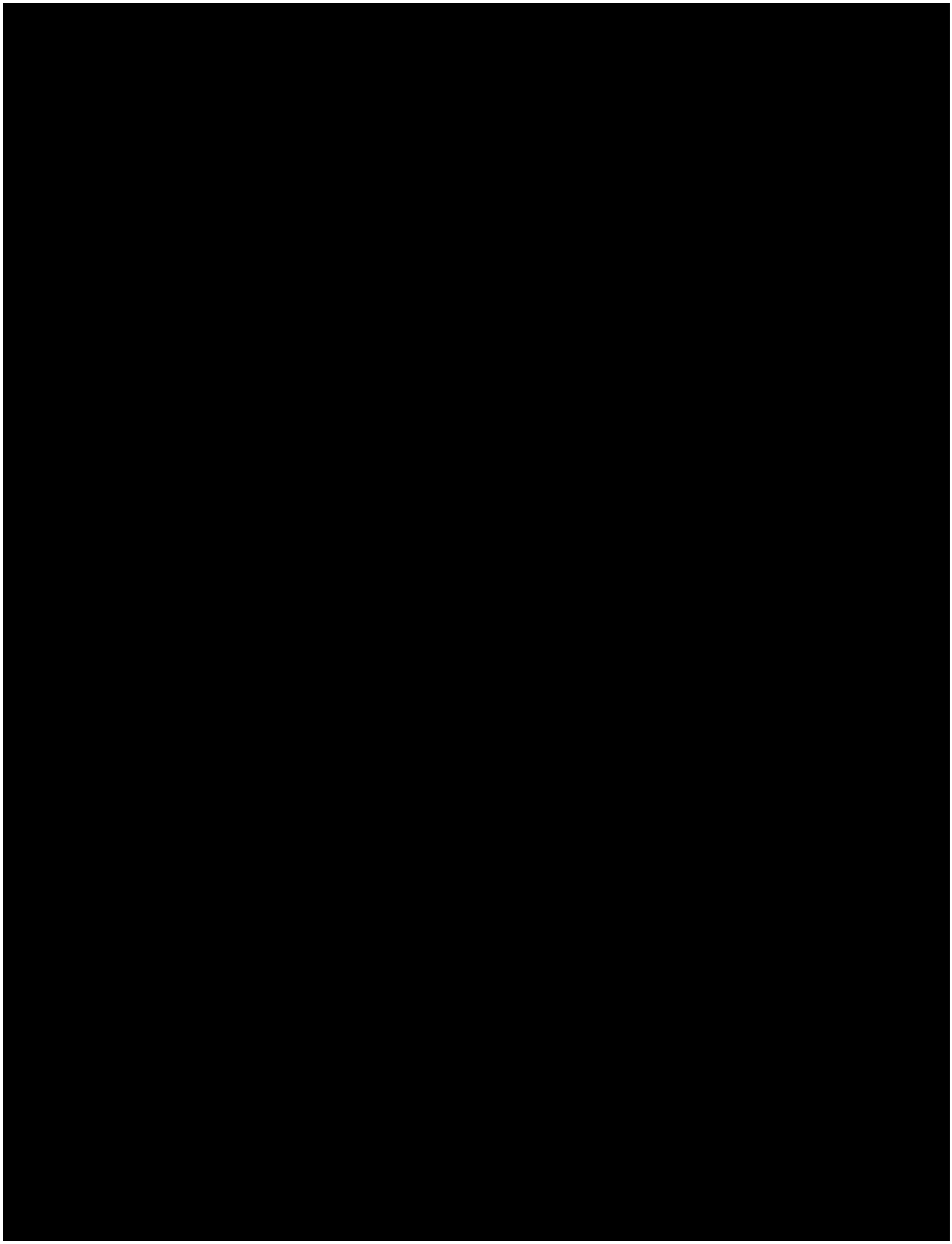
If the Offeror has no current or recent clients, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support information provided. Acceptance of the explanation provided is at the discretion of the Division.

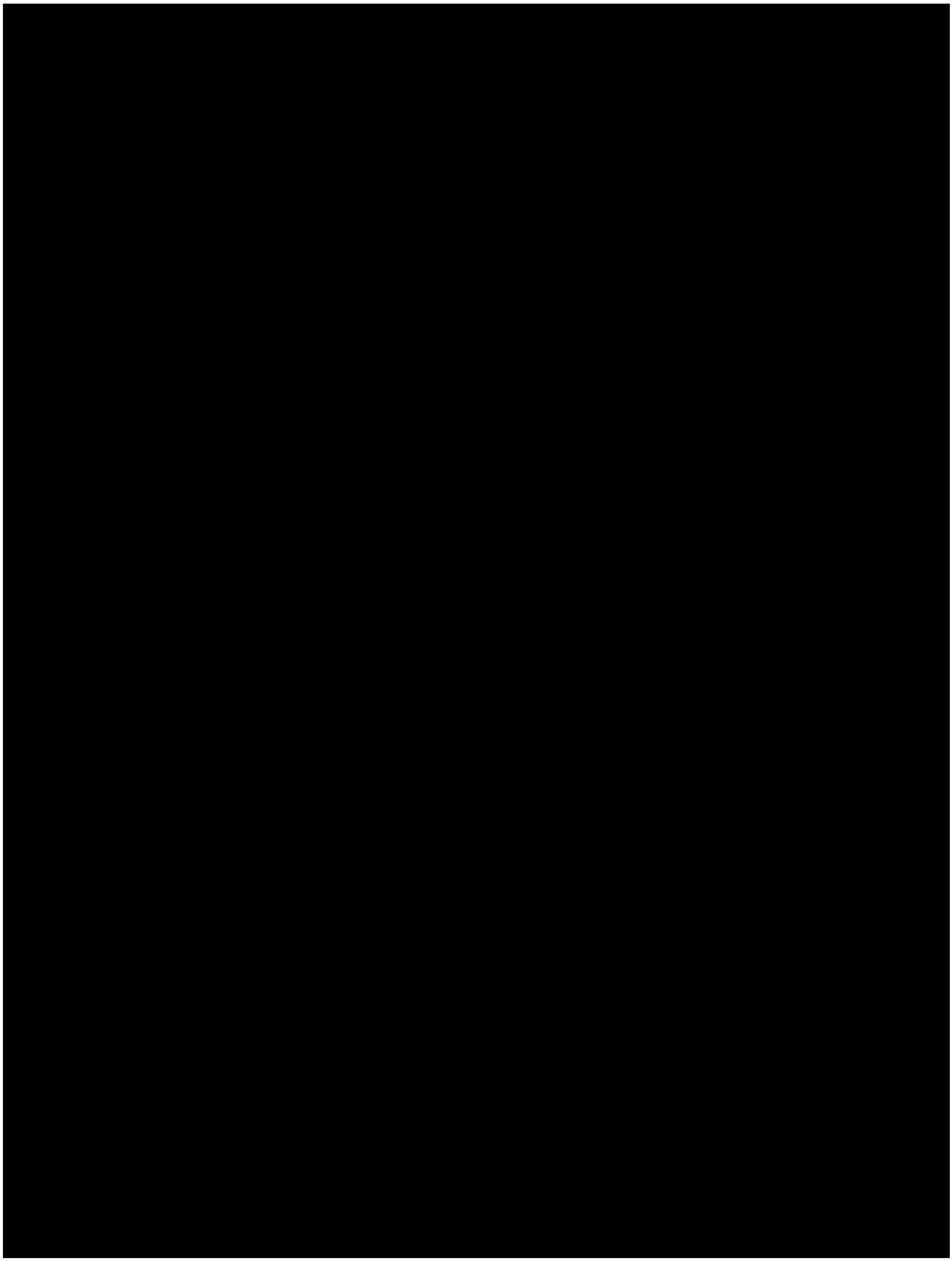
Mississippi True's Corporate Experience Explanation

Mississippi True is a not-for-profit Mississippi health maintenance organization that was formed by a coalition of Mississippi's most well-established hospitals and health systems to serve as Mississippi's one and only provider-sponsored health plan. As an entity formed to pursue a Mississippi Medicaid managed care contract, Mississippi True has not yet had the opportunity to do same. For this RFQ, we have formed an alliance with CareSource Management Services, LLC (CareSource), a nationally recognized managed care organization with more than 30 years of Medicaid managed-care experience, a not-for-profit mission, a unique member-centric focus, and an established reputation as a leader in quality and operational excellence.

TrueCare will harness the synergy between Mississippi True's and CareSource's unique strengths: Mississippi True will bring local expertise and oversight, and CareSource will serve as the plan's managed-care program administrator running the day-to-day operations. By combining Mississippi True's deep and longstanding relationship to the Mississippi provider community with CareSource's extensive experience in Medicaid health-plan operations, TrueCare offers significant advantages over the typical Medicaid plan and has the power to improve the health of Mississippians and transform the delivery of healthcare in Mississippi. Consequently, also attached is another Appendix F, 4.3.1.2. presenting CareSource's deep Medicaid managed care experience in Georgia, Indiana, and Ohio with the type of Medicaid services to be provided under this RFQ.







[END OF RESPONSE]

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.

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage: **N/A** %			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): **N/A**		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No

Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): **N/A**		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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**
N/A	**N/A**	**N/A**

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? [ ] Yes [**X**] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [**X**] 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.**
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	City: **N/A**	City: **N/A**	City: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	City: **N/A**	City: **N/A**	City: **N/A**

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

Name of Subcontractor/ Subcontractor's Owner	Name of Offeror's Owner	Relationship
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]			
[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]

If the above noted individual is an owner, please select one of the following options and give the effective date:

[ ] Direct/Indirect Owner **N/A**	[ ] Partner **N/A**
Effective Date (MM/DD/YYYY): **N/A**	
Ownership Percentage **N/A%**	

If the above noted individual is a managing employee, please select all that apply and give the effective date:

Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	

If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:

[ ] Authorized Official **N/A**	[ ] Delegated Official **N/A**
Effective Date (MM/DD/YYYY): **N/A**	

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	City: **N/A**	City: **N/A**	City: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	City: **N/A**	City: **N/A**	City: **N/A**

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

Name of Subcontractor/ Subcontractor's Owner	Name of Offeror's Owner	Relationship
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): **N/A**		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No

Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

[redacted]

If the above noted individual is an owner, please select one of the following options and give the effective date:	
[ ] Direct/Indirect Owner **N/A**	[ ] Partner **N/A**
Effective Date (MM/DD/YYYY): **N/A**	
Ownership Percentage **N/A%**	

If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	

If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:	
[ ] Authorized Official **N/A**	[ ] Delegated Official **N/A**
Effective Date (MM/DD/YYYY): **N/A**	

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:	**N/A**	**N/A**
Relationship (e.g., sibling): **N/A**		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No

Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/27/2018**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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**
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.**
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**09/28/2021**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No

Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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**
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.**
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(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.

If the above noted individual is an owner, please select one of the following options and give the effective date:	
[ ] Direct/Indirect Owner **N/A**	[ ] Partner **N/A**
Effective Date (MM/DD/YYYY): **N/A**	
Ownership Percentage **N/A%**	

If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	

If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:	
[ ] Authorized Official **N/A**	[ ] Delegated Official **N/A**
Effective Date (MM/DD/YYYY): **N/A**	

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

[redacted]

If the above noted individual is an owner, please select one of the following options and give the effective date:

[ ] Direct/Indirect Owner **N/A**	[ ] Partner **N/A**
Effective Date (MM/DD/YYYY): **N/A**	
Ownership Percentage **N/A%**	

If the above noted individual is a managing employee, please select all that apply and give the effective date:

Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	

If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:

[ ] Authorized Official **N/A**	[ ] Delegated Official **N/A**
Effective Date (MM/DD/YYYY): **N/A**	

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No

Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported on this form:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing Offeror**
- **All managing employees of the disclosing Offeror**
- **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.

[redacted]

If the above noted individual is an owner, please select one of the following options and give the effective date:

[ ] Direct/Indirect Owner **N/A**	[ ] Partner **N/A**
Effective Date (MM/DD/YYYY): **N/A**	
Ownership Percentage **N/A%**	

If the above noted individual is a managing employee, please select all that apply and give the effective date:

Title	Effective Date		Effective Date
[**X**] Director/Officer	**06/08/2015**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	

If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:

[ ] Authorized Official **N/A**	[ ] Delegated Official **N/A**
Effective Date (MM/DD/YYYY): **N/A**	

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No

Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**09/28/2021**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No

Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**09/28/2021**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**
Business Location			
Address Line 1: **N/A**			
Address Line 2: **N/A**			
City: **N/A**	State: **N/A**	Zip Code: **N/A**	County: **N/A**

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

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

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

Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported on this form: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing Offeror** • **All managing employees of the disclosing Offeror** • **All authorized and delegated officials** If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual.			
[redacted]			
If the above noted individual is an owner, please select one of the following options and give the effective date:			
[ ] Direct/Indirect Owner _ N/A _ [ ] Direct/Indirect Owner **N/A**		[ ] Partner **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			
Ownership Percentage **N/A%**			
If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date		Effective Date
[**X**] Director/Officer	**09/05/2019**	[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	
If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:			
[ ] Authorized Official **N/A**		[ ] Delegated Official **N/A**	
Effective Date (MM/DD/YYYY): **N/A**			

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:	**N/A**	**N/A**
Relationship (e.g., sibling): N/A		

Section 2: Disclosure of Subcontractor Information

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

Address Line 2: N/A			
City: N/A	State: N/A	Zip Code: N/A	County: N/A
Business Location			
Address Line 1: N/A			
Address Line 2: N/A			
City: N/A	State: N/A	Zip Code: N/A	County: N/A

Disclosure of Subcontractor Information (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
N/A	**N/A**	**N/A**

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? [ ] Yes [X] No

Do any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [X] 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.
N/A	**N/A**	**N/A**	**N/A**

[END OF RESPONSE]

4.3.2.2 WHEN AND TO WHOM INFORMATION WILL BE DISCLOSED

In accordance with 42 C.F.R. § 455.104(c), disclosures from the Offeror/winning Contractor are due at any of the following times:
1. Upon the Contractor submitting a qualification in accordance with the State's procurement process;
2. Annually, including upon the execution, renewal, and extension of the contract with the State; and,
3. Within thirty-five (35) days after any change in ownership of the Contractor.
In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State's designated Medicaid agency.
The Offeror must use the appropriate form in Appendix G as its response to this section.

Our response can be found in Appendix G: 4.3.2.2, immediately following 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.

TrueCare
Name of Offeror

Chuck Reece
Printed name of person attesting for Offeror

Chairman of Mississippi True d/b/a TrueCare
Title of person attesting for Offeror

Signature of person attesting for Offeror

02/03/2022
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.

Our response can be found in Appendix G 4.3.2.3, immediately following this section.

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

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

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

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

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

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

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

The Offeror does not have:

[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.

[X] 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.

TrueCare
Name of Offeror

Chuck Reece
Printed name of person attesting for Offeror

Chairman of Mississippi True d/b/a TrueCare
Title of person attesting for Offeror

Signature of person attesting for Offeror

02/03/2022
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.

Our response can be found in Appendix G 4.3.2.4, immediately following 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.

TrueCare
Name of Offeror

Chuck Reece — Chairman of Mississippi True d/b/a TrueCare
Printed name of person attesting for Offeror — **Title of person attesting for Offeror**

02/03/2022
Signature of person attesting for Offeror — **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.

Our response can be found in Appendix G 4.3.2.5, immediately following 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.

TrueCare
Name of Offeror

Chuck Reece
Printed name of person attesting for Offeror

Chairman of Mississippi True d/b/a TrueCare
Title of person attesting for Offeror

Signature of person attesting for Offeror

02/03/2022
Date

Criminal Convictions and Other Sanctions
Provide the requested information in this section for any person who: (1) Has an ownership or control interest in the Offeror OR is an agent or managing employee of the Offeror AND (2) Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Titles XIX or XXI services since the inception of those programs, OR (3) Has been convicted of a crime referenced in Miss. Code Ann. § 43-13-121(7)(c) – (h), (4) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13121(7)(c-h), (5) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program, (6) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program, (7) Has had his/her/its license or certification revoked, or (8) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.
Identify the person and each conviction/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Provide a copy of any documentation. Include additional copies of this page as necessary.

Name	Criminal/Sanction Information	Date
N/A	N/A	N/A
Agency/Court/Administrative Body	**Resolution**	
N/A	N/A	
Name	Criminal/Sanction Information	Date
N/A	N/A	N/A
Agency/Court/Administrative Body	Resolution	
N/A	N/A	
Name	Criminal/Sanction Information	Date
N/A	N/A	N/A
Agency/Court/Administrative Body	Resolution	
N/A	N/A	
Name	Criminal/Sanction Information	Date
N/A	N/A	N/A
Agency/Court/Administrative Body	Resolution	
N/A	N/A	
Name	Criminal/Sanction Information	Date
N/A	N/A	N/A
Agency/Court/Administrative Body	Resolution	
N/A	N/A	

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.

Audited Financial Statements

Our last three years of financial statements can be found in Attachment 4.3.2.6-1 starting on page 124.

- Attachment 4.3.2.6-1.a: 2020 MS True Audited Fin. Statement (Page 125)
- Attachment 4.3.2.6-1.b: 2020 CareSource Audited Fin. Statement (Page 137)
- Attachment 4.3.2.6-1.c: 2019 MS True Audited Fin. Statement (Page 181)
- Attachment 4.3.2.6-1.d: 2019 CareSource Audited Fin. Statement (Page 193)
- Attachment 4.3.2.6-1.e: 2018 MS True Audited Fin. Statement (Page 243)
- Attachment 4.3.2.6-1.f: 2018 CareSource Audited Fin. Statement (Page 255)

Available Line of Credit

[redacted]

Documentation for this line of credit can be found in Attachment 4.3.2.6-2 (Page 303).

Three Year Pro Forma

The completed Pro Forma Excel template is included with our electronic submission to the response of this RFQ.

Documentation for this line of credit can be found in Appendix G 4.3.2.6-1 (Page 304).

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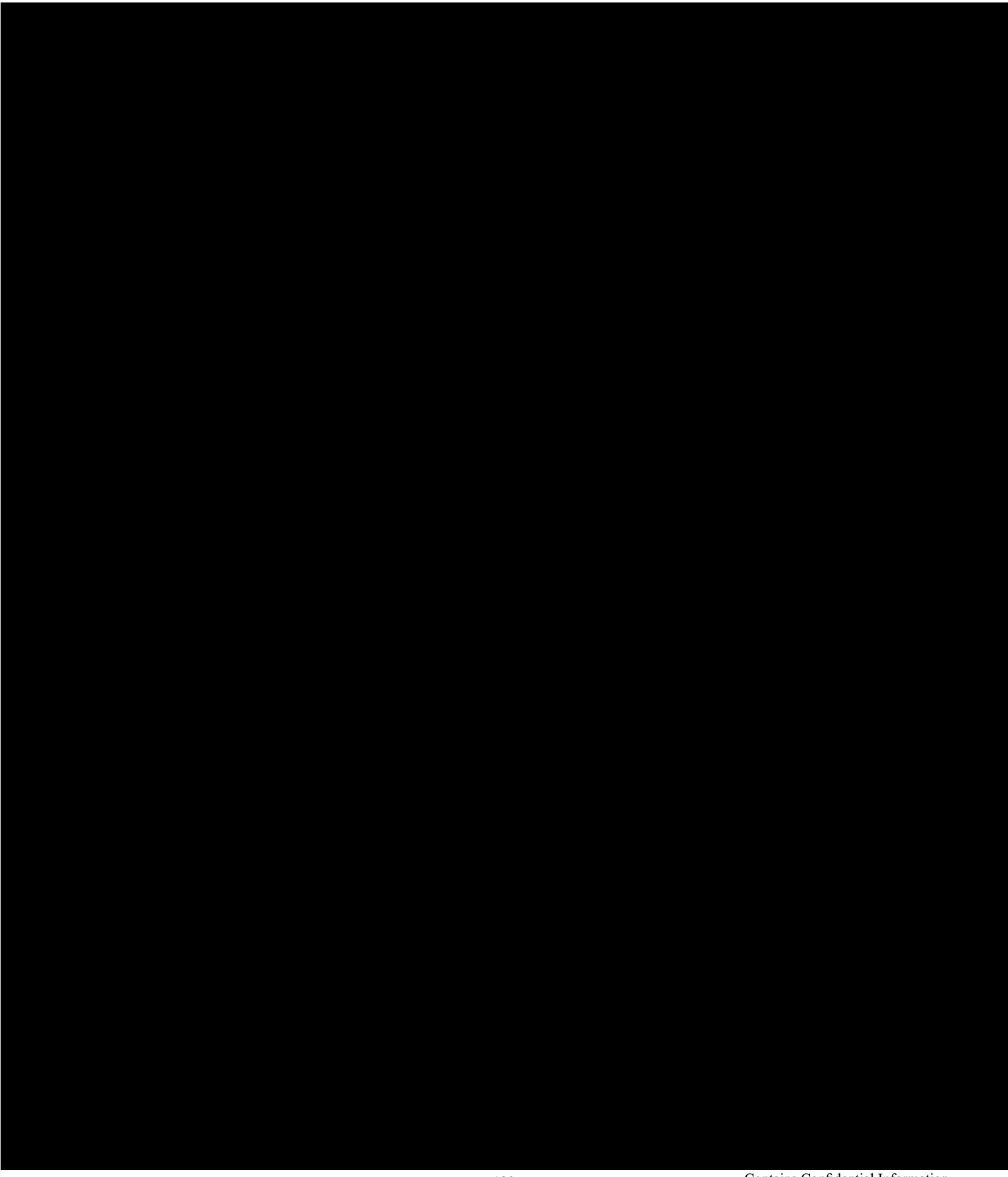

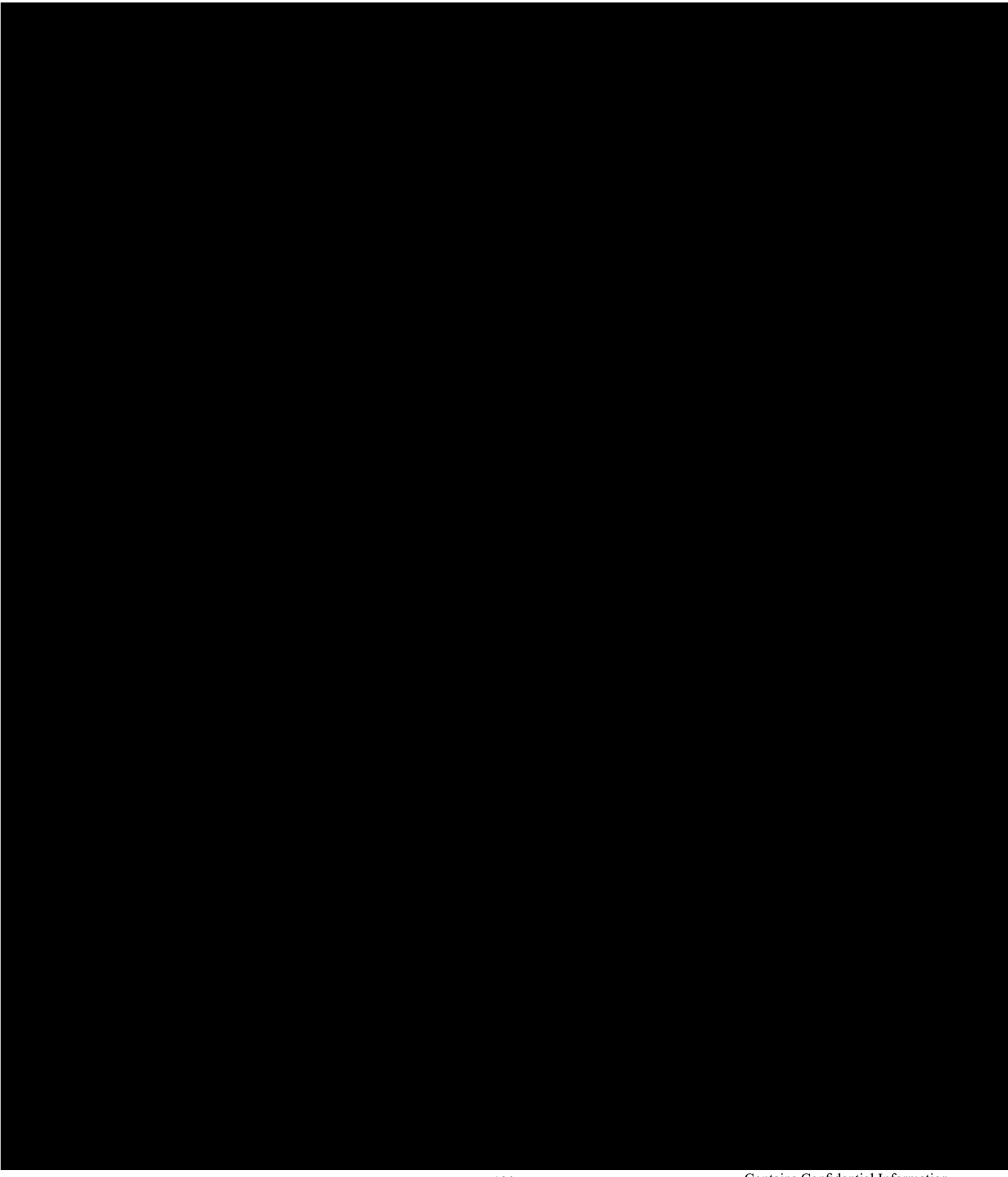

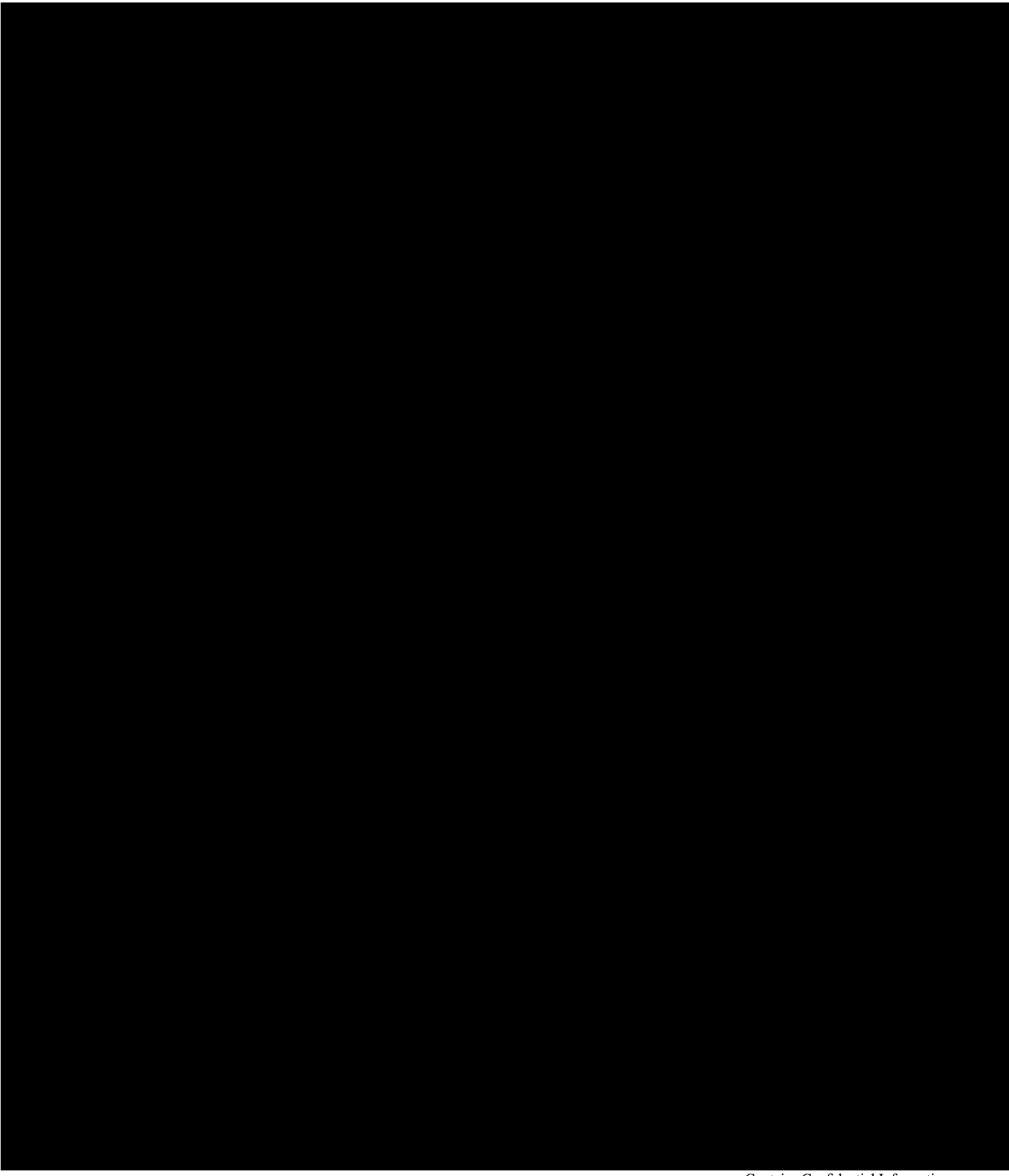

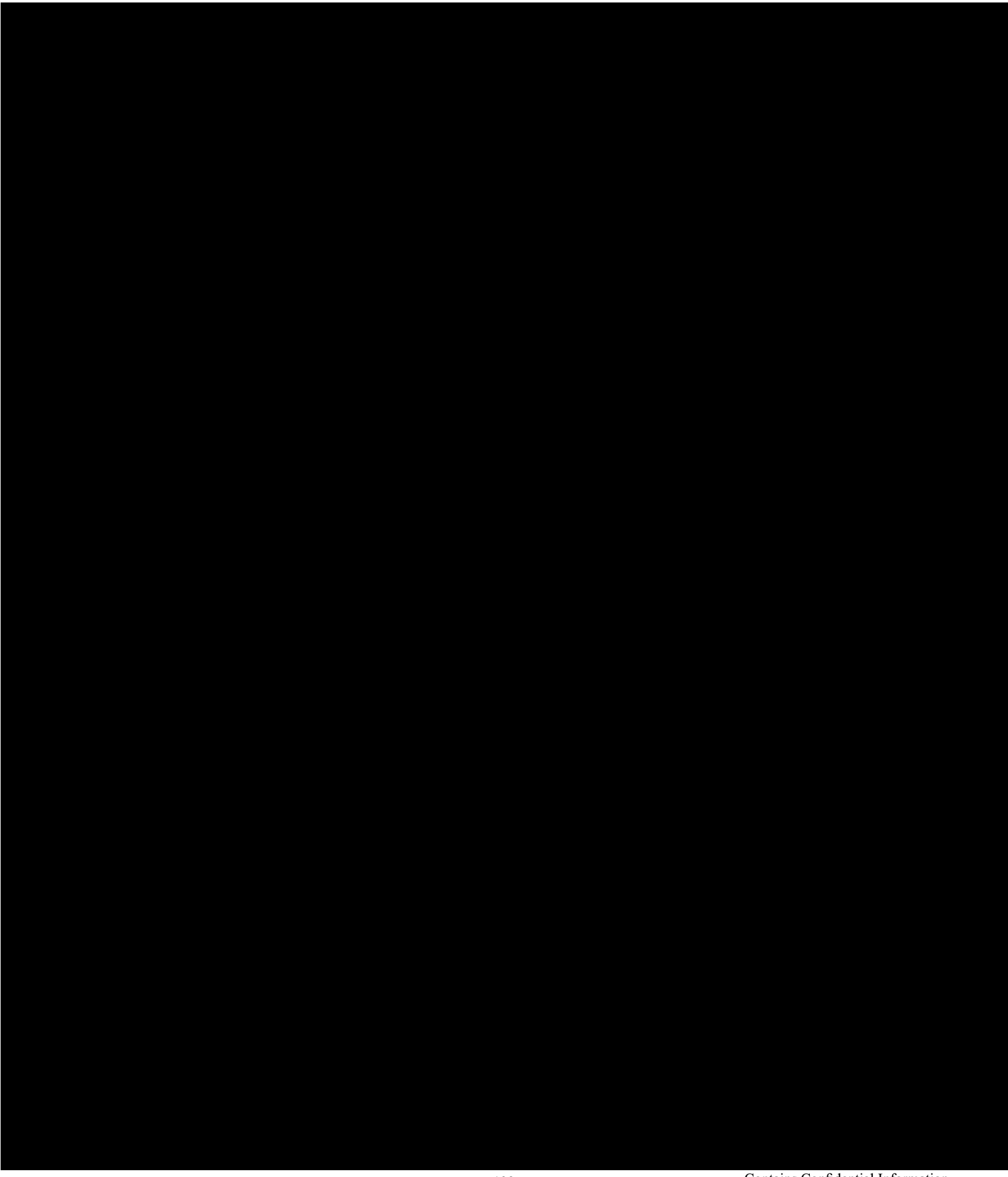

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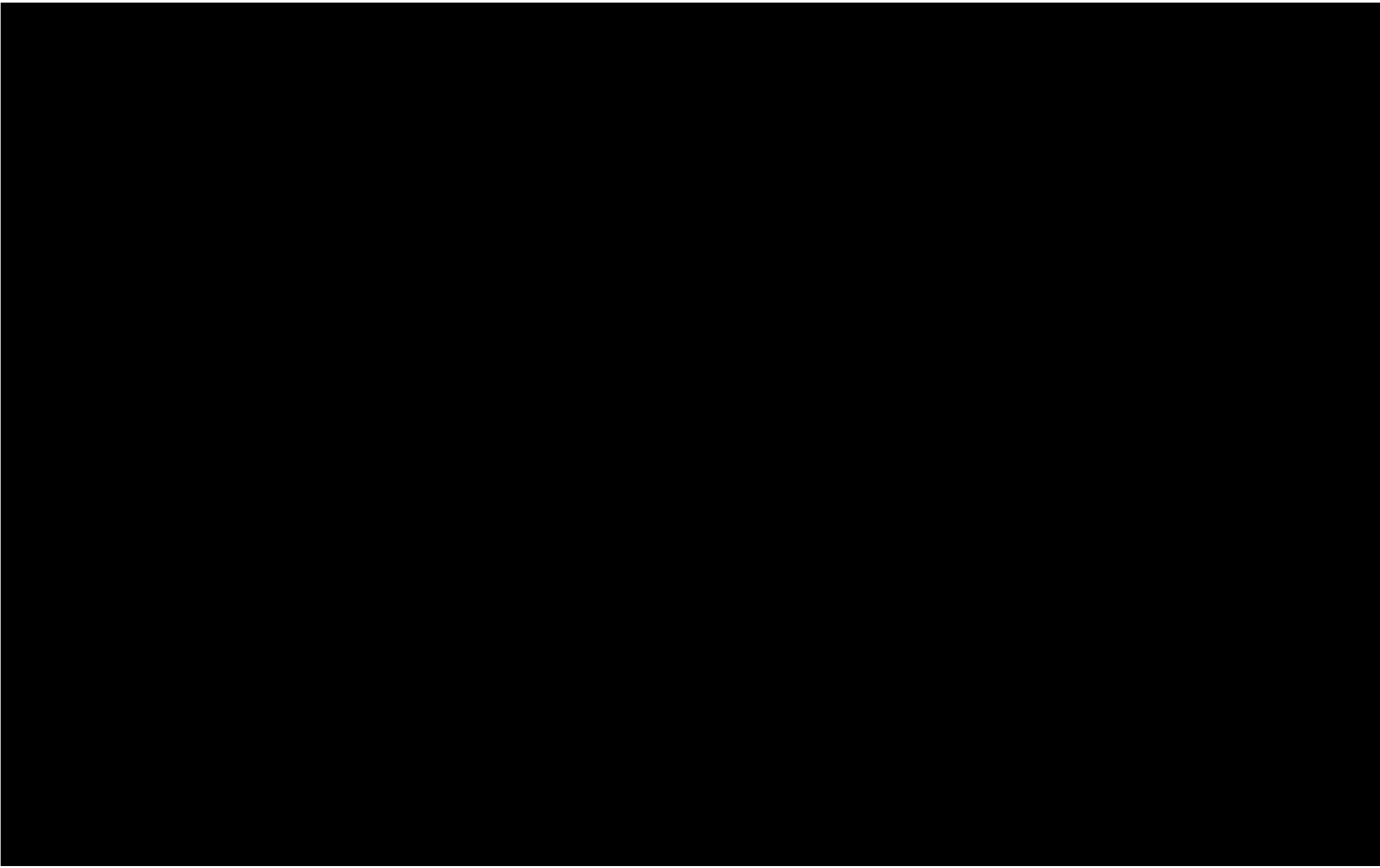

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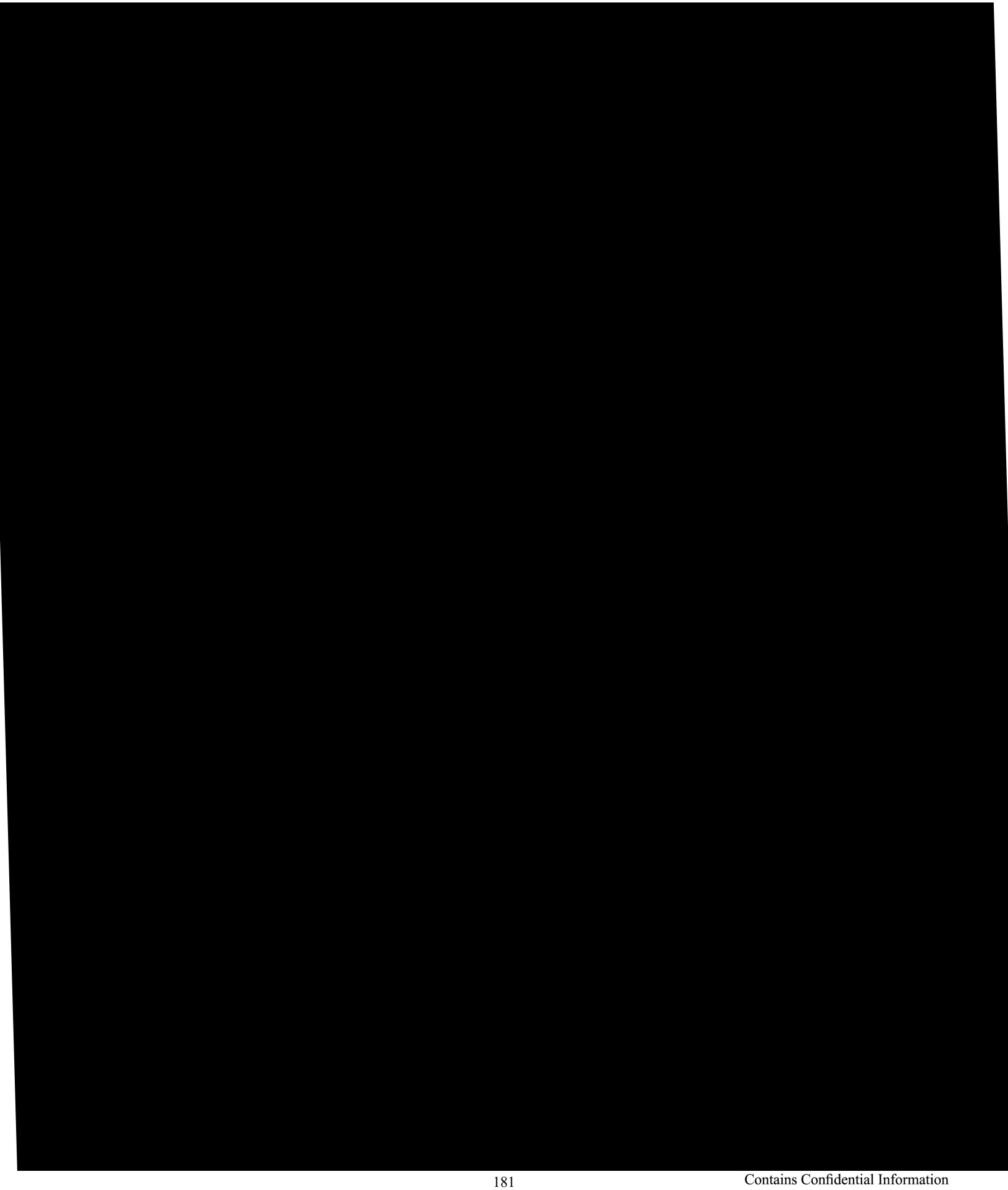

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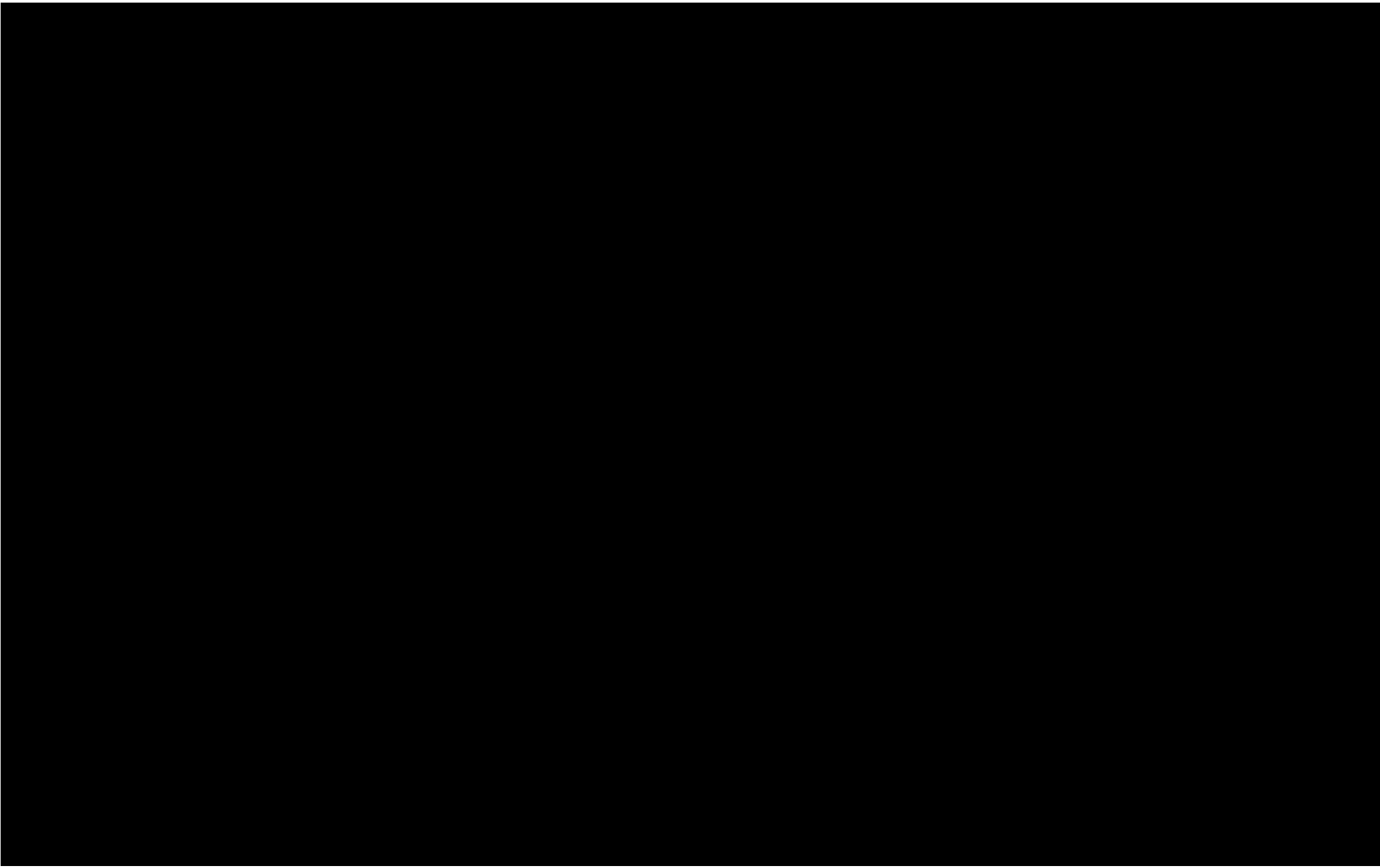

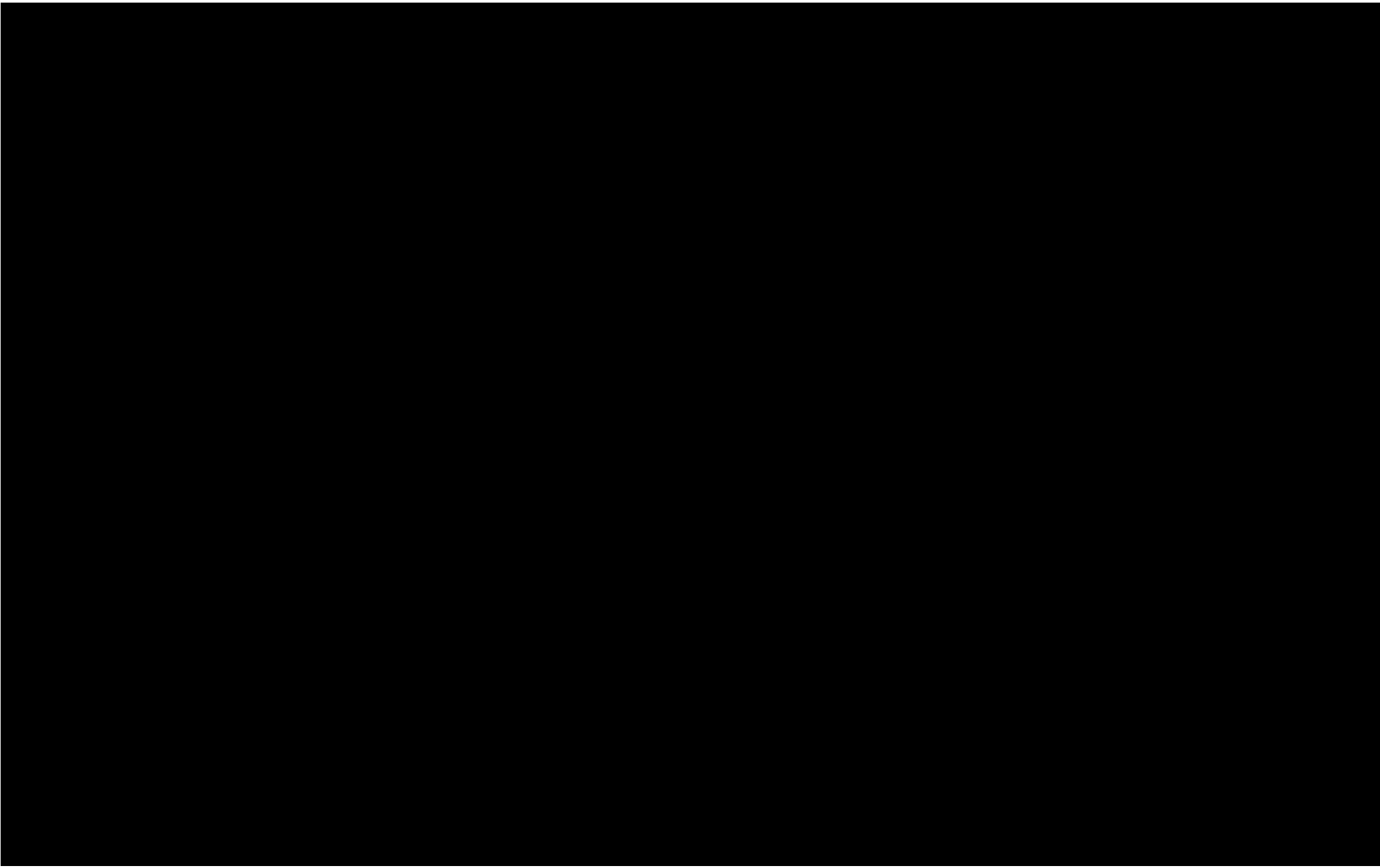

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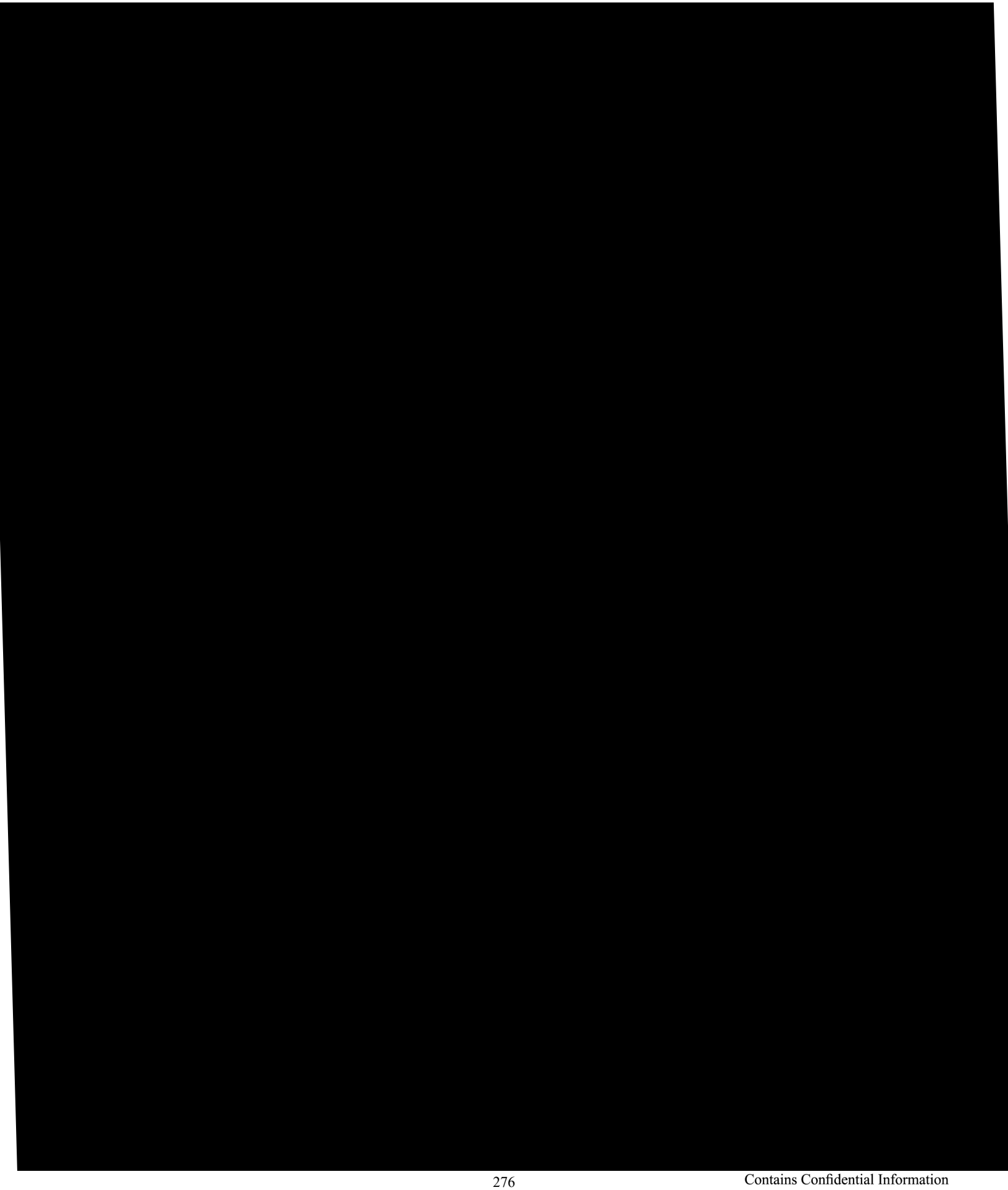

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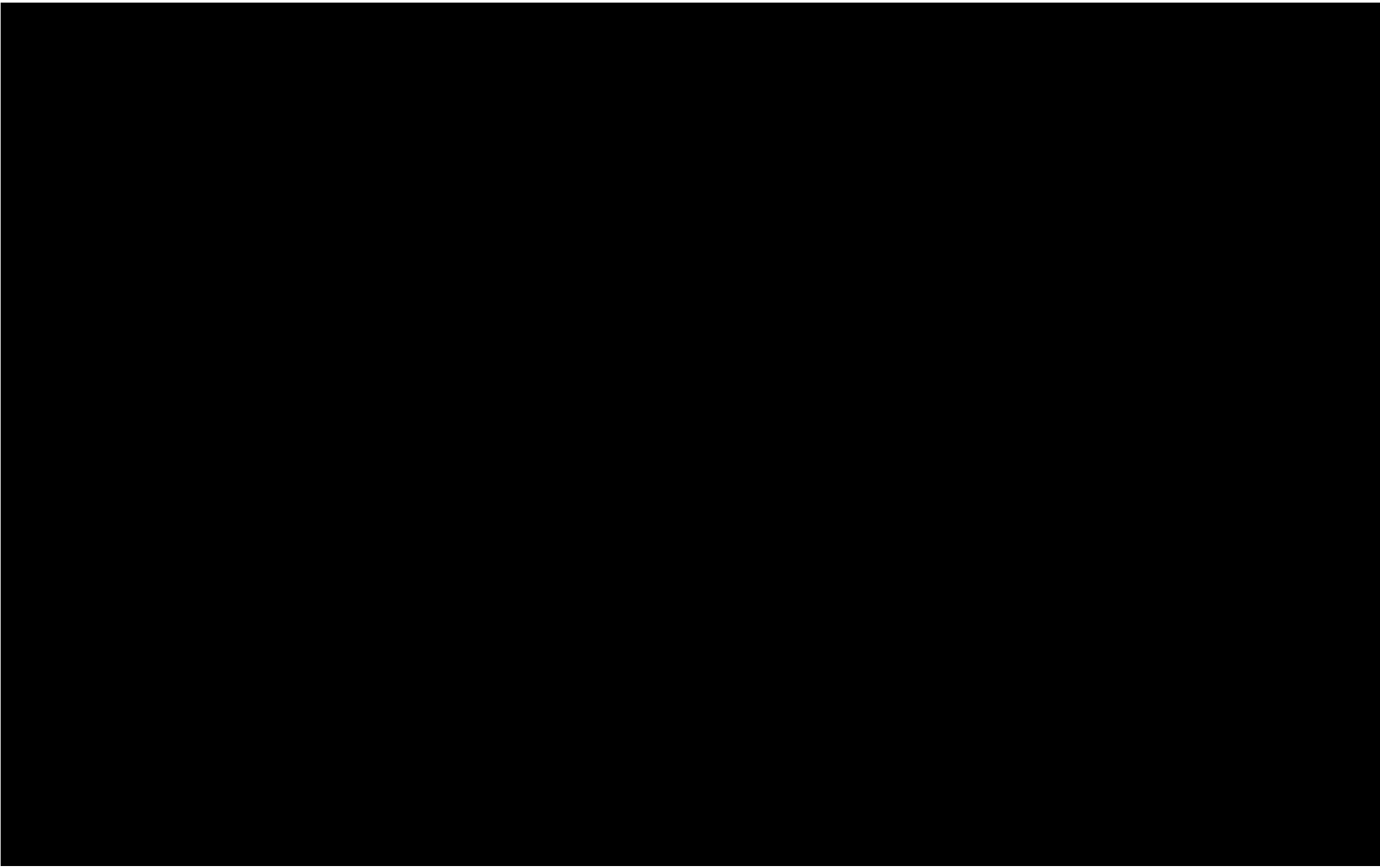

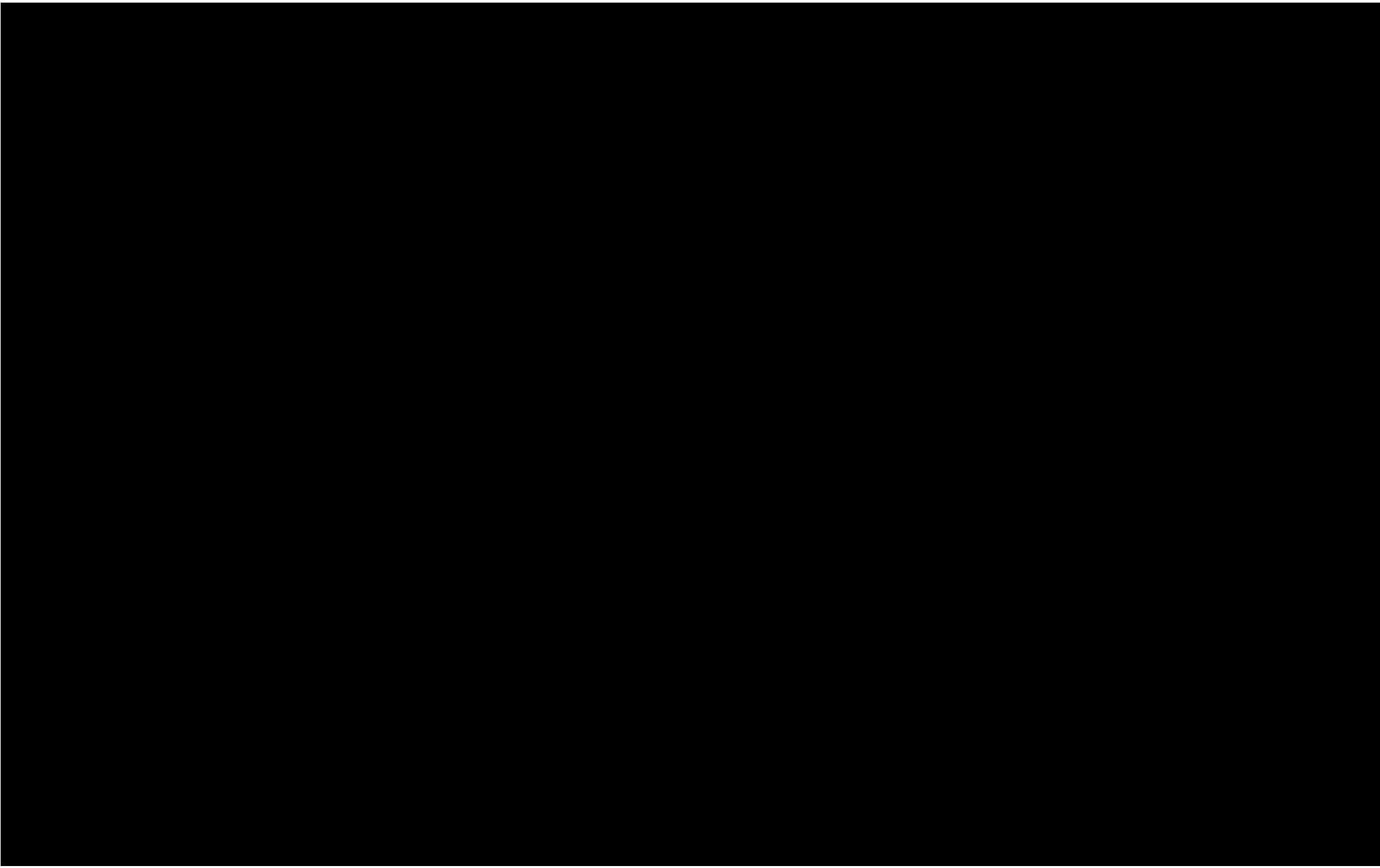

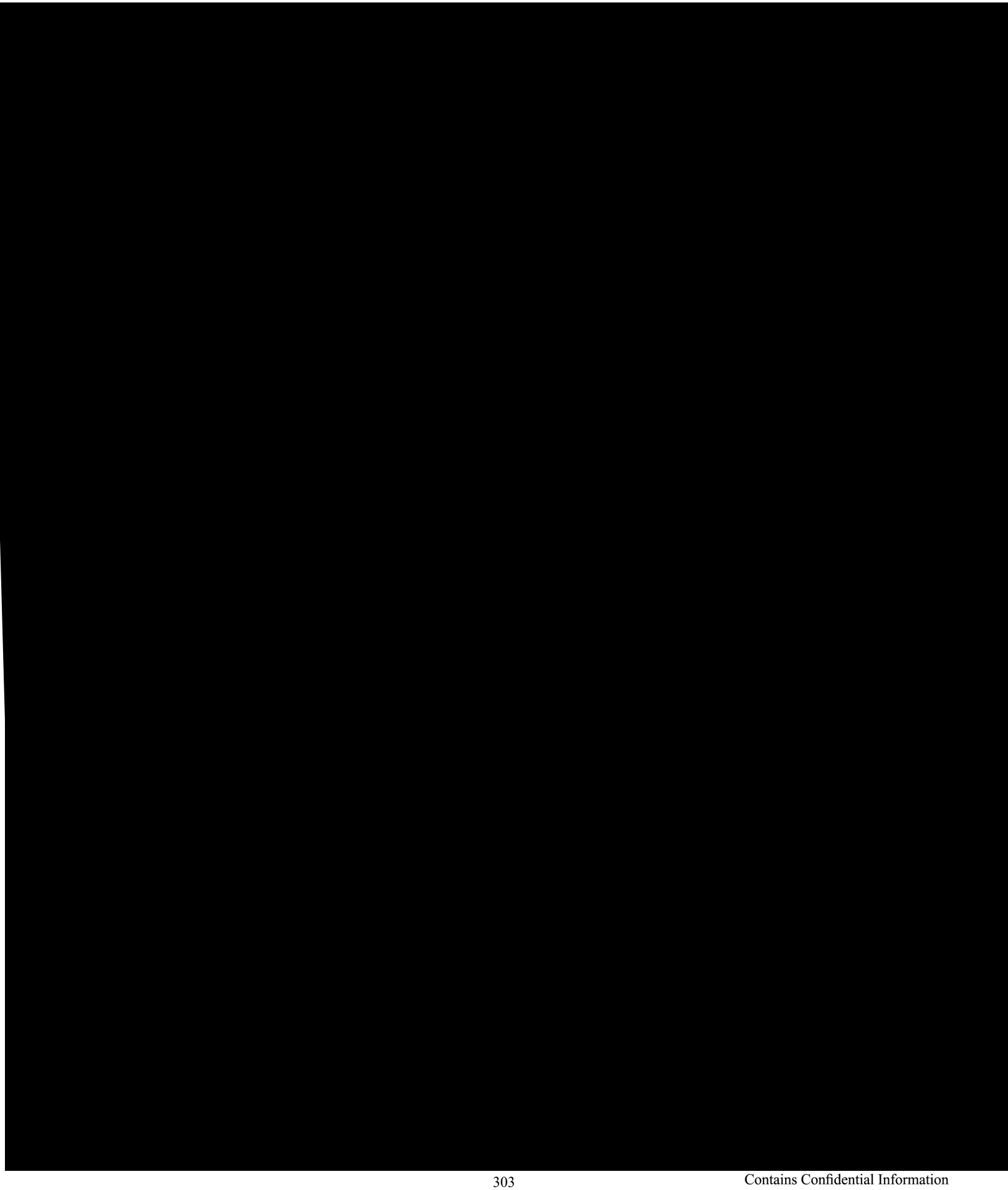

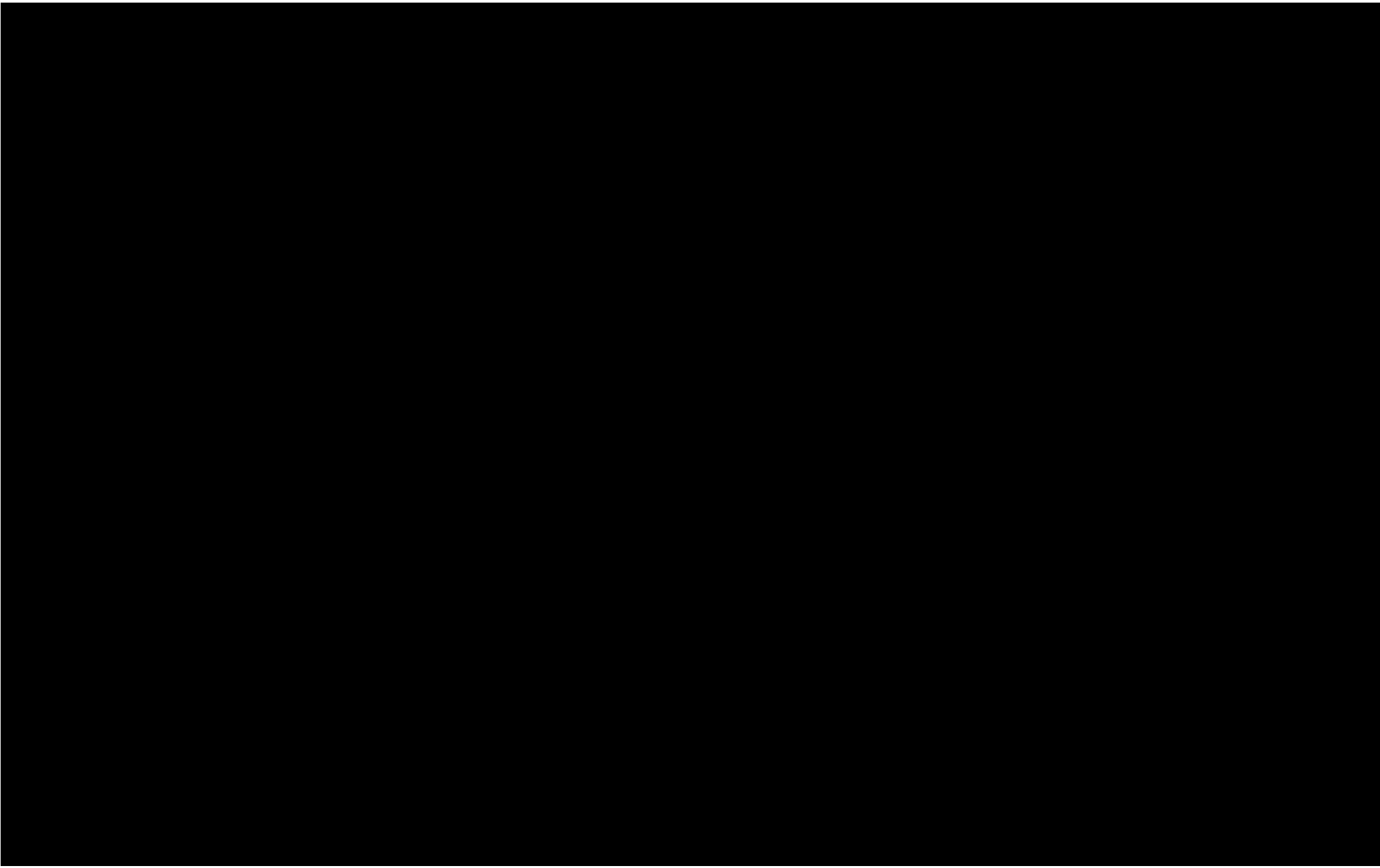

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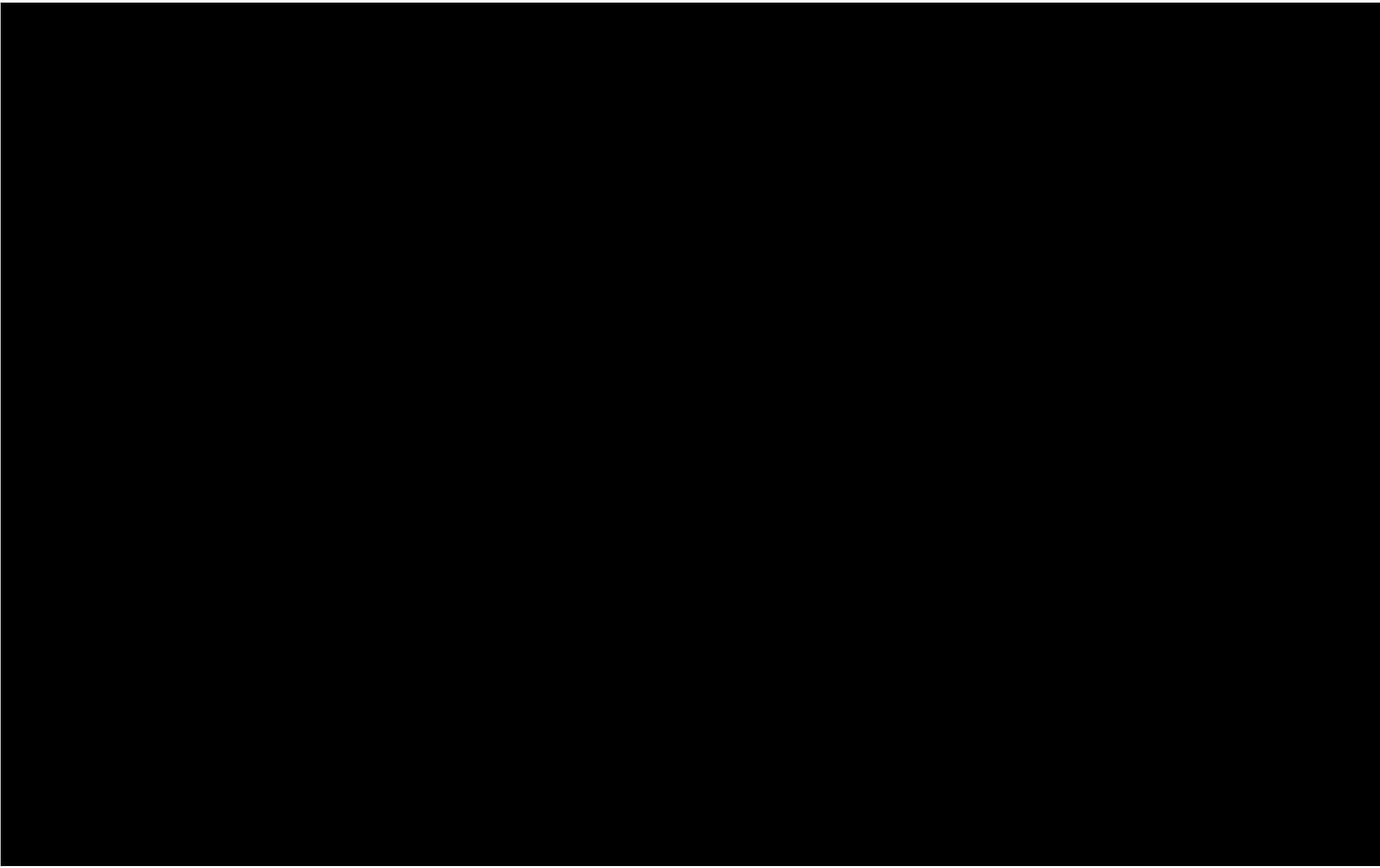

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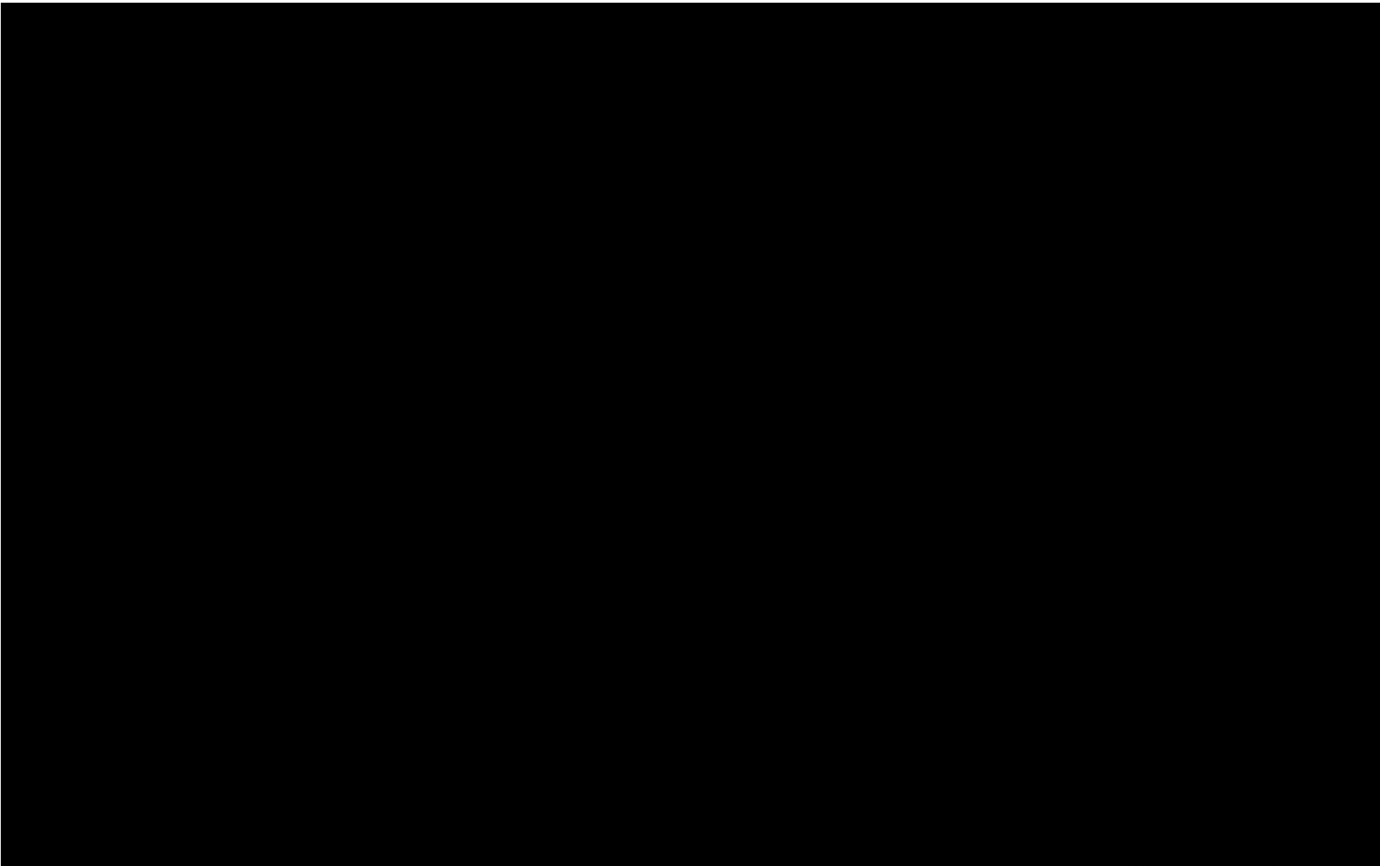
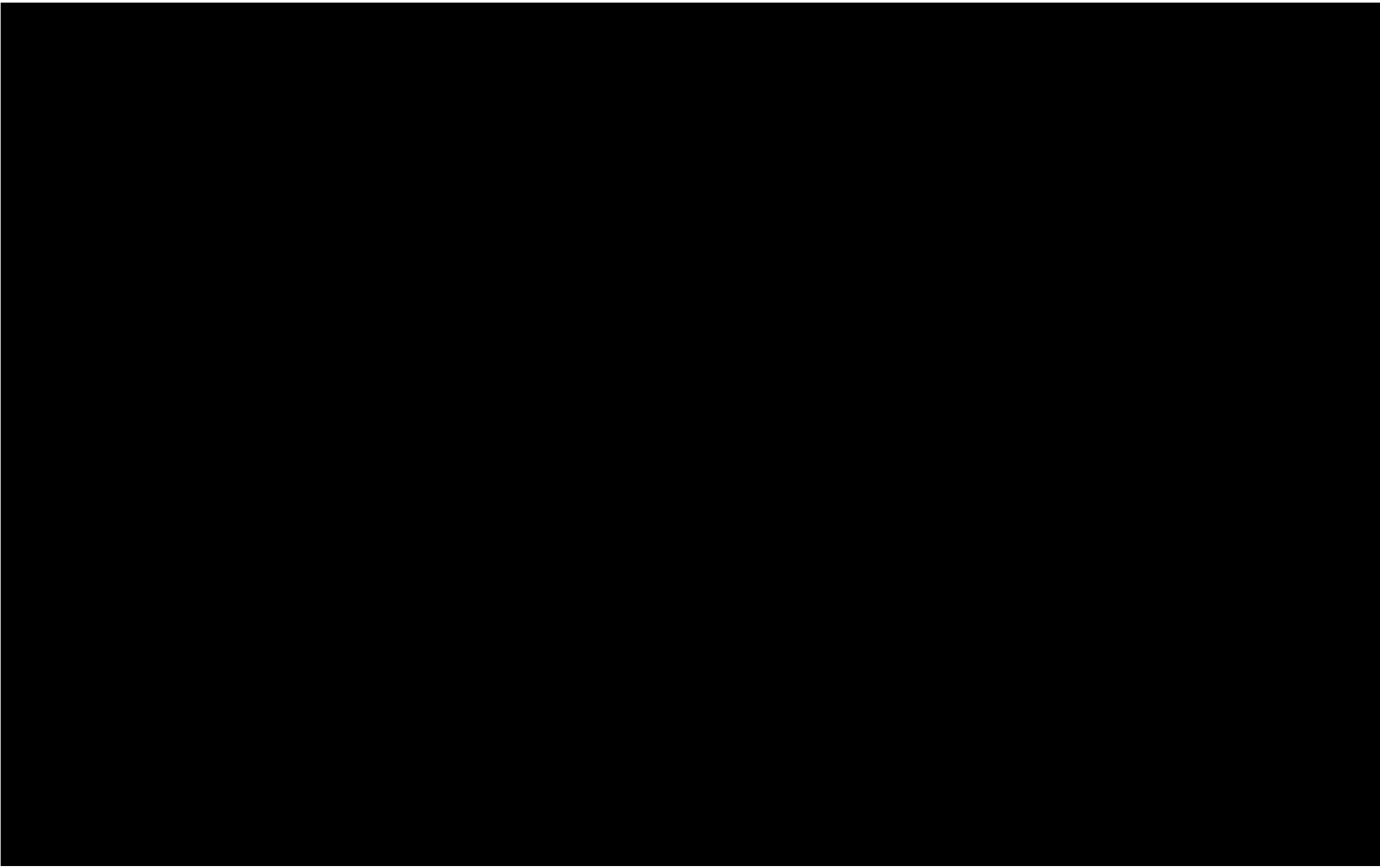
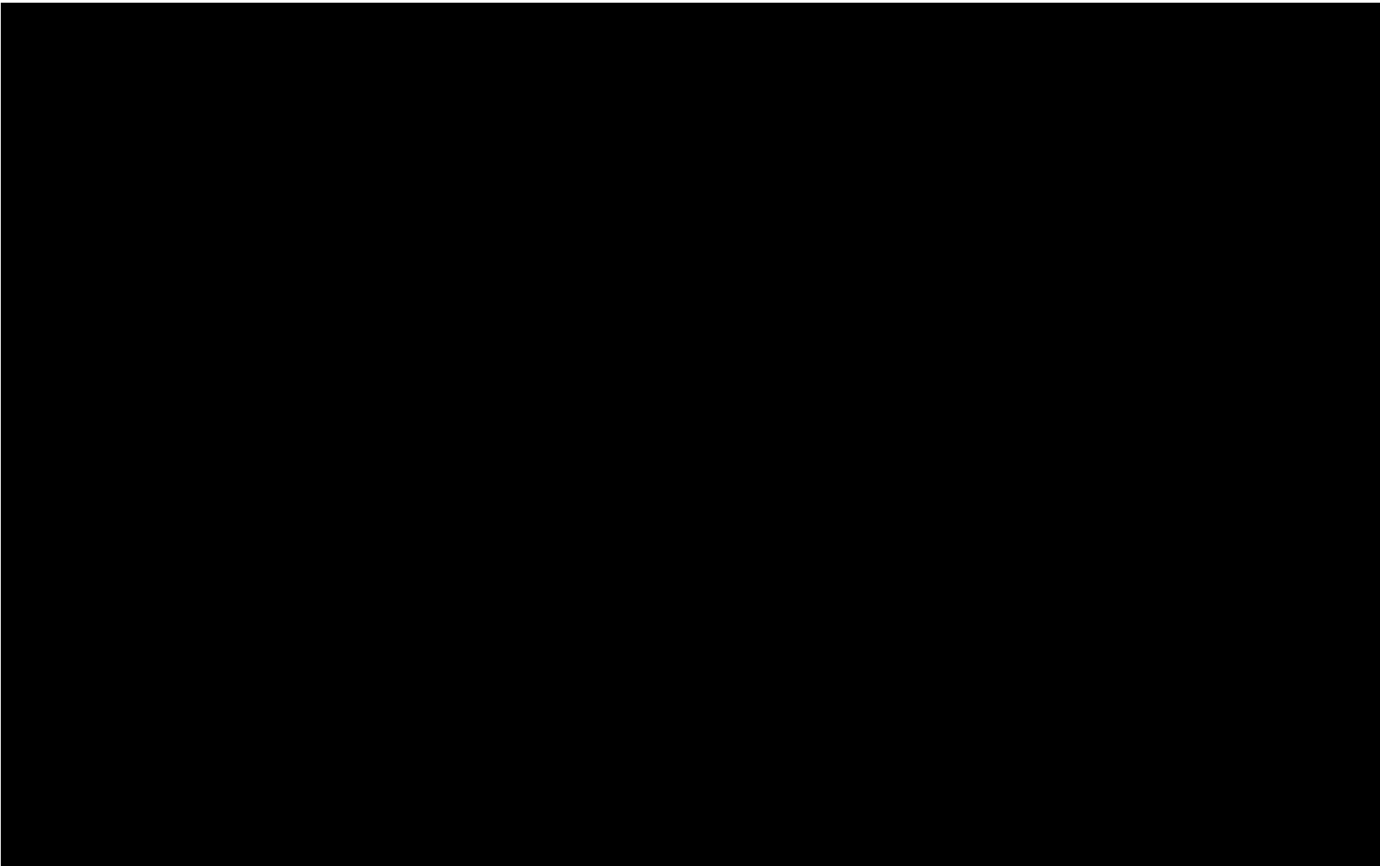
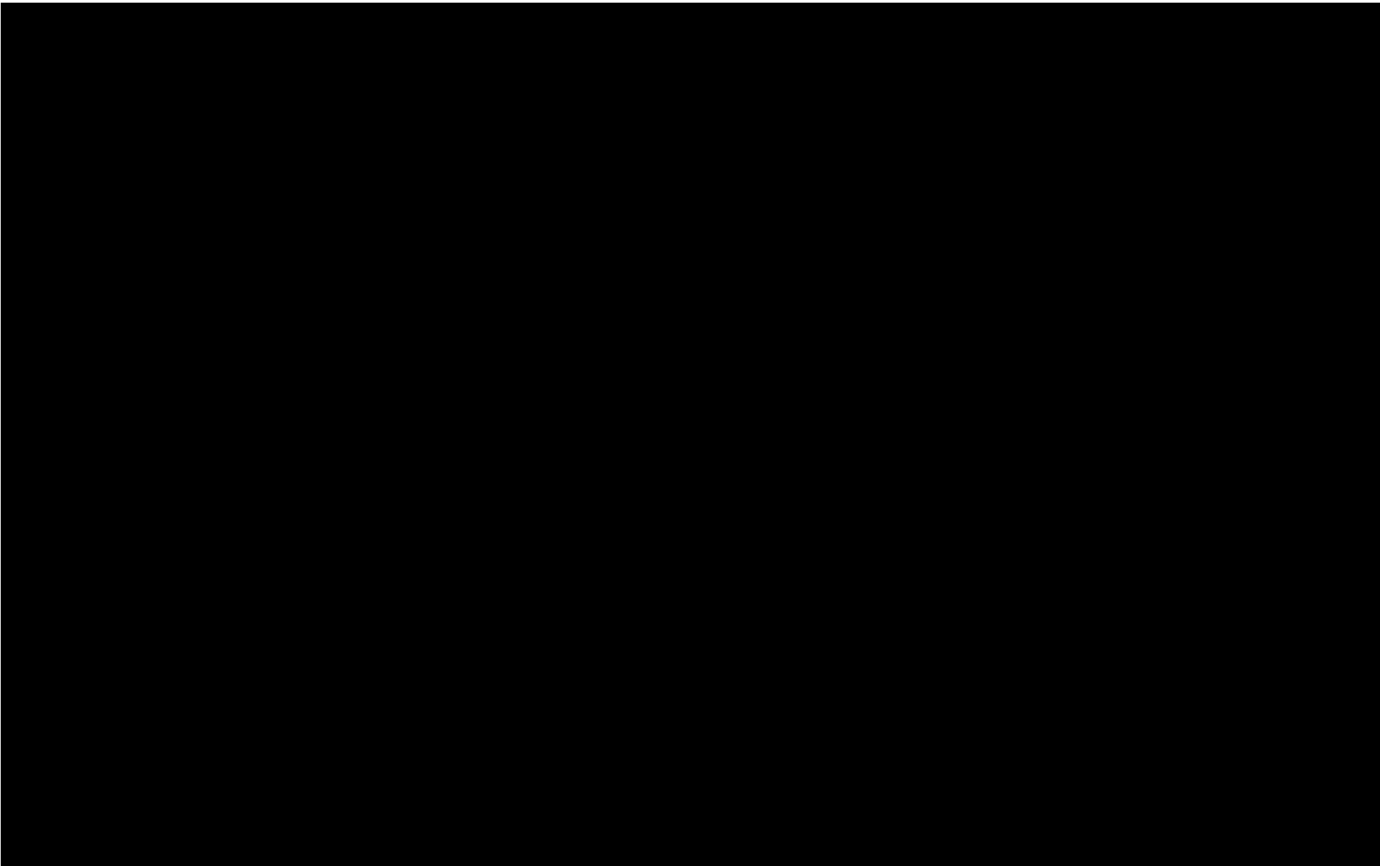
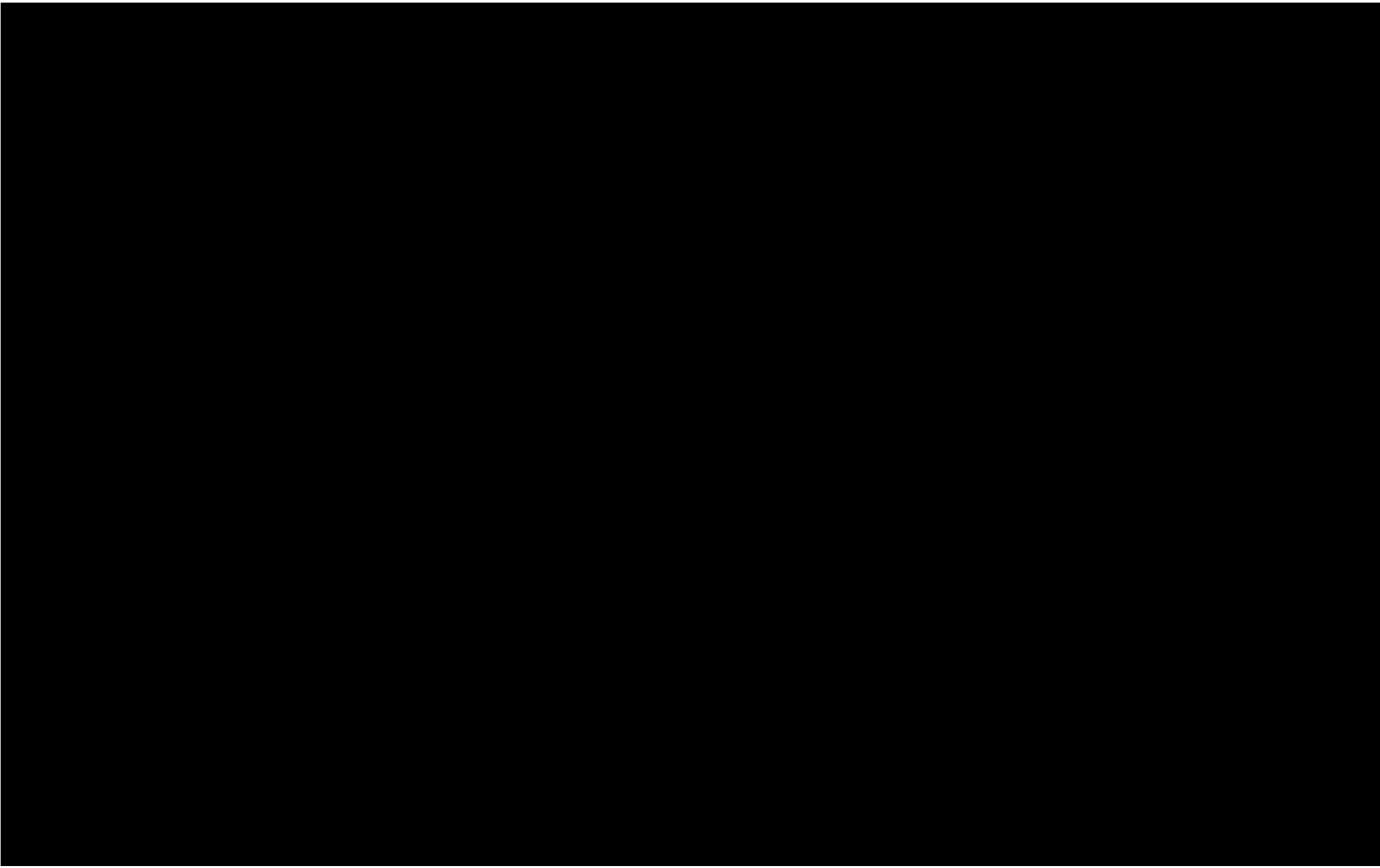










[redacted]

[redacted]

[redacted]

4.3.3 ORGANIZATION AND STAFFING

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

4.3.3.1 ORGANIZATION CHARTS

The organization charts shall show:
1. Organization and staffing during each phase as described in the RFQ;
2. Full-time, part-time, and temporary status of all employees; and
3. Indication if staff shall be wholly dedicated to the associated contract or if the staff member is shared.
For the purposes of this RFQ, "full-time" employment is considered at least forty (40) work hours per week and/or 2,080 work hours per year. Anything less is considered "part-time."

To best serve Mississippi Coordinated Access Network (MSCAN) and Children's Health Insurance Program (CHIP) members, TrueCare will implement a new model based on a solid foundation of locally established healthcare providers with CareSource serving as the plan's managed-care program administrator running the day-to-day operations and ensuring responsibility. This unique and strategic alliance will combine industry-leading managed care operational excellence with a local, member-centric approach to healthcare. [redacted]

Upon award, we will mobilize staffing resources ensuring compliance to the hiring specifications detailed in Appendix A, Section 1.13.

We are a CCO committed to changing the trajectory of Mississippi's healthcare system and will bring a new era of provider collaboration to Mississippi via our transparent service delivery model that is fully integrated with most of our providers through real-time bidirectional data exchange. Our mission is to ensure Mississippians can easily access their benefits, using our next generation member engagement and education, and community-based coordinated care to help them lead healthier lives while we prudently manage State resources.

Organization During the Implementation Phase

TrueCare's Chief Executive Officer (CEO) will serve as the Divisions' single point of contact for Project Management throughout the Implementation Phase. We will assign an Implementation Project Manager (PM) familiar with the MSCAN and CHIP landscape to manage the implementation workplan and related tasks under the direction of the TrueCare CEO/PM. Our Implementation Management Organization (IMO) team consists of Medicaid implementation specialists with more than 30 years of experience supporting the Implementation Project Manager.

Proven Readiness Review Success

Our IMO has successfully met all readiness review requirements on schedule for previous implementations in Ohio, Georgia, Indiana, and Arkansas.

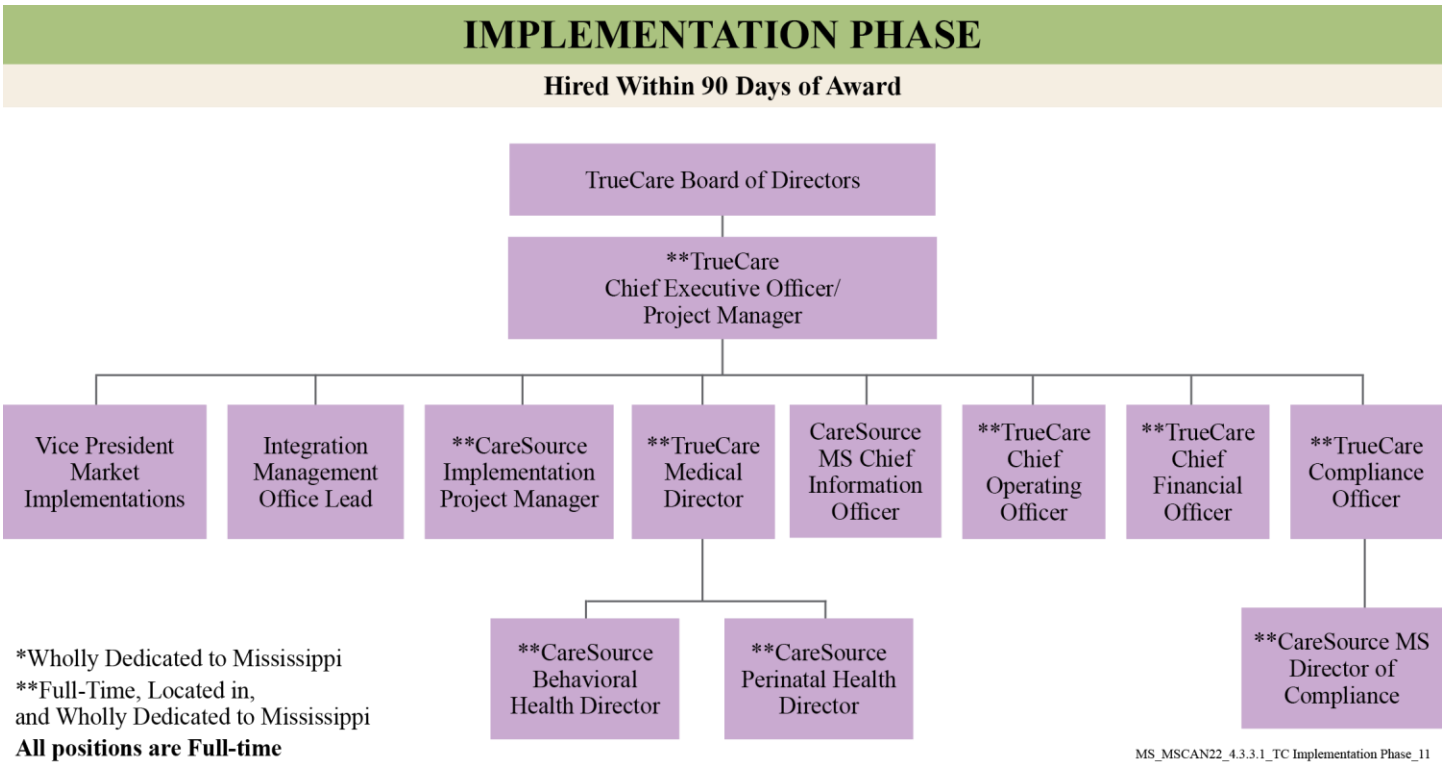
CareSource brings experience and best practices from Medicaid implementations in states such as Ohio, Georgia, Indiana, and Arkansas in the form of a New Market Implementation Playbook (Playbook). This Playbook allows us to leverage a library of repeatable tools; processes and procedures; Suppliers, Inputs, Processes, Outputs, and Customers (SIPOCs); roadmaps; templates; and other artifacts to drive efficiency across the implementation phases from initiation to deployment.

Figure 4.3.3.1_A provides the reporting structure to support all functions during the Implementation Phase. Unless otherwise indicated, all positions are full-time, permanent staff who are in and will be wholly dedicated to Mississippi.

[1] [redacted]

Figure 4.3.3.1_A: TrueCare Implementation Phase

TrueCare's implementation phase organization chart is a culmination of local and national experts working towards an efficient and effective commitment to improve individual lives and communities in Mississippi.

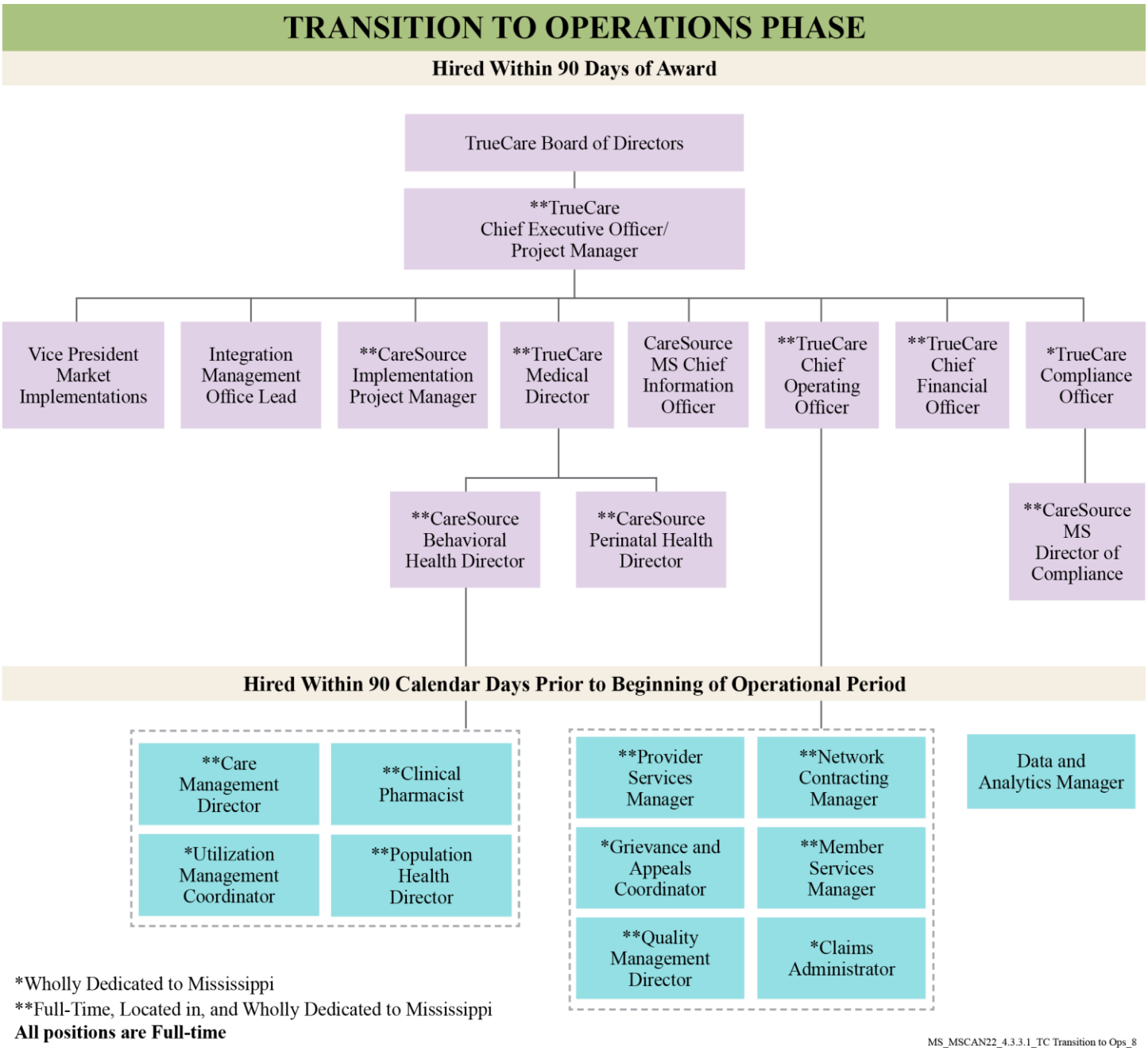


Transition to Operations Phase

The IMO supports ongoing operations leaders for each department and facilitates timely resolutions of any issues reported by members, providers, partners, or regulators as necessary to confirm a strong start. The IMO provides an extra layer of monitoring to ease the transition as well as additional support to new operations while the positions in Figure 4.3.3.1_B will be hired no later than 90 calendar days prior to the beginning of the operational period. After implementation is completed, the IMO will transition all management functions, tools, and plans to the ongoing operations management team. The vice president of market implementations, IMO lead, implementation PM, and other IMO team members will transition out systematically, but not before Mississippi operations are soundly in place.

Figure 4.3.3.1_B: TrueCare Transition to Operations Phase

A smooth hand off, and seamless transition of functions and responsibility will be the focus during this phase as the Mississippi team maintains all operations.

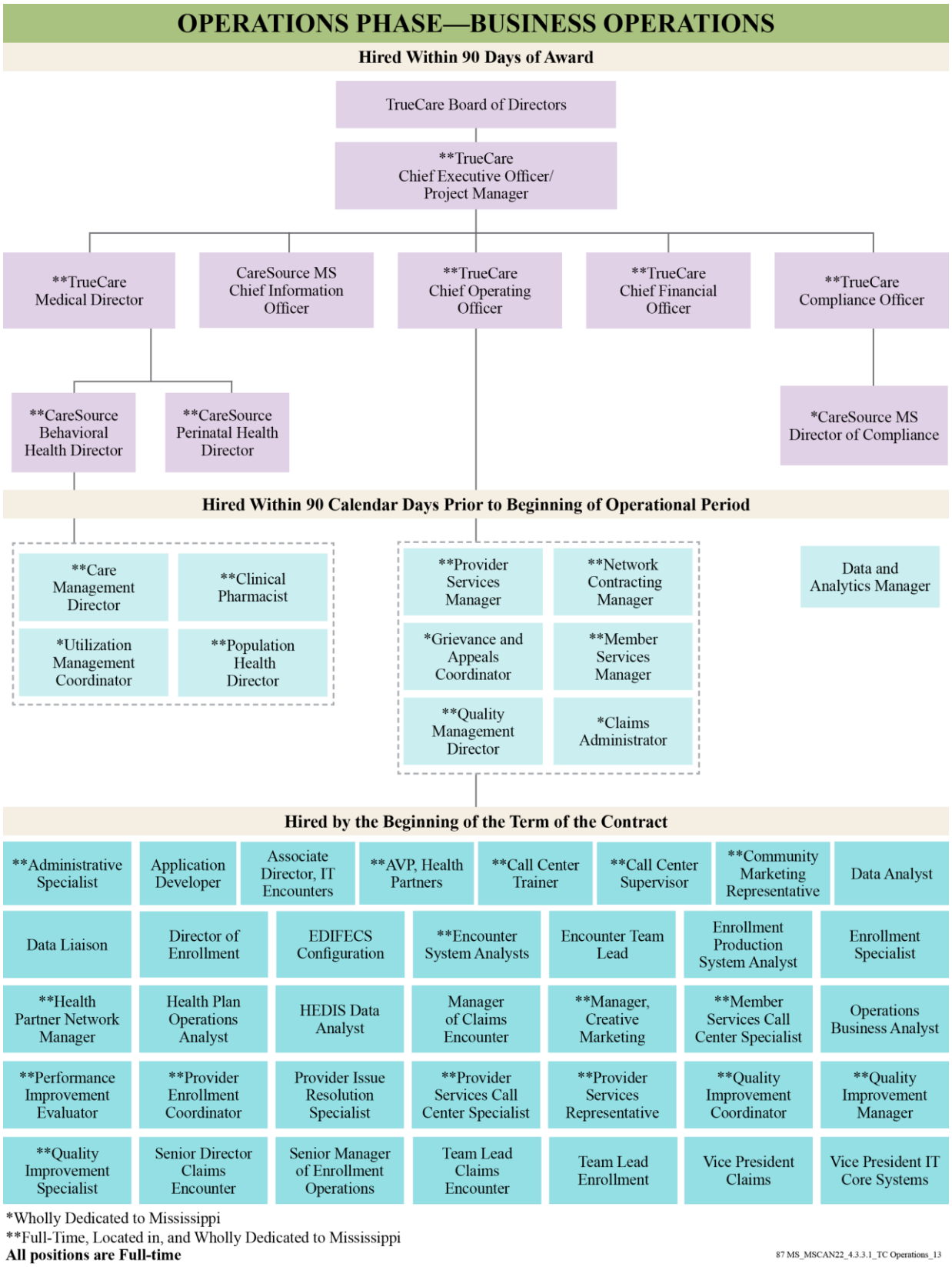


Operations Phase

Our management team, based in Mississippi and staffed with experienced professionals, will assume control of all day-to-day management of operations focusing on fulfilling the requirements included in Appendix A, Draft Contract, in line with all performance standards, metrics, and Division objectives. The following staff, identified in Figures 4.3.3.1_C thru 4.3.3.1_E is displayed the Operations Phase in three separate charts separated by function. Operations Phase positions will be hired and onboarded at or before the begin date of the contract period. We will enforce quality and accountability in all day-to-day operations while never losing sight of the overall goals such as improving maternal, child, and adolescent health.

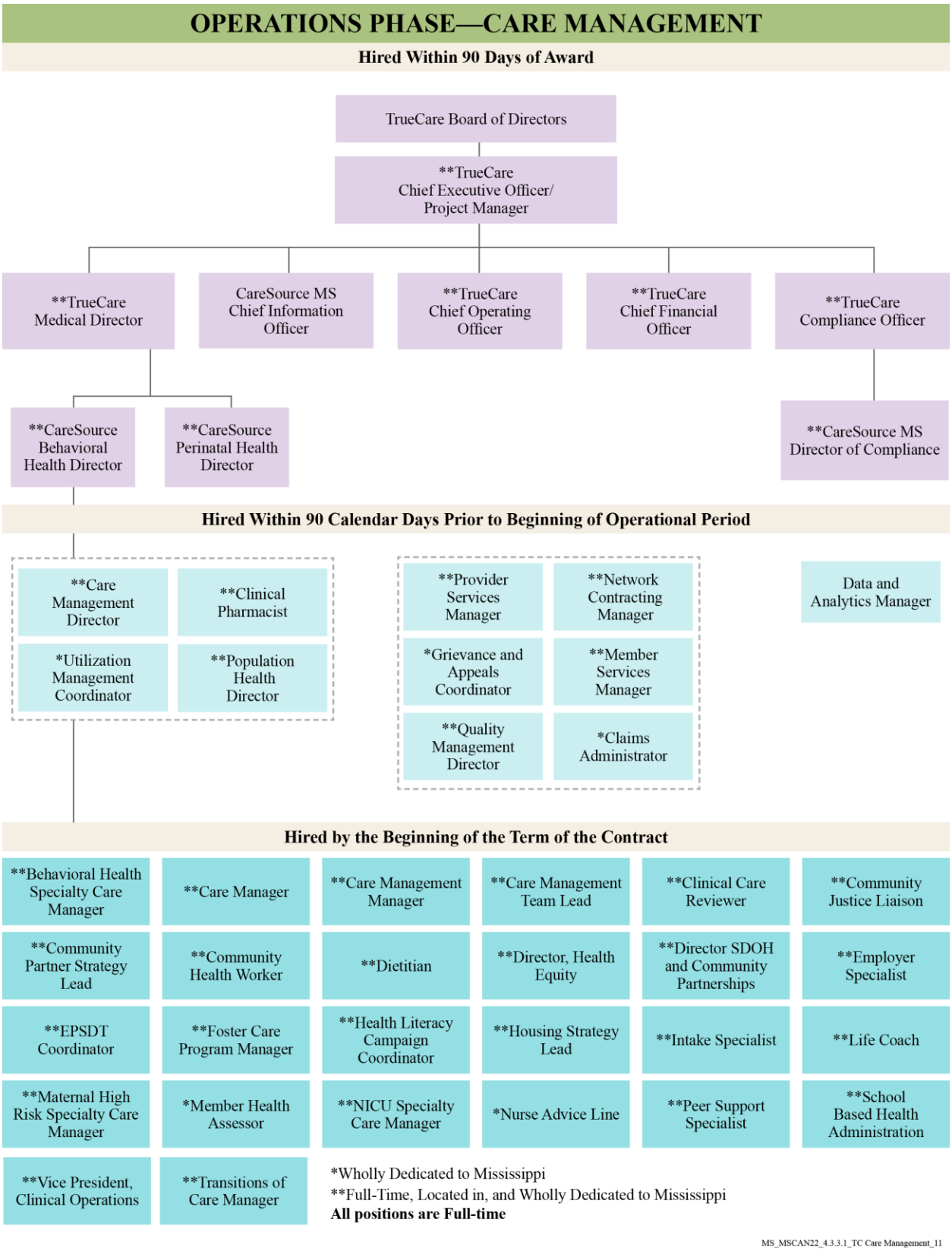
Figures 4.3.3.1_C: TrueCare Operations Phase- Business Operations

Business operations staff will be hired, trained, and in place on or before the begin date of the contract ready to answer calls and support all operational functions.



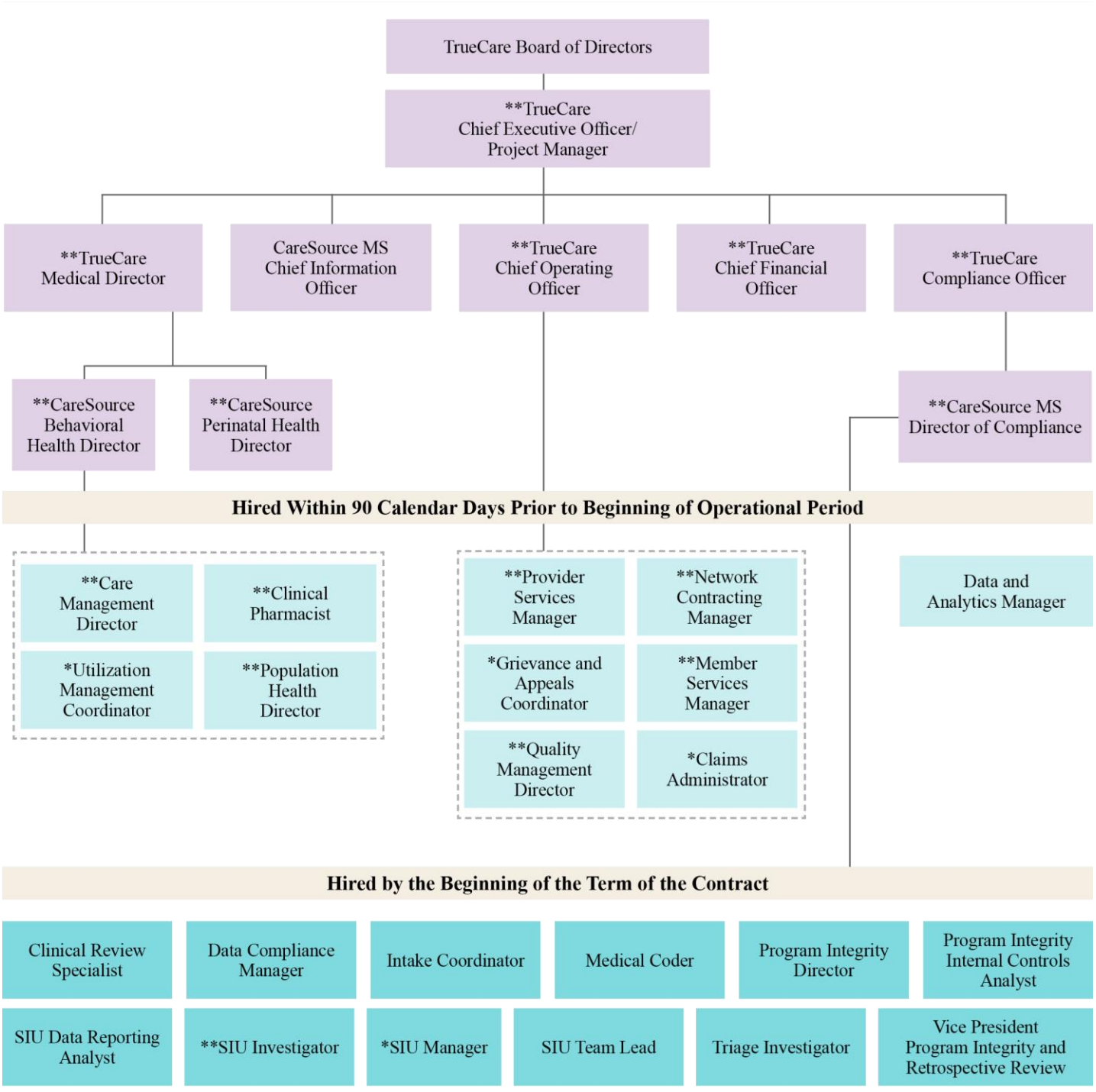
Figures 4.3.3.1_D: TrueCare Operations Phase- Care Management

Staffed largely with wholly dedicated, care management professionals in Mississippi our Care Management team will be in place and ready to serve members on day one of the contract.



Figures 4.3.3.1_E: TrueCare Operations Phase- Compliance

Comprised of local and national experts, our compliance teams are well equipped and prepared to support all operations in the Mississippi market, and to be a worry-free partner of the Division.



*Wholly Dedicated to Mississippi
**Full-Time, Located in, and Wholly Dedicated to Mississippi
All positions are Full-time

MS_MSCAN22_4.3.3.1_TC Compliance_13

We will contact the Mississippi Division of Medicaid in compliance with Appendix A, Section 1.13 should there be situations or conditions specific to Mississippi service level needs requiring any changes to our staffing approach.

[END OF RESPONSE]

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.

Our TrueCare alliance, employment of local, Medicaid knowledgeable and experienced professionals, and CareSource's extensive Medicaid managed care experience will demonstrate that we are committed to change the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi and displays our **commitment to being a worry-free partner of the Division.** TrueCare will utilize the expertise from CareSource's corporate chief medical officer who is from Mississippi, has extensive experience working with Mississippi Medicaid, and will provide medical oversight to TrueCare. *Appendix H, Section 4.3.3.2 Job Descriptions and Responsibilities of Key Positions*, contains detailed job descriptions for the positions listed in **Table 4.3.3.2_A: Mississippi TrueCare Key Positions.** Alphabetical by title, each position in the following table includes additional information indicating staffing during the contract phases, hire date by phase, Full-time status, if the position will be located in Mississippi, and those wholly dedicated to our Mississippi line of business.

Table 4.3.3.2_A: Mississippi TrueCare Key Positions

Job Title	Phase	Hire Date	Full time Status	Located in Mississippi	Wholly Dedicated or Shared	Page Number
Administrative Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	330
Application Developer	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	332
Associate Director Information Technology Encounters	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	334
Associate Vice President, Health Partners	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	336
Behavioral Health Director	Implementation Phase	Within 90 Days of Award	Full-time	Yes	Wholly	339
Behavioral Health Specialty Care Manager	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	341
Call Center Supervisor	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	343
Call Center Trainer	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	345
Care Management Director	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	Yes	Wholly	347
Care Management Manager	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	349
Care Management Team Lead	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	351
Care Manager RN	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	353
Care Manager Social Worker	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	355
Transitions of Care Manager	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	357
Chief Executive Officer	Implementation Phase	Within 90 Days of Award	Full-time	Yes	Wholly	359
Chief Financial Officer	Implementation Phase	Within 90 Days of Award	Full-time	Yes	Wholly	361

Job Title	Phase	Hire Date	Full time Status	Located in Mississippi	Wholly Dedicated or Shared	Page Number
Chief Information Officer	Implementation Phase	Within 90 Days of Award	Full-time	No	Shared	363
Chief Operating Officer	Implementation Phase	Within 90 Days of Award	Full-time	Yes	Wholly	365
Claims Administrator	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	No	Wholly	367
Clinical Pharmacist	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	Yes	Wholly	369
Clinical Care Reviewer	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	Yes	Shared	371
Clinical Review Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	373
Community Health Worker	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	375
Community Justice Liaison	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	377
Community Marketing Representative	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	379
Community Partner Strategy Lead	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	381
Compliance Officer	Implementation Phase	Within 90 Days of Award	Full-time	Yes	Wholly	383
Data Analyst	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	No	Shared	386
Data and Analytics Manager	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	No	Shared	388
Data Compliance Manager	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	390
Data Liaison	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	392
Dietician	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	394
Director Health Equity	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	395
Director of Enrollment	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	397
Director, SDOH & Community Partnerships	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	399
EDIFECS Configuration	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	401
Employer Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	402
Encounters Team Lead	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	404
Encounters System Analyst	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	406
Enrollment Production System Analyst	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	408
Enrollment Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	410
EPSDT Coordinator	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	412
Foster Care Program Manager	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	414
Grievance and Appeals Coordinator	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	No	Wholly	416
Health Literacy Campaign Coordinator	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	418

Job Title	Phase	Hire Date	Full time Status	Located in Mississippi	Wholly Dedicated or Shared	Page Number
Health Partner Network Manager	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	420
Health Plan Operations Analyst	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	422
HEDIS Data Analyst	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	424
Housing Strategy Lead	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	426
Implementation Project Manager	Implementation Phase	Within 90 Days of Award	Full-time	No	Shared	428
Intake Coordinator	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	430
Intake Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Shared	432
Life Coach	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	434
Manager of Claims Encounters	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	436
Manager Creative Marketing	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	438
Maternal High Risk Specialty Care Manager	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	440
Medical Coder	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	442
Medical Director	Implementation Phase	Within 90 Days of Award	Full-time	Yes	Wholly	444
Member Health Assessor	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	446
Member Services Manager	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	Yes	Wholly	448
Member Services Call Center Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	449
Network/Contracting Manager	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	450
NICU Specialty Care Manager	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	452
Nurse Advice Line	Operations Phase	Hired by Contract Begin Date	Full-time	No	Wholly	454
Operations Business Analyst	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	456
Peer Support Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	458
Performance Improvement Evaluator	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	460
Perinatal Health Director	Implementation Phase	Within 90 Days of Award	Full-time	Yes	Wholly	462
Population Health Director	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	Yes	Wholly	464
Program Integrity Director	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	466
Program Integrity Internal Controls Analyst	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	468
Project Manager	Implementation Phase	Within 90 Days of Award	Full-time	Yes	Wholly	470
Provider Enrollment Coordinator	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	472
Provider Services Call Center Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	474
Provider Issue Resolution Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	475

Job Title	Phase	Hire Date	Full time Status	Located in Mississippi	Wholly Dedicated or Shared	Page Number
Provider Services Representative	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	477
Provider Services Manager	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	Yes	Wholly	479
Quality Improvement Coordinator	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	480
Quality Improvement Manager	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	482
Quality Improvement Specialist	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	484
Quality Management Director	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	Yes	Wholly	486
School Based Health Administrator	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	488
Senior Manager of Enrollment Operations	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	490
Special Investigations Unit (SIU) Data Reporting Analyst	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	492
Special Investigations Unit (SIU) Investigator	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	494
Special Investigations Unit (SIU) Team Lead	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	497
Special Investigations Unit (SIU) Manager	Operations Phase	Hired by Contract Begin Date	Full-time	No	Wholly	499
Senior Director Claims Encounters	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	501
Team Lead Claims Encounters	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	503
Team Lead Enrollment	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	505
Triage Investigator	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	507
Utilization Management Coordinator	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	No	Wholly	509
Vice President, Claims	Transition to Operations Phase	Within 90 Days of Operational Period	Full-time	No	Shared	511
Vice President, Clinical Operations	Operations Phase	Hired by Contract Begin Date	Full-time	Yes	Wholly	513
Vice President Information Technology Core Systems	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	515
Vice President, Program Integrity and Retrospective Reviews	Operations Phase	Hired by Contract Begin Date	Full-time	No	Shared	517

Key Position: Job Description
Title of Position: Administrative Specialist
Description of Position: The Administrative Specialist is responsible for meeting the administrative needs of their assigned organization within the company.
Description of Responsibilities of Position: ▪ Compose and prepare business presentation documents and spreadsheets. ▪ Establish and maintain a variety of documents, records and reports. Ensure records management guidelines are adhered to. ▪ Coordinate large group meetings and events for department management. Makes necessary arrangements such as, securing meeting rooms, prepare agenda, coordinating catering and preparation of audio and visual needs. ▪ Respond to routine telephone requests which have standard answers; refers calls and visitors to appropriate staff. ▪ Facilitate a variety of support tasks such as but not limited to requisitions printing, maintenance, or other services through appropriate channels. ▪ Review and prepare invoices and compose reports, memos, letters and other documents. ▪ Read and review incoming memos, submissions, and reports in order to determine their significance and plan their distribution. ▪ Perform a variety of general office duties supporting a large department or multiple departments such as ordering supplies, copying and filing. ▪ Coordinate and secure travel arrangements for supervisor and department staff. ▪ Maintains basic knowledge of department activities. ▪ Perform routine department operational procedures.
Minimum Experience Required: ▪ High school diploma is required. ▪ Associates degree in business or related field or equivalent years of relevant work experience is preferred. ▪ Two to four (2 to 4) years of administrative support experience is required.
Skills Required: ▪ Proficient in Microsoft Office Suite to include Word, Excel PowerPoint, Outlook, Visio and Adobe Professional Excellent written and verbal communication skills. ▪ Ability to work independently and within a team environment Effective listening and critical thinking skills. ▪ Effective problem solving skills with attention to detail. ▪ Strong interpersonal skills and high level of professionalism. ▪ Strong knowledge of general office practice. ▪ Ability to balance multiple priorities and to work under tight deadlines while providing consistent and professional service. ▪ Maintain complete confidentiality, possess a professional demeanor, and exercise discretion at all times.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ High school diploma is required. ▪ Associates degree in business or related field or equivalent years of relevant work experience is preferred.
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: N/A

Key Position: Job Description

Title of Position: Application Developer

Description of Position:
The Application Developer is responsible for the designing, coding, testing, and analyzing software programs and applications including research, design, documenting and modifying throughout the production life cycle.

Description of Responsibilities of Position:

- Analyze, design, code and test software through the production life cycle according to functional/technical specifications that meet business requirements.
- Run and monitor software performance tests on new and existing software for the purposes of correcting errors, isolating areas for improvement, and general debugging.
- Administer critical analysis of test results and deliver solutions to problem areas.
- Assist in software deployment as required based on build specification.
- Liaise with network administrators, systems analysts, and software engineers to assist in resolving problems with software products or company software systems.
- Perform technical code reviews of peers to ensure that proper coding methodology is being adhered to.
- Work within an iterative approach methodology.
- Triage and work incident management requests.
- Maintain an understanding of software development life cycle (SDLC), continuous integration/continuous delivery (CI/CD), and configuration management.
- Set day-to-day objectives and deliver job responsibilities that may vary outside typical norms or practices. Work consists of tasks that are occasionally not routine and often works independently and is required to apply discretion within established operational boundaries and procedures.

Minimum Experience Required:

- Bachelor of Science in the field of computer science or software engineering or equivalent years of relevant work experience required.
- Minimum of three (3) years of technical experience required.
- Minimum of three (3) years of advance OOP principles and design experience required.
- Experience developing and designing n-tier applications with multi-tier architectures required.
- UML Modeling experience required.

Skills Required:

- Hands on experience working in integrated development environments.
- Hands on software troubleshooting experience.
- Experience with specific phases of the software development life cycle, especially Agile, Test Driven Development, and Waterfall.
- Strong interpersonal skills including excellent written and verbal communication skills.
- Knowledge of configuration management tools, scripting, programming and automated testing tool sets.
- Flexible and adaptable in regards to learning and understanding new technologies.
- Highly self-motivated and directed, technically proficient, highly logical with strong attention to detail.

- Proven analytical and problem-solving abilities,
- Ability to effectively prioritize and execute tasks while working both independently and in a team-oriented, collaborative environment.
- Innovative and pioneering spirit.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor of Science in the field of computer science or software engineering or equivalent years of relevant work experience required.

Are any professional licenses or certifications required for this position? [X] Yes [] No
If yes, list below:

- Certifications in Microsoft Training or comparable certifications for Java or other OOP languages (MCSD, etc.) preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Associate Director Information Technology Encounters
Description of Position: The Associate Director, Information Technology – Encounters is responsible for leading a team of Information Technology professionals supporting the encounters function.
Description of Responsibilities of Position: ▪ Provide Delivery leadership for IT Encounters organization. ▪ Set vision, direction and execution for the Encounters IT groups. ▪ Expert level understanding of the lifecycle of claims to encounters for medical, pharmacy, dental, and vision services. ▪ Collaborate and lead engagements with internal stakeholders and external entities including state and federal agencies and third party vendors as related to Encounters domain. ▪ Support Senior leadership communication for the responsible functions. ▪ Maintain, support, and optimize technical environment for encounters system and related tools. ▪ Facilitate the data interface between claims processing system and encounters system ensuring accuracy and completeness. ▪ Work closely with architecture groups and business teams to establish processes and efficiencies for data transfers related to encounter submissions, agency responses, and associated reconciliations. ▪ Support transactional files in HIPAA compliant and proprietary formats for encounters and RAPS submissions. ▪ Accountable for maintaining production schedules to ensure the timeliness of encounter submission and responses. ▪ Manage ad-hoc submissions within established production windows. ▪ Oversee and work with internal and external entities to assist in the analysis and resolution of issues in both core claims processing and encounters systems. ▪ Collaborate with business intelligence resources and reporting analysts to ensure accurate encounters reporting to internal and external stakeholders to support operational needs, rate setting, and risk adjustment. ▪ Provide leadership, vision, management goals, priorities, metrics, measures, recognition, and discipline. ▪ Contribute to performance goals by developing and growing a team that is knowledgeable in the encounters process and regulations for the environments in which we do business. ▪ Responsible for the relationship between key business stakeholders and IT and accountable for the team's delivery of the associated business services. ▪ Regularly assess the associated technology platforms to ensure that the platforms meet the required standards for reliability, availability, security, cost and performance, business value justification, regulatory compliance, and architecture. ▪ Drive strategy and implementation of delivery of new technology for encounters domain. ▪ Develop, document, and maintain short and long-term plans for the responsible teams. ▪ Represent IT Leadership in project and/or business meeting and engagements. ▪ Participate in conference calls or visits with vendors/third parties. ▪ Participate in departmental meetings/activities and contribute to a collaborative team environment.

- Responsible for managing projects, organizing and directing people and projects.
- Provide technical guidance, training, and work direction to direct reports.
- Coordinate and manage vendor relationships and accountability on project involvement and deliverables.

Minimum Experience Required:

- Bachelor's degree in Business, Computer Science or related field or equivalent years of relevant work experience is required.
- Minimum of Five (5) years of experience in management of encounters teams is required.
- Minimum of Ten (10) years of relevant IT experience is required.
- Experience translating business requirements into technical specifications is preferred.
- Project planning and project management experience is preferred.

Skills Required:

- Project planning skills and abilities.
- Process and/or workflow planning and design skills.
- Knowledge of Application Development tools.
- Advanced troubleshooting and problem-solving capabilities.
- Proficient in Microsoft technologies (infrastructure or application development).
- Strong knowledge of best practices relative to application development or infrastructure standards.
- Excellent oral and written communication.
- Ability to manage personal and team time effectively.
- Effective organization and prioritization.
- Effective management and leadership.
- Knowledge of the healthcare and managed care philosophy and culture.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in Business, Computer Science or related field or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description

Title of Position: Associate Vice President, Health Partners

Description of Position:
The Associate Vice President, Health Partners designs and implements strategies to increase provider engagement, driving toward better quality and Member satisfaction, improved population health, and reduced healthcare cost.

Description of Responsibilities of Position:

- Create government relations strategy that supports advocacy campaigns.
- Responsible to execute on Market Provider Relations Model and drive Market performance.
- Align and integrate operations, systems, and processes for Providers to ensure a collaborative partnership.
- Drive quality outcomes through execution of Value Based Reimbursement agreements with providers.
- Collaborate with Enterprise and Market leadership on the development of overall program strategy and business objectives with respect to Providers.
- Establishes objectives and annual goals in conjunction with the Chief Executive Officer.
- Participate in the development of the Network strategy and execute defined initiatives to achieve Network goals.
- Monitor and ensure the health plan's execution of meeting or exceeding all appropriate requirements by Federal, State, and Accrediting bodies.
- Responsible for translating business/program vision and strategy into operational tactics – collaborating to build the necessary enterprise matrix and market support infrastructure.
- Lead large scale transformational change in the market, working effectively with all levels of the organization.
- Foster external and internal intra/inter departmental relationships with hospitals, physicians, community agencies, trade associations and key vendors.
- Collaborate with Provider/Health Partner Relations and Community Stakeholders to facilitate access, address barriers to care and improve coordination that support health care outcomes.
- Develop health plan Network policies, procedures and goals as needed to align with the market requirements and CareSource strategy/model.
- Ensure budget and financial goals are set in conjunction with the Chief Executive Officer.
- Monitor health plan Network budgets; describe variance detail monthly with effective action plans.
- Participate and represent internally and externally with speaking engagements, State and regional committee work.
- Advocate for the populations and health plan at state and federal agencies.
- In collaboration with Consumer Experience Team, monitor and analyze member satisfaction surveys to identify and develop appropriate action plans with reporting activities as needed.
- In collaboration with Health partner and Quality Team, monitor and analyze provider satisfaction surveys to identify and develop appropriate action plans with reporting activities as needed Experience Team.

- Produce team results that demonstrate engagement rates, low Grievances & Appeals, Continuous Improvement, Human Capital metrics that demonstrate leadership behavior is supporting improved outcomes, positive culture and consumer experience.
- Develop and maintain an in-depth knowledge of the company's business, regulatory environments and high-level of Health plan knowledge.

Minimum Experience Required:

- Bachelor of Science/Arts Degree or equivalent years of relevant work experience is required
- Master's degree in Business or Health Care preferred
- A minimum of five (5) years of leadership/management experience is required
- Five (5) years of Managed Care experience is preferred
- Demonstrated management of multiple regulatory and accreditation requirements of populations and programs

Skills Required:

- Intermediate proficiency level with Microsoft Office, including Outlook, Word and Excel
- Ability to operate smart phone, iPad, or other mobile communication devices
- Prior experience with and knowledge of provider contracting
- Knowledge of provider operations preferred
- Strong financial background
- Strong interpersonal skills
- Knowledge of managed care industry, trends, and accreditation
- Knowledge of quality improvement and HEDIS programs/outcomes measurement
- Excellent verbal and written communication skills
- Excellent leadership, management and supervisory skills
- Ability to work independently and within a team environment
- Attention to detail and work plan creation, implementation, and evaluation
- Critical listening and thinking skills
- Negotiation skills/experience
- Customer service oriented
- Decision making/problem solving skills
- Proven track record in driving continuous improvement efforts to improve member experience and tracked results
- Critical listening and systematic thinking skills
- Ability to attract, manage and develop team members; Inspirational Leadership
- Energetic, enthusiastic, and politically astute
- Strategic management skills
- Conflict resolution skills
- Planning, problem identification, and resolution skills

Are there any educational requirements for this position? [X] Yes [ ] No

If yes, list below:

- Bachelor of Science/Arts Degree or equivalent years of relevant work experience is required
- Master's degree in Business or Health Care preferred

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: N/A

Key Position: Job Description
Title of Position: Behavioral Health Director
Description of Position: The Behavioral Health Director is responsible for the development, implementation and revision of the market-level clinical care standards and practice guidelines ensuring compliance with nationally accepted quality standards.
Description of Responsibilities of Position: ▪ Support market provider network development and maintenance. ▪ Provider education, training, data sharing, performance evaluations and orientation to the plan. ▪ Participate in peer-to-peer discussions. ▪ Community collaborative participation. ▪ Participate in the evaluation and investigations of cases suspected of fraud, abuse, and quality of care concerns. ▪ Provide cross-coverage for other Medical Directors and/or markets, as needed. ▪ Understand and provide support to prior authorization and utilization review functions. ▪ Support staff by providing training, clinical consultation, and clinical case review for members. ▪ Conduct clinical reviews for designated members.
Minimum Experience Required: ▪ Successful completion of a residency training program, preferably in primary care is required. ▪ Actively practicing physician with a specialty in behavioral health in Mississippi or have been an actively practicing physician in Mississippi with a specialty in behavioral health in the past five (5) years and located in Mississippi ▪ Managed care medical review/medical director experience is preferred.
Skills Required: ▪ Basic Microsoft Word skills. ▪ Excellent communication skills, both written and oral. ▪ Ability to work well independently and within a team environment. ▪ Ability to create strong relationships with Providers and Members. ▪ High ethical standards. ▪ Attention to detail. ▪ Critical listening and systematic thinking skills. ▪ Ability to maintain confidentiality and act in the company's best interest. ▪ Ability to act with diplomacy and sensitivity to cultural diversity. ▪ Decision making/problem solving skills. ▪ Conflict resolution skills. ▪ Strong sense of mission and commitment of time, effort, and resources to the betterment of the communities served. ▪ Ability to analyze healthcare data from a variety of sources to evaluate physician practice patterns. ▪ Leadership experience and skills.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Completion of an accredited Medical Degree program as a medical doctor (MD) or Doctor of Osteopathic (DO) medicine is required. ▪ Successful completion of a residency training program, preferably in primary care is required.

▪ Bachelor's or Master's degree in Business Administration, Operational Excellence, Healthcare Administration or Medical Management is preferred.
Are any professional licenses or certifications required for this position? [X] Yes [ ] No **If yes, list below:** ▪ Current, unrestricted license to practice medicine in Mississippi is required.
Are there any continuing education requirements for this position? [ ] Yes [X] No **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Behavioral Health Specialty Care Manager
Description of Position: Supports members with complex BH and substance use disorder (SUD) needs and collaborates with Community Mental Health Centers and other BH providers.
Description of Responsibilities of Position: ▪ Understand and implement Person-Centered Thinking. ▪ Facilitate the Person-Centered planning process and coordinate services and health benefits for members who meet criteria. ▪ Participate in person-centered care training in order to maximize the development of the Person-Centered plan. ▪ Consult with members, families, and legally responsible people to discuss behavioral and physical health care needs. ▪ Consult and collaborate with other professionals and community members to coordinate care and develop Person-Centered plans. ▪ Maintain ongoing communication with the internal complex clinical team. ▪ Educate members about their condition, medication and assist with any necessary instruction. ▪ Monitor service delivery to ensure appropriateness of care and compliance with waiver. ▪ Assist Providers with technical questions regarding process. ▪ Complete psychosocial health care questionnaires and behavioral assessments by gathering information from the member, family, provider, and other stakeholders. ▪ Monitor and evaluate Person-Centered care plan on an ongoing basis through member, family, provider, and stakeholder contact by modifying the plan as needed based on member choice. ▪ Assist with internal care coordination activities to support member outcomes. ▪ Maintain current and accurate documentation of contacts, treatment plans, case notes, referrals, and assessments in the electronic record according to current accreditation and compliance guidelines. ▪ Participate in meetings with providers to inform them of services and benefits available to members. ▪ Engage members through participating in information collection and assertive outreach, including home visits and telephone calls. ▪ Assist in education of member/caregiver regarding healthcare access and benefits, and provide member/caregiver with health education and wellness materials. ▪ Precept and/or mentor new staff. ▪ Regular travel to conduct member visits, provider visits and community-based visits as needed to ensure effective administration of the program.
Minimum Experience Required: ▪ Master's degree in a human service field and two years of post-degree professional experience is required. ▪ Valid licensure as a counselor or social worker is required. ▪ Valid licensure or certification as a SUD expert is preferred. ▪ Minimum of two years of supervisory experience is required. ▪ Managed care experience is preferred. ▪ Current unrestricted clinical license in state of practice as a social worker or counselor is required.

Skills Required:

- Intermediate proficiency level with Microsoft Office, including Outlook, Word, and Excel.
- Ability to communicate effectively with a diverse group of individuals.
- Ability to multi-task and work independently within a team environment.
- Knowledge of local, state & federal healthcare laws and regulations & all company policies regarding case management practices.
- Knowledge of and adherence to Case Management Society of America (CMSA) standards for case management practice.
- Strong advocate for members at all levels of care.
- Strong understanding and respect of all cultures and demographic diversity.
- Ability to interpret and implement current research findings.
- Awareness of community & state support resources.
- Critical listening and thinking skills.
- Decision making and problem-solving skills.
- Strong organizational and time management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Master's degree in a human service field and two years of post-degree professional experience is required

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current unrestricted clinical license in state of practice as a social worker or counselor is required.
- Valid licensure as a counselor or social worker is required.
- Valid licensure or certification as a SUD expert is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Call Center Supervisor
Description of Position: The Call Center Supervisor is responsible for leading and directing their team to ensure goals, regulatory, compliance and department standards are met.
Description of Responsibilities of Position: ▪ Conduct regularly scheduled coaching conversations, listening, and providing feedback for improved performance. ▪ Complete performance appraisals and create performance improvement plans. ▪ Conduct monthly team meetings to drive an environment of team building and allow for ongoing communications. ▪ Demonstrate an ability to leverage data to make recommendations, decisions and improve team performance. ▪ Monitor key performance indicators on a daily, weekly, monthly basis to identify key trends and develop action plans that address opportunities. ▪ Identify processes, tools and systems that cause negative impact on efficiency and customer service results, creating continuous improvement solutions. ▪ Build positive relationships and interactions with internal peers, leaders and cross functional partners through consistency, strong follow through and proactive communication. ▪ Promote positive change management. ▪ Facilitate timely resolution of member, provider and all other tasks in which deadlines are important. ▪ Coordinate incoming information and disseminate to staff to ensure accuracy of communication to internal and external members and providers. ▪ Create, review, revise and implement company and departmental policies and procedures.
Minimum Experience Required: ▪ High School Diploma or GED is required. ▪ Associates Degree or equivalent years of relevant work experience is preferred. ▪ Minimum of three years (3) of customer service experience, to include a minimum of one (1) year in a call center environment is required. ▪ Previous supervisory/leadership experience in a call center environment is strongly preferred.
Skills Required: ▪ Intermediate proficiency level in MS Word, Excel, and PowerPoint. ▪ Ability to communicate verbally and in written form with a variety of levels within organization. ▪ Ability to work independently and within a team environment. ▪ Familiarity of the healthcare field and knowledge of Medicaid is preferred. ▪ Attention to detail. ▪ Critical listening and thinking skills. ▪ Coaching and development skills. ▪ Strategic management skills. ▪ Proper grammar usage. ▪ Time management skills. ▪ Proper phone etiquette. ▪ Customer service oriented.

▪ Leadership experience and skills. ▪ Critical listening and thinking skills. ▪ Decision making/problem solving skills.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ High School Diploma or GED is required ▪ Associates Degree or equivalent years of relevant work experience is preferred
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: N/A

Key Position: Job Description
Title of Position: Call Center Trainer
Description of Position: The Call Center Trainer delivers new hire, upskill and refresher training for Call Center team members.
Description of Responsibilities of Position: ▪ Demonstrate SME expertise on business process for Call Center Member or Provider Services. ▪ Facilitate courses, leveraging effective techniques for both Virtual and In-Classroom trainings. ▪ Responsible for all aspects of the classroom environment, to include preparation, delivery, and outcomes. ▪ Responsible for performance management of new hires while in the classroom environment; partner with HR to address behavioral or competency issues for new hires. ▪ Assist with the development of new courses and provide ongoing feedback to address process and content gaps. ▪ Oversee participant communications and class participation. ▪ Execute effectively to evaluation process to determine program effectiveness and employee proficiency. ▪ Attend front-line staff meetings to maintain current knowledge of client issues and recommend possible training resolutions. ▪ Conduct research and analysis to remain current with managed care practices across all lines of business. ▪ Research developments in the fields of training, organizational. ▪ Serve as a key point of contact in partnership with Talent Development and Call Center Business Integration Teams.
Minimum Experience Required: ▪ Associate's degree in Adult Education, Organizational Development, Instructional Design or related field or equivalent years of relevant work experience is required. ▪ Bachelor's degree is preferred. ▪ Minimum of two (2) years related call center or healthcare experience is required. ▪ Previous training or curriculum development experience is preferred.
Skills Required: ▪ Intermediate proficiency level in Microsoft Word, Excel, and PowerPoint. ▪ Working knowledge of call center related systems. ▪ Experience with e-learning options preferred. ▪ Experience with virtual training preferred. ▪ Demonstrated knowledge of adult learning environment. ▪ Ability to communicate verbally and in written form with a variety of levels within organization. ▪ Ability to work independently and in team environment. ▪ Ability to create and present strong customer-focused materials across topics. ▪ Demonstrated ability to translate business objectives into training activities. ▪ Leadership experience and skills. ▪ Critical listening and thinking skills. ▪ Strong time management and organizational skills. ▪ Ability to build relationships across all levels of the organization.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Associate's degree in Adult Education, Organizational Development, Instructional Design or related field or equivalent years of relevant work experience is required. ▪ Bachelor's degree is preferred.
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: N/A

Key Position: Job Description
Title of Position: Care Management Director
Description of Position: The Care Management Director oversees the key functions of a team that works with members, providers and multidisciplinary team members to assess, facilitate, plan and coordinate an integrated delivery of care across the continuum, including behavioral health, for members with high need potential, ensuring that patients 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: ▪ Develops, implements and/or 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. ▪ Facilitate/promote problem identification, analysis and resolution within clinical operations to improve member experience. ▪ Utilize formal and informal meetings to gather information and provide feedback and developmental ideas to all levels of staff within the Care Management structure and dependent teams within clinical operations. ▪ Collaborates with and keeps the VP informed of operational issues, staffing, resources, system and program needs and presents solution action plan for issues. ▪ Department goal setting to meet regional market-specific objectives. ▪ Monitor all regulatory requirements and oversight of all submissions in existing and future lines of business. ▪ Facilitates and participates in committees, task forces, work groups and multidisciplinary teams as needed to promote standardized enterprise-wide approach to Care Management programs. ▪ Understands the mission and ensure alignment of compliance-based activity in strategic planning / department goal-setting and regional market support. ▪ Oversight and evaluation of clinical processes to ensure continuous review and improvement of business process workflow. ▪ Establish strong operational metrics and auditing to ensure quality. ▪ Analyze data and identify trends monthly to ensure company expectations meet or exceed industry benchmarks, regulatory requirements, and SLAs. ▪ Responsible for ongoing communication with market leaders to report outcomes, adherence to corrective action plan, and collaborate with regulatory agencies as appropriate.
Minimum Experience Required: ▪ A minimum of five (5) years of managed healthcare experience with line management responsibility including clinical operations is required. ▪ A minimum of two (2) years of experience developing programs/processes to support care management and member wellness is required. ▪ Experience working within applicable state, federal, and third-party regulations is required. ▪ Operational and process improvement experience is preferred.

Skills Required:

- Display a customer service, member-focused orientation.
- Strong data analysis and trending skills.
- Strong project management skills.
- Strong team and staff development skills.
- Strong collaboration and conflict resolution skill sets.
- Proven leadership with the ability to build relationships/collaborate and influence at all levels.
- Strong process and analytical skills with the ability to articulate and define outcome measures that capture key performance metrics.
- Ability to develop, prioritize and accomplish goals/time management.
- Strong decision making and problem-solving skills.
- Exceptional communication skills (both written and verbal) with the ability to present information in a variety of different formats to all levels.
- Strong ability to teach best practice, engagement strategies for successful member participation (including motivational interviewing, best practice engagement techniques).
- Executive and Strategic management skills.
- Ability to work in a fast-past environment.
- Ability to work independently and within a team environment.
- Advanced knowledge of Microsoft Word, Excel, PowerPoint, and Visio.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree or equivalent years of relevant work experience is required; Master's degree is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Active, unrestricted State Registered Nursing (RN) license, Social Work license, or Counselor license is preferred
- Healthcare or Management certification is preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Care Management Manager
Description of Position: The Care Management Manager provides operational management and oversight for providing members with the right care at the right place at the right time and assisting them to achieve optimal clinical, financial, and quality of life outcomes.
Description of Responsibilities of Position: ▪ Oversee a team of clinical and nonclinical staff to achieve quality service level and production expectations. ▪ Facilitate/promote problem identification, analysis, and resolution to improve member experience, ensuring compliance with state and federal regulatory and accrediting standards and implementation of the Care Model. ▪ Manages and evaluates team member performance; provides coaching, counseling, employee development, and recognition; ensures ongoing, appropriate staff training; and has responsibility for the selection, orientation and mentoring of new staff. ▪ Ensures adequate staffing and service levels and maintains customer satisfaction by implementing and monitoring staff productivity and other performance indicators. ▪ Ensures completion of staff quality audit reviews. Evaluates services provided and outcomes achieved and recommends enhancements/improvements for programs and staff development to ensure consistent cost effectiveness and compliance with all state and federal regulations and guidelines. ▪ Maintains professional relationships with provider community, internal and external customers, and state agencies as appropriate, while identifying opportunities for improvement. ▪ Utilize available tools / platforms for efficiencies. ▪ Understand the mission and ensure alignment of compliance-based activity in strategic planning / department goal-setting and regional market support. ▪ Assist in new market development and implementation of department initiatives.
Minimum Experience Required: ▪ Bachelor's degree or equivalent years of relevant work experience is required. ▪ A minimum of five (5) years of managed healthcare experience is required. ▪ A minimum of two (2) years of supervisory experience is required. ▪ Managed care experience is preferred.
Skills Required: ▪ Display a customer service, member-focused orientation. ▪ Strong team and staff development skills. ▪ Strong collaboration and conflict resolution skill sets. ▪ Ability to develop, prioritize and accomplish goals/time management. ▪ Strong decision making and problem-solving skills. ▪ Exceptional communication skills (both written and verbal) with the ability to present information in a variety of different formats to all levels. ▪ Strong ability to teach best practice, engagement strategies for successful member participation (including motivational interviewing, best practice engagement techniques). ▪ Ability to work in a fast-past environment. ▪ Ability to work independently and within a team environment. ▪ Advanced knowledge of Microsoft Word, Excel, PowerPoint, and Visio.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's degree or equivalent years of relevant work experience is required.
Are any professional licenses or certifications required for this position? [X] Yes [ ] No **If yes, list below:** ▪ Active, unrestricted State Licensed Practical Nurse (LPN), Registered Nurse (RN) license, Social Work license, or Counselor license is preferred. ▪ Healthcare or Management certification is preferred.
Are there any continuing education requirements for this position? [ ] Yes [X] No **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Care Management Team Lead
Description of Position: The Care Management Team Lead provides support to the Manager, Care Management by ensuring adherence to the established Care Model.
Description of Responsibilities of Position: ▪ Functions as a "hands-on" supervisor, assisting in day to day operations and supervision of staff with adherence to departmental expectations. ▪ Assist with implementation of interventions to maintain and/or improve the quality and efficiency of the operations/services provided. ▪ Prepares and utilizes reports to monitor and audit all systems, procedures and the quality of customer services provided. Assist with representing the unit at Departmental and Planning meetings as requested. ▪ Ensures staffing policies, procedures and SOPs are standardized and are current to meet business needs. ▪ Supports the Strategic Plan, serve as the technical and content support to align programs/processes. ▪ Assists the Managers as needed to develop new projects/processes as requested. ▪ Responsible for recruiting, hiring, onboarding, training and ongoing support of the departmental team. ▪ Utilize available tools / platforms for efficiencies. ▪ Understand the mission and ensure alignment of compliance-based activity in strategic planning / department goal-setting and regional market support. ▪ Monitor for potential risk, escalate to senior leadership as appropriate, and develop corrective action plans as necessary.
Minimum Experience Required: ▪ High School Diploma or GED is required. ▪ A minimum of two (2) years of managed healthcare experience is required.
Skills Required: ▪ Display a customer service, member-focused orientation. ▪ Strong data analysis and trending skills. ▪ Strong team and staff development skills. ▪ Strong collaboration and conflict resolution skill sets. ▪ Ability to develop, prioritize and accomplish goals/time management. ▪ Strong decision making and problem solving skills. ▪ Exceptional communication skills (both written and verbal) with the ability to present information in a variety of different formats. ▪ Strong ability to teach best practice, engagement strategies for successful member participation (including motivational interviewing, best practice engagement techniques). ▪ Executive and Strategic management skills. ▪ Ability to work in a fast-past environment. ▪ Ability to work independently and within a team environment.

- Advanced knowledge of Microsoft Word, Excel, PowerPoint and Visio.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- High School Diploma or GED is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Active, unrestricted State Licensed Practical Nurse (LPN), Registered Nurse (RN) license, Social Work license, or Counselor license is preferred.
- Healthcare or Management certification is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Care Manager, RN

Description of Position:
The Care Manager, RN collaborates with members of an inter-disciplinary care team (ICT) to meet the needs of the individual and the population and identifies problems or opportunities that would benefit from care coordination.

Description of Responsibilities of Position:

- Engage the member and complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each member.
- Facilitate regularly scheduled ICT meetings to meet the needs of the member.
- Engage with the member in a variety of settings to establish an effective, professional relationship. Settings for engagement include but are not limited to hospital, provider office, community agency, member's home, telephonic or electronic communication.
- Develop an individualized care plan (ICP) in collaboration with the ICT, based on member's needs and preferences.
- Identify and manage barriers to achievement of care plan goals.
- Identify and implement effective interventions based on clinical standards and best practices.
- Assist with empowering the member to manage and improve their health, wellness, safety, adaptation, and self-care through effective care coordination and care management.
- Facilitate coordination, communication and collaboration with the member the ICT in order to achieve goals and maximize positive member outcomes.
- Educate the member/caregivers about treatment options, community resources, insurance benefits, etc. so that timely and informed decisions can be made.
- Employ ongoing assessment and documentation to evaluate the member's response to and progress on the ICP.
- Evaluate member satisfaction through open communication and monitoring of concerns or issues.
- Collaborate with facility based care managers and providers to plan for post-discharge care needs or facilitate transition to an appropriate level of care in a timely and cost-effective manner.
- Coordinate with care managers and other service providers to ensure coordination and avoid duplication of services.
- Appropriately terminate care coordination services based upon established case closure guidelines for members
- Provide clinical oversight and direction to unlicensed team members as appropriate.
- Document care coordination activities and member response in a timely manner according to standards of practice and policies regarding professional documentation.
- Look for ways to improve the process to make the members experience easier and shares with leadership to make it a standard, repeatable process.
- Regular travel to conduct member, provider and community based visits as needed to ensure effective administration of the program.

Minimum Experience Required:

- Nursing degree from an accredited nursing program is required.
- Bachelors of Science in Nursing is preferred.

- Licensure as a Registered Nurse is required.
- A minimum of three (3) years of relevant experience in nursing (i.e discharge planning, case management, care coordination, and/or home/community health management experience) is required.
- Experience with infant, pediatric and adolescent is preferred.
- Three (3) years or more Medicaid and/or Medicare managed care experience is preferred.

Skills Required:

- Intermediate proficiency level with Microsoft Office, including Outlook, Word and Excel.
- Ability to communicate effectively with a diverse group of individuals.
- Ability to multi-task and work independently within a team environment.
- Knowledge of local, state & federal healthcare laws and regulations & all company policies regarding care management practices.
- Adhere to code of ethics that aligns with professional practice.
- Knowledge of and adherence to Case Management Society of America (CMSA) standards for case management practice.
- Strong advocate for members at all levels of care.
- Strong understanding and respect of all cultures and demographic diversity.
- Ability to interpret and implement current research findings.
- Awareness of community & state support resources.
- Critical listening and thinking skills.
- Decision making and problem solving skills.
- Strong organizational and time management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Nursing degree from an accredited nursing program is required.
- Bachelors of Science in Nursing is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current unrestricted clinical license in state of practice as a Registered Nurse is required.
- Case Management Certification is highly preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Care Manager, Social Worker
Description of Position: The Care Manager, Social Worker collaborates with members of an inter-disciplinary care team (ICT) to meet the needs of the individual and the population and identifies problems or opportunities that would benefit from care coordination.
Description of Responsibilities of Position: ▪ Engage the member and complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each member. ▪ Facilitate regularly scheduled inter-disciplinary care team (ICT) meetings to meet the needs of the member. ▪ Engage with the member in a variety of settings to establish an effective, professional relationship. Settings for engagement include but are not limited to hospital, provider office, community agency, member's home, telephonic or electronic communication. ▪ Develop an individualized care plan (ICP) in collaboration with the ICT, based on member's needs and preferences. ▪ Identify and manage barriers to achievement of care plan goals. ▪ Identify and implement effective interventions based on clinical standards and best practices. ▪ Assist with empowering the member to manage and improve their health, wellness, safety, adaptation, and self-care through effective care coordination and care management. ▪ Facilitate coordination, communication and collaboration with the member the ICT in order to achieve goals and maximize positive member outcomes. ▪ Educate the member/caregivers about treatment options, community resources, insurance benefits, etc. so that timely and informed decisions can be made. ▪ Employ ongoing assessment and documentation to evaluate the member's response to and progress on the ICP. ▪ Evaluate member satisfaction through open communication and monitoring of concerns or issues. ▪ Collaborate with facility based care managers and providers to plan for post-discharge care needs or facilitate transition to an appropriate level of care in a timely and cost-effective manner. ▪ Coordinate with care managers and other service providers to ensure coordination and avoid duplication of services. ▪ Appropriately terminate care coordination services based upon established case closure guidelines for members ▪ Provide clinical oversight and direction to unlicensed team members as appropriate. ▪ Document care coordination activities and member response in a timely manner according to standards of practice and policies regarding professional documentation. ▪ Look for ways to improve the process to make the members experience easier and shares with leadership to make it a standard, repeatable process. ▪ Regular travel to conduct member, provider and community based visits as needed to ensure effective administration of the program.

Minimum Experience Required:

- Bachelor's degree in a health care field or equivalent years of relevant work experience is required.
- Master's degree is preferred.
- Licensure as a Social Worker or Counselor, paramedic, allied health professional, LPN is required.
- A minimum of three (3) years of relevant experience in social work or counseling (i.e. discharge planning, case management, care coordination, and/or home/community health management experience) is required.
- Three (3) years or more Medicaid and/or Medicare managed care experience is preferred.
- Experience with infant, pediatric, and adolescent preferred.

Skills Required:

- Intermediate proficiency level with Microsoft Office, including Outlook, Word and Excel.
- Ability to communicate effectively with a diverse group of individuals.
- Ability to multi-task and work independently within a team environment.
- Knowledge of local, state & federal healthcare laws and regulations & all company policies regarding care management practices.
- Adhere to code of ethics that aligns with professional practice.
- Knowledge of and adherence to Case Management Society of America (CMSA) standards for case management practice.
- Strong advocate for members at all levels of care.
- Strong understanding and respect of all cultures and demographic diversity.
- Ability to interpret and implement current research findings.
- Awareness of community & state support resources.
- Critical listening and thinking skills.
- Decision making and problem solving skills.
- Strong organizational and time management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in a health care field or equivalent years of relevant work experience is required.
- Master's degree is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current unrestricted clinical license in state of practice as a Social Worker or Counselor or current unrestricted Licensed Practical nurse or paramedic or allied health professional required.
- Case Management Certification is highly preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Transitions of Care Manager
Description of Position: Promotes timely coordination and safe transitions for members experiencing inpatient hospitalization. Facilitates coordination of care through direct support to members and communication and collaboration with primary care providers, primary care medical homes, and community health providers (e.g., hospitals, home health care providers).
Description of Responsibilities of Position: ▪ Develop an individualized care plan (ICP) in collaboration with the ICT, based on member's needs and preferences. ▪ Identify and manage barriers to achievement of care plan goals. ▪ Identify and implement effective interventions based on clinical standards and best practices. ▪ Assist with empowering the member to manage and improve their health, wellness, safety, adaptation, and self-care through effective care coordination and care management. ▪ Facilitate coordination, communication and collaboration with the member the ICT in order to achieve goals and maximize positive member outcomes. ▪ Educate the member/caregivers about treatment options, community resources, insurance benefits, etc. so that timely and informed decisions can be made. ▪ Employ ongoing assessment and documentation to evaluate the member's response to and progress on the ICP. ▪ Evaluate member satisfaction through open communication and monitoring of concerns or issues. ▪ Collaborate with facility based care managers and providers to plan for post-discharge care needs or facilitate transition to an appropriate level of care in a timely and cost-effective manner. ▪ Coordinate with care managers and other service providers to ensure coordination and avoid duplication of services. ▪ Appropriately terminate care coordination services based upon established case closure guidelines. ▪ Provide clinical oversight and direction to unlicensed team members as appropriate. ▪ Document care coordination activities and member response in a timely manner according to standards of practice and policies regarding professional documentation. ▪ Look for ways to improve the process to make the members experience easier and shares with leadership to make it a standard, repeatable process.
Minimum Experience Required: ▪ Minimum of three years of healthcare or managed care experience is required. ▪ Medicaid, Medicare, and Marketplace experience is preferred. ▪ Bachelor of Science degree or equivalent years of relevant work experience is required. ▪ Nursing or Social Work degree from an accredited program is required.

Skills Required:

- Knowledge of health care services regarding clinical processes and outcomes.
- Effective problem solving skills with attention to detail.
- Ability to develop, prioritize and accomplish goals.
- Strong written and verbal communication skills.
- Strong interpersonal skills and high level of professionalism.
- Demonstrated experience in the use of electronic medical records.
- Proficient in Microsoft Office Suite to include, Word, Excel and PowerPoint.
- Ability to act with diplomacy and sensitivity to cultural diversity.
- Ability to provide input in determining the needs of members.
- Knowledge of privacy and security regulations related to health information.
- Change resiliency.
- Excellent conflict resolution skills.
- Customer service oriented.
- Knowledge of healthcare resources, benefits and entitlements in the local area.
- Proven track record of demonstrating empathy and compassion for individuals.
- Proven track record for improving processes to make things easier for those you have served.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor of Science degree or equivalent years of relevant work experience is required.
- Nursing or Social Work degree from an accredited program is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current unrestricted clinical license in state of practice as a Registered Nurse, Licensed Social Worker or Licensed Clinical Social Worker is required.
- Case Management Certification is highly preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Chief Executive Officer
Description of Position: President, Market is responsible for leading and collaborating with the Market Executive team to establish strategic and operational goals for the Market.
Description of Responsibilities of Position: ▪ Develop annual operating budget in conjunction with Enterprise services; monitor the financial activities of the plan including budgeting and forecasting to ensure financial goals are met. ▪ Lead local strategy efforts and operational planning; provide oversight of all plan operations. ▪ Accountable for plan performance/health plan P&L, including but not limited to: maintaining and growing market share, meeting operational and membership targets, maintaining or improving customer satisfaction ratings, and enhancing quality and HEDIS results (NCQA). ▪ Ensure compliance with the contract with the State. ▪ Ensure the plan is customer and quality driven, and at the same time, develop or participate in a continuum of care responsible to members' needs. ▪ Work with the organization to coordinate the delivery of all required operational services. ▪ Establish and maintain strong cooperative working relationships with regulatory agencies and state legislators. ▪ Oversee and monitor physician and provider contracting and ongoing relationships with the plan's physician and provider network. ▪ Provide leadership, oversight and monitoring of the activities of the plan Medical Director in conjunction with the Corporate Medical Director leadership. ▪ Recruit, develop and lead key staff. ▪ Develop and implement operational policies and procedures. ▪ Perform any other job duties as requested.
Minimum Experience Required: ▪ Bachelor's degree in finance, business, healthcare, or other related field is required; Master's in business administration, healthcare administration and/or other related discipline is preferred. ▪ A minimum of five (5) years leading division and corporate initiatives; Senior Executive Leadership experience with 5 years of experience in a managed care setting (preferably Medicaid/Medicare); preference to candidate with health plan experience as a Plan President/Senior Executive. ▪ Depth in governmental product design and experience working with underserved populations. ▪ Extensive experience leading large, diverse teams to successful outcomes. ▪ Experience leading an organization through start up growth phases and/or new joint venture partnerships.
Skills Required: ▪ Understanding of Medicare/Medicaid/Exchange/Special Populations' regulatory environment. ▪ Acumen in strategic positioning, infrastructure development and design, and proven ability to introduce new products. ▪ Effective communication, presentation skills, and board presentation experience. ▪ Strong understanding of healthcare finances and medical economics. ▪ Commitment to the mission and values of the CareSource Family of Companies.

▪ Strong collaborative skills, working with cross-functional stakeholders and external partners including state agencies, elected officials, community partners and business leaders.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** Bachelor's degree in finance, business, healthcare or other related field is required; Master's in business administration, healthcare administration and/or other related discipline is preferred.
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: N/A

Key Position: Job Description

Title of Position: Chief Financial Officer

Description of Position:
The AVP, Market Chief Financial Officer provides financial oversight, leadership, and support to the region/market/corporate; ensures the department proactively collaborates with other departments within the organization; and provides strategic/tactical support to region/market leaders to reach targets.

Description of Responsibilities of Position:

- Provide timely, accurate, comprehensive, and transparent financial reporting including, but not limited to, operating statements, trend reports, and key business reports as needed to region/market and corporate leadership.
- Assist growth and business development opportunities in existing/additional markets; work with appropriate region/market leadership to ensure reasonable assumptions are made around premium and claims for new markets or products.
- Provide strategic support to region/market/senior leaders to establish/reach targets.
- Work with region/market leaders to prepare/present Monthly/Quarterly Business Review documents.
- Ability to act with diplomacy and sensitivity to drive favorable resolution to internal and external issues.
- Understand reimbursement methodologies impacting market products.
- Support monthly close process by providing journal entries, accruals, and supporting analysis as needed; have region/market specific knowledge of trends/drivers to influence IBNR models.
- Drive QAI plan for region/market; responsible for coordinating with market/work stream leaders to identify, implement, and measure QAI initiatives to exceed targets.
- Coordinate with department leaders on rate advocacy, revenue maximization efforts (risk adjustment and quality initiatives) and regarding pricing of Medicare, marketplace and other products as appropriate.
- Responsible for cost reports and other regulatory filing requirements, interact with regulatory agencies as needed.
- Support the annual budget and monthly/quarterly forecasting process for applicable region/market; provide necessary region/market specific data to ensure assumptions are reasonable.
- Support the strategic planning process by providing long term financial projections reflecting the assumptions outlined in the strategic plan.
- Provide insight into the risk sensitivity associated with the current and future business drivers.
- Coordinate and support independent financial accounting audits and other regulatory financial related audits.
- Utilize ad hoc and trending analysis – both proactively and as requested – to identify drivers and mitigating QAI opportunities; modeling to support market specific contracting and enhancement initiatives; lead trend discussions with region/market leaders.
- Responsible for management of departmental staff and expense budget.
- Responsible for making staffing decisions.
- Develop, implement, and modify processes to ensure efficiency and effectiveness.

- Assess internal controls and make appropriate changes to ensure compliance with MAR, regulatory, and other organization requirements.
- Perform any other job duties as requested.

Minimum Experience Required:

- Bachelor's degree in accounting, finance or related field or equivalent years of relevant work experience is required.
- A minimum of seven (7) years of experience in accounting/finance is required.
- Previous senior level management experience is required.
- Managed care or healthcare experience is preferred.

Skills Required:

- Familiar with variety of financial analysis concepts, practices, and procedures.
- Rely on extensive experienced and judgment to plan and accomplish goals.
- Familiar with variety of accounting concepts, practices, and procedures.
- Intermediate proficiency level with Microsoft Office.
- Ability to interact and provide insight and guidance to region/market leadership as well as executive leadership regarding financial and business matters.
- Ability to lead the region/market finance function as well as interact with external partners (including Regulators, Actuaries, providers, and peer MCOs).
- Ability to multitask and demonstrate flexibility in supporting several market leaders/business areas simultaneously.
- Ability to lead and direct the work of others including the development, motivation, and rewarding of staff.
- Knowledgeable of internal control framework and ability to successfully perform and document owned internal controls.
- Decision making/problem solving skills.
- Critical listening and thinking skills analytical skills.
- Conflict resolution skills.
- Planning, problem identification and resolution skills.
- Detail oriented.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in accounting, finance or related field or equivalent years of relevant work experience is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified Public Accountant (CPA) or other equivalent certification is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Chief Information Officer

Description of Position:
The Chief Information Officer (CIO) is responsible for providing technical and administrative direction in the development of new programs and the maintenance of current programs.

Description of Responsibilities of Position:
- Develop long-term strategic plan for system enhancements and expanded capabilities.
- Organize all corporate systems development projects and assignments.
- Prepare IT budget and be accountable for the adherence to it.
- Supervise the design and development functions of projects.
- Prepare cost estimates for systems development projects.
- Supervise activities relating to feasibility studies and recommending courses of action for systems under consideration.
- Create and maintain a plan for disaster recovery.
- Responsible for the coordination of all PC, including LAN, functions for the organization.
- Responsible for maintaining a data management system that is capable of data collecting and processing, including claims payment and reporting in timely and accurate manner.
- Supervise the day-to-day operations of the IT department.
- Assist human resources in the hiring of IT staff.
- Serve as the HIPAA Security Officer and oversee compliance with all applicable provisions of HIPAA Security.
- Perform any other job-related instructions, as requested.

Minimum Experience Required:
- Bachelor's degree in computer science, business, or equivalent experience.
- Ten (10) years of experience in an IT related field.
- One (1) year of experience in managed care (preferably in systems management).
- Experience with coordinating hardware and software agreements with vendors.
- Eight (8) years of managing technical and non-technical staff.

Skills Required:
- Microsoft Office proficient.
- Proficient in all CareSource technical software, hardware, and telecommunications.
- Critical listening and systematic thinking skills.
- Ability to maintain confidentiality and act in the company's best interest.
- Oral, written, and interpersonal communication skills.
- Leadership experience and skills.
- Responsive to a changing environment.
- Planning, problem identification, and resolution skills.
- Strategic management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:
- Bachelor's degree in computer science, business, 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: N/A

Key Position: Job Description

Title of Position: Chief Operating Officer

Description of Position:
Responsible for developing the overall market program strategy and business objectives; lead alignment and collaboration to establish CareSource as the industry leader in member and provider engagement, member and provider experience, and plan management in the market.

Description of Responsibilities of Position:

- Develop the overall market program strategy and business objectives; lead alignment and collaboration to establish CareSource as the industry leader in member and provider engagement, member and provider experience, and plan management in the market.
- Primary responsibility for translating business/program vision and strategy into operational tactics and building the necessary organizational support and infrastructure.
- In new markets, lead program implementation, allocate implementation team resources, and facilitate ongoing operations; establish post-implementation strategy and goals to mitigate program risks.
- Ongoing responsibility for day-to-day program operations for market, including establishing and overseeing controls to ensure requirements are in place.
- Responsible for leading regular market business reviews with various stakeholder groups (including, but not limited to, human resources, information technology, finance, Business Partner Group, quality improvement, and care management) to ensure market requirements are met.
- Develop, translate, and execute key strategies or functional/operational requirements for market.
- Facilitate leadership team in the establishment of organizational goals and priorities to align and focus the organization.
- Ensure market operations team achieves its short- and long-term strategic priorities with maximum effectiveness and efficiency.
- Oversee allocation of staffing resources and responsibilities for market operations.
- Initiate and oversee operational plans and initiatives to create cross-functional capabilities required across key functional areas.
- In collaboration with corporate compliance, escalate key issues and work to resolve to maintain contract compliance and responsiveness, develop and maintain in-depth knowledge of the company's regulatory environment, and assist in transforming regulatory procedures into polices, plan changes, reporting or other operational outcomes.
- Collaborate with Finance and Data Management to develop internal reporting for ongoing management as well as production of external reporting for compliance.
- Work with management to oversee departmental finances/budget and sales forecast/budget are met.

Minimum Experience Required:
Education and Experience:

- Bachelor of Science degree in finance, business, or health care field or equivalent work experience is required.
- Master's degree is preferred.

- Five (5) years of health plan operations (i.e., claims, enrollment, provider agreements, etc.) experience is required.
- Five (5) years of leading division and corporate initiatives to drive systemic change and consumer adoption of health insurance and engagement initiatives is required.
- Five years of management experience in managed care setting is required.

Skills Required:

Competencies, Knowledge and Skills:

- Intermediate proficiency level with Microsoft Office.
- Knowledge of full range of product requirements from regulatory, operations, clinical, reporting and compliance.
- Critical listening and systematic thinking skills.
- Ability to attract, manage and develop team members and act as Inspirational Leadership.
- Ability to maintain confidentiality and act in the company's best interest.
- Oral, written, and interpersonal communication skills.
- Leadership experience and skills.
- Energetic, enthusiastic, and politically astute.
- Ability to act with diplomacy and sensitivity to cultural diversity.
- Responsive to a changing environment.
- Health Plan Financial & Administration Management Acumen.
- Strategic management skills.
- Conflict resolution skills.
- Planning, problem identification and resolution skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor of Science degree in finance, business, or health care field or equivalent work experience is required.
- Master's degree is preferred.

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: N/A

Key Position: Job Description

Title of Position: Claims Administrator

Description of Position:
The Claims Administrator is responsible for the management of payment cycle activities to ensure providers are paid accurately and timely, including resolution of regulatory complaints related to payment discrepancies or lack of payments for providers.

Description of Responsibilities of Position:

- Perform proactive analysis of claim payment trends to identify and resolve issues prior to receiving complaints from state departments such as DCH, DOI, CMS, or providers.
- Manage and oversee activities of payment escalations for assigned market, including direct supervision of employees.
- Maintain appropriate reimbursement levels, overseeing review of new procedure methodologies/research of payment mechanisms.
- Oversee Market Benefits Analyst and all supporting Medicaid benefit design and implementation.
- Support implementation of identified required IT enhancements, configuration changes, and business processes to support Market requirements for efficient claims and COB processing.
- Identify and manage configuration and special project (MCA) priorities to ensure benefit, pricing, clinical edits, medical policy, and regulatory requirements are implemented to support claim payment accuracy for assigned market.
- Support forecasting and workforce management models to ensure appropriate level of staffing and training.
- Assist in the development and implementation of departmental policies and procedures.
- Prepare and monitor various management and oversight metrics and reports as required.
- Provide support to the Market Health Partner team, MLSS, Appeals & Grievances, and Customer Advocacy Group to address claim issues for providers and prepare for JOC meetings.
- Ensure quantitative and qualitative objectives are used to meet department performance objectives.
- Collaborate with other departments to improve quality to members through implementation of quality initiatives and efficiency improvements; ensure that processes are documented and that appropriate quality measures are implemented.
- Maintain positive and strategic relationships with internal and external stakeholders.
- Perform any other job duties as requested.

Minimum Experience Required:

- Associate degree or equivalent years of relevant work experience is required.
- Bachelor's degree is preferred, or equivalent experience.
- A minimum of three to five (3-5) years of experience interpreting payment policies and reimbursement is required.
- A minimum of one (1) year of previous leadership experience is preferred.
- Extensive experience with and understanding of health care claims department is preferred.

Skills Required:

- Demonstrated understanding of claims operations specifically related to managed care.
- Working knowledge of coding and billing processes, including CPT, ICD-10 and HCPCS coding.
- Effective identification of business problems, assessment of proposed solutions to those problems, and understanding of the needs of business partners.
- Knowledge of regulatory reporting and compliance requirements.
- Excellent interpersonal skills and the ability to influence and work with external stakeholders to mutually benefit each organization and third party constituents.
- Support the development of effective working relationships with business partners.
- Demonstrated competencies with direct and indirect management of exempt and non-exempt staff.
- Effective communication and interaction skills.
- Working knowledge of health care/managed care or similar heavily regulated environment.
- Strong financial acumen preferred.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Associate degree or equivalent years of relevant work experience is required.
- Bachelor's degree is preferred, or equivalent experience.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Six Sigma certification or similar methodologies is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Clinical Pharmacist

Description of Position:
The Clinical Pharmacist is responsible for researching scientific and medical literature to develop moderate to complex pharmacy criteria and clinical policies for Medicare, Medicaid, Marketplace, and Medicare-Medicaid Plan (MMP) products.

Description of Responsibilities of Position:

- Develop prior authorization, step therapy criteria and utilization management edits.
- Create and update new and existing policy bibliographies.
- Ensure all pharmacy criteria and policies are compliant with relevant regulations across all lines of business and adhere to company, state, and federal guidelines.
- Monitor new drug pipeline.
- Answer questions from staff regarding prior authorization and appeal requests.
- Research clinical and scientific literature and consensus guidelines to create work products for team input.
- Support internal departments and processes in the development and implementation of pharmacy criteria and policies.
- Share formulary change and clinical information with pharmacy team.
- Identify reporting, rDUR, and communication needs.
- Ensure regulatory requirements and submission deadlines are met.
- Provide input and information to Clinical Policy Committee (CPC), Pharmacy and Therapeutics Committee (P&T), and Value Assessment Committee (VAC) and other applicable committees.
- Participate in department and team initiatives and projects.
- Participate in relevant pharmacy research projects and educational programs.
- Collaborate with interdisciplinary team members to achieve team goals.
- Advise and precept APPE students and residents.
- Perform any other job duties as requested.

Minimum Experience Required:

- PharmD and completion of a residency is preferred.
- Minimum of one (1) year of specialty or formulary pharmacy experience is preferred.
- Minimum of two (2) years of healthcare-related writing preferred, medical policy development and/or implementation preferred.
- Two (2) years of previous health plan or PBM experience strongly preferred.

Skills Required:

- Demonstrated advanced computer skills/proficiency with Microsoft Word, Excel, search engines, and bibliographic software.
- Knowledge of medical terminology and claims payment policies.
- Strong clinical expertise and healthcare administration understanding.
- Advanced analytical skills, with the ability to interpret and synthesize complex healthcare literature.
- Ability to interpret complex clinical information and apply it to policy development.
- Excellent verbal and written communications skills.

- Effective presentation and decision-making skills.
- Excellent organization and tracking skills.
- Good problem-solving skills.
- Ability to interface and collaborate with employees at all levels.
- Ability to handle multiple priorities/projects simultaneously.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree in Pharmacy is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current, unrestricted Registered Pharmacist (RPh) licensure in state of practice is required.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Clinical Care Reviewer

Description of Position:
Clinical Care Reviewer II is responsible for processing medical necessity reviews for appropriateness of authorization for health care services, assisting with discharge planning activities (i.e. DME, home health services) and care coordination for members enrolled in a line of business, as well as monitoring the delivery of healthcare services in a cost effective manner.

Description of Responsibilities of Position:

- Complete prospective, concurrent and retrospective review of acute inpatient admissions, post acute admissions, elective inpatient admissions, outpatient procedures, homecare services and durable medical equipment.
- Coordinate care and facilitate discharge to an appropriate level of care in a timely and cost-effective manner.
- Refer cases to Medical Directors when clinical criterial is not met or case conference is needed/appropriate.
- Maintain knowledge of state and federal regulations governing, State Contracts and Provider Agreements, benefits, and accreditation standards.
- Identify and refer quality issues to Quality Improvement.
- Identify and refer appropriate members for Care Management.
- Document, identify and communicate with Health Partners, Care Managers and Discharge Planners to establish safe discharge planning needs and coordination of care.
- Provide guidance to non-clinical medical management staff.
- Provide guidance to and assist with oversight of LPN and LISW medical management staff.
- Attend medical advisement and State Hearing meetings, as requested.
- Assist Team Leader with special projects or research, as requested.

Minimum Experience Required:

- Completion of an accredited registered nursing (RN) degree program is required.
- Minimum of three (3) years clinical experience is required.
- Med/surgical, emergency acute clinical care or home health experience is preferred.
- Medical management experience is preferred.
- Medicaid/Medicare/Commercial experience is preferred.

Skills Required:

- Basic data entry skills and internet utilization skills.
- Working knowledge of Microsoft Outlook, Word, and Excel.
- Effective oral and written communication skills.
- Ability to work independently and within a team environment.
- Familiarity of the healthcare field.
- Proper grammar usage and phone etiquette.
- Time management and prioritization skills.
- Customer service oriented.
- Decision making/problem solving skills.
- Strong organizational skills and attention to detail.
- Change resiliency.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Completion of an accredited registered nursing (RN) degree program is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current, unrestricted Registered Nurse (RN) Licensure in state(s) of practice is required.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Clinical Review Specialist

Description of Position:

The Clinical Review Specialist manages and monitors all SIU fraud reporting mechanisms (hotline, facets routing, fax, emails) to ensure compliance with regulatory requirements.

Description of Responsibilities of Position:

- Monitors SIU issued Corrective Action Plans and Settlement Agreements
- Facilitates provider terminations initiated by SIU investigators
- Handles straightforward and uncomplicated investigations to closure or referral
- Interview members, providers and provider staff in support of investigative efforts
- Maintains the SIU e-manual
- Generates SIU intake metrics monthly
- Responsible for triaging and managing the fraud reporting mechanisms daily including case input into SIU case tracking software, claim data pulls, grievances information, phone calls, etc.
- Responsible for identifying any needed fraud reporting mechanism process improvement
- Maintains fraud allegiants confidentiality and anonymity
- Proactively assists investigators in case development such as records requests/reviews, letter generation, and documentation
- Serves as a liaison to other departments to obtain information needed to support SIU investigative efforts
- Ensure consistency in the execution of actions with providers, members and other departments

Minimum Experience Required:

- High School Diploma or GED is required
- Associate's Degree in Health-Related Field, Law Enforcement, or Insurance is preferred
- Minimum of three (3) years of SIU experience is required

Skills Required:

- Intermediate computer skills consisting of Microsoft Excel, Access, Outlook, Word, and Power Point
- Ability to navigate multiple software systems at a high proficiency level
- Facets Claim System knowledge a requirement
- Good communication skills
- Ability to work independently and within a team environment
- High attention to detail
- Critical listening and thinking skills
- Proper grammar usage
- Time management skills
- Proper phone etiquette
- Customer service oriented
- Decision making/problem solving skills
- Strong organization skills

▪ Customer service oriented
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ High School Diploma or GED is required ▪ Associate's Degree in Health-Related Field, Law Enforcement, or Insurance is preferred
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: N/A

Key Position: Job Description

Title of Position: Community Health Worker

Description of Position:
The Community Health Worker is responsible for participating as a member of the Regional Care Coordination Team to coordinate care for members.

Description of Responsibilities of Position:

- Engage with the member in a variety of settings to establish an effective, professional relationship. Settings for engagement include, but are not limited to, hospital, provider office, community agency, member's home, telephonic, or electronic communication.
- Accompany members to appointments and other social service encounters when necessary.
- Coordinate logistics to support care plan goals and interventions – reminders, transportation, and childcare arrangements – for members.
- Verify eligibility, previous enrollment history, demographics and current health status of each member.
- Contribute to assessments by gathering information from the member, family, provider, and other stakeholders.
- Contribute to the development and implementation of care plans, reporting information to the Care Coordinator.
- Assist with the provision of health education and wellness materials as directed by the Care Coordinator(s) or Team Leader.
- Maintain appropriate documentation within protocols and guidelines of the Care Management program.
- Start each intervention with members wondering, "What does the world look like for this person, and how can I meet him or her where they are? What are his or her unique needs, and how can we help?" In each interaction, the employee will aspire to help the member to feel informed and empowered.
- Look for ways to improve the process to make the member's experience easier and share with leadership to make it a standard, repeatable process.
- Regular travel to conduct member visits, provider visits, and community based visits as needed to ensure effective administration of the program.

Minimum Experience Required:

- High School Diploma or General Education Diploma (GED), is required.
- Minimum of two (2) years of experience in either volunteer or paid position working in community settings with at risk populations providing coordination of services is preferred.
- Experience with infant, pediatric, and adolescents preferred.

Skills Required:

- Proficient with Microsoft Office, including Outlook, Word and Excel.
- Sensitivity to and experience working within different cultures.
- Good interpersonal skills.
- Ability to work independently and within a team environment.
- Ability to identify problems and opportunities and communicate to management.
- Developing knowledge of local, state, and federal healthcare laws and regulations and all company policies regarding case management practices.

- Demonstrate compassion, support and collaboration with members and families.
- Self-motivated and inquisitive.
- Comfort with asking pertinent questions.
- Ability to work in a fast-paced environment.
- Ability to demonstrate and promote ethical conduct.
- Ability to develop positive relationships with all stakeholders.
- Awareness of community and state support resources.
- Organized and detail-oriented.
- Conflict resolution skills.
- Ability to keep composure and professionalism during times of high emotional stress.
- Ability to maintain confidentiality and act in the company's best interest.
- Proven track record of demonstrating empathy and compassion for individuals.
- Proven track record for improving processes to make things easier for those you have served.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- High School Diploma or General Education Diploma (GED), is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Harold P. Freeman Patient Navigation Institute Certification, or equivalent approved training program, is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Community Justice Liaison

Description of Position:
Under the direction of Clinical Operations and Medical Director, this role will be responsible for engaging with members prior to their release from incarceration and during the transition period as these members re-enter the community. Will assist in delivering a coordinated re-entry experience for our members through collaboration with the Department of Corrections and internal and external stakeholders. The Liaison will help ensure end-to-end care coordination by engaging with incarcerated members prior to release, obtaining information on the physical, behavioral, and social needs of the member and providing that information to the care management and Life Services staff for case planning.

Description of Responsibilities of Position:

Care Coordination

- Responsible for interfacing with the existing care coordination continuum, including the member, Department of Corrections, care management staff, community health partners, and community agencies to foster the transition of the member back into the community.
- Engage with the member in a variety of settings to establish an effective, professional relationship. Settings for engagement may include, but are not limited to, correctional facility, hospital, provider office, community agency, and telephonic or electronic communication.
- Start each intervention with members wondering, "What does the world look like for this person, and how can I meet him or her where they are? What are his or her unique needs, and how can I help?" In each interaction, the employee will aspire to help the member to feel informed, empowered, and supported.
- Regular travel to conduct member visits as needed to ensure effective administration of the program.
- Maintain appropriate documentation within protocols and guidelines of the Care Management program.
- Ensure the creation of a care plan and help coordinate the connection of the member to community providers and resources.
- Provide in-reach education and engagement services to offenders and staff in the Department of Corrections and its prison system.

Operations

- Responsible for gathering offender data as assigned.
- Support the gathering of information from member, family, institution, or other relevant parties.
- Participate in relevant governmental and advocacy meetings.
- Contribute to operational and strategic feedback to programmatic development.

Quality

- Responsible to serve as an interdepartmental and inter-market liaison to gather and share information about issues and barriers related to the successful execution of our community justice population initiative.
- Help develop and deliver training and training materials related to re-entry.
- Act as a liaison to government agencies and social service/community resources to communicate ideas, address concerns, and relay solutions.
- Educate members through implementation of tools, processes, and competencies.

- Perform any other job related instructions as requested and other duties as assigned.

Minimum Experience Required:

- Bachelor's degree in health care, business, or related field or equivalent years of relevant work experience is required.
- A minimum of two (2) years of care coordination or related experience is required.
- Experience working with community justice population preferred.

Skills Required:

- Proficiency with Microsoft Office Suite to include Word, Excel, and PowerPoint.
- Excellent written and verbal communication skills.
- Excellent active listening and critical thinking skills.
- Strong problem solving skills with attention to detail.
- Strong interpersonal skills and high level of professionalism.
- Ability to work independently and within a team environment.
- Ability to develop, prioritize and accomplish goals.
- Knowledge of regulatory requirements.
- Knowledge of health plan policies and community based organization that can impact outcomes.
- Strong relationship building and management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in health care, business, or related field or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description

Title of Position: Community Marketing Representative

Description of Position:

Community Marketing Representative is responsible to support the sales enrollment strategy in collaboration with management to ensure all membership goals are successfully achieved

Description of Responsibilities of Position:

- Utilize a consultative sales approach to specified industries to promote the Family of Products and differentiating factors to gain access to their employees for holistic education sessions for all products
- Serve as a subject matter expert line of businesses
- Contribute and support the development of educational and enrollment opportunities with community and government agencies, community housing, providers and health systems, community business associations, targeted industries and faith based organizations
- Assist in community outreach strategies and programs with guidance to internal departments and staff while adhering to all applicable state and federal regulatory requirements
- Collaborate cross functionally in the development of Sales & Marketing specific strategies for enhanced engagement including collaboration with Care Managers, High Risk Care Management, Life Services and Health Partner teams
- Conduct sales presentations, marketing activities and other informational events in accordance with current approved marketing guidelines and State/Federal regulations
- Deliver educational staff presentations to targeted industries, hospitals, clinics, doctors' offices, public housing, faith based organizations, community organizations and government agencies
- Strictly adhere to all State and Federal Marketing regulations
- Perform all required training to successfully satisfy all State and Federal requirements
- Monitor competition by gathering current market information on benefits, services, trends, changes, strategies/tactics, new products, etc.
- Maintain professional and technical knowledge by attending educational workshops; training, reviewing professional publications; participating in industry Continuing Education Courses
- Cross trained in all lines of products and benefits
- Provide proactive, high-level relationship management and support with Key Agencies in order to access and drive new membership acquisition and member retention
- Manage budget of sponsorship and Promotional items spend
- Keep management informed by documenting detailed sales activity and records of all agency/organization contacts in the Customer Relationship Management tool (“CRM”) and weekly reports
- Drive new membership acquisition by managing lead generation and direct marketing outreach during AEP (Annual Enrollment Period)
- Effectively coordinate activities with Communications/Marketing, Inside Sales/Member Services, Health Partners, Life Services and Care Management counterparts to ensure achievement of desired results
- Develop and implement territory plan to achieve desired membership and retention goals
- Participate in the negotiation, development and staff coordination of Community/Agency/Provider events
- Regular travel to conduct member visits, provider visits and community-based visits as needed to ensure effective administration of the program

Minimum Experience Required:

- Associate degree in Marketing, Communications, Business Administration or related field, or equivalent years of relevant work experience, is required
- Minimum of two (2) years of experience in Sales, Marketing or Account Management or Community Outreach and/or Social Delivery is required
- Medicare, Medicaid and/or Commercial Health Insurance experience is required

Skills Required:

- Proficient in Microsoft Suite, to include Word, PowerPoint and Excel
- Excellent computer skills and ability to effectively use CRM system
- Knowledge of managed care principles, marketing guidelines and market dynamics
- Maintain marketing regulatory knowledge for compliance to State and Federal regulatory insurance guidelines and requirements
- Proven self-starter: able to work independently and within a team environment to achieve goals
- Effective listening and critical thinking skills
- Strong problem-solving skills with attention to detail & excellent follow-up
- Excellent written and verbal communication skills
- Excellent presentation skills and negotiation skills in both small and large group settings
- Excellent organizational and time management skills
- Ability to develop, prioritize and accomplish goals
- Strong interpersonal skills and high level of professionalism
- Demonstrated strategic thinking and planning skills
- Excellent research and analytical skills
- Proven experience of selling new products to existing customers
- Excellent Time and territory management skills
- Ability to lift up to 50lbs on occasion

Are there any educational requirements for this position? [X] Yes [ ] No

If yes, list below:

- Associate degree in Marketing, Communications, Business Administration or related field, or equivalent years of relevant work experience, is required

Are any professional licenses or certifications required for this position? [X] Yes [ ] No

If yes, list below:

- Current, unrestricted State Insurance License in Accident and Health within state(s) of assigned territory is/are required
- Applicable Certification as required within state(s) of assigned territory or ability to achieve certification(s) within 30 days of hire and annual recertification each year thereafter is required. If a Federally Facilitated Marketplace (FFM) State, certification from the Health Insurance Marketplace is required.

Are there any continuing education requirements for this position? [ ] Yes [X] No

If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Community Partner Strategy Lead
Description of Position: Foster relationships with strategic partners and CBOs that have value-based contracts to drive higher member engagement and connectivity to social services programs and promote community connectedness of our plan.
Description of Responsibilities of Position: ▪ Maintain working relationships with existing community stakeholders/partners, including providing high-level support to drive the overall satisfaction and engagement of key community partners. ▪ Provide support to the JobConnect member-facing team as it relates to developing understanding of community dynamics within targeted geographies, helping the team to maintain a higher understanding of the members in the region. ▪ Coordinate activities for JobConnect team to engage with current and potential members and support recruitment within targeted geographical communities. ▪ Provide research and analysis on the unique needs, challenges, strengths, and resources within a community to allow JobConnect to best serve members, and make strategic recommendations to leadership accordingly. ▪ Keep leadership informed of community partnership statuses and opportunities for relationship enhancement. ▪ Understand, gather, and utilize data as it applies to targeted geographic regions that are being served within the JobConnect program. ▪ Serve as a primary contact person for JobConnect in targeted geographical communities, as needed.
Minimum Experience Required: ▪ Bachelor's degree in public administration, political science, urban affairs, social work, or related field, or equivalent years of relevant work experience is required. ▪ Minimum of three (3) years of community development experience is required. ▪ Previous experience in working with Medicaid population is preferred.
Skills Required: ▪ Basic computer skills. ▪ Strong collaborative skills, working with cross-functional stakeholders and external partners including community partners and business leaders. ▪ Communication skills. ▪ Ability to work independently and within a team environment. ▪ Attention to detail. ▪ Familiarity of asset based community development. ▪ Proper grammar usage. ▪ Time management skills.

▪ Proper phone etiquette. ▪ Customer service oriented. ▪ Decision making/problem solving skills.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's degree in public administration, political science, urban affairs, social work, or related field, or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: Compliance Officer
Description of Position: The Director, Mississippi Plan Compliance Officer is responsible for ensuring and documenting Mississippi has an effective ethics and compliance program including prevention, detection, and correction activities.
Description of Responsibilities of Position: ▪ Serves as the market Compliance Officer. ▪ Direct reporting relationship to the Corporate Compliance Officer and a strong dotted line reporting relationship to the Plan President. ▪ Accountable for drafting at least quarterly status reports for the Corporate Compliance Officer. ▪ Provide strategic leadership to ensure organizational compliance with federal, state, CMS and applicable regulatory and accreditation requirements. ▪ Ensure that regulatory requirements impacting products offered in Mississippi are tracked and implemented in a timely manner utilizing the process and forms prescribed by the corporate Regulatory team. ▪ Work with the business, Regulatory, and Legal to help ensure proper interpretation and implementation of such laws, regulations, guidance, contracts, and similar regulatory requirements (collectively "laws"). ▪ Provide review and input on proposed laws. As appropriate, serve as an advocate and build goodwill and trust with regulators. ▪ Ensure appropriate reporting is created, maintained, and provided to the Corporate Compliance Officer, senior leadership, and as necessary the Risk Committee of the Board to document compliance. ▪ Serve as the primary point of contact with state regulators (e.g., Medicaid and Marketplace) for all Compliance issues. ▪ Establish and maintain positive working relationships with state regulators, drive internal functional area accountability for timely and accurate regulatory submissions. ▪ Monitor and review regulatory and legislative requirements and changes; respond to regulator requests, audits, and investigations; communicate and implement regulatory requirements; and follow-up with appropriate areas to ensure required changes are effectively implemented. ▪ Ensure direct line leadership and the Corporate Compliance Officer are informed of all material regulatory initiatives, compliance concerns, operational issues, and associated corrective actions/remediation impacting CareSource. ▪ Align, oversee, and maintain Mississippi compliance and regulatory operations in accordance with agreed upon best practices and corporate standards. Actively participate in Corporate Compliance hosted meetings to identify and implement best practices and templates. ▪ Develop, implement, and oversee an annual compliance monitoring program utilizing a risk-based approach. Ensure the plan is developed in coordination with and consultation with Internal Audit. Develop reporting utilizing corporate templates and protocol. ▪ Ensure that all elements of an effective compliance program are in place and working effectively.

- Oversee the risk assessment and mitigation process for compliance issues. Ensure the risk process is developed in coordination with and consultation with the Enterprise Risk Management team. Develop reporting utilizing corporate templates and protocol.
- Ensure staff and leadership training of regulatory and government contracts requirements are completed within the timeframes outlined in the Company's Standards of Conduct.
- Serve on designated external and internal committees to represent regulatory and contractual requirements.
- Assist business partners in interpreting audit findings, preparing and completing audit responses, and developing corrective actions.
- Manage, coordinate, and lead organizational participation in state and EQRO regulatory audits, site visits and other regulatory audits. Utilize Corporate defined forms and protocol where available and appropriate.
- Create and maintain compliance related dashboards, including health plan compliance plan objectives, projects, timelines, and deliverables for all federal and state, analyzing and trending data to evaluate performance.
- Staff the Mississippi Market Compliance Committee and support reporting to the Corporate Compliance Committee or Corporate Compliance Officer, and as appropriate the Risk Committee of the Board.
- Partner with the Corporate Privacy Officer to ensure a comprehensive and effective HIPAA Privacy compliance program is in place to meet federal, state, and accreditation requirements.
- Provide management and strategic direction for compliance program staff in Mississippi.

Minimum Experience Required:

- Bachelor's degree in business/healthcare administration or a related discipline, or equivalent years of relevant work experience are required.
- Master of Business Administration (MBA), Juris Doctorate, or other advanced degree, is preferred.
- A minimum of five (5) years of relevant work experience within health plan operations is required, with at least three (3) years directly involved in government programs or managed care compliance activities preferred.
- Established relationships with the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), state Departments of Insurance and/or state Medicaid Departments is preferred.

Skills Required:

- Basic proficiency with computer skills, including MS Office suite.
- Ability to motivate, influence, and lead matrixed and cross-functional teams.
- Excellent relationship management skills that will build and maintain strong working relationships in a matrix environment and influence action across the organization around risk management.
- Excellent oral and written communication skills.
- Ability to effectively interact with all levels of management within the organization and across multiple organizational layers.
- Excellent analysis, attention to detail, and collaboration skills.
- Ability to deal with ambiguity – integrate, prioritize, and roll out programs without clearly defined guidelines.

- Knowledge of regulatory environment and regulators (CMS/HHS/DOI/Medicaid).

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in business/healthcare administration or a related discipline, or equivalent years of relevant work experience are required.
- Master of Business Administration (MBA), Juris Doctorate, or other advanced degree, is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified in Healthcare Compliance (CHC) preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Data Analyst

Description of Position:
The Data Analyst is responsible for performing analysis of all data into, out of and within the organization in support of Data Warehousing efforts.

Description of Responsibilities of Position:

- Perform analysis of all data into, out of, and within the enterprise in support of Data Warehousing efforts.
- Identify and quantify data issues within the organization and assist in the development plans to resolve data issues.
- Support regular data management processes and ad hoc user requests.
- Monitor the quality of data submitted external to the organization including to regulatory agencies.
- Support the verification of data accuracy within analytic systems and source systems.
- Support the maintenance of the analytic systems data dictionaries.
- Develop, document, and perform testing and validation.
- Assist in Extract/Transform/Load (ETL) development, documentation. and testing.
- Work with subject matter experts to develop business rules that support the transformation of data and facilitate discussions between users and modelers.
- Set day-to-day objectives and deliver job responsibilities that may vary outside typical norms or practices. Work consists of tasks that are occasionally not routine. Often required to work independently and to apply discretion within established operational boundaries and procedures.
- Problems and issues faced are occasionally vague, and may need some analysis to understand. Make adjustments to work methods to solve problems that may not be immediately evident in existing work processes and systems. However, may have references or help from norms and/or standard procedures to solve these problems.

Minimum Experience Required:

- Bachelor's degree or equivalent years of relevant work experience required.
- Minimum of three (3) years of experience in data analysis or equivalent analytic experience.
- Experience in data mapping preferred.
- Healthcare experience preferred.

Skills Required:

- Proven understanding of database relationships.
- Proven programming skills with emphasis on mining/manipulation.
- Advanced Microsoft Excel and/or Access skills.
- Flexibility during organizational and/or business changes.
- Effective problem-solving skills with attention to detail.
- Ability to develop, prioritize, and accomplish goals.
- Strong interpersonal skills including excellent written and verbal communication, listening, and critical thinking skills.
- Ability to effectively prioritize and execute tasks while working both independently and in a team-oriented, collaborative environment.
- Customer service oriented.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's degree or equivalent years of relevant work experience 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: N/A

Key Position: Job Description

Title of Position: Data and Analytics Manager

Description of Position:
The Data and Analytics Manager reviews and analyzes the effectiveness and efficiency of existing market operation processes and systems, participates in development of solutions to improve or further leverage these functions, supports all business units directly in market and competitive intelligence, and provides oversight of employees within assigned team.

Description of Responsibilities of Position:

- Manage new market operation initiatives from concept to implementation and provide statistics measuring progress throughout.
- Perform cost-benefit and return on investment analyses for proposed initiatives to aid in the decision-making process; collect and analyze data in support of business case creation and realization.
- Ensure operational effectiveness by assisting in the development of strategic plans for community engagement, population health, and network development.
- Conduct analysis in support of market operations and manage scope and expected outcomes across the market to HPLC's strategic initiatives and process improvements.
- Research new products and/or markets and provide analysis to senior leadership.
- Support sales and market research needs.
- Collect and analyze competitive information for all products/markets.
- Collaborate with functional areas to help define system requirements.
- Develop the strategic direction of member benefits across all states and product lines.
- Ensure compliance with member benefit regulations across all product lines (Essential Health Benefits, State Provider agreements, CMS requirements, Mental Health Parity, etc.).
- Design and implement the development and execution of test plans and scenarios for all benefit or reimbursement designs.
- Audit configuration to ensure accuracy and tight internal controls to minimize fraud and abuse and overpayment related issues.
- Perform research and build presentation of findings in a format digestible by executive management.
- Develop and manage the procurement, reporting, and analysis of competitors rates, membership and market surveys, and benefits files.
- Assist with the reporting and analysis on the results of various marketing activities.
- Assume a leading role in the review of reports and data for pattern identification, special cause variation identification, trend analysis, or other techniques; prepare and deliver summaries, recommendations, or alternatives of the analyzed information.
- Daily, weekly, and monthly LOB reporting – varies by product and need.
- Collect and analyze competitive information for all products/markets.
- Provide oversight of employees within assigned team.

Minimum Experience Required:

- Bachelor's degree in marketing or related business field or equivalent years of relevant work experience is required.
- Minimum of ten (10) years of involved market research analysis experience and/or configuration experience is required, preferably in the healthcare market.

- Business experience in a matrix organization is preferred.
- Managed care or healthcare experience is preferred.
- Experience with insurance rates and benefits files preferred.

Skills Required:

- Expert proficiency in MS Office Suite.
- Experiencing using market research and competitive intelligence software and BI Software.
- Understanding of DRG and APC reimbursement methods preferred.
- Understanding of CPT, HCPCs, and ICD-CM Codes preferred.
- Ability to analyze, discover root cause analysis, and create reporting of results.
- Ability to present data in a visual way to facilitate a fast understanding.
- Ability to communicate results in a meaningful way that tells the complete story.
- Strong interpersonal skills and high level of professionalism.
- Data analysis and trending skills.
- Knowledge of the healthcare field and knowledge of Medicaid and Medicare a plus.
- Facets knowledge/training preferred.
- Critical listening and thinking skills.
- Time management skills.
- Decision making/problem solving skills.
- Strong interpersonal skills and high level of professionalism.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in marketing or related business field or equivalent years of relevant work experience is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- AAPC Coding designation preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Data Compliance Manager

Description of Position:
The Data Compliance Manager oversees ethics, the development and maintenance of compliance technology, and reporting to meet the day-to-day activities and information needs of the compliance organization.

Description of Responsibilities of Position:

- Responsible for onboarding, training, and development of Compliance technology and reporting staff.
- Lead development, design, and maintenance of technology solutions and workflows to support ethics and compliance processes.
- Lead development of routine operational/analytical reports for management of compliance processes and functions as needed.
- Provide subject matter expertise (SME) on technology and reporting projects impacting the compliance organization.
- Work with business areas to identify and implement opportunities for improvement that impact compliance through the delivery of appropriate reporting and data.
- Identify and resolve data quality issues within compliance tools and reporting.
- Develop and utilize reports to analyze and stratify ethics and compliance data in response to requests and issues within the compliance organization or by other departments.
- Incorporate critical thinking skills and judgment in the process to determine best course of action for each inquiry/problem.
- Collaborate with compliance leadership to communicated technology and reporting opportunities based data and stakeholder feedback.
- Represent the compliance department in project meetings and other meetings that require subject matter knowledge and input.

Minimum Experience Required:

- Bachelor's degree or equivalent years of relevant work experience is required.
- Minimum of five (5) years of experience in data analytics.
- Healthcare and/or compliance experience is preferred.

Skills Required:

- Understanding of database relationships.
- Advanced Microsoft Excel, Power Query, Power Pivot, Formula Development skills.
- SharePoint development (Flow and PowerApps) skills.
- Knowledge of working with Power BI and ServiceNow.
- Graphic development/presentation skills.
- Critical listening and thinking skills.
- Decision making/problem solving skills.
- Communication skills both written and verbal.
- Ability to work independently and within a team environment.
- Knowledge of managed care preferred.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's degree or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description

Title of Position: Data Liaison

Description of Position:
The Data Liaison is responsible for creating and leading a seamless ability for business partners to leverage the services and expertise of the technology organization to obtain the solutions necessary to ensure success.

Description of Responsibilities of Position:

- Be the initial point of contact for business partners to engage the technology organization and provide leadership for the engagement (bringing technology and the business together) and enhance the relationship.
- Manage the expectations of business partners.
- Represent IT in project and/or business meetings and engagements.
- Provide technical leadership and guidance to Enterprise.
- Assess, analyze, and identify impacted teams and manage engagement of those teams.
- Understand the business interest in order to be a partner for the requestor to guide impacted technology teams and external vendors.
- Facilitate the communication and understanding of high level business needs between business areas and within technology amongst peers, managers, directors, and executive level.
- Understand the overarching business model as well as the intricacies and nuances of the functional business areas.
- Collaborate with architecture to ensure initiatives align with and support the overall architecture goals.
- Understand the role of technology and technology innovation in business areas to flesh out competitiveness-enhancing initiatives.
- Provide analytics of business engagement to Senior Technology Leadership.
- Define requirements for management information dashboards.

Minimum Experience Required:

- Bachelor's degree in or equivalent years of relevant work experience is required.
- Minimum of seven (7) years of business relationship management experience is required.
- Experience developing and managing relationships with key business stakeholders and business leaders is required.
- Experience with general IT applications and infrastructure environment, engineering systems, customer facing solutions (E-Commerce, Mobility, end user platforms), HRIS, data warehouse is required.

Skills Required:

- Proven ability to effectively interact, develop relationships, and collaborate with key client stakeholders in all levels within the organization.
- Effective written and verbal communication skills with demonstrated ability to explain technical information to non-technical people and non-technical information to technical people.
- Propose ideas and actions that gain acceptance from peers, managers, directors, and executive management.
- Proven business acumen that leads to positive results.

- Ability to manage competing priorities and adapt to a fast-paced environment.
- Ability to work independently and within a team environment.
- Ability to develop, prioritize, and accomplish goals.
- Excellent listening and critical thinking skills.
- Strong problem solving skills with attention to detail.
- Strong interpersonal skills and high level of professionalism.
- Gains understanding of business strategies.
- Intermediate to advanced proficiency with Microsoft Office to include Word, Excel, PowerPoint, and SharePoint.
- Presentation and analytical skills.
- Stays abreast of industry trends in business and technology.
- Project management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in or equivalent years of relevant work experience is 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: N/A

SKey Position: Job Description

Title of Position: Dietician

Description of Position:
Facilitates behavioral change to prevent or restore health for individuals and groups through educational counseling, skill development, and promoting attitudes conducive to weight management and healthy eating.

Description of Responsibilities of Position:

- Assess and identify risk, needs, and challenges related to health, eating, and nutrition.
- Provide assessment of nutritional and health needs and diagnose nutritional impact to medical conditions and treatment through medical nutritional therapy.
- Design diets to treat medical conditions and counsel members on nutrition; develop and implement plan to address health eating habits, meal planning, and nutrition plan; and promote health eating habits with balanced lifestyle.

Minimum Experience Required:

- Bachelors degree (up to one year of post degree work approved by ADA and or internship).
- Current license from Mississippi board of dietetics and current registered dietitian or registry eligible from American Dietic Association.
- One year of experience as a dietician.
- Experience with community designed program for population health and/or experience with diabetic and obesity program design preferred.

Skills Required:

- Intermediate proficiency level with Microsoft Office, including Outlook, Word and Excel.
- Ability to communicate effectively with a diverse group of individuals.
- Ability to multi-task and work independently within a team environment.
- Adhere to code of ethics that aligns with professional practice.
- Strong advocate for members at all levels of care.
- Strong understanding and respect of all cultures and demographic diversity.
- Ability to interpret and implement current research findings .
- Awareness of community and state support resources.
- Critical listening and thinking skills.
- Decision making and problem solving skills.
- Strong organizational and time management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelors degree (up to one year of post degree work approved by ADA and or internship).

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current license from Mississippi board of dietetics and current registered dietitian or registry eligible from American Dietic Association.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Director, Health Equity
Description of Position: The Director, Health Equity provides leadership and oversight of all SDOH and Health Equity activities occurring in Mississippi.
Description of Responsibilities of Position: ▪ Inform decision-making around best payer practices related to disparity reductions, including the provision of health equity and social determinant of health resources and research to leadership and programmatic areas. ▪ Inform decision-making regarding best payer practices related to disparity reductions, including providing teams with relevant and applicable resources and research and ensuring that the perspectives of members with disparate outcomes are incorporated into the tailoring of intervention strategies. ▪ Collaborate with the Chief Information Officer to ensure we collect and meaningfully uses race, ethnicity, and language data to identify disparities. ▪ Coordinate and collaborate with members, providers, local and state government, community-based organizations, and other managed care entities to impact health disparities at a population level. ▪ Ensure that efforts addressed at improving health equity, reducing disparities, and improving cultural competence are designed collaboratively with other contracted managed care entities to have a collective impact for the population and that lessons learned are incorporated into future decision-making.
Minimum Experience Required: ▪ Bachelor's degree or equivalent years of relevant work experience is required. ▪ Masters of Business Administration is preferred. ▪ A minimum of ten (10) years of experience in health care external stakeholder and community program development, project and program management; complex business processes, strategic and business planning or related is required. ▪ Prior management experience is required.
Skills Required: ▪ Proficient in Microsoft Excel, Word, PowerPoint and Excel. ▪ Critical listening and systematic thinking skills. ▪ Planning, problem identification and resolution skills. ▪ Business process/management skills. ▪ Ability to maintain confidentiality and act in the company's best interest. ▪ Strong oral, written, and interpersonal communication skills. ▪ Excellent leadership, management and supervisory skills and experience. ▪ Energetic, enthusiastic, and politically astute. ▪ Ability to act with diplomacy and sensitivity to cultural diversity. ▪ Responsive to a changing environment. ▪ Strategic deployment and management skills. ▪ Conflict resolution skills. ▪ Knowledge of regulatory reporting and compliance requirements. ▪ Proficiency with quality improvement, performance improvement and operations. ▪ Ability to work with multi-disciplinary departments across the organization.

- Demonstrated ability to develop, prioritize and accomplish goals.
- Strong interpersonal skills and high level of professionalism.
- Ability to work independently and within a team environment.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree or equivalent years of relevant work experience is required.
- Masters of Business Administration is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified Professional in Healthcare Quality (CPHQ) is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Director of Enrollment

Description of Position:
Provide leadership and direction to the Enrollment team to ensure goals and standards of the department, and organization are met.

Description of Responsibilities of Position:

- Manage daily enrollment operations and projects through effective allocation of resources.
- Responsible for hiring, training, coaching, and developing direct reports including completing performance appraisals and disciplinary actions.
- Mentor managers, team leads and individual contributors to produce consistent, high-quality deliverables.
- Challenge the status quo and propose improvements in processes for higher efficiency and effectiveness.
- Fully understand enrollment end-to-end processes and be able to comprehend impact of enrollment issues on various departments.
- Accountable for quality of outputs and operational efficiency of the team.
- Accountable for the member enrollment, financial reconciliation and vendor reconciliations for assigned lines of business.
- Accountable for complying with and meeting all regulatory requirements assigned to the enrollment team.
- Manage enrollment technology and process analysts and associated activities involving 834 file processes and departmental policies and procedures.
- Accountable for all enrollment audit engagements to ensure accurate and timely response. As necessary, develop and implement corrective action plans to address audit results.
- Accountable for ensuring that all internal enrollment and external SLAs are met for enrollment exceptions including requests from other departments.
- Establish, monitor, and enforce enrollment policies and procedures and internal controls.
- Accountable for researching existing and new legislative changes in enrollment requirements and ensure compliant.

Minimum Experience Required:

- Bachelor degree in accounting, finance, healthcare management or related field or equivalent years of work experience is required.
- Master of Business Administration (MBA) or other related post-graduate degree is preferred.
- Minimum of seven (7) or more years of leadership and management experience is required.
- Minimum of five (5) years of business operations or similar experience is required, preferably in a health care environment.
- Medicaid managed care, Medicare Advantage, or other healthcare experience is preferred.

Skills Required:

- Extensive knowledge of operational processes, preferably with a healthcare company.
- Strong knowledge of compliance, audit and regulatory framework and managing internal and external controls.
- Able to create long term strategy for enrollment and develop short/medium term initiatives for implementation.
- Ability to manage competing priorities, demands, and timelines through analytical and problem-solving capabilities.

- Strong leadership skills and able to direct the work of others including development, motivation and rewarding of staff.
- Adept at conducting research into operational issues and conformable with managing crisis-like situations.
- Wide degree of creativity and latitude (independent judgment).
- Possesses problem solving, critical listening/thinking skills.
- Ability to interact with all levels of management.
- Advanced computer skills, including proficiency with Microsoft Office suite; ability to learn new technologies quickly.
- Advanced interpersonal, written, and oral communication skills and organization change management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor degree in accounting, finance, healthcare management or related field or equivalent years of work experience is required.
- Master of Business Administration (MBA) or other related post-graduate degree is preferred.

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: N/A

Key Position: Job Description
Title of Position: Director, SDoH & Community Partnerships
Description of Position: Provides leadership and oversight of all SDoH activities, strategic partnership and SDoH staff including Life Coaches, Housing Strategy Lead, Community Partner and Employer Partner Specialist.
Description of Responsibilities of Position: ▪ Direct the development, implementation, and evaluation of Social Determinant of Health (SDoH) processes and workflows into all population health programs to improve member health and wellness. ▪ Identify and prioritize the development of scalable, evidence based SDoH-focused programming and standardized interventions tailored to the communities we serve. ▪ Oversee the development of key partnerships with external agencies, retailers, and consumer advocacy coalitions and other external stakeholders. ▪ Serve as trusted advisor to market and enterprise leaders to optimize throughput, and ensure the delivery of SDoH projects/enhancements that maintain operational stability. ▪ Ensure internal and external stakeholders receive education on newly identified SDoH data streams and/or programs. ▪ Integrate continuous improvement and innovation into all projects and enhancements. ▪ Monitor and research emerging industry, policy, regulatory, and accreditation changes for analysis and integration into the corporate business development plan. ▪ Participate in the development of key partnerships with external agencies, associations and consumer advocacy coalitions and other external stakeholders. ▪ Serve as an organizational ambassador in representing SDoH inclusion. ▪ Participate in local, state, and national meetings and discussions specific to SDoH and Population Health providing and receiving input on behalf of CareSource and ensuring identification of new SDoH data streams. ▪ Assist with development of newly required programming and interventions associated with the procurement of new business.
Minimum Experience Required: ▪ Bachelor's degree in Social Work, Public Health, Organizational Leadership or related field or equivalent years of relevant work experience is required. ▪ Master's degree in related field is preferred. ▪ A minimum of five (5) years of population health and/or social services experience is required. ▪ A minimum of five (5) years of management experience is required. ▪ Previous managed care experience is required. ▪ SDoH integration experience preferred.
Skills Required: ▪ Demonstrated understanding of food programs including development and operations required. ▪ Ability to manage and prioritize multiple tasks, promote teamwork and fact-based decision making. ▪ Business acumen and strategic thinking, yet able to execute tactically. ▪ Demonstrated ability to adjust to shift priorities, multi-task, work under pressure and meet deadlines. ▪ Proven ability to recognize opportunity for improvement and lead change. ▪ Excellent leadership and communication skills, with ability to effectively manage a high performing team, and provide coaching and development. ▪ Strong collaborative skills, working with cross-functional stakeholders and external partners.

- Population health, disease management and wellness program knowledge.
- Basic level skills utilizing Microsoft Word, Excel, and PowerPoint; intermediate Microsoft Office skills preferred.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in Social Work, Public Health, Organizational Leadership or related field or equivalent years of relevant work experience is required.
- Master's degree in related field is preferred.

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: N/A

Key Position: Job Description
Title of Position: EDIFECS Configuration
Description of Position: The EDIFECS Configuration role is focused on implementing Edifecs' Encounter Management solutions.
Description of Responsibilities of Position: ▪ Installing, configuring, and overseeing the implementation of Edifecs' Encounter Management product. ▪ Configuration and development of programs, tasks, and guidelines. ▪ Implement Edifecs.
Minimum Experience Required: ▪ Bachelor's degree, or equivalent years of experience, in Computer Science, Computer Applications, Information Technology, or related field. ▪ 4 years of experience as an Implementation Consultant, Software Developer, or related occupation.
Skills Required: ▪ Experience developing and deploying Java or Middleware based applications using at least one technology such as IBM Websphere, TIBCO Business works, Oracle web logic, Oracle Glassfish, Oracle JCaps, or related technologies; ▪ Experience using software life-cycle methodologies such as waterfall, agile-scrum in developing products and IT applications. ▪ Experience using software engineering tools for configuration management, defect tracking, unit testing, build and deployment; and ▪ Experience with Electronic Data Interchange (EDI) mapping, and EDI analysis.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's degree, or equivalent years of experience, in Computer Science, Computer Applications, Information Technology, 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: N/A

Key Position: Job Description

Title of Position: Employer Specialist

Description of Position:
The Employer Specialist fosters relationships with key employers and educators throughout Mississippi to ensure a robust network of educational and employment opportunities for our members enrolled in our Life Services program.

Description of Responsibilities of Position:

- Provides support to Life Services Leadership in managing the long-term relationships with employers in assigned market.
- Maintains working relationships with the Human Resources departments of area employers who are interested in hiring Life Services members.
- Maintains regular contact with employers once a member is referred, interviewed, and hired.
- Provides feedback to Life Coaches on the hiring process and overall experience of Life Services members.
- Provide proactive, high-level support in order to drive the overall satisfaction and engagement of key community employers/partners.
- Provide contact point for Life Services employers/partners.
- Seek and create contacts with these partners to address any issues with Life Services candidates and find resolutions.
- Visit employers in the region on a quarterly basis or as needed to continue to deepen the relationship.
- Keep management informed of employer status & opportunities for relationship enhancement.
- Identify internal procedures that adversely affect employer satisfaction and work with internal areas to build consensus to initiate improvements.
- Support recruitment efforts by developing strong interpersonal relationships with employers.
- Ensure timelines and follow up of onboarding process are occurring in timely manner.
- Understand, gather, and utilize data as it applies to employer development.

Minimum Experience Required:

- Bachelor's Degree in Business Administration, Healthcare Administration or related field, or equivalent years of relevant work experience is required.
- Minimum of three (3) years of Human Resources experience is required.
- Previous experience in Workforce Development is preferred.
- Previous experience in working with Medicaid population is preferred.

Skills Required:

- Basic computer skills.
- Strong collaborative skills, working with cross-functional stakeholders and external partners including community partners and business leaders.
- Communication skills.
- Ability to work independently and within a team environment.
- Attention to detail.
- Familiarity of economic development and workforce development.
- Proper grammar usage.
- Time management skills.
- Proper phone etiquette.
- Customer service oriented.
- Decision making/problem solving skills.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's Degree in Business Administration, Healthcare Administration or related field, or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description

Title of Position: Encounters Team Lead

Description of Position:

The Encounters Team Lead is responsible for day-to-day activities surrounding the knowledge and insight for Encounter Submissions and critical issues impacting Encounter Submissions.

Description of Responsibilities of Position:

- Responsible for day-to-day activities surrounding the knowledge and insight for Encounter Submissions and critical issues impacting Encounter Submissions.
- Understand the financial and clinical impact of changes and decisions to the business process to ensure that the Service Level Agreements (SLAs) are achieved.
- Guide and direct successful completion of daily tasks. Responsible for onboarding, training, and development of staff.
- Prioritize all work, requests and activities. Escalate any area of significant issues or risk with recommendation for resolution.
- Recommend changes or modify solutions as necessary to implement enhancements, resolve issues, or improve operational efficiency.
- Track issues and status to ensure proper follow-up, coordination with business area and provide solutions.
- Update management on projects/initiatives the Claims Encounters team is involved with and coordinate any needed changes with manager.
- Monitor and communicate Corporate & Market management with Encounter oversight metrics and reports as required.
- Identify and communicate root cause of issues and appropriate proactive resolution to reduce Encounter issues preventing submissions in the future.
- Ensure controls, communication and approvals are followed prior to system implementation.
- Provide support of vendors, managing SLA’s, regulatory/compliance requirements and contractual metrics conducted by the team. Ensure timely responses and resolution.
- Assist in auditing system and process to ensure accuracy and internal controls are in place to minimize any business issues, financial penalties, and sanctions from State and Federal agencies.

Minimum Experience Required:

- Associates Degree or equivalent years of relevant work experience is required.
- Minimum of three (3) years of health plan business or systems solutions experience is required.
- Exposure to Facets or equivalent system is preferred.
- Prior supervisory experience is preferred.

Skills Required:

- Advanced proficiency in Microsoft Suite to include Word, Excel, and Access.
- Edifecs and Encounters knowledge is preferred.
- Data trending and data analysis skills.
- High level of programming and systems development knowledge.
- Effective identification of business problems, assessment of proposed solutions to those problems, and understanding of the needs of business partners.

- Demonstrated ability to successfully define a portfolio of initiatives including business requirements gathering, definition/prioritization, project scope definition, project staffing requirements, application configuration, testing approach, training, documentation, reporting strategy, and change management process.
- Knowledge of regulatory reporting and compliance requirements.
- Excellent listening and critical thinking skills.
- Effective problem-solving skills with attention to detail.
- Excellent written and verbal communication skills.
- Ability to work independently and within a team environment.
- Strong interpersonal skills and high level of professionalism.
- Ability to develop, prioritize and accomplish goals.
- Experience with claims processing skills is preferred.
- Advanced knowledge of coding and billing processes, including CPT, ICD-9, ICD-10 and HCPCS coding.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Associates Degree or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: Encounters System Analyst
Description of Position: The Encounters System Analyst is responsible for compiling and analyzing Encounters data and understanding the financial and clinical impact of changes and decision to the business process to ensure that Service Level Agreements are achieved.
Description of Responsibilities of Position: ▪ Compile and analyze Encounter data. Understand the financial and clinical impact of changes and decisions to the business process to ensure that the Service Level Agreements (SLAs) are achieved. ▪ Provide analytical support and leadership for Claims Encounters Regulatory Data projects. ▪ Responsible for reviewing Encounter rejections and providing resolution of minor to complex data issues or process changes. ▪ Provide Claims Encounter Subject Matter Expertise (SME) for State agencies and internal impacted organizations (IT, Claims, New Business, Enrollment, etc.). ▪ Build, sustain and leverage relationships with persons within his/her responsibility to constantly allow for continuous improvement of the Encounter Data business process. ▪ Direct responsibility for the design, testing and delivery of supporting processes to the business. ▪ Lead the claims data processes to ensure accuracy and compliance with state agencies. ▪ Provide support for other key claims data management and readiness to state and governing entities. ▪ Understand the Claims Encounter Data requirements in detail to enable one to lead efforts to ensure claims data submissions achieve the required SLAs through requested changes internally and externally. ▪ Recognize inconsistencies and gaps to improve productivity, accuracy and data usability and streamlining procedures and policies. ▪ Responsible for Claims Encounters regulatory reporting. ▪ Provide critical reporting and analysis of functional performance, and make recommendations for enhancements, cost savings initiatives and process improvements. ▪ Prepare and monitor various management and oversight metrics and reports as required. ▪ Lead Claims Encounter initiatives such as working with IT and others internal departments to automate Claims Encounters functions; improve regulatory report development with SIS. ▪ Provide support of vendors, managing SLA's, regulatory requirements, and contractual metrics. ▪ Maintain positive and strategic relationships with internal and external stakeholders. ▪ Contribute to and/or develop user stories or provide user story guidance for sprint planning. ▪ Understanding of how claims payment methodologies, adjudication processing and State Encounter regulations interrelate to maintain compliant Encounter reconciliation processes and SLA's.
Minimum Experience Required: ▪ Bachelor's degree or equivalent years of relevant work experience is required. ▪ Minimum of five (5) years of managed healthcare, claims, or managed care regulated environment experience is required.

Skills Required:

- Knowledge of relational databases (SQL Server, Oracle, etc.).
- Experience with SQL Server - 2016 or newer.
- Strong database querying, data analysis and trending skills.
- Edifecs knowledge is desired.
- Demonstrated understanding of claims operations specifically related encounters.
- Advanced knowledge of coding and billing processes, including CPT, ICD-9, ICD-10 and HCPCS coding.
- Knowledge of Claims IT processes/systems.
- Knowledge of claims analytic processes/systems.
- Advanced working knowledge of managed care and health claims processing and reimbursement methodologies.
- Experience with 837O files to States and/or CMS (MA EDS) preferred.
- Experience with 835 files preferred.
- Excellent communication skills; both written and verbal.
- Ability to work independently and within a team environment.
- Time management skills; capable of multi-tasking and prioritizing work.
- Attention to detail.
- Critical thinking and listening skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: Enrollment Production System Analyst
Description of Position: The Enrollment Production System Analyst is responsible for providing technical and analytical support and leadership for key production-related activities and projects within Business Partner Operations (BPO).
Description of Responsibilities of Position: ▪ Collaborate daily with business owners and vendors to facilitate production processes and issue resolution. ▪ Conduct ad-hoc analysis pulling data from multiple sources including historical performance trends / benchmarking. ▪ Develop department-based business systems to support production-related business processes and drive process and operational improvements through effective use of technology solutions. ▪ Gather and analyze data, define, and document business requirements, recommend technology requirements, review functional specs, and test systems. ▪ Serve as expert in multiple production-related data and data sources, including print production, membership and member materials extracts, and all proprietary files supported by the Enrollment, Print Production and eBusiness Department. ▪ Review and analyze the effectiveness and efficiency of existing processes and systems and participate in development of solutions to improve or further leverage these functions. ▪ Perform cost-benefit and return on investment analyses for proposed initiatives to aid decision-making process as well as collect and analyze data in support of business case creation and realization. ▪ Provides ongoing analysis and interpretation of production-related statistics to identify issues and recommend operational improvements. ▪ Develop, document, and perform testing and validation as needed.
Minimum Experience Required: ▪ Bachelor of Science degree in MIS or Business Analysis or equivalent work experience is required. ▪ Minimum of three (3) years of health care operations experience in insurance, managed care, or related industry is preferred. ▪ Experience working with mailing databases and print fulfillment vendors a plus.
Skills Required: ▪ Intermediate level skill in Microsoft Word, Excel, PowerPoint. ▪ Basic troubleshooting and problem-solving capabilities, able to solve moderately complex problems. ▪ Knowledge of sequel and relational databases preferred. ▪ Skill documenting business requirements for IT systems or applications. ▪ Working knowledge of relevant CareSource systems/technologies. ▪ Knowledge of regulatory reporting and compliance requirements. ▪ Demonstrates excellent analysis and collaboration skills. ▪ Demonstrated communication (verbal and written), facilitation and presentation skills. ▪ Effective time management and prioritization skills. ▪ Decision making and problem-solving skills.

▪ Exceptional attention to detail.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor of Science degree in MIS or Business Analysis or equivalent work experience is required.
Are any professional licenses or certifications required for this position? [X] Yes [ ] No **If yes, list below:** ▪ Six Sigma or other performance improvement experience is preferred.
Are there any continuing education requirements for this position? [ ] Yes [X] No **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Enrollment Specialist

Description of Position:
The Enrollment Specialist is responsible for reviewing files and interpreting data to enter members into eligibility systems according to appropriate regulatory guidelines.

Description of Responsibilities of Position:

- Process work items according to appropriate regulatory guidelines.
- Review files and interpret the data to enter members into eligibility systems.
- Completion of daily change file pre-processor exceptions and monthly full file pre-processor exceptions.
- Research member eligibility and take appropriate actions to resolve issues across all eligibility systems.
- Process mass Primary Care Physician (PCP) changes with Provider Operations.
- Research, review, and interpret eligibility data to respond to eligibility inquiries from contracted vendors.
- Access state and federal government systems to review and confirm eligibility status.
- Process paper applications received for all applicable lines of business.
- Inbound phone coverage to answer inquiries from both internal and external customers.
- Complete all required corporate training within stated timelines to a satisfactory manner.

Minimum Experience Required:

- High School Diploma or equivalent required.
- Associate's degree in accounting, finance or business-related field or equivalent work experience is preferred.
- Minimum of two (2) years of healthcare, insurance, or related industry experience to include at least one (1) year of enrollment/eligibility or similar experience is required.

Skills Required:

- Familiarity with Microsoft Word and Excel.
- Excellent verbal and written communication skills.
- Ability to work independently and within a team environment.
- Attention to detail.
- Familiarity of the healthcare field.
- Knowledge of Medicaid and Medicare preferred.
- Critical listening and thinking skills.
- Proper grammar usage.
- Time management skills.
- Proper phone etiquette.
- Customer service oriented.
- Decision making/problem solving.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- High School Diploma or equivalent required.
- Associate's degree in accounting, finance or business-related field or equivalent work experience is preferred.

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: N/A

Key Position: Job Description

Title of Position: EPSDT Coordinator

Description of Position:

The EPSDT Coordinator provides specific assigned outreach related to improving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) compliance.

Description of Responsibilities of Position:

- Responsible for outreach for EPSDT health checks and must maintain appropriate documentation according to policies, procedures and regulatory guidelines
- Engage providers, schools and child development centers on the EPSDT program and the importance of developmental screenings
- Make initial contact with new members telephonically to educate on the EPSDT benefit within established time frame and guidelines
- Verify eligibility, enrollment history, demographic data, primary care physician, and current health status of members
- Assist in education of members regarding health conditions, available benefits and providers, plan services and EPSDT special services available, according to established policies and procedures
- Assist members to locate providers and make appointments
- Accurately complete and maintain documentation related to member interaction, assessment(s), and demographic data
- Create and maintain a system to accurately and timely follow up with members regarding future appointments
- Establish relationships with members, providers, and internal personnel
- Accurately create and maintain reports, as needed
- Respond to, forward and return calls as appropriate from members, providers, medical facilities, and staff
- In collaboration with the care management departmental staff, assist in short and long-term outreach programs for member population
- Collaborate with the Quality and care management teams to develop and implement projects related to improving health outcomes for the membership
- Assist with completing various components of specific projects related to outreach to members and providers on specific health outcomes
- Identify and organize project communications to ensure consistency with business objectives
- Assess, prioritize, and mitigate project risks
- Track project milestones and deliverables and communicate status
- Provide general administrative support for the Accreditation and Quality team

Minimum Experience Required:

- High school diploma or general equivalency degree (GED) is required
- Associate’s degree or other formal medical education/certification is preferred
- Minimum of two (2) years of managed care experience is required
- Previous case management experience is preferred

- Previous experience with Medicaid managed care is required

Skills Required:

- Intermediate proficiency level with Microsoft Office
- Customer service oriented
- Knowledge of medical terminology is required
- Ability to gather work related information and coordinate workflow and assist Health Services team
- Ability to multi-task as needed
- Effective oral & written communication skills
- Able to work independently and within a team environment
- Effective time management skills
- Strong organizational skills
- Critical listening and thinking skills
- Decision making/problem solving skills

Are there any educational requirements for this position? [X] Yes [ ] No

If yes, list below:

- High school diploma or general equivalency degree (GED) is required
- Associate's degree or other formal medical education/certification is preferred

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: N/A

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Foster Care Program Manager

Description of Position:
The Foster Care Program Manager assists with development of strategy and key initiatives to impact health outcomes of foster population based on best practice and acts as the Subject Matter expert with thorough understanding of Foster population and system.

Description of Responsibilities of Position:

- Continually assess programs, initiatives and interventions for effectiveness and positive member outcomes.
- Collaborate with key stakeholders/business owners to ensure progress on initiatives.
- Monitor and report on defined performance metrics.
- Prepare presentations, reports, and other briefings as needed specific to foster children and services.
- Act as a subject matter expert to the Integrated Care team in coordination of care of foster children.
- Collaborates with Clinical Operations to support the development of training to support care for foster children.
- Provides education to key stakeholders regarding the foster program, and services/benefits.
- Represents in a positive manner to all internal and external audiences.
- Collaborate and build relationships with county and private foster care agencies, providers, and state representatives for the primary purpose of integration between health and social services to produce quality health care management to children in foster care.
- Familiarize health care professionals with the effect of the foster care system on child, foster parents, and birth parents, especially concerning issues of separation and loss and the long-term impact of abuse and neglect.
- Coordinate and link health care services among different health care professionals, agency staff, children, foster parents, and birth parents.
- Assist the county and private foster care agencies in integrating health care information into the permanency planning for the child.
- Develop process for bidirectional communication and data sharing to enhance the coordination of health care services.
- Collaborate with agency on identification of trends and/or risks that may pose imminent or immediate threat to health, safety, and welfare of member.
- Collaborate with case management team to identify and recommend any needs, resources and/or referrals as part of care planning process.
- Collaborate with the county, private foster care agencies' and applicable Care Managers (Agency and/or Plan) to develop process for effective transition plan upon notice of an enrollee child leaving foster care and/or current placement.
- Work with both internal business partners and county agencies and/or managing agencies to have effective process for foster care children enrolling in the plan or existing members enrolling in foster care have the appropriate identification cards or other documentation, as well as access to medically necessary services.
- Coordinate health care services, which includes ensuring children have access to health care, monitoring children's use of the health care system, and enduring that children receive services appropriate to their health care needs.

Minimum Experience Required:

- Bachelor's degree in a relevant human services field such as nursing, social work, psychology, counseling, or related discipline or equivalent year of relevant work experience is required.
- Master's Degree is preferred.
- Minimum of five (5) years of experience in Child Welfare System field is required.
- Program/policy development and implementation experience is preferred.

Skills Required:

- Proven relationship development skills.
- Strong proficiency level with Microsoft Word, Excel, Outlook.
- Proven leadership and mentoring experiences.
- Strong written and verbal communication and presentation skills.
- Demonstrated ability to develop and grow relationships in complex healthcare systems and/or social organizations.
- Excellent organizational and time management skills.
- Ability to prioritize.
- Strong interpersonal skills.
- Demonstrated strategic thinking and planning skills.
- Excellent research and analytical skills.
- Prior experience with and knowledge of Altruista and Facets/Streamline is preferred.
- Knowledge of managed care industry, trends, and accreditation preferred.
- Ability to work independently and within a team environment.
- Attention to detail and work plan creation, implementation, and evaluation.
- Critical listening and thinking skills.
- Training/teaching skills.
- Customer service oriented.
- Decision making/problem solving skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in a relevant human services field such as nursing, social work, psychology, counseling, or related discipline or equivalent year of relevant work experience is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current, unrestricted license in the state of practice as a Registered Nurse (RN), Licensed Independent Social Worker (LISW), Psychologist, or Licensed Professional Clinical Counselor (LPCC) is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Grievance and Appeals Coordinator

Description of Position:
The Grievance and Appeals Coordinator is responsible for oversight of the Grievance, Appeal, IRE/IRO and State Hearing teams.

Description of Responsibilities of Position:

- Provide leadership and direction to staff to ensure the goals and standards of the department are successfully achieved.
- Manage staff to ensure timely and accurate completion of tasks and issues are accomplished.
- Oversee and monitor processes to ensure department is meeting all regulatory requirements and accreditation standards.
- Oversee and ensure grievances and appeals are resolved and reported appropriately.
- Oversee, analyze, and provide feedback to all areas that submit grievances and appeals.
- Develop, implement, and execute grievances and appeals training to business areas as needed.
- Analyze and evaluate operations and identify process improvement.
- Identify irregular trends with grievances and appeals; work with other areas as appropriate to identify root causes and appropriate steps for resolution.
- Monitor trends and regulatory changes for impact to the department.
- Report data to appropriate committees.
- Oversee, develop, and execute the grievances and appeals process for new product lines.
- Review and interpret regulatory requirements and ensure business policies and processes are in compliance.
- Lead initiatives to track and trend grievances and appeals data in order to drive process improvements.
- Develop a culture of accountability and flexibility within the team to support the organizational mission and vision.

Minimum Experience Required:

- Prior experience in the healthcare industry is preferred.
- Minimum of three (3) years of management experience is preferred.
- Minimum of four (4) years of grievance and appeals experience is preferred.

Skills Required:

- Proficient in Microsoft Office Suite to include Word, Excel, and PowerPoint.
- Basic experience with ACD systems.
- Basic experience with Call Management Systems.
- Excellent written and verbal communication skills.
- Strong interpersonal skills, high level of professionalism and a collaborative management style.
- Effective problem-solving skills with attention to detail.
- Effective listening and critical thinking skills.
- Ability to work independently and within a team environment.
- Ability to develop, prioritize and accomplish goals.
- Strategic management skills.
- Familiarity of the healthcare field with knowledge of Medicaid and Medicare.
- Ability to work in a fast-paced and constantly changing environment.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's degree or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: Health Literacy Campaign Coordinator
Description of Position: The Health Literacy Campaign Coordinator works with quality, care management, and member services staff to develop, implement, and evaluate all health literacy campaigns. Both positions will liaison with the Division and CCOs to develop and implement statewide health literacy campaigns.
Description of Responsibilities of Position: ▪ Responsible for developing, implementing, and evaluating all health literacy campaigns. ▪ Develop and maintain collaborative relationships that focus on health literacy development, preservation, policy, and supportive service provision. ▪ Collaborates with Quality, Care Management, and Member Services. ▪ Lead and conduct business process and gap analysis to diagnose process improvement opportunities and to develop re-usable solutions using principles of process excellence and related tools. ▪ Using data analytics, assist with the identification of opportunities for improvement. ▪ Works closely with product and market teams to understand goals of the product and regulatory guidelines surrounding the products.
Minimum Experience Required: ▪ Bachelor's Degree in Social Service, Human Service, Organizational Leadership, or related field or equivalent years of relevant work experience is required. ▪ Master's Degree preferred. ▪ Minimum of three (3) years of program development, implementation, and evaluation in health literacy required. ▪ Minimum of one (1) year of experience in data analysis and/or analytic programming required. ▪ Healthcare and/or Managed Care experience preferred.
Skills Required: ▪ Microsoft Suite skills required. ▪ Relationship Management skills required. ▪ Communication, graphic development/presentation skills required. ▪ Strategic management skills. ▪ Planning, problem identification, and resolution skills. ▪ Excel, Access, and SAS skills. ▪ Excellent customer service skills. ▪ Ability to work independently and within a team environment. ▪ Critical listening, thinking skills, and verbal and written communication skills. ▪ Decision making/problems solving skills. ▪ Knowledge of government or social investment funding mechanisms required.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's Degree in Social Service, Human Service, Organizational Leadership, or related field or equivalent years of relevant work experience is required. ▪ Master's Degree preferred.
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: N/A

Key Position: Job Description

Title of Position: Health Partner Network Manager

Description of Position:
The Health Partner Network Manager executes the Health Partner contracting strategy, develops contract provisions based on cost, quality/analysis and monitors key metrics for the assigned Market.

Description of Responsibilities of Position:

- Create, execute and administer value based reimbursement (VBR) strategies as directed.
- Conduct annual effectiveness review of contracting strategies; ensure corporate compliance with all contracting initiatives.
- Responsible for provider recruitment, contracting and initiating the loading and credentialing processes.
- Responsible for following up / auditing providers as they proceed through the loading process to ensure accuracy.
- Create contract language and review with legal to develop approved contract templates specific to the assigned Market and within the established corporate guardrails.
- Analyze financial data and establish rates in collaboration with Provider Contracting leadership and Finance.
- Negotiate and re-negotiate hospital, ancillary, physician and behavioral health contracts, terms, reimbursement rates, etc., in a manner that complies with corporate policies.
- Build networks to support new products within the market and on-board new providers.
- Responsible for complying with all regulatory requirements.
- Perform gap analysis to ensure no gaps and/or sanctions occur; identify potential providers to recruit that will fill the gaps; identify and implement solutions that mitigate risk; develop corrective action plans as needed.
- Participate in training sessions for providers and staff as appropriate.
- Support the contracting requirements of the corporation for geographic regions and products.
- Knowledgeable of federal and state laws and regulations pertaining to provider contracting.
- Assist with development and review of payment policies and provider notifications.
- As requested, become a Subject Matter Expert on specific provider types.
- Mentor junior contractors, as requested.

Minimum Experience Required:

- Bachelor's degree in a healthcare related field, or equivalent years of relevant work experience is required.
- Master's Degree is preferred.
- Minimum of three (3) years of healthcare experience, to include one (1) year of work experience in managed care provider relations or provider contracting.
- Managed care experience is highly preferred.

Skills Required:

- Intermediate proficiency level with Microsoft Outlook Word, and Excel.
- Knowledge of Provider Network Management Processes & Services.
- Ability to manage and prioritize multiple tasks, promote teamwork and fact-based decision making.
- Strong negotiation skills.
- Effective oral and written communication skills.

- Critical listening and thinking skills.
- Training/teaching skills.
- Time management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in a healthcare related field, or equivalent years of relevant work experience is required.
- Master's Degree is preferred.

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: N/A

Key Position: Job Description
Title of Position: Health Plan Operations Analyst
Description of Position: The Health Plan Operations Analyst reviews and analyzes the effectiveness and efficiency of existing market operation processes and systems and participates in development of solutions to improve or further leverage these functions.
Description of Responsibilities of Position: ▪ Manage new market operation initiatives from concept to implementation and provide statistics measuring progress throughout. ▪ Perform cost-benefit and return on investment analyses for proposed initiatives to aid in the decision-making process; collect and analyze data in support of business case creation and realization. ▪ Ensure operational effectiveness by assisting in the development of strategic plans for market operations, including business, financial, and operational goals and objectives; recognize and manage scope and expected outcomes across the Market to HPLC's strategic initiatives and process improvements. ▪ Assist in the review of reports and data for pattern identification, special cause variation identification, trend analysis, or other techniques; prepare and deliver summaries, recommendations, or alternatives of the analyzed information. ▪ Develop, document and perform testing and validation as needed. ▪ Work with peers to achieve cross-functional capability with project execution and subject matter expertise. ▪ Challenge the standard thinking with new ideas, approaches, and solutions which focus on process improvement and growth.
Minimum Experience Required: ▪ Bachelor's degree in Engineering, Business, Finance, Economics or related field or equivalent years of relevant work experience is required. ▪ Minimum of one (1) years of analytical experience is required. ▪ A minimum of three (3) years of health care operations or project management experience is required.
Skills Required: ▪ Advanced proficiency in Microsoft Office Suite to include Word, Excel, Access, and PowerPoint. ▪ Familiar with a variety of analysis concepts, practices, and procedures. ▪ Excellent written and verbal communication, facilitation, and presentation skills. ▪ Strong interpersonal skills and high level of professionalism. ▪ Effective listening and critical thinking skills. ▪ Effective problem-solving skills with attention to detail. ▪ Ability to work independently and within a team. ▪ Strong analytical skills. ▪ Ability to create and maintain excellent working relationships. ▪ Time management skills, ability to develop, prioritize and accomplish goals with a sense of urgency. ▪ Ability to effectively interact with all levels of management within the organization and across multiple organizational layers. ▪ Ability to multi-task and remain flexible during organizational and/or business changes.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's degree in Engineering, Business, Finance, Economics or related field or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: HEDIS Data Analyst
Description of Position: Perform analysis of all HEDIS data information, out of and within the business in support of HEDIS performance measures and accreditation requirements.
Description of Responsibilities of Position: ▪ Work collaboratively with Configuration, Claims, Quality Improvement, and other operational business owners to complete HEDIS coding analysis, program development and implementation to support coding as it relates to HEDIS. ▪ Identify and quantify HEDIS data issues within the organization and assist in the development plans to resolve these issues. ▪ Monitor the quality of HEDIS data submitted and received. ▪ Responsible in ensuring HEDIS data is submitted both timely and accurately to all applicable governing bodies. ▪ Work with Quality Improvement, Claims and other operational business owners to ensure accuracy of HEDIS data. ▪ Responsible for working with HEDIS team to identify HEDIS analytics to drive HEDIS efficiencies. ▪ In conjunction with the HEDIS management team ensures alignment of all interventions with the HEDIS Strategic Plan. ▪ Maintain an understanding of Federal and State Regulatory requirements, i.e., CMS, ODM and other regulatory bodies. ▪ Review and maintain newsletter material, Provider Tools, CareSource Quality Improvement Job Aids, etc. to ensure they are kept current with Annual NCQA HEDIS Technical Specification updates. ▪ Support regular HEDIS data processes and ad hoc HEDIS requests. ▪ Perform all job functions with a high degree of discretion and confidentiality in compliance with federal, state, and departmental confidentiality guidelines.
Minimum Experience Required: ▪ Bachelor's Degree in business, healthcare administration, or related field, or equivalent years of relevant work experience is required. ▪ Minimum of one (1) year of experience working with data and/or performing analysis using data and analytic tools. ▪ Managed Care experience preferred.
Skills Required: ▪ Intermediate proficiency in Microsoft Word, Excel, and SharePoint preferred. ▪ Data analysis and trending skills. ▪ Excellent written and oral communications skills. ▪ Ability to work independently and within a team environment. ▪ Decision making/problem solving skills. ▪ Situational awareness. ▪ Knowledge of Medicaid/Medicare preferred. ▪ Familiarity with healthcare field preferred. ▪ Proven understanding of database relationships. ▪ Knowledge of structured query language strongly preferred. ▪ Facets and iCES training/knowledge.

▪ Knowledge of NCQA/HEDIS and URAC. ▪ Excellent customer service skills. ▪ Critical listening and thinking skills. ▪ Ability to manage and meet workloads and deadlines.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's Degree in business, healthcare administration, or related field, or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: Housing Strategy Lead
Description of Position: The Housing Specialist is responsible for building relationships with landlords and developers to promote adequate and accessible housing for our members.
Description of Responsibilities of Position: ▪ Responsible for gathering business intelligence and managing research and analysis on housing as a social determinant of health, specialized populations, federal and state legislative proposals and initiatives, new product launches, rules and regulations that may impact the identification of populations in the state of interest with the goal to implement innovative best practice strategies into population health models and meet the triple aim. ▪ Develop and maintain collaborative relationships with high profile external partners that focus on affordable housing development, preservation, policy, and supportive service provision. ▪ Support the management of financial investments made by the Market in affordable housing to ensure all fiscal outcomes are achieved and connections of business needs to the housing providers. ▪ Collaborates with Market Life Service Director, Enterprise Housing Director, and other leadership to evaluate housing opportunities for improved members experience with focus on measureable benefits. ▪ Lead and conduct business process and gap analysis to diagnose process improvement opportunities and to develop re-usable solutions using principles of process excellence and related tools. ▪ Develop and maintain expertise in Federal and state specific requirements that impact housing and the social determinant of health model, and recommend innovative standardized population health strategies while maintaining a disciplined approach when addressing market specific nuances. ▪ Collaborate with Business Development and Integration during the RFP process and the implementation of new lines of business to ensure that responses incorporate the totality of the social determinant of health model and the overall impact of new business on the holistic care of members. ▪ Using data analytics, assist with the identification of opportunities for improvement through collaboration with Population Health Analytics team. ▪ Conduct examination and explanation of complex data relationships to answer questions identified either within the department or by other departments. ▪ Design, implement and evaluate programs that address housing needs with the goal of achieving increased quality and cost effectiveness. ▪ Works closely with product and market teams to understand goals of the product and regulatory guidelines surrounding the products. ▪ Assist in the review of reports and data for pattern identification, special cause variation identification, trend analysis, or other techniques that will reveal intelligence for identification of any associative or causal relationships and provide management level summaries that explain key findings across the organizations markets and products.

Minimum Experience Required:

- Bachelor's Degree in Social Service, Human Service, Organizational Leadership, or related field or equivalent years of relevant work experience is required.
- Master's Degree preferred.
- Minimum of three (3) years of program development, implementation, and evaluation in housing or community development required.
- Minimum of one (1) year of experience in data analysis and/or analytic programming required.
- Healthcare and/or Managed Care experience preferred.

Skills Required:

- Microsoft Suite skills required.
- Relationship Management skills required.
- Communication, graphic development/presentation skills required.
- Strategic management skills.
- Planning, problem identification, and resolution skills.
- Experience in the management of large data project including responsibility for meeting deadlines, accuracy requirements and reporting to upper management required.
- Excel, Access, and SAS skills.
- Excellent customer service skills.
- Ability to work independently and within a team environment.
- Critical listening, thinking skills, and verbal and written communication skills.
- Decision making/problems solving skills.
- Knowledge of government or social investment funding mechanisms required.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree in Social Service, Human Service, Organizational Leadership, or related field or equivalent years of relevant work experience is required.
- Master's Degree preferred.

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: N/A

Key Position: Job Description
Title of Position: Implementation Project Manager
Description of Position: The Implementation Project Manager is responsible for overseeing the implementation of the contract requirements during the implementation phase and managing medium to high complexity projects within programs and high complexity standalone projects.
Description of Responsibilities of Position: ▪ Possess knowledge of Medicaid programs, particularly with Medicaid managed care programs ▪ Responsible for successful delivery of project. ▪ Ensure project milestone deliverables are completed and approved at every stage of the project lifecycle. ▪ Assist with the continuous improvement of project management best practices, processes, and tools. ▪ Responsible for ensuring project closure activities are completed. ▪ Lead stakeholders in the refinement of the project charter if applicable. ▪ Collaborate with business owners on the identification and assignment of business resources. ▪ Develop and maintain project schedule and WBS. ▪ Collaborate with IT point of contact on the identification and assignment of IT resources. ▪ Develop project resource plan including forecast of EPMO FTEs and contractors. ▪ Schedule project audits and ensure compliance to EPMO Governance audit requirements. ▪ Develop and maintain project budget if applicable. ▪ Capture and consolidate EPMO, IT and business estimates for the Project. ▪ Assess, manage, and control project scope, schedule, and budget change impacts. ▪ Escalate issues to Business Owner, Program Manager, and EPMO Leadership as applicable. ▪ Maintain project stakeholder matrix. ▪ Drive cross-functional communication between impacted business and IT areas. ▪ Work with Talent Development and Communications to develop project communication and training plans. ▪ Mentor junior Project Managers or Program Coordinators. ▪ Schedule and facilitate project meetings including weekly status meetings and stakeholder meetings. ▪ Represent project in program meetings or in Portfolio Governance meetings. ▪ Capture and report on meeting notes, decisions, and action items. ▪ Accurately track and report project status against plan to stakeholders at all levels. ▪ Track, compile and report project metrics and budget. ▪ Advocate for and adhere to EPMO standards, tools, and processes. ▪ Implement mitigation strategies, contingency plans, and communicate/escalate to stakeholders. ▪ Maintain RAID for project items. ▪ Identify, log, assign and manage risks and issues. ▪ Maintain project SharePoint site and project document repository. ▪ Produce detailed reports, business decision documents, meeting minutes, and notification on assigned projects. ▪ Develop project operations and support plan.
Minimum Experience Required:

- Minimum of five (5) years of Project Management experience is required

Skills Required:

- Excellent proficiency with Microsoft Office tools, including Project, Word, PowerPoint, Excel, Visio, Teams, Outlook, etc.
- Experience working in project management software is required.
- Demonstrates excellent analysis and reporting skills.
- Excellent decision making/problem solving skills.
- Exceptional interpersonal and relationship building skills.
- Excellent critical listening and thinking skills.
- Proven ability to effectively interact with all levels of the organization of management within and externally to the organization.
- Excellent written and verbal communication skills.
- Customer service oriented.
- Ability to proactively, effectively, and efficiently lead a project team of 20+ core members and multiple vendors.
- Experience managing a project of up to $3.5M in budget.
- Proven ability to prioritize work and team assignments to deliver projects on time, on budget, and meeting stakeholders' expectations.
- Demonstrates a sense of urgency.
- Extensive understanding of project management processes, techniques and tools, and development lifecycle (ideally Agile).
- Familiarity of healthcare payer industry and knowledge of Medicaid and Medicare a plus.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree in Project Management, Business, Computer Science or related field or equivalent years of relevant work experience is required.
- Master's Degree in related field is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Project Management Professional (PMP) certification is strongly preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Intake Coordinator
Description of Position: The Intake Coordinator manages and monitors all SIU fraud reporting mechanisms (hotline, facets routing, fax, emails) to ensure compliance with regulatory requirements.
Description of Responsibilities of Position: ▪ Monitors SIU issued Corrective Action Plans and Settlement Agreements. ▪ Facilitates provider terminations initiated by SIU investigators. ▪ Handles straightforward and uncomplicated investigations to closure or referral. ▪ Interview members, providers and provider staff in support of investigative efforts. ▪ Maintains the SIU e-manual. ▪ Generates SIU intake metrics monthly. ▪ Responsible for triaging and managing the fraud reporting mechanisms daily including case input into SIU case tracking software, claim data pulls, grievances information, phone calls, etc. ▪ Responsible for identifying any needed fraud reporting mechanism process improvement. ▪ Maintains fraud allegiants confidentiality and anonymity. ▪ Proactively assists investigators in case development such as records requests/reviews, letter generation, and documentation. ▪ Serves as a liaison to other departments to obtain information needed to support SIU investigative efforts. ▪ Ensure consistency in the execution of actions with providers, members, and other departments.
Minimum Experience Required: ▪ High School Diploma or GED is required. ▪ Associate's Degree in Health-Related Field, Law Enforcement, or Insurance is preferred ▪ Minimum of three (3) years of SIU experience is required.
Skills Required: ▪ Intermediate computer skills consisting of Microsoft Excel, Access, Outlook, Word, and Power Point. ▪ Ability to navigate multiple software systems at a high proficiency level. ▪ Facets Claim System knowledge a requirement. ▪ Good communication skills. ▪ Ability to work independently and within a team environment. ▪ High attention to detail. ▪ Critical listening and thinking skills. ▪ Proper grammar usage. ▪ Time management skills. ▪ Proper phone etiquette. ▪ Customer service oriented. ▪ Decision making/problem solving skills. ▪ Strong organization skills. ▪ Customer service oriented .

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ High School Diploma or GED is 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: N/A

Key Position: Job Description
Title of Position: Intake Specialist
Description of Position: Intake Specialist II is a provider oriented role that is responsible for the intake of all authorization requests received via various methods into the Utilization Management department. The Intake Specialist role handles incoming calls from providers, assists with reviewing authorization details, requirements or updates. The Intake Specialist II role processes all requests into our systems for medical review as well as contacting the provider/member if additional and or clinical information is required.
Description of Responsibilities of Position: ▪ Convert information obtained from providers/members, (received via fax, phone, provider portal or mail) into electronic records while verifying member eligibility, provider network status, and benefit coverage. ▪ Review requests and send fax back for ineligible members, duplicate requests and items not covered by medical benefit. ▪ Facilitate the authorization of benefits for participating and out-of-network providers including completion of appropriate forms that are distributed to physicians' offices, provider relations and the generation of approval letters. ▪ Place prior authorizations when approval is appropriate per SOP into the medical management systems. ▪ Initiate process for routing prior authorizations requiring medical necessity review by clinical care reviewer. ▪ Answer calls from providers regarding prior authorization requests and troubleshoot issues from providers. ▪ Provide authorization information to provider, facility and/or member. ▪ Assist Clinical team as directed to ensure requests for authorization that require clinical review are received and processed timely. ▪ Maintain awareness of current workload aging and respond with appropriate sense of urgency. ▪ Expectation to meet department standards and goals. ▪ Collaborate across company departments to assist with issues, overrides, and questions. ▪ Maintain knowledge and understanding of all processes and procedures for multiple markets. ▪ Sufficiently cross-trained in multiple markets and products. ▪ Adhere to all departmental and company policies and procedures.
Minimum Experience Required: ▪ High School Diploma or equivalent required. ▪ Minimum of two (2) years of clinical and/or insurance experience, or related healthcare education or certification (i.e., STNA, MA, etc.) is required. ▪ Managed care experience preferred.

Skills Required:

- Computer proficiency with knowledge and experience with Microsoft Office in a Windows based environment.
- Ability to analyze information.
- Communication skills.
- Ability to work independently and within a team environment.
- Attention to detail.
- Proper grammar usage.
- Critical listening and thinking skills.
- Professional phone etiquette.
- Customer service oriented.
- Decision making/problem solving.
- Change resiliency.
- Knowledge of behavioral health systems.
- Ability to accurately communicate summary information in a written format.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- High School Diploma or equivalent required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Medical Terminology Certificate is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Life Coach
Description of Position: The Life Coach works directly with members with identified significant SDoH needs to develop a plan to address those needs.
Description of Responsibilities of Position: ▪ Complete Life Services needs assessment by gathering information from the member, the member's family, stakeholders, and other parties. ▪ Support a positive environment for the member by motivating, recognizing, and engaging participants through proper communication and individualized practices. ▪ Maintain consistent documentation on Life Services participants including but not limited to: training records, Life Learning Plan development and status updates, agency contacts, employment/interviewing activities and life service needs. ▪ Research developments in the fields of workforce and career development for those in and working to get out of poverty. ▪ Act as a liaison to social service agencies, government agencies, employers, employment programs & education programs and advocate for Life Services participants. ▪ Documents all sessions and interactions in the appropriate databases in a timely manner. ▪ Coordinate logistics for appointments as necessary. ▪ Support development of Life Learning Plan and monitoring and reporting on participant status. ▪ Arrange and coordinate services with community leaders; partners to maximize utilization of available resources and support groups. ▪ Facilitate individualized service plans based on member needs. ▪ Regular travel to conduct member, provider and community-based visits as needed to ensure effective administration of the program.
Minimum Experience Required: ▪ Associate's Degree or equivalent years of relevant work experience is required. ▪ Bachelor's Degree in Social Work, Human Services Administration, or non-profit Management is preferred. ▪ A minimum of two (2) years of social service delivery experience is required. ▪ Experience working with populations in poverty is preferred. ▪ Understanding of or experience with Motivational Interviewing and Change Readiness is preferred.
Skills Required: ▪ Intermediate proficiency in Microsoft Office Suite to include Word, Excel, and PowerPoint. ▪ Demonstrated coaching and counseling skills. ▪ Ability to influence and change individual behavior and assist individuals to achieve a high level of success and productiveness. ▪ Demonstrated leadership skills to effectively develop, lead, inspire and motivate Life Services participants successfully navigate the "cliff effect". ▪ Ability to think analytically to identify qualitative or quantitative trends and take appropriate actions. ▪ Demonstrated change management aptitude and ability. ▪ Excellent written and verbal communication skills. ▪ Ability to work in a fast-paced environment. ▪ Adaptable to a constantly changing environment.

- Ability to develop, prioritize and accomplish goals.
- Ability to work effectively independently and within a team environment.
- Effective problem-solving skills with attention to detail Sensitivity to and experience working with those in poverty.
- Ability to separate personal from professional and to set boundaries with members.
- Ability to work in compassionate, supportive, and collaborative ways with members and community agencies.
- Strong interpersonal skills and high level of professionalism
- Ability to maintain confidentiality and act in participant and company's best interests.
- Ability to act with diplomacy and sensitivity to cultural diversity.
- Critical listening and thinking skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Associate's Degree or equivalent years of relevant work experience is required.
- Bachelor's Degree in Social Work, Human Services Administration, or non-profit Management is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Coaching/Mentoring certification is preferred.
- Training/Working with population in poverty certification is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Manager of Claims Encounters
Description of Position: The Manager of Claims Encounters oversees the claims encounters team and responsible for daily management of claims encounters regulatory data projects.
Description of Responsibilities of Position: ▪ Responsible for Claims Encounters Data process for both CMS and State agencies. ▪ Manage the claims data processes to ensure accuracy and compliance with CMS and state agencies. ▪ Responsible for other key claims data management and readiness to state and governing entities. ▪ Ensure department meets claims data submission requirements. ▪ Responsible for identifying areas of improvement and streamlining procedures and policies to ensure effective and efficient workflow. ▪ Lead departmental efforts to locate and modify claims data anomalies that impact regulatory claims data completeness. ▪ Provide leadership and direction to employees in the Claims Encounters department to ensure the goals and standards of the department are being met. ▪ Guide staff relative to daily operational functions. ▪ Ensure quantitative and qualitative measures are used to meet performance objectives. ▪ Manage staffing and scheduling functions to meet regulatory requirements and service level agreements (SLA's). ▪ Engage direct reports through consistent performance feedback and development opportunities. ▪ Participate in strategic planning and implement action plans. ▪ Interface with team leads on effective people management strategies such as staffing, coaching, and mentoring. ▪ Lead and participate in strategic department/company projects. ▪ Identify and facilitate process improvements to improve productivity, accuracy, and data usability. ▪ Provides analytical support and leadership for key Claims Encounters-related projects. ▪ Responsibility for Claims Encounters regulatory reporting. ▪ Act as Claims Encounters representative for corporate projects and internal and external audits. ▪ Assist in the development and implementation of departmental policies and procedures. ▪ Provide critical reporting and analysis of functional performance, and make recommendations for enhancements, cost savings initiatives and process improvements. ▪ Prepare and monitor various management and oversight metrics & reports as required. ▪ Oversee Claims Encounters initiatives such as working with IT and others internal departments to automate Claims Encounters functions; improve regulatory report development with SIS. ▪ Implement new business including the design, testing and delivery of supporting processes to the business. ▪ Business owner for Claims Encounters oversight of support vendors, managing SLA's, regulatory requirements, and contractual metrics. ▪ Maintain positive and strategic relationships with internal and external stakeholders. ▪ Understanding of how claims payment methodologies, adjudication processing and State Encounters regulations interrelate to maintain compliant Encounters reconciliation processes and SLA's.

Minimum Experience Required:

- Bachelor's degree or equivalent years of relevant work experience is required
- Minimum of five (5) years of managed healthcare, claims, or managed care regulated environment experience is required
- Minimum of three (3) years of previous leadership experience is required

Skills Required:

- Advanced computer skills.
- Knowledge of Claims IT processes/systems required.
- Knowledge of claims analytic processes/systems required.
- Advanced working knowledge of managed care and health claims processing and reimbursement methodologies.
- Experience with 837O files to States and/or CMS (MA EDS) preferred.
- Excellent communication skills; both written and verbal.
- Ability to work collaboratively with other management .
- Time management skills; capable of multi-tasking and prioritizing work.
- Effective decision making / problem solving skills.
- Ability to effectively interact with senior management and executive staff.
- Strong critical thinking and listening skills.
- Strong financial acumen preferred .

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: Manager, Creative Marketing
Description of Position: Provides leadership and direction in developing marketing, creative, digital, external communications strategy and campaigns.
Description of Responsibilities of Position: ▪ Assist with the selection and implementation of an appropriate workflow solution. ▪ Manage web content and social media strategies Lead advertising campaigns. ▪ Manage support for all products and brokers in the areas of materials/tools, brand awareness, life cycle of product and enrollment. ▪ Develop, implement, write content, marketing plans and advertising campaigns. ▪ Manage the brand implementation in consumer/provider/member touch points and provide recommendations to business owners for optimization (i.e., web content, advertising campaigns, external communications). ▪ Manage project budget report, Media flight, as required. ▪ Ensure that all regulatory and compliance requirements of each deliverable are met. ▪ Create, analyze, develop, and distribute routine Marketing reporting to allow for strategic and tactical adjustments in Marketing / Sales plans and development/coaching of team and optimizing their activities. ▪ Create process for tracking all deliverables and develop template process to facilitate nimble market/communication adjustments. ▪ Manage the models that ensure growth and retention of members as well as gaining future members that align with product group goals and initiatives.
Minimum Experience Required: ▪ Bachelor's degree in marketing or related business field or equivalent years of relevant work experience, is required. ▪ Master of Business Administration (MBA), Health Administration (MHA), or related graduate degree is preferred. ▪ Minimum of five (5) years of marketing, communication, advertising, or product management experience is required. ▪ Minimum of three (3) years of management/supervisory experience is required.
Skills Required: ▪ Intermediate proficiency level with Microsoft Word, Excel, PowerPoint, Visio, Photoshop, and project. ▪ Effective marketing, strategy, communication skills. ▪ Consultative skills. ▪ Ability to work independently and within a team environment. ▪ Familiarity of the healthcare field – Medicare/Medicaid. ▪ Critical listening and thinking skills. ▪ Presentation skills. ▪ Negotiation skills/experience. ▪ Project management skills. ▪ Marketing, advertising, direct mail writing skills.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's degree in marketing or related business field or equivalent years of relevant work experience, is required ▪ Master of Business Administration (MBA), Health Administration (MHA), or related graduate degree is preferred
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: N/A

Key Position: Job Description
Title of Position: Maternal High Risk Specialty Care Manager
Description of Position: The Maternal High Risk Specialty Care Manager collaborates with members of an inter-disciplinary care team (ICT) to meet the needs of the individual and the population and identifies problems or opportunities that would benefit from care coordination.
Description of Responsibilities of Position: ▪ Engage the member and complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each member. ▪ Facilitate regularly scheduled inter-disciplinary care team (ICT) meetings to meet the needs of the member. ▪ Engage with the member in a variety of settings to establish an effective, professional relationship. Settings for engagement include but are not limited to hospital, provider office, community agency, member's home, telephonic or electronic communication. ▪ Develop an individualized care plan (ICP) in collaboration with the ICT, based on member's needs and preferences. ▪ Identify and manage barriers to achievement of care plan goals. ▪ Identify and implement effective interventions based on clinical standards and best practices. ▪ Assist with empowering the member to manage and improve their health, wellness, safety, adaptation, and self-care through effective care coordination and care management. ▪ Facilitate coordination, communication, and collaboration with the member the ICT in order to achieve goals and maximize positive member outcomes. ▪ Educate the member/caregivers about treatment options, community resources, insurance benefits, etc. so that timely and informed decisions can be made. ▪ Employ ongoing assessment and documentation to evaluate the member's response to and progress on the ICP. ▪ Evaluate member satisfaction through open communication and monitoring of concerns or issues. ▪ Collaborate with facility-based care managers and providers to plan for post-discharge care needs or facilitate transition to an appropriate level of care in a timely and cost-effective manner. ▪ Coordinate with care managers and other service providers to ensure coordination and avoid duplication of services. ▪ Appropriately terminate care coordination services based upon established case closure guidelines for members. ▪ Provide clinical oversight and direction to unlicensed team members as appropriate. ▪ Document care coordination activities and member response in a timely manner according to standards of practice and policies regarding professional documentation. ▪ Look for ways to improve the process to make the members experience easier and shares with leadership to make it a standard, repeatable process. ▪ Regular travel to conduct member, provider and community-based visits as needed to ensure effective administration of the program.

Minimum Experience Required:

- Nursing degree from an accredited nursing program is required.
- Bachelors of Science in Nursing is preferred.
- Licensure as a Registered Nurse is required.
- A minimum of three (3) years of experience in nursing focused with maternity experience (i.e., discharge planning, case management, care coordination, and/or home/community health management experience) is required.
- Three (3) years or more Medicaid and/or Medicare managed care experience is preferred.

Skills Required:

- Intermediate proficiency level with Microsoft Office, including Outlook, Word, and Excel.
- Ability to communicate effectively with a diverse group of individuals.
- Ability to multi-task and work independently within a team environment.
- Knowledge of local, state & federal healthcare laws and regulations & all company policies regarding case management practices.
- Adhere to code of ethics that aligns with professional practice.
- Knowledge of and adherence to Case Management Society of America (CMSA) standards for case management practice.
- Strong advocate for members at all levels of care.
- Strong understanding and respect of all cultures and demographic diversity.
- Ability to interpret and implement current research findings.
- Awareness of community & state support resources.
- Critical listening and thinking skills.
- Decision making and problem-solving skills.
- Strong organizational and time management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Nursing degree from an accredited nursing program is required.
- Bachelors of Science in Nursing is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current unrestricted clinical license in state of practice as a Registered Nurse is required
- Case Management Certification is highly preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Medical Coder
Description of Position: The Medical Coder is the subject matter expert for complex coding concerns and serves as primary coding resource for Program Integrity (PI).
Description of Responsibilities of Position: ▪ Use concepts and knowledge of CPT, ICD10, HCPCS, DRG, REV coding rules to analyze complex provider claims submissions. ▪ Take a lead role to determine root cause of provider claim issues and resolve by analyzing system configuration, payment policy, and claims data. ▪ Research, comprehend and interpret various state specific Medicaid, federal Medicare, and ACA/Exchange laws, rules, and guidelines. ▪ Maintain knowledge and stay current with Federal and State Regulatory requirements, as well as coding guidelines, federal laws, rules, and billing guidelines for various provider specialty types and lines of business. ▪ Prepare and respond to legal activities which includes discovery and trial preparation and testifying as needed. ▪ Identify audit payment integrity issues for PI investigations, audits, provider pre-pay, etc. ▪ Assist in the development and implementation of an annual audit plan for providers with high risk for fraud using appropriate risk-based methodology. ▪ Provide critical research and analysis of functional performance, and make recommendations for enhancements, cost savings initiatives and process improvements. ▪ Prepare and monitor various management and oversight metrics & reports as required. ▪ Manage quality audits of our internal coding validation analysts and produce monthly reports for the manager. ▪ Recognize inconsistencies and gaps in Program Integrity business processes and work collaboratively to resolve the identified issues. ▪ Generate comprehensive, clear, concise, and in-depth reporting and analysis and provide recommendations based on findings. ▪ Provide support to the claims pre-pay team to analyze and identify trends in claims. ▪ Manage the entry and tracking of system change requests, via appropriate ticketing system, for configuration or other Program Integrity improvements, act as primary resource and SME in corporate meetings and projects. ▪ Identify payment integrity issues with claims reimbursement methodologies. ▪ Analyze and report financial savings related to process improvements. ▪ Build strong working relationships with Markets and departments that are essential for resolving systemic issues and driving process improvements.
Minimum Experience Required: ▪ Bachelor's degree in Business Administration or related field or equivalent years of relevant work experience is required. ▪ A minimum of five (5) years of experience in medical coding, to include experience in program integrity coding audit, is required. ▪ Experience with reimbursement methodology (APC, DRG, OPPS) is required.

Skills Required:

- Proficient in Microsoft Office toolset.
- Proven ability to establish effective working relationships with stakeholders at all different levels.
- Excellent written and verbal communication skills.
- Effective identification of business problems, assessment of proposed solutions to those problems, and understanding of the needs of stakeholders.
- Ability to work independently and within a team environment.
- Ability to multi-task and prioritize work to meet project deadlines.
- Effective listening and critical thinking skills.
- Flexibility during organizational and/or business changes.
- Strong interpersonal and relationship building skills.
- Effective problem-solving skills with attention to detail.
- Ability to effectively and efficiently work within a project team.
- Time management skills.
- Customer service oriented.
- Decision making/problem solving skills.
- Ability to develop, prioritize and accomplish goals.
- Ability to coordinate and lead cross-functional teams.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in Business Administration or related field or equivalent years of relevant work experience is required

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified Professional Coder (CPC) or equivalent billing/coding designation is required

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Medical Director
Description of Position: The Medical Director is responsible for development, implementation and revision of the market-level clinical care standards and practice guidelines ensuring compliance with nationally accepted quality standards.
Description of Responsibilities of Position: ▪ Development, implementation and revision of the market-level clinical care standards and practice guidelines ensuring compliance with nationally accepted quality standards. ▪ Collaborate with market/product leaders to help define market strategy. ▪ Represent at state and regulatory venues. ▪ Support market provider network development and maintenance. ▪ Provider education, training, data sharing, performance evaluations and orientation to the plan. ▪ Support program design and development. ▪ Participate in peer-to-peer discussions. ▪ Participate in the development, implementation and revision of the Quality Improvement Plan and market level quality initiatives. ▪ Community collaborative participation. ▪ Participate in the evaluation and investigations of cases suspected of fraud, abuse, and quality of care concerns. ▪ Development of policies and procedures. ▪ Provide cross-coverage for other Medical Directors and/or markets, as needed. ▪ Understand and provide support to prior authorization and utilization review functions. ▪ Support staff by providing training, clinical consultation, and clinical case review for members. ▪ Conduct clinical reviews for designated members. ▪ Identify utilization management trends and take appropriate action. ▪ Support of regulatory and accreditation functions and compliance for all programs.
Minimum Experience Required: ▪ Actively practicing physician in Mississippi or have been actively practicing physician in Mississippi in the past five (5) years and be located in Mississippi ▪ Minimum of five (5) years of clinical practice experience is required. ▪ Managed care medical review/medical director experience is preferred.
Skills Required: ▪ Basic Microsoft Word skills. ▪ Excellent communication skills, both written and oral. ▪ Ability to work well independently and within a team environment. ▪ Ability to create strong relationships with Providers and Members. ▪ High ethical standards. ▪ Attention to detail. ▪ Critical listening and systematic thinking skills. ▪ Ability to maintain confidentiality and act in the company's best interest. ▪ Ability to act with diplomacy and sensitivity to cultural diversity. ▪ Decision making/problem solving skills. ▪ Conflict resolution skills.

- Strong sense of mission and commitment of time, effort, and resources to the betterment of the communities served.
- Ability to analyze healthcare data from a variety of sources to evaluate physician practice patterns.
- Leadership experience and skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

Education and Experience:

- Completion of an accredited Medical Degree program as a medical doctor (MD) or Doctor of Osteopathic (DO) medicine is required.
- Successful completion of a residency training program, preferably in primary care is required.
- Bachelor's or Master's degree in Business Administration, Operational Excellence, Healthcare Administration or Medical Management is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current, unrestricted license to practice medicine in Mississippi is required.
- Board Certification, preferably in primary care specialty is required; re-certification, as required by specialty board, must be maintained.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Member Health Assessor
Description of Position: The Member Health Assessor engages with the member to establish an effective, professional relationship with primary responsibility to conduct a standardized Health Risk Appraisals (HRA).
Description of Responsibilities of Position: ▪ Verify eligibility, previous enrollment history, demographics, and current health status of each member prior to outreach. ▪ Engage the member to gather information to assess and facilitate coordination of integrated care across the continuum, including behavioral health and long-term care, for members with high need potential. ▪ Conduct standardized Health Risk Appraisals (HRA) by gathering information from the member, family, provider, and other stakeholders, as directed by Member and/or their Legally authorized representative. ▪ Assist with the provision of health education, wellness materials and coaching ,as appropriate ▪ Maintain appropriate documentation within protocols and guidelines of the Care Management program. ▪ Looks for ways to improve the process to make the members experience easier and streamlines time to complete the HRA and follow-up. ▪ Expected to meet daily production standards in terms of member outreach.
Minimum Experience Required: ▪ High School Diploma or General Education Diploma (GED) is required. ▪ Minimum of two (2) years of experience in either volunteer or paid position working in community settings with at risk populations providing coordination of services is preferred.
Skills Required: ▪ Proficient with Microsoft Office, including Outlook, Word, and Excel. ▪ Sensitivity to and experience working within different cultures. ▪ Good interpersonal skills. ▪ Ability to work independently and within a team environment. ▪ Ability to identify problems and opportunities and communicate to management. ▪ Developing knowledge of local, state & federal healthcare laws and regulations & all company policies regarding case management practices. ▪ Demonstrate compassion, support and collaboration with members and families. ▪ Self-motivated and inquisitive. ▪ Comfort with asking pertinent questions. ▪ Ability to work in a fast-paced environment. ▪ Ability to demonstrate and promote ethical conduct. ▪ Ability to develop positive relationships with all stakeholders. ▪ Awareness of community & state support resources. ▪ Organized , detail-oriented and conflict resolution skills. ▪ Ability to keep composure and professionalism during times of high emotional stress. ▪ Ability to maintain confidentiality and act in the company's best interest. ▪ Proven track record of demonstrating empathy and compassion for individuals. ▪ Proven track record for improving processes to make things easier for those you have served.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ High School Diploma or General Education Diploma (GED), is 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: N/A

Key Position: Job Description
Title of Position: Member Services Manager
Description of Position: The Member Services Manager is responsible to guide Team Leaders and staff relative to daily operational issues involving member services.
Description of Responsibilities of Position: ▪ Ensure quantitative and qualitative objectives are used to meet performance objectives. ▪ Manage staffing and scheduling functions. ▪ Compile reports and departmental communications. ▪ Participate in strategic planning and recommendation of action plans. ▪ Interface with team leaders on effective people management strategies such as staffing, coaching, and mentoring. ▪ Lead/participate in strategic department/company projects. ▪ Recommend process improvements. ▪ Maintain positive relationship with internal and external customers.
Minimum Experience Required: ▪ Minimum of three (3) years of previous management/leadership experience preferred. ▪ Previous experience in an HMO environment or related industry preferred.
Skills Required: ▪ Proficient in Microsoft Word, Excel, and PowerPoint. ▪ Knowledge of Medicaid. ▪ Familiarity of healthcare field. ▪ Strong management skills. ▪ Strong collaboration and conflict resolution skill sets. ▪ Proven leadership with the ability to build relationships, collaborate and influence at all levels. ▪ Ability to work in a fast-past environment. ▪ Attention to detail. ▪ Ability to develop, prioritize and accomplish goals/time management. ▪ Strong decision making and problem-solving skills. ▪ Exceptional written and verbal communication skills. ▪ Ability to work independently and within a team environment. ▪ Effective active listening and critical thinking skills. ▪ Display a customer service, member-focused orientation.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's Degree in business related field or equivalent years of experience 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: N/A

Key Position: Job Description
Title of Position: Member Services Call Center Specialist
Description of Position: The Call Center Specialist assists members or providers with routine service inquiries.
Description of Responsibilities of Position: ▪ Resolve member or provider routine service inquiries; examples include claims processing, member benefit education, contracting and credentialing requests, eligibility inquiries, and transportation arrangements. ▪ Ensure all HIPAA and State requirements/regulations are always adhered to. ▪ Research, follow up, and resolve all open/pending issues in a timely manner to ensure member or provider satisfaction. ▪ Build and strengthen member or provider relationships by providing quality customer service. ▪ Maintain knowledge and understanding of all processes and procedures. ▪ Adhere to all departmental and company policies and procedures. ▪ Maintain complete and accurate documentation of all of telephone and written communications. ▪ Act as a mentor to new hire employees.
Minimum Experience Required: ▪ High School Diploma or equivalent is required. ▪ Two (2) years customer service experience is preferred. ▪ Customer Service experience in a call center is preferred.
Skills Required: ▪ Critical thinking and listening skills. ▪ Decision making and problem-solving skills. ▪ Computer proficiency with knowledge and experience in a Windows environment. ▪ Typing speed of 35 words per minute (WPM). ▪ Strong written and communication skills. ▪ Works well under pressure. ▪ Professional phone etiquette. ▪ Proper use of grammar. ▪ Ability to work in a fast-paced environment. ▪ Adaptable to a constantly changing environment. ▪ Attention to detail. ▪ Ability to multitask. ▪ Ability to work independently and with a team.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ High School Diploma or equivalent is 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: N/A

Key Position: Job Description

Title of Position: Network/Contracting Manager

Description of Position:

The Network/Contracting Manager is responsible for hospital, provider and ancillary provider contracting, service, and provider data integrity to facilitate optimal member access, successful business growth initiatives and sound plan financial performance as it relates to unit pricing in select states, regions or markets.

Description of Responsibilities of Position:

- Responsible for the development of networks in new markets
- Will have significant interactions with third parties, contractors, and various companies engaged to develop networks in new markets
- Responsible for provider recruitment of states, geographic regions, or markets as defined in the corporate strategic plans
- Develop a Contracting Strategy on an as needed basis for the various targeted markets
- Develop the key metrics to ensure a high level of network adequacy
- Responsible for robust competitor and provider competitive analysis and the creation of other information to formulate a business decision related to the provider network
- Compile quarterly and annual statistics
- Responsible for the effective integration of new providers into the Network Operations infrastructure
- Ensure that the provider setup for new markets or regions is consistent with the Departmental standards
- Provide oversight of provider contracting activities when completed by contractors or other individuals or entities working on behalf of the Health Plan
- Responsible for aggressive recruitment programs including recruitment materials and development and facilitation of quarterly reports
- Provide formal feedback, documentation and resolution of areas for improvement and monitor sustained improvement
- Review audits of all performance from a productivity, performance and quality perspective; address issues as identified
- Ensure the network complies with all regulatory requirements as well as with all company-mandated policies and procedures
- Ensure provider network is adequate, cost effective, competitive, stable and meets the corporate and regulatory access requirements
- Interact with the Finance Department in terms of pricing for provider contracts
- Participate in training sessions for providers and staff as appropriate.
- Implement performance improvement initiatives to improve Provider Satisfaction Scores incrementally on an annual basis

Minimum Experience Required:

- Bachelor's degree or equivalent in health-related field
- Master's Degree or equivalent preferred
- Minimum 5 years management experience required
- Minimum of 3 years contract negotiation experience required

- Managed care experience highly preferred

Skills Required:

- Intermediate computer skills
- Proficient in Microsoft Word, Outlook and Excel
- Knowledge of Network Management Processes & Services
- Ability to manage and prioritize multiple tasks, promote teamwork and fact-based decision making
- Communication skills
- Ability to work independently and within a team environment
- Attention to detail
- Familiarity of the healthcare field
- Critical listening and thinking skills
- Training/teaching skills
- Strategic management skills
- Proper grammar usage
- Time management skills
- Proper phone etiquette
- Decision making/problem solving skills
- Leadership experience and skills
- Resiliency in a changing environment

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree or equivalent in health-related field
- Master's Degree or equivalent preferred

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: N/A

Key Position: Job Description
Title of Position: NICU Specialty Care Manager
Description of Position: The NICU Specialty Care Manager collaborates with members of an inter-disciplinary care team (ICT) to meet the needs of the individual and the population and identifies problems or opportunities that would benefit from care coordination.
Description of Responsibilities of Position: ▪ Engage the member and complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each member. ▪ Facilitate regularly scheduled inter-disciplinary care team (ICT) meetings to meet the needs of the member. ▪ Engage with the member in a variety of settings to establish an effective, professional relationship. Settings for engagement include but are not limited to hospital, provider office, community agency, member's home, telephonic or electronic communication. ▪ Develop an individualized care plan (ICP) in collaboration with the ICT, based on member's needs and preferences. ▪ Identify and manage barriers to achievement of care plan goals. ▪ Identify and implement effective interventions based on clinical standards and best practices. ▪ Assist with empowering the member to manage and improve their health, wellness, safety, adaptation, and self-care through effective care coordination and case management. ▪ Facilitate coordination, communication and collaboration with the member the ICT in order to achieve goals and maximize positive member outcomes. ▪ Educate the member/caregivers about treatment options, community resources, insurance benefits, etc. so that timely and informed decisions can be made. ▪ Employ ongoing assessment and documentation to evaluate the member's response to and progress on the ICP. ▪ Evaluate member satisfaction through open communication and monitoring of concerns or issues. ▪ Collaborate with facility based care managers and providers to plan for post-discharge care needs or facilitate transition to an appropriate level of care in a timely and cost-effective manner. ▪ Coordinate with care managers and other service providers to ensure coordination and avoid duplication of services. ▪ Appropriately terminate care coordination services based upon established case closure guidelines for members ▪ Provide clinical oversight and direction to unlicensed team members as appropriate. ▪ Document care coordination activities and member response in a timely manner according to standards of practice and policies regarding professional documentation. ▪ Look for ways to improve the process to make the members experience easier and shares with leadership to make it a standard, repeatable process. ▪ Regular travel to conduct member, provider and community based visits as needed to ensure effective administration of the program.

Minimum Experience Required:

- Nursing degree from an accredited nursing program is required.
- Bachelors of Science in Nursing is preferred.
- Licensure as a Registered Nurse is required.
- A minimum of three (3) years of experience in nursing focused with NICU experience (i.e. discharge planning, case management, care coordination, and/or home/community health management experience) is required.
- Three (3) years or more Medicaid and/or Medicare managed care experience is preferred.

Skills Required:

- Intermediate proficiency level with Microsoft Office, including Outlook, Word and Excel.
- Ability to communicate effectively with a diverse group of individuals.
- Ability to multi-task and work independently within a team environment.
- Knowledge of local, state & federal healthcare laws and regulations & all company policies regarding case management practices.
- Adhere to code of ethics that aligns with professional practice.
- Knowledge of and adherence to Case Management Society of America (CMSA) standards for case management practice.
- Strong advocate for members at all levels of care.
- Strong understanding and respect of all cultures and demographic diversity.
- Ability to interpret and implement current research findings.
- Awareness of community & state support resources.
- Critical listening and thinking skills.
- Decision making and problem solving skills.
- Strong organizational and time management skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Nursing degree from an accredited nursing program is required
- Bachelors of Science in Nursing is preferred

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current unrestricted clinical license in state of practice as a Registered Nurse is required
- Case Management Certification is highly preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Nurse Advice Line
Description of Position: The Nurse Advice Line is responsible for using decision support software to perform telephonic clinical triage and health information service for the managed health plans and external clients.
Description of Responsibilities of Position: ▪ Utilize assessment skills and the nursing process for care of healthy, as well as acutely or chronically ill or injured clients, including pediatric, adult, maternity, and geriatric members ▪ Function as patient advocate by facilitating accessibility to healthcare and provide collaborative service for other departments. ▪ Educate members to assist them in making informed decisions regarding personal healthcare. ▪ Assess health status and direct members to the most appropriate level of care. ▪ Utilize critical reasoning in clinical decision-making. ▪ Inform callers of preventative healthcare measures. ▪ Identify and refer appropriate members for Care Management. ▪ Provide information about benefits, services and programs that allows members to maximize healthcare resources. ▪ Assess caller's needs and assists with issues related to member's care. ▪ Manage telephone interactions with compassion and respect for cultural, educational, and psychosocial differences of individuals. ▪ Utilize multiple computer applications to document all information in an accurate manner. ▪ Practice in compliance with standards and regulatory requirements. ▪ Keep abreast of trends in healthcare delivery and managed care. ▪ Participate in self-managed team: daily operations, quality audits, preceptor/training resource, etc. ▪ Maintains and contributes to a collaborative professional and ethical work environment.
Minimum Experience Required: ▪ RN license required. ▪ Bachelor’s Degree in Nursing preferred. ▪ Minimum of three (3) years of progressive clinical experience is required. ▪ Triage, Emergency Nursing or Critical Care experience is preferred. ▪ Behavioral Health experience is preferred. ▪ Telephone Triage in a call center setting preferred.
Skills Required: ▪ Beginning level computer skills. ▪ Clinical assessment skills. ▪ Communication skills. ▪ Ability to work independently and within a team environment. ▪ Attention to Detail. ▪ Critical listening and thinking skills. ▪ Proper grammar usage. ▪ Proper phone etiquette. ▪ Decision making/problem solving skills. ▪ Customer service oriented. ▪ Broad base of clinical knowledge.

- Teaching skills.
- Ability to remain calm under pressure and in life threatening situations.
- Ability to multitask-simultaneously thinks, talks, and types.
- Understand and support philosophy of HMO and managed healthcare programs.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Nursing degree required
- Bachelor's Degree in Nursing preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current, unrestricted RN licensure in state of practice is required.
- Ability to be licensed in multiple states in a timely fashion.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Operations Business Analyst
Description of Position: The Operations Business Analyst is responsible for reviewing and analyzing the effectiveness and efficiency of existing processes and systems, and participate in development of solutions to improve or further leverage these functions.
Description of Responsibilities of Position: ▪ Review and analyze the effectiveness and efficiency of existing processes and systems, and participate in development of solutions to improve or further leverage these functions. ▪ Perform cost-benefit and return on investment analyses for proposed initiatives to aid decision-making process as well as collect and analyze data in support of business case creation and realization. ▪ Ensures operational effectiveness by assisting in strategic and business planning, including business, financial, and operational goals and objectives definition as well as feasibility studies. ▪ Recognizes and proactively manages scope and expected benefits across the organization's strategic initiatives and process improvements. ▪ Assists in operational readiness process by reviewing transitional activities and associated documentation for completion prior to initiative implementation, including operational reports, turnover documentation, departmental policies and procedures and job aids. ▪ Assist in the review of reports and data for pattern identification, special cause variation identification, trend analysis, or other techniques; prepare and deliver summaries, recommendations, or alternatives of the analyzed information. ▪ Develop, document and perform testing and validation as needed.
Minimum Experience Required: ▪ Bachelor of Science/Arts degree or equivalent work experience is required. ▪ Three to five (3-5) years of health care operations experience in insurance, managed care, or related industry is preferred.
Skills Required: ▪ Knowledge of regulatory reporting and compliance requirements. ▪ Ability to effectively interact with all levels of management within the organization and across multiple organizational layers. ▪ Demonstrates excellent analysis and collaboration skills. ▪ Ability to multi-task and juggle competing priorities. ▪ Exceptional communication (verbal and written), facilitation and presentation skills. ▪ Strong interpersonal, leadership and relationship building skills. ▪ Critical listening and thinking skills. ▪ Customer service oriented. ▪ Effective time management and prioritization skills. ▪ Decision making and problem solving skills.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor of Science/Arts degree or equivalent work experience is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No **If yes, list below:** ▪ Six Sigma or other performance improvement experience is preferred
Are there any continuing education requirements for this position? [ ] Yes [X] No **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Peer Support Specialist
Description of Position: Peer Support Specialist is responsible for developing and implementing on-going outreach efforts that encourage participation in the plan, by educating plan members and supporting providers to render appropriate services. This position supports members using face-to-face, virtual, and telephonic contacts to encourage members to engage in recovery activities utilizing recognized peer support principles and tools including recovery coaching, Wellness Resource Action Planning (WRAP) development and engagement in a recovery community.
Description of Responsibilities of Position: ▪ Support the creation of and assist with the implementation of a comprehensive training and education program with peers, families, providers, and staff. ▪ Assist consumers who are dealing with the most complex and difficult issues, including homelessness, trauma, physical health issues, etc. ▪ Provide 1-on-1 peer support, facilitate support groups, share experiences, linkage to services and resources, advocacy, training, and supervision. ▪ Perform a wide range of tasks to support individuals in living their own lives and directing their own path to achieving their life goals. ▪ Provides assistance with treatment planning and system navigation (accessing housing, employment, benefits, etc.) during reentry. ▪ Establish and maintain strong collaborative relationships with existing consumer and family organizations. ▪ Prepare individuals in jails and prisons to develop plans and identify resources to ensure uninterrupted treatment and connection with a recovery community prior to release. ▪ Effectively communicate plan information to consumers and consumer operated organizations and with families and family organizations as well as consumer and family rights and responsibilities, in addition to a wide array of other topics including clinical policies, analysis of data and program evaluation. ▪ Identify and outreach to community and leaders of ethnic minority groups to identify and develop programs that are both culturally competent and use recovery and resiliency. ▪ Work with the Clinical Program Director, Clinical Director, and the clinical team to implement care coordination when requested, which may include peer support as well as other community - based services designed to stabilize the consumer's condition. ▪ Be available to provide direct support to family members of consumers being discharged from 24 - hour care, coordinate peer coaching if available and / or to refer them to a support group. ▪ Collaborate with Care Managers, providers, and community agencies and organizations to facilitate access to and transition between services. ▪ Collaborate with Care Managers, providers, and community agencies and organizations to identify consumers and family members of consumers who may benefit from peer support. Participate in treatment planning with consumers and families who request that support. ▪ Work with community agencies along with and / or on behalf of consumers and families. ▪ Regular travel to conduct member, provider and community-based visits as needed to ensure effective administration of the program.

Minimum Experience Required:

- High School Diploma / GED or higher.
- Lived experience with complex and difficult issues which may include homelessness, criminal justice system, substance use disorders, severe mental illness, and foster care programs.
- Experience utilizing the principles of recovery and resiliency (i.e., concept of recovery plans, the 12-step model, family reunification, re-entry, and community reintegration.

Skills Required:

- Relevant experience to perform the functions of a mentor.
- Strong interpersonal and communication skills.
- Good judgment in maintaining responsibilities of the position in advocating for the best interest of members served.
- High level of ability with oral and written communication.
- Ability to work effectively with diverse individuals and groups.
- Maintain ethical standards with attention to boundaries and self-care.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- High School Diploma / GED or higher

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified Recovery Specialist preferred OR the ability to become certified within 12 months of employment

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Performance Improvement Evaluator
Description of Position: The Performance Improvement Evaluator leads, implements, and evaluates performance improvement and population health processes through the integration of quality improvement science. The Performance Improvement Evaluator is responsible for pulling evidence-based interventions for individuals like the PIP cohort and presenting the information to the core PIP team. The evaluator knows how to communicate complex data findings to a lay audience since the core PIP team varies in backgrounds and expertise. The evaluator will develop and track the intervention effectiveness, work with targeted provider groups (if applicable), and develop PIP documents for submission to the state. This evaluator studies the data, compares the results to the initial objectives and aims and summarizes findings. The evaluator identifies changes that may be made and work with the core PIP team to determine the next cycle for improvement.
Description of Responsibilities of Position: ▪ Serve as the market professional expert for program evaluation, study designs, and methodological techniques. ▪ Support market Quality Director to conduct assessments using qualitative and quantitative methodologies and continuous improvement tools to identify issues and opportunities to improve health outcomes. ▪ Contribute to the development, implementation and monitoring of action plans based on performance metrics (State Agencies, AHRQ, HEDIS, CAHPS). ▪ Support the market Quality Director and market business owners in developing and monitoring Performance Improvement Projects (PIPs). ▪ Develop quarterly and annual quality data analysis reports. ▪ Use statistical techniques, graphics, and data to summarize HEDIS analytical needs to measure impact of various actions/results. ▪ Monitor and provide reports regarding, process of provider profiling, focus groups and stakeholder interviews. ▪ Identify opportunities for improvement in performance measure and survey scores based on evidence-based, results of quantitative and qualitative analysis. ▪ Assist in the development of focus studies using epidemiological methodology to target population for interventions. ▪ Conduct assessments to identify issues and opportunities using qualitative and quantitative methodologies and continuous improvement tools to improve health outcomes. ▪ Contribute to the development of surveys, evaluation designs and facilitation guides. ▪ Conduct process and gap analysis to diagnose process improvement opportunities and to develop re-usable solutions using principles of process excellence and related tools. ▪ Explore best practices across various industries to bring to the work team.
Minimum Experience Required: ▪ Master of public health or related field degree (e.g., health promotion, evaluation etc.) is required or equivalent years of experience. ▪ Minimum of five (5) years of relevant work experience in program evaluation is required. ▪ Experience using the model for improvement (PDSA-Plan, Do, Study, Act) is required. ▪ Education or work experience in maternal and child health or chronic conditions is preferred. ▪ Previous healthcare or managed care experience is preferred.

Skills Required:

- Proficient in Microsoft Word, Access and advanced proficiency in Excel is required.
- Knowledge of a variety of quality improvement methodologies – Model for Improvement, Lean, Six Sigma.
- Knowledge of establishing and documenting PDSA cycles and key driver diagrams.
- Analytic skills for solving problems.
- Knowledge of managed care and health care data coding is preferred.
- Graphic development/presentation skills
- Familiar with descriptive statistical application and techniques.
- Critical listening, thinking skills, and verbal and written communication skills.
- Problem solving skills.
- Excellent writing skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Master of public health or related field degree (e.g., health promotion, evaluation etc.) is required or equivalent years of 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: N/A

Key Position: Job Description
Title of Position: Perinatal Health Director
Description of Position: The Perinatal Health Director is responsible for the development, implementation and revision of the Perinatal Health policy through covered services to Members.
Description of Responsibilities of Position: ▪ Support market provider network development and maintenance. ▪ Provider education, training, data sharing, performance evaluations and orientation to the plan. ▪ Participate in peer-to-peer discussions. ▪ Community collaborative participation. ▪ Participate in the evaluation and investigations of cases suspected of fraud, abuse, and quality of care concerns. ▪ Provide cross-coverage for other Medical Directors and/or markets, as needed. ▪ Understand and provide support to prior authorization and utilization review functions. ▪ Support staff by providing training, clinical consultation, and clinical case review for members. ▪ Conduct clinical reviews for designated members.
Minimum Experience Required: ▪ Successful completion of a residency training program, preferably in primary care is required. ▪ Actively practicing physician with a specialty in obstetrics and gynecology in Mississippi or have been an actively practicing physician in Mississippi with a specialty in obstetrics and gynecology in the past five (5) years and located in Mississippi. ▪ Managed care medical review/medical director experience is preferred.
Skills Required: ▪ Basic Microsoft Word skills. ▪ Excellent communication skills, both written and oral. ▪ Ability to work well independently and within a team environment. ▪ Ability to create strong relationships with Providers and Members. ▪ High ethical standards. ▪ Attention to detail. ▪ Critical listening and systematic thinking skills. ▪ Ability to maintain confidentiality and act in the company's best interest. ▪ Ability to act with diplomacy and sensitivity to cultural diversity. ▪ Decision making/problem solving skills. ▪ Conflict resolution skills. ▪ Strong sense of mission and commitment of time, effort, and resources to the betterment of the communities served. ▪ Ability to analyze healthcare data from a variety of sources to evaluate physician practice patterns. ▪ Leadership experience and skills.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Completion of an accredited Medical Degree program as a medical doctor (MD) or Doctor of Osteopathic (DO) medicine is required. ▪ Successful completion of a residency training program, preferably in primary care is required.

▪ Bachelor's or Master's degree in Business Administration, Operational Excellence, Healthcare Administration or Medical Management is preferred.
Are any professional licenses or certifications required for this position? [X] Yes [ ] No **If yes, list below:** ▪ Current, unrestricted license to practice medicine in Mississippi is required
Are there any continuing education requirements for this position? [ ] Yes [X] No **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Population Health Director
Description of Position: Population Health Director is responsible to work directly with the Medical Director in the execution of the population health strategies in collaboration with population health corporate and market leadership.
Description of Responsibilities of Position: ▪ Actively work with Corporate and Market leadership in the ongoing oversight of operational procedures as they relate to the model. ▪ Ongoing collaboration with corporate and market leadership to ensure that business objectives are being defined and achieved; drive the prioritization of projects ensuring alignment with organization wide initiatives. ▪ Direct and oversees population health systems to support corporate and markets. ▪ Set vision, direction and execution for population health business applications. ▪ Develop strategy and high-level implementation plan for the delivery of new applications. ▪ Develops the portfolio strategy to facilitate alignment across programs, coordination or deliverables and optimization of resources. ▪ Act as a liaison to the Enterprise Project Office, Continuous Improvement, Information Technology, Corporate Compliance, Internal Audit, and any other related functions to ensure alignment with organizational standards and processes. ▪ Ensures that projects align with the technology that best provides maximum return on investment and helps directs IT strategy in support of the overall business goals. ▪ Oversee the operational governance and participate in the prioritization of population health projects ensuring alignment with organization wide initiatives. ▪ Lead the development of aligned collaborative core infrastructure to ensure organization wide alignment with population health model. ▪ In collaboration with market leadership, create an effective organizational structure that clearly delineates roles and responsibilities. ▪ Ensures that strategies are in place for risk identification, mitigation, and contingency planning. ▪ Lead in the development of process to achieve operational excellence in all areas within the model. ▪ In collaboration with population health leadership, provide strategic oversight of development and maintenance of documentation related to workflows and process. ▪ Report and communicate the results from process improvement efforts to leadership. ▪ Ensure staff and leadership training on the model, programs, and requirements, to include new hire training, annual training for all staff, and other specific training as appropriate. ▪ Collaborate with marketing to inform and educate community via media outlets. ▪ Develop community partnerships to address population health issues. ▪ Oversee and control process changes that result from market level regulatory/compliance requirements to ensure alignment with the model and minimize unintended model variance.
Minimum Experience Required: ▪ Minimum of five (5) years of experience in health care is required. ▪ A minimum of five (5) years of business/operational improvement or process redesign experience is required.

- Prior management experience is required.

Skills Required:

- Proficient in Microsoft Excel, Word, PowerPoint, and Excel.
- Critical listening and systematic thinking skills.
- Planning, problem identification and resolution skills.
- Business process/management skills.
- Ability to maintain confidentiality and act in the company's best interest.
- Strong oral, written, and interpersonal communication skills.
- Excellent leadership, management and supervisory skills and experience.
- Energetic, enthusiastic, and politically astute.
- Ability to act with diplomacy and sensitivity to cultural diversity.
- Responsive to a changing environment.
- Strategic deployment and management skills.
- Conflict resolution skills.
- Knowledge of regulatory reporting and compliance requirements.
- Proficiency with quality improvement, performance improvement and operations.
- Ability to work with multi-disciplinary departments across the organization.
- Demonstrated ability to develop, prioritize and accomplish goals.
- Strong interpersonal skills and high level of professionalism.
- Ability to work independently and within a team environment.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree in Finance, Business, or Health Care field or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: Program Integrity Director
Description of Position: The Program Integrity Director is responsible for scoping, planning, prioritizing, and managing all functions relating to program integrity.
Description of Responsibilities of Position: ▪ Formulates strategies and implements approach to identify and address FWA risks to members and the Company. ▪ Drives advocacy and awareness efforts for healthcare/Medicaid/Medicare FWA issues with state and federal legislators. ▪ Monitors emerging FWA legislative and policy issues at state and federal levels with the goal of proactive organizational response to opportunities and issues. ▪ Collaborates with state and national trade associations on key FWA investigations, policy issues and advocacy objectives. ▪ Mitigates company risks identified in the course of investigations such as policies and procedures, claim system edits, and other deficiencies, etc. ▪ Prepares, monitors, and executes the department budget; monitors and approves department expenses. ▪ Chairs the Investigations Committee where investigative results and recommended corrective actions are presented to Executive Management to obtain their endorsement. ▪ Reports investigative actions to the Compliance Committee. ▪ Hires, trains, develops, and appraises Special Investigation staff ensuring a strong, competent, and talented team of high integrity professionals. ▪ Presents FWA schemes and training internally and at national conferences. ▪ Conducts on-site audits of medical professionals, business partners and contracted entities. ▪ Collaborates with law enforcement, regulatory agencies, Fraud Task Force members, medical boards, etc. to facilitate FWA identification, prevention, and investigation. ▪ Provides testimony as needed in any FWA matters involving litigation both criminally and civilly. ▪ Prepares timely reports regarding identified FWA to all appropriate state and federal agencies. ▪ Participates in departmental and corporate strategic planning, initiative prioritization and recommended action plans as they relate to Program Integrity. ▪ Required to know and uphold the provisions of the Corporate Compliance Plan.
Minimum Experience Required: ▪ Bachelor's degree or equivalent work experience in Law Enforcement, Accounting, or a medical discipline with significant experience in health insurance investigations is required. ▪ Minimum seven (7) years healthcare investigation experience required. ▪ Minimum five (5) years healthcare management experience required.
Skills Required: ▪ Advanced level experience in Microsoft Office products. ▪ Data analysis and trending skills. ▪ Executive leadership experience and skills. ▪ Knowledge of medical insurance and/or state regulatory requirements desirable. ▪ High level investigative experience. ▪ Excellent written and oral communication skills.

- Ability to communicate effectively with executive management and business community.
- Proven results-oriented leadership.
- Attention to detail.
- Critical listening and thinking skills.
- Training/teaching experience.
- Negotiation skills/experience.
- Customer service orientation.
- Communication skills.
- Strategic management skills.
- Negotiation skills/experience.
- Decision making/problem solving skills.
- Advanced knowledge of healthcare billing and coding.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree or equivalent work experience in Law Enforcement, Accounting, or a medical discipline with significant experience in health insurance investigations is required

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- NICB, IASIU, ACFE, or NHCAA certificates or training in healthcare fraud and abuse investigations, preferred but not required

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Program Integrity Internal Controls Analyst
Description of Position: The Program Integrity Internal Controls Analyst is responsible for analyzing complex Program Integrity requirements for all product lines to ensure delivery on commitments.
Description of Responsibilities of Position: ▪ Lead SIU implementation of Program Integrity Medicaid/Medicare legal, regulatory and contract requirements with little direction. ▪ Develop and document all required state and federal monthly, quarterly, and annual reports. ▪ Monitor and audit Grievance and Appeals and Prior Authorizations for fraud trends/patterns and under- and overutilization of benefits. ▪ Establish, control, evaluate and revise FWA detection, deterrent and prevention policies and procedures/processes; ensure compliance with all state and federal requirements. ▪ Draft responses to all required state and federal audits, questionnaires, surveys and other inquires. ▪ Draft responses to state and federal Readiness Review Tools (RRTs) and Requests for Proposals. ▪ Calculate financial impact for SIU Investigative Corrective Actions. ▪ Draft and submit responses to SIU Management surveys. ▪ Lead implementation of new compliance/legal requirements. ▪ Represent SIU on key external and internal committees. ▪ Assist in training SIU department personnel on SIU policies, procedures and processes and implementation status. ▪ Write and present reports and participate in department level projects. ▪ Attend any training required by state and federal agencies about Program Integrity compliance. ▪ Initiate and maintain network and outreach activities to ensure best practices in SIU functions. ▪ Oversee the member/provider recovery account receivable process. ▪ Prepare, update and/or contribute to all FWA prevention and reporting materials including Provider Manuals, Member Handbooks, Employee Handbook, Member/Provider Newsletters, website pages, check flyers, reporting forms, FWA E-Learning, FWA reporting mechanisms, FWA Policies and Procedures ,etc. ▪ Update, prepare, distribute, and collect attestations for FWA informational letters to Delegated Entities. ▪ Capture and draft report of required EOB data to state and federal agencies. ▪ Create and maintain detail, audit-ready, and product specific documentation for all FWA requirements. ▪ Capture SIU management statistics and prepares report for department management monthly. ▪ Attend FWA and/or compliance seminars annually to stay current on Program Integrity issues. ▪ Establish and maintain collaborative working relationships with state, federal and other managed care Medicaid/Medicare Program Integrity functions. ▪ Support NCQA and URAC Program Integrity accreditation initiatives to include any policy, procedure and process changes required and educating SIU staff on requirements. ▪ Know and uphold the provision of the Corporate Compliance Plan. ▪ Maintain confidentiality of all SIU investigative case information.

- Present FWA overview and employee responsibilities at each new hire training class.

Minimum Experience Required:

- Bachelor's Degree in Compliance, Healthcare or a Legal field or equivalent years of relevant work experience is required.
- Minimum of four (4) years of experience in a compliance or legal field is required.
- Previous experience in internal and external auditing, risk management and performance improvement is required.
- Previous experience in financial calculations is required.
- Experience with Marketplace, Medicaid and/or Medicare products is strongly preferred.

Skills Required:

- Advanced level of proficiency with Microsoft Office Suite.
- Strong written and oral presentation skills.
- High level of integrity and ethics.
- High level communication skills both verbal and written.
- Ability to work independently and collaboratively within a team environment.
- High attention to detail.
- Familiarity with the healthcare field.
- Critical listening and thinking skills.
- Skill in negotiating issues and resolving problems.
- Leadership experience and ability required.
- Strong decision making/problem solving ability.
- Ability to manage multiple projects and deadlines.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree in Compliance, Healthcare or a Legal field or equivalent years of relevant work experience is required

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Fraud or Compliance designation/certification is required

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Project Manager

Description of Position:
The Project Manager leads the delivery of complex programs/projects that significantly enhance business operations and strategic goals for the Market.

Description of Responsibilities of Position:

- Establish a trusted advisor relationship with assigned business area executives—as primary liaison prepare and execute the long range plan and tactical roadmap, optimize throughput, and ensure the delivery of projects/enhancements that maintain operational stability, enable industry parity, and achieve targeted industry leadership
- Ensure compliance with the contract with the state or Commonwealth
- Establish and maintain strong cooperative working relationships with regulatory agencies and state legislators
- Partner with the Business and IT to ensure the successful on-time delivery and operational readiness of sustainable (and preferably scalable) business solutions
- Identify and manage risks, and assist with the mitigation strategies, contingency plans, and stakeholder communication
- Identify and assist with the rapid resolution or escalation of issues, blockers, and hindrances
- Use the Corporate governance process to manage and control scope / budget / schedule changes
- Integrate continuous improvement and innovation into all projects and enhancements
- Assist with the improvement of project management and service delivery best practices and tools
- Establish market policies, processes and procedures

Minimum Experience Required:

- Bachelor's degree in finance, business, healthcare or other related field is required; Master's in Business Administration, Healthcare Administration and/or other related discipline is preferred
- A minimum of five (5) years of experience driving systemic innovation and improvement is required
- Deep working knowledge of Government-regulated (Federal and/or State) health insurance products including Medicaid, Medicare and Marketplace is required
- Understanding of Medicare/Medicaid/Exchange/Special Populations' regulatory environment

Skills Required:

- Demonstrated ability to lead direct reports and matrixed teams to successfully deliver complex initiatives within budget and against immovable deadlines
- Extensive knowledge of Agile and Project Management methodologies
- Exceptional collaboration, relationship building, and influencing skillset
- Flexibility in leading organizational change
- Exceptional planning and time management skills

- Excellent listening and critical thinking skills
- Excellent decision-making and problem solving skills
- Proven ability to effectively interact at all levels within the organization
- Excellent written and verbal communication skills
- Hands on proficiency in Microsoft Office tools, including Project, Outlook, Word, PowerPoint and Excel
- Business acumen and politically astute—ability to act with diplomacy and sensitivity to cultural diversity
- Ability to work independently and within a team environment

Are there any educational requirements for this position? [X] Yes [ ] No

If yes, list below:

- Bachelor's degree in finance, business, healthcare or other related field is required; Master's in Business Administration, Healthcare Administration and/or other related discipline is preferred

Are any professional licenses or certifications required for this position? [ ] Yes [X] No

If yes, list below: N/A

Are there any continuing education requirements for this position? [ ] Yes [X] No

If yes, list below: N/A

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Provider Enrollment Coordinator
Description of Position: The Provider Enrollment Coordinator is responsible for ensuring that credentialing activities comply with URAC, NCQA, state and federal regulations.
Description of Responsibilities of Position: ▪ Ensure credentialing activities comply with URAC, NCQA, state and federal regulations. ▪ Check daily work queues to determine priority of workload including routine credentialing processing and maintenance. ▪ Perform review functions on files prior to initiating Primary Source Verification (PSV) and Secondary Source Verification (SSV) including, but not limited to discontinuations, provider notifications, and other credentialing functions. ▪ Coordinate efforts with Provider Relations (PR), Provider Data Integrity and provider to complete/obtain all missing components of each application. ▪ Complete PSV and SSV for providers and organizations. ▪ Utilize critical thinking skills when reviewing provider files to determine if provider meets established criteria. ▪ Submit completed applications for auditing prior to Credentialing Committee. ▪ Responsible for staying abreast of: state and federal regulations pertaining to provider credentialing and re-credentialing and NCQA and URAC Credentialing Standards to ensure compliance and continued accreditation. ▪ Perform monthly mailings for providers due for re-credentialing. ▪ Complete provider re-credentialing within required time-frame. ▪ Respond to calls and emails from internal/external customers, Monday-Friday, 8am-5pm. ▪ Scan credentialing files and attach in Cactus in a timely manner. ▪ Assist customers while on the Credentialing phone queue. ▪ Adhere to Credentialing Service Level Agreements. ▪ Identify and prepare provider issue files to present to Medical Director for review, decision and signature prior to Credentialing Committee presentation. ▪ Prepare and reconcile weekly Credentialing Committee Roster and present to Medical Director for review, approval and signature. ▪ Process approved weekly Credentialing Committee files utilizing Cactus to generate roster, close records, create appointment letters and update status codes. ▪ Work on special projects as assigned that include reconciliation projects, processing urgent provider and organization applications, and others. ▪ Maintain confidentiality of provider information and ensure all provider files are securely stored in the credentialing file drawer or in the provider file room at close of business each day.
Minimum Experience Required: ▪ High School Diploma or equivalent is required. ▪ Minimum of one (1) year credentialing experience/knowledge is required.
Skills Required: ▪ Intermediate computer skills and ability to type 60+ WPM. ▪ Proficient in Microsoft Word and Excel. ▪ Knowledge of URAC and NCQA accreditation credentialing standards. ▪ Communication skills.

- Ability to work independently and within a team environment.
- Attention to detail.
- Familiarity of the healthcare field.
- Knowledge of medical terminology.
- Knowledge of Medicaid & Medicare managed care.
- Critical listening and thinking skills.
- Uses proper grammar.
- Technical writing skills.
- Time management skills.
- Proper phone etiquette.
- Customer service orientated.
- Decision making/problem solving skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- High School Diploma or equivalent is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- NAMSS certification in credentialing is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Provider Services Call Center Specialist
Description of Position: The Call Center Specialist assists members or providers with routine service inquiries.
Description of Responsibilities of Position: ▪ Resolve member or provider routine service inquiries; examples include claims processing, member benefit education, contracting and credentialing requests, eligibility inquiries, and transportation arrangements. ▪ Ensure all HIPAA and State requirements/regulations are always adhered to. ▪ Research, follow up, and resolve all open/pending issues in a timely manner to ensure member or provider satisfaction. ▪ Build and strengthen member or provider relationships by providing quality customer service. ▪ Maintain knowledge and understanding of all processes and procedures. ▪ Adhere to all departmental and company policies and procedures. ▪ Maintain complete and accurate documentation of all of telephone and written communications. ▪ Act as a mentor to new hire employees.
Minimum Experience Required: ▪ High School Diploma or equivalent is required. ▪ Two (2) years customer service experience is preferred. ▪ Customer Service experience in a call center is preferred.
Skills Required: ▪ Critical thinking and listening skills. ▪ Decision making and problem-solving skills. ▪ Computer proficiency with knowledge and experience in a Windows environment. ▪ Typing speed of 35 words per minute (WPM). ▪ Strong written and communication skills. ▪ Works well under pressure. ▪ Professional phone etiquette. ▪ Proper use of grammar. ▪ Ability to work in a fast-paced environment. ▪ Adaptable to a constantly changing environment. ▪ Attention to detail. ▪ Ability to multitask. ▪ Ability to work independently and with a team.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ High School Diploma or equivalent is 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: N/A

Key Position: Job Description
Title of Position: Provider Issue Resolution Specialist
Description of Position: The Provider Issue Resolution Specialist is responsible for capturing, resolving/facilitating resolution, and reporting on requests from providers.
Description of Responsibilities of Position: ▪ Resolve complex COB issues through member information updates and adjustment of claims. ▪ Maintain accountability for daily tasks and goals to ensure completion of requests within requested SLA and department standards. ▪ Identify potential process improvements. ▪ Work with peers to ensure implementation of identified process improvements through the Plan, Do, Study, Act (PDSA) cycle with proper documentation updates and sharing of improvement with team and department. ▪ Process/adjust a wide variety of claims accurately and timely following established guidelines for accuracy, quality, and productivity. ▪ Act as a technical resource for training, providing job shadowing, departmental communication, and coaching. ▪ Ensure all assigned provider issues are resolved and communicated to the provider within appropriate timeframes and claims resolutions are coordinated with all appropriate departments in order to resolve. ▪ Assist providers with inquiries including but not limited to; verifying proper medical coding, explanation of benefits, negative balance requests, claims, and appeal procedures. ▪ Identify, track and trend claims payment errors in order to determine root causes and actions needed to correct problems. Work directly with Configuration, Network Operations, and call center through resolution of payment errors. ▪ Ensure reporting on provider inquires and complaints is compliant with current and future regulatory and accreditation bodies ▪ Adhere to all HIPAA, State, and Federal requirements and regulations at all times in existing and future lines of business.
Minimum Experience Required: ▪ High School Diploma or equivalent is required. ▪ Minimum of one (1) year of experience in claims environment or related healthcare operations experience required. ▪ Previous experience in an HMO or related industry preferred. ▪ Previous Medicare/Medicaid dual eligible claims experience is preferred. ▪ Managed Care Organization or related healthcare industry experience preferred.
Skills Required: ▪ Proficient in Microsoft Office Suite, to include Word, Excel, and PowerPoint. ▪ Medical terminology; CPT and ICD coding knowledge strongly preferred. ▪ Knowledge of medical billing practices. ▪ Intermediate level data entry skills. ▪ Excellent written and verbal communication skills. ▪ Ability to develop, prioritize and accomplish goals. ▪ Effective listening and critical thinking skills. ▪ Strong interpersonal skills and a high level of professionalism.

- Ability to coach and provide feedback effectively.
- Effective problem-solving skills with attention to detail.
- Ability to work independently and within a team environment.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- High School Diploma or equivalent is 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: N/A

Key Position: Job Description
Title of Position: Provider Services Representative
Description of Position: The Provider Services Representative is responsible for collaborating with key Health Partners in the development of specific strategies for enhanced engagement.
Description of Responsibilities of Position: ▪ Support the account strategy and provide account support with the goal of driving the overall satisfaction and engagement of key Health Partners. ▪ Resolve routine issues with the Health Partners in the market in accordance with the department's service level agreements/expectations. ▪ Participate in the maintenance and development of key relationships within defined Key Accounts. ▪ Proactively and in response to concerns reach out to Health Partners to ensure their needs are being met and to see if there are any issues that they need help resolving. ▪ Perform maintenance tasks in designated system(s). ▪ Complete Health Partner education, compliance, and/or complaint resolution. ▪ Maintain PR Customer Relationship Management (CRM) tool and assignment of tasks for the Health Partner Consultant when appropriate. ▪ Work collaboratively with departmental staff and management personnel to ensure continuous performance improvement in an effort to improve customer satisfaction and internal operations. ▪ Document all provider concerns in applicable systems and work collaboratively within the organization to resolve identified issues. ▪ Prepare and review analysis to assist in the review of provider performance. ▪ Support recruitment and contracting efforts by developing strong interpersonal relationships with providers. ▪ Regular travel to conduct health partner visits and community-based visits as needed to ensure effective administration of the program.
Minimum Experience Required: ▪ Bachelor's degree in business, communications, or related field or equivalent experience is required. ▪ One to three (1-3) years of healthcare industry, account management or sales experience, preferably in the Healthcare field is preferred.
Skills Required: ▪ Intermediate proficiency level with Microsoft Outlook, Word, and Excel. ▪ Knowledgeable of Cactus or other like system. ▪ Knowledge of various reimbursement methodologies to include capitation, per diems, discounts, etc. ▪ Strong customer service skills. ▪ Excellent written and oral communication skills. ▪ Strong problem-solving skills. ▪ Strong interpersonal skills. ▪ Ability to work as a team. ▪ Ability to manage multiple projects and prioritize.

▪ Intermediate negotiation skills. ▪ Excellent research and analytical skills. ▪ Marketing competencies.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's degree in business, communications, or related field or equivalent experience is 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: N/A

Key Position: Job Description
Title of Position: Provider Services Manager
Description of Position: The Provider Services Manager is responsible to guide Team Leaders and staff relative to daily operational issues regarding provider issues.
Description of Responsibilities of Position: ▪ Ensure quantitative and qualitative objectives are used to meet performance objectives. ▪ Manage staffing and scheduling functions. ▪ Compile reports and departmental communications. ▪ Participate in strategic planning and recommendation of action plans. ▪ Interface with team leaders on effective people management strategies such as staffing, coaching, and mentoring. ▪ Lead/participate in strategic department/company projects. ▪ Recommend process improvements. ▪ Maintain positive relationship with internal and external customers.
Minimum Experience Required: ▪ Minimum of three (3) years of previous management/leadership experience preferred. ▪ Previous experience in an HMO environment or related industry preferred.
Skills Required: ▪ Proficient in Microsoft Word, Excel, and PowerPoint. ▪ Knowledge of Medicaid. ▪ Familiarity of healthcare field. ▪ Strong management skills. ▪ Strong collaboration and conflict resolution skill sets. ▪ Proven leadership with the ability to build relationships, collaborate and influence at all levels. ▪ Ability to work in a fast-past environment. ▪ Attention to detail. ▪ Ability to develop, prioritize and accomplish goals/time management. ▪ Strong decision making and problem-solving skills. ▪ Exceptional written and verbal communication skills. ▪ Ability to work independently and within a team environment. ▪ Effective active listening and critical thinking skills. ▪ Display a customer service, member-focused orientation.
Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor's Degree in business related field or equivalent years of experience 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: N/A

Key Position: Job Description
Title of Position: Quality Improvement Coordinator
Description of Position: The Quality Improvement Coordinator assists in project management of QI projects with the Clinical Quality Care Analysts and across the Enterprise
Description of Responsibilities of Position: ▪ Responsible for interacting with the QI team to develop and implement QI projects, activities, and studies (PIPs, QIPs, EDV study, etc.). ▪ Supports QI Department team meetings by assisting in the coordination and facilitation of the meetings. ▪ Assist in the preparations of QI presentations, coordinate the documentation and collaborate schedules of external and internal QI activities and projects. ▪ Develop detailed reports of data for analysis of clinical quality of care grievances, quality of care concerns, sentinel events, readmissions, complications, morbidity and mortality for QI department and Markets. ▪ Research Internet, OnBase, SharePoint, Streamline and other systems to support QI projects and activities. ▪ Assist in retrieval of all Clinical Quality of Care Grievances (all products) and Quality of Care Concerns, Sentinel events, etc. routed to Enterprise QI and disperse daily to the appropriate QI reviewer. ▪ Maintain all QI projects, activities, etc. in a secure manner. ▪ Request medical records, information, etc. from providers/facilities to assist in QI investigations, as applicable. ▪ Assist in Quality Enterprise Committee and Market Quality Improvement Committees preparation of reports, documents, etc. ▪ Coordinate dental clinical quality of care grievances and quality of care concerns and assist in streamlining these issues. ▪ Develop policy and procedures, Quick tools, SOPs for the QI Department. ▪ Assist in tracking and trending member health, safety, and welfare issues in regards to specific providers, facilities, etc. ▪ Demonstrates aptitude for project management by collaborating with internal/external teams. ▪ Respond to, forward and return calls from providers, facilities and/or other staff. ▪ Examine and identify ways to improve existing processes/workflows. ▪ Under the direction of the Enterprise QI Manager and Enterprise QI Director is responsible for the coordination of QI activities, reports, studies, etc. ▪ Assist in the discovery, design and implementation of the Single Member View Altruista system. ▪ Assist in preparation of CAC/PAC committee documents.
Minimum Experience Required: ▪ Bachelor's degree or equivalent years of relevant work experience is required. ▪ Minimum of two (2) years of healthcare, managed care, or administrative experience is required. ▪ Knowledge of the Model of Improvement (PDSA) is preferred.

Skills Required:

- Intermediate skill in Microsoft Excel, and Word.
- Intermediate skill level with SharePoint.
- Strong written and verbal communication skills.
- Ability to work independently and within a team environment.
- Ability to engage teams in a positive, energetic manner.
- Familiarity of the healthcare field and managed care.
- Effective listening and critical thinking skills.
- Strong interpersonal skills and high level of professionalism.
- Effective problem-solving skills with attention to detail.
- Ability to develop, prioritize and accomplish goals.
- Research, data analysis and trending knowledge.
- Ability to coordinate complex projects.
- Filing and organizational skills.
- Ability to work with a variety of disciplines and levels of staff across departments.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: Quality Improvement Manager
Description of Position: The Quality Improvement Manager manages the day-to-day prioritization of staff activities in collaboration with Quality Management Director.
Description of Responsibilities of Position: ▪ Responsible for Corporate oversight of the HEDIS Medical Record Review Unit as needed for the assigned market. ▪ Responsible for development and oversight of Quality Improvement (QI) Projects and Performance Improvement Projects related to HEDIS and pay for performance (P4P) requirements. ▪ Ensures compliance with External Quality Review audits/studies, Performance Improvement Projects, and Quality Improvement Projects required by the state, NCQA, and other accreditation bodies. ▪ Responsible for the review of QI issues regarding compliance with Federal, State, and Accreditation requirements. ▪ Ensure all policies and procedures are aligned with Federal, State, and Accreditation requirements. ▪ Responsible for the annual review, program description, program plan, and update of QI Department policies and procedures. ▪ Provide education to internal and external customers on quality improvement functions ▪ Respond to questions that pertain to HEDIS and Quality Improvement from providers and internal staff members. ▪ Foster relationships with all internal departments and represents at community-based and state programs. ▪ Collaborate with business owners to establish, implement, and develop best practices for P4P quality directives. ▪ Implement opportunities for process improvement that impact quality measurements in assigned market. ▪ Leads Quality Monitoring Unit in identifying and evaluating the markets risk areas related to Federal, State and Accreditation requirements and monitor plan performance against the requirements. ▪ Monitor industry trends as it relates to healthcare and identify areas of opportunity for improvements. ▪ Responsible for ensuring business owners successfully complete all deliverables related to performance improvement plans (PIPs) and quality improvement plans (QIPs) within defined timeframes. ▪ Conducts analysis, including root cause analyses with support from identified business units and ensure data is presented and used efficiently to meet the quality goals. ▪ Follows enterprise standards and procedures for all quality reporting and documentation and communicate areas of strengths as well as needs to the Quality Improvement Committee. ▪ Perform all facets of quality management to include the development of detail work plans, setting deadlines, assigning responsibilities and monitoring/summarizing project progress. ▪ Establish, monitor, and review mechanisms to assess and document each business units' level of compliance with each measure and coordinate corrective actions.

- Attends and participates in market quality committees.
- Guide and direct successful completion of daily tasks and projects.
- Interview, select and train new team members.
- Conduct performance management activities for direct reports, to include monthly one-on-one meetings, annual performance appraisals, and discipline as appropriate.

Minimum Experience Required:

- Bachelor's Degree or equivalent years of relevant work experience is required.
- Completion of an accredited Registered Nursing degree program or Bachelors of Science in Nursing (BSN) is preferred.
- Master's Degree in Nursing (MSN) or healthcare related field is preferred.
- A minimum of three (3) years of experience in a healthcare or managed care organization is required.
- Previous management experience is required.
- Medicaid and/or Medicare experience preferred.
- Experience in quality metrics preferred.

Skills Required:

- Intermediate proficiency in Microsoft Word, Excel, and PowerPoint.
- Solid leadership skills, able to effectively manage a high performing team, provide coaching and development.
- Demonstrated ability to adjust and shift priorities, multi-task, work under pressure and meet deadlines.
- Proven ability to recognize opportunity for improvement and lead change.
- Data analysis and trending skills.
- Effective communication skills.
- Prior supervisory skills.
- Ability to work independently & in a team environment.
- Training/teaching skills.
- Time management skills.
- Critical listening and thinking skills.
- Strategic management skills.
- Decision making/problem solving skills.
- Customer service oriented.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree or equivalent years of relevant work experience is required
- Completion of an accredited Registered Nursing degree program or Bachelors of Science in Nursing (BSN) is preferred
- Master's Degree in Nursing (MSN) or healthcare related field is preferred

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current, unrestricted Registered Nurse (RN) licensure in the state of practice is preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Quality Improvement Specialist
Description of Position: The Quality Improvement Specialist collaborates with department manager and other leadership to evaluate opportunity for HEDIS data and process improvement in new or existing projects with focus on measurable benefits.
Description of Responsibilities of Position: ▪ Conducts business process and gap analysis to diagnose process improvement opportunities and to develop re-usable solutions using principles of process excellence and related tools. ▪ Directly responsible for improvement work teams, to include: working with management to identify the appropriate team members, coordination and facilitation of team meetings and management of improvement work team projects. ▪ Collaborates with management team to support necessary documentation of QIPs and PIPs and other quality activities. ▪ Trains, educates, and deploys improvement tools, methods and processes throughout the departments assigned. ▪ Analyzes work processes using improvement tools and methodology to identify improvement opportunities. ▪ Works with management and the improvement team to establish and implement effective measurement and data collection methods. ▪ Reviews and measures progress with management and work team and takes appropriate action. ▪ Explores best practices across various industries to bring to the work team. ▪ Develops, evaluates, and implements survey tools. ▪ Analyzes data from survey sources in order to provide input into improvement initiatives. ▪ Coordinates and participates in quality improvement committee meetings; develops agendas, prepares meeting minutes, prepares, and makes presentations, and follows-up on action items. ▪ Communicates in a clear, concise, and complete manner with upper management, peers, department staff, other disciplines within the organization, outside agencies and other entities to ensure prompt and proper exchange of information and resolution of issues. ▪ Assist with tracking, compiling, and reporting program and project metrics. ▪ Research, gather and analyze data to identify improvement opportunities. ▪ Work closely with Maternal Child and Health Outcomes Management and Vendor Management to monitor vendor and community partner performance. ▪ Monitor monthly/quarterly/annual reporting of vendors and ensure timely receipt and accuracy in completed material. ▪ Participate in workgroups and applicable committees. ▪ Prepare reports, briefing materials and other requested deliverables for programs and projects.
Minimum Experience Required: ▪ Bachelor's degree or equivalent years of relevant work experience is required. ▪ Minimum of three (3) years of healthcare or managed care experience is required. ▪ Experience using the Model for Improvement (PDSA – Plan, Do, Study, Act) is preferred. ▪ Medicaid and/or Medicare experience is preferred.

Skills Required:

- Knowledge of a variety of quality improvement methodologies – Model for Improvement, Lean, Six Sigma.
- Proficient in leading teams through establishing aim statements and identifying small tests of change.
- Proficient in establishing and documenting PDSA cycles and key driver diagrams.
- Excellent team facilitation skills.
- Ability to engage teams in a positive, energetic manner.
- Research, data analysis and trending.
- Proficient in Microsoft Office Suite to include Word, Excel, and PowerPoint.
- Excellent written and verbal communication skills.
- Ability to develop, prioritize and accomplish goals.
- Ability to work independently and within a team environment.
- Attention to detail.
- Familiarity of the health care field.
- Familiarity with applicable Federal regulations, State regulations, and accreditation standards.
- Effective listening and critical thinking skills.
- Strong interpersonal skills and high level of professionalism.
- Effective problem solving skills with attention to detail.
- Training/teaching skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree or equivalent years of relevant work experience is required

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified Professional in Healthcare Quality (CPHQ) or American Society for Quality (ASQ) certification preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Quality Management Director
Description of Position: The Quality Management Director is responsible for directing market activities to improve quality performance.
Description of Responsibilities of Position: ▪ Ensure market compliance with NCQA accreditation and quality requirements. ▪ Develops, organizes and monitors the Quality Improvement Plan and QAPI annually, and guides the implementation. ▪ Annually reviews, revises and communicates the Quality Improvement program and the QAPI to appropriate stakeholders by defined timeframes. ▪ Annually evaluates the previous year's Quality Improvement Program in order to develop the work plan for the upcoming year. ▪ Analyze potential member risk data and quality data to improve quality performance and care for members across organizational lines of business. ▪ Oversees market workgroups and committees, to improve quality measure outcomes. ▪ Leads market quality department r to improve quality of care to members through implementation of quality initiatives and interventions. ▪ Ensures business owners across the lines of business successfully deliver quality related standards compliance within defined timeframes. ▪ Ensures quality requirements are met through continual review, audit and monitoring of quality improvement / performance improvement activities. ▪ Attends and participates in quality committees as indicated. ▪ Responds to administrative inquiries related to quality issues or audits Oversees the development of corrective action plans, as needed. ▪ Oversees analysis, including root cause analyses, with support from identified business owners and departments; ensures data is presented and used effectively to address quality and performance improvement identified issues. ▪ Participates in community-based initiatives related to QI program initiatives. ▪ Establishes and maintains standards and procedures for quality reporting and documentation and communicates areas of strengths as well as opportunities for improvement through the Quality Committees. ▪ Oversees quality management including the development of work plans, setting deadlines, assigning responsibilities and monitoring/ summarizing progress to goals. ▪ Externally represents to appropriate committees, consultants, representatives and accreditation authorities. ▪ Chairs committees as assigned and reports outcomes / status as appropriate. ▪ Oversees performance improvement projects as directed by state regulators. ▪ Ensures compliance with regulatory quality reporting requirements. ▪ Provide assistance in the budgeting and financial forecasting/ analysis process. ▪ Maintain an in-depth knowledge of the company's business and regulatory and accreditation environments. ▪ Assist in strategic and business planning. ▪ Directs the day-to-day prioritization of staff activities.

Minimum Experience Required:

- Minimum of five (5) years of leadership/management experience is required.
- Minimum of three (3) years of experience in Medicaid, or a managed care organization is required.
- A minimum of five (5) years of experience developing, implementing and/or evaluating Quality Improvement Programs is required.
- Previous experience in quality is required.

Skills Required:

- Experience in data collection, analysis and trending of processes and outcomes.
- Intermediate computer skills; proficient in Microsoft Word, Excel, and PowerPoint.
- Demonstrated understanding of complex healthcare industry, health plan and business processes specific to Quality and Performance Improvement.
- Demonstrated experience in a high-growth business environment.
- Demonstrated detailed, in-depth knowledge of the principles of performance improvement, quality methodology, regulations and standards to meet health plan quality requirements.
- Strong working knowledge of health plan policies and procedures.
- High level of analytical and statistical skills.
- Ability to present pertinent data and recommendations clearly and concisely in a manner appropriate to end user audience(s).
- Ability to work in a fast-past environment and quickly reprioritize.
- Effective problem-solving skills with attention to detail.
- Ability to develop, prioritize and accomplish goals.
- Strong communication skills (both written and verbal) and ability to work with multi-disciplinary departments across the organization.
- Strong interpersonal skills and high level of professionalism.
- Ability to work independently and within a team environment.
- Active listening and critical thinking skills.
- Strategic leadership/management skills.
- Customer service, member-focused orientation.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor of Science in Nursing (BSN) or other degree in a healthcare, business, management, or related field is required
- Master's in Nursing, Business, Management, or related field is preferred

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

Must possess, or obtain within 6 months of hire, training in one or more of the following areas:

- Strategic Planning
- Six Sigma Certification
- Lean Six Sigma Certification
- Plan-Do-Study-Act Cycle
- Rapid Cycle Improvement

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: School Based Health Administrator
Description of Position: The School Based Health Administrator collaborates with other departments and business owners to improve quality of care to school-age members through implementation of quality initiatives and interventions.
Description of Responsibilities of Position: ▪ Develop and enhance relationships with school-based health centers (SBHCs) with the goal of providing accessible quality preventive and primary care services to school-aged members. ▪ Assist SBHCs in identifying gaps in care and expected outcomes in the health status of targeted populations. ▪ Participate in population health quality assurance and improvement activities with SBHCs. ▪ Enhance effectiveness of SBHCs' population health through a variety of member health outcome and quality improvement techniques. ▪ Strategize with SBHCs to develop and enhance the practice's engagement strategies for individual members. ▪ Link SBHCs to internal resources to ensure understanding of all operational and billing processes. ▪ Participate in driving and achieving established HEDIS initiatives as assigned. ▪ Support local presence by participating in community outreach programs/health events, meetings, and other opportunities in the community. ▪ Participate in national and/or state school-based health coalitions/ committees and focus groups and provide input regarding any suggested revision(s). ▪ Participate in internal workgroups/committees to improve quality measures, accreditation, and clinical monitoring outcomes. ▪ Assist in the determination of benchmarks, goals, and outcomes for all school-based health programs. ▪ Assist in development and implementation of regional plans in collaboration with the regional leadership and population health analytics team. ▪ Identify trends and patterns using standard company processes, reports, tools, and databases. ▪ Generate graphics that effectively describe, explore, and summarize analyses for communication to appropriate parties. ▪ Provide education on available resources to SBHCs for population health management. ▪ Initiate and maintain ongoing professional contacts with physicians, area health facilities, community organizations and institutions. ▪ Educate and provide information on services, benefits, and resources available. ▪ Collaborate to identify areas of opportunity to improve capabilities and partnership processes. ▪ Work independently under general supervision with considerable latitude for initiative and independent judgment. ▪ Look for ways to improve the process to make the members' experience easier and share with leadership to make it a standard, repeatable process. ▪ Regular travel to conduct provider visits and community-based visits as needed to ensure effective administration of the program.

Minimum Experience Required:

- Bachelor's Degree in Health and Human Services, nursing, public health, or related field or equivalent years of relevant work experience is required.
- Minimum of three (3) years of experience in nursing, social work, public health, or related healthcare field is preferred.
- Minimum of three (3) years of experience in school health, community health, Medicaid Managed Care, and/or similar setting is preferred.
- Experience working with data and data analytics is preferred.
- Experience working directly with providers is preferred.

Skills Required:

- Analytic skills for solving problems.
- Word, Excel, and/or Access skills are required; SQL and/or SAS experience preferred.
- Ability to operate a smart phone, tablet, or other mobile communication devices to ensure productivity and ability to perform essential functions.
- Ability to act with diplomacy and sensitivity to cultural diversity.
- Strong interpersonal skills and high level of professionalism.
- Ability to maintain confidentiality and act in the company's best interest.
- Ability to work independently and within a team environment.
- Knowledge of quality management/statistical reporting.
- Change resiliency.
- Excellent conflict resolution skills.
- Customer service oriented.
- Critical listening and thinking skills.
- Excellent written and verbal communication skills.
- Knowledge of local, state, and Federal laws and regulations.
- Knowledge of healthcare resources, benefits, and entitlements throughout the state.
- Ability to develop, prioritize and accomplish goals.
- Proven track record for improving processes to make things easier for those you have served.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree in Health and Human Services, nursing, public health, or related field or equivalent years of relevant work experience is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current unrestricted license in field of practice including (if applicable): Licensed Social Worker (LSW), Licensed Social Worker (LSW), Registered Nurse (RN) or Licensed Practical Nurse (LPN) license in the State of Service is preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Senior Manager of Enrollment Operations
Description of Position: The Senior Manager, Enrollment Operations provides leadership and direction to the Enrollment team to ensure the goals and standards of the department are met.
Description of Responsibilities of Position: ▪ Mentor managers, team leads and individual contributors to produce consistent, high quality deliverables. ▪ Responsible for team development and growth. ▪ Challenge the status quo and propose improvements in processes for higher efficiency and effectiveness. ▪ Understand enrollment end to end processes and able to comprehend impact of any enrollment issues to various departments in the organization. ▪ Responsible for quality of outputs and operational efficiency of the team. ▪ Responsible for managing staff to ensure timely, accurate and high quality completion of service items for internal customers. ▪ Oversee the financial and member enrollment reconciliation for assigned lines of business. ▪ Monitor vendor eligibility extract processes for all LOB's to ensure accurate and timely processing of eligibility data. ▪ Responsible for complying with and meeting all regulatory requirements assigned to their team. ▪ Manage enrollment technology and process analysts and associated activities involving 834 file processes and departmental P&P's. ▪ Manage all enrollment audit engagements to ensure accurate and timely response. As necessary, develop and implement corrective action plans to address audit results. ▪ Gather, analyze, and report data related to the performance of the department and make recommendations for process improvement(s). ▪ Actively participate in ongoing development of new products and technologies. ▪ Manage daily operations and projects through effective allocation of resources. ▪ Develop and maintain an in-depth knowledge of the company's business and regulatory environments. ▪ Incorporate effective change and risk management controls. ▪ Responsible for hiring, training, coaching, and developing direct reports including completing performance appraisals and disciplinary actions. ▪ Mentor team leads and team members to produce consistent, high quality deliverables.
Minimum Experience Required: ▪ Bachelor's Degree or equivalent work experience is required. ▪ Minimum of five (5) years of leadership/management experience is required. ▪ Minimum of five (5) years of business operations or similar experience is required, preferably in a health care environment. ▪ Medicaid managed care, Medicare Advantage, or other healthcare experience is preferred.

Skills Required:

- Strong understanding of health plan enrollment processes.
- Expert proficiency in Facets subscriber and member setup, benefits eligibility [including COB].
- Strong Knowledge of enrollment reconciliation is preferred.
- Strong Knowledge of regulatory reporting and compliance requirements is preferred.
- Expert in use of online services to verify member eligibility for each CareSource program, and internal and external eligibility search functions.
- Advanced people management/leadership skills.
- Strong knowledge of database management desired.
- Knowledge of working with IT teams and providing requirements.
- Ability to effectively prioritize and execute tasks in a high-pressure environment.
- Ability to defuse tension and manage conflict among and between teams and members.
- Advanced communication skills (both written and verbal) and ability to work with multi-disciplinary departments across the organization and all levels of management.
- Excellent mentoring and coaching skills.
- Persuasive, encouraging, and motivating.
- Excellent decision making/problem solving skills.
- Strong critical thinking and listening skills.
- Analytical thinking.
- Actively gathers appropriate level of participation and input to decision-making and fosters it within teams.
- Focuses and aligns actions and decisions on ways to enhance service and Member experience.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree or equivalent work experience is 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: N/A

Key Position: Job Description
Title of Position: Special Investigations Unit (SIU) Data Reporting Analyst
Description of Position: The SIU Data Reporting Analyst is responsible for the production, preparation and reporting of various analyses that meet the data information needs of the SIU.
Description of Responsibilities of Position: ▪ Analyze and quantify claim payment issues and provide recommendations to mitigate identified program integrity risks. ▪ Identify fraud and abuse trends and patterns by creating queries utilizing business intelligence software, analyzing, and formatting the data, and creating detailed reports of findings along with recommendations. ▪ Analyze claim data and create reports to address strategic benefit design/contracting issues affecting program integrity identified in investigative cases and/or the Payment Integrity Committee. ▪ Work closely with Financial Planning and Analysis to ensure the financial accuracy of claim data pulled for SIU recoveries and financial impact analysis. ▪ Conduct, examine and explain complex data relationships that answer questions regarding claim payments. ▪ Monitor quality of data submitted to regulatory and law enforcement agencies. ▪ Verify data accuracy utilized for reports and analysis using Facets and other systems. ▪ Represent the SIU in Business Continuity Testing. Take responsibility to test and report in system functionality for all SIU system applications. ▪ Develop routine operational/analytical reports to evaluate data integrity to identify patterns and trends and data aberrancies/schemes to evaluate investigative findings. ▪ Maintain knowledge of current regulatory environment and CPT coding guidelines and terminology. ▪ Incorporate critical thinking skills and judgment to determine best course of action for each data inquiry/issue. ▪ Create reference material and standard operating procedures for SIU Data Analyst or/and other applicable positions. ▪ Provide training for any new SIU Data Analyst and any other applicable positions. ▪ Maintain the technical aspects of our fraud reporting methods to ensure that the appropriate updates are completed. ▪ Act as primary contact for initiating and coordinating data analytic projects with other business units of the organization. ▪ Utilize claims data and Geo Networks software to support SIU investigative efforts by generating geography map of providers or members. ▪ Perform investigations on own initiative or at the request of management. ▪ Attends NHCAA, AHIP, ACFE and compliance seminars annually to stay current on fraud and abuse and compliance issues. ▪ Work with SIU investigators to develop a strategy for SIU pended claims and works with the Claims Department to implement that strategy. ▪ Responsible for assisting SIU in meeting all regulatory and departmental deadlines. ▪ Provides legal testimony as needed to support data analytics, statistically valid sampling, etc. ▪ Maintain confidentiality of all SIU investigative case information.

- Know and uphold the provision of the Corporate Compliance Plan.

Minimum Experience Required:

- Bachelor of Science/Arts degree in management information systems (MIS), Computer Science, Business or related field or equivalent years of relevant work experience is required.
- Minimum of five (5) years of experience in data analysis and reporting is required.
- Minimum of two (2) years of experience in CPT coding knowledge and medical terminology is required.
- Previous experience in Healthcare billing experience is preferred.
- Experience in data mapping is preferred.
- Training in statistical process control methodology is preferred but not required.

Skills Required:

- Proven understanding of database relationships required.
- Proven programming skills with emphasis on mining/manipulation.
- Data analysis and trending skills.
- Facets Data Modeling knowledge preferred.
- Advanced MS Excel and/or Access.
- SAS experience preferred.
- Statistical knowledge desired.
- Advanced level experience in Microsoft Applications: Excel, Word, and PowerPoint.
- Advanced level of investigative experience preferred.
- Critical listening and thinking skills.
- In-depth data analysis skills.
- Demonstrated knowledge of business operations related to managed care.
- Knowledge of healthcare coding and billing processes, including CPT4, HCPCS, ICD-9, DRG and Revenue Codes preferred.
- Knowledge of Medicaid, Medicare and managed care preferred.
- Attention to detail.
- Customer service oriented.
- Decision making/problem solving skills.
- Communication skills both written and verbal.
- Ability to work independently and within a team environment to accomplish a common goal.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor of Science/Arts degree in management information systems (MIS), Computer Science, Business or related field or equivalent years of relevant work experience is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- IASIU, ACFE, AHIP or AFHI certificates/designations and/or advanced training in healthcare fraud and abuse investigations is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Special Investigations Unit (SIU) Investigator
Description of Position: The SIU Investigator is responsible for investigating and resolving all assigned allegations of healthcare FWA by medical professional, facilities, and members
Description of Responsibilities of Position: ▪ Conducts investigations on own initiative or at the request of management. Investigation includes data analysis, record review, cross company discussions, clinic inspections, member/provider interviews, coordination with legal representative, and legal case preparation. ▪ Performs data mining utilizing fraud, waste and abuse detection software to identify aberrancies and outliers. ▪ Provides updates and reports on investigation cases' progress and coordinates with SIU team members and management on recommendations, developing investigative plans, further actions and/or resolution. ▪ Coordinates claim audits by requesting probe and full statistical claim samples utilizing either random or targeted methodologies. ▪ Works with the RN Investigator to compare medical records to bills submitted for payment looking at documentation compared to ICD-9, CPT, and HCPCS codes. ▪ Examines abnormal claims and billing trends to determine if they appear to be fraudulent. ▪ Consults with medical directors and physician experts when necessary. ▪ Applies subject -matter knowledge to solve common and complex investigations. ▪ Conducts or participates in on-site audits of medical professionals, business partners and contracted entities. ▪ Arranges and conducts meetings with providers, provider employees, business partners and where appropriate, representatives from regulatory agencies and law enforcement in the conduction of investigations. ▪ Creates proposed provider education and corrective action plans. ▪ Collaborates with other departments including, but not limited to, Pharmacy, Medical Management, Provider Relations, Claims, Finance, Internal Audit, Regulatory, and Legal. ▪ May act as a team or project leader providing direction for team activities, facilitating information validation and team decision-making processes. ▪ Responsible for maintaining confidentiality of all sensitive investigative information. ▪ Develops and maintains contacts/liaison with law enforcement, regulatory agencies, task force members, other company SIU staff and external contacts involved in fraud investigation, detection and prevention. ▪ Prepares summary and/or detailed reports on investigative findings and/or referrals to state and federal agencies and local law enforcement. ▪ Creates, prepares and presents external, formal presentations including, but not limited to, local and national fraud training conferences, law enforcement and other agencies. ▪ Responsible for departmental educational training on clinical issues, CPT coding and medical updates as determined by collaboration with management. ▪ Assists in achieving and maintaining compliance with state and federal FWA compliance and other rules and regulations. ▪ Assist with unit's efforts to increase fraud and abuse training and awareness to all employees, members, and providers.

- Documentation of internal process or procedure deficiencies based on investigative findings with recommended changes.
- Know and uphold the provisions of the Corporate Compliance Plan.
- Proactively uses analytical skills to identify potential areas of FWA or areas of risk to FWA and develop investigative plans for solutions.
- Contacts members, pharmacies, providers and third parties via telephone interview and/or letter to validate claim submissions and clarify allegation of FWA.
- Responsible for assisting SIU in meeting all regulatory and departmental deadlines.
- Recommends and participates in development and implementation of internal departmental policies and procedures.

Minimum Experience Required:

- Bachelor's Degree or equivalent years of relevant work experience in Health-Related Field, Law Enforcement, or Insurance required.
- Minimum of three (3) years of experience in healthcare fraud investigations, medical coding, pharmacy, medical research, auditing, data analytics, or related field is required.

Skills Required:

- Intermediate computer skills consisting of Microsoft Excel, Access, Outlook, Word, and Power Point.
- Experience with EDI Watch's Intelligent Investigator Software and I-Sight Case Management Software.
- Ability to perform research and draw conclusions.
- Ability to present issues of concern alleging schemes or scams to commit FWA.
- Ability to organize a case file, accurately and thoroughly document all steps taken.
- Ability to report work activity on a timely basis.
- Ability to work independently and as a member of a team to deliver high quality work.
- Ability to support heavy workload and meet critical regulatory guidelines.
- Ability to compose correspondence, and prepare recommendations, reports, and referral summaries.
- Ability to communicate effectively, internally and externally.
- Presentation skills necessary.
- Knowledge of Medicaid preferred.
- Good knowledge of medical terminology, medical diagnostic, procedural terms, and medical billing.
- Critical Listening and Thinking Skills.
- Works on problems/projects of diverse complexity and scope.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree or equivalent years of relevant work experience in Health-Related Field, Law Enforcement, or Insurance required

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified Fraud Examiner (CFE) or Anti-Healthcare Fraud Investigator (AHFI) is preferred
- Certified Professional Coder (CPC) is preferred
- NHCAA or other fraud and abuse investigation training is preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No **If yes, list below:**
Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Special Investigations Unit (SIU) Team Lead
Description of Position: The Team Lead drives and encourages innovative Investigative and Triage ideas to reduce turnaround time and produce positive Investigative and Triage outcomes.
Description of Responsibilities of Position: ▪ Conduct reviews and approvals of Triage and Investigative reports. ▪ Provide subject matter expertise to Investigative and Triage Team. ▪ Serve as investigative planning consultant to the Triage and Investigative Teams. ▪ Assign cases for Triage or Investigation to staff. ▪ Monitor and prioritize investigation allocation to maximize output and effectiveness of staff to ensure assigned cases report requirements and standards are achieved. ▪ Lead the Investigative team through investigative resolution including corrective action plans, terminations, Fair Hearings, recoveries, negotiations, mediation, and litigation. ▪ Identify knowledge gaps and provide training opportunities to direct reports. ▪ Lead, arrange and conduct Investigative and Triage staff meetings. ▪ Coordinate the training of new and existing investigative staff to increase recognition of fraud and abuse indicators. ▪ Mentor direct reports including, coaching, development, performance feedback, disciplinary issues, annual performance evaluations and bonus review. ▪ Engage with direct reports through individually based monthly one-on-ones and design of Developmental Plans. ▪ Lead and promote Employee Engagement. ▪ Continue leadership training and apply skills to lead a highly innovative and engaged SIU Investigative and Triage Team. ▪ Identify workflow and process inefficiencies. ▪ Identify, recommend, develop, and implement internal departmental standard operating procedures. ▪ Collaborate cross functionally between the Investigative and Triage teams. ▪ Proactively use analytic skills to identify potential areas of FWA and recommend future investigations. ▪ Maintain knowledge and stay current on Health Care Fraud trends and schemes. ▪ Recommend process or procedure changes and work with cross departmental teams on identified internal system gaps that may present a FWA or financial risk. ▪ Assist in response to state and federal regulatory audits. ▪ Provide monthly Investigation and Triage Summary Reports to SIU Manager. ▪ In conjunction with the SIU Manager, identify, assess, and control risk to achieve compliance with state and federal integrity rules. ▪ Support SIU Management in vision to grow the investigative team.
Minimum Experience Required: ▪ Bachelor of Science/Arts Degree in Criminal Justice, Medical/Health Care Field or related industry or equivalent years of relevant work experience is required. ▪ Minimum of five (5) years of investigative or health care experience is required. ▪ Extensive experience in health care, legal, auditing, claims and/or investigative services is required.

- Leadership training and leadership experience preferred.

Skills Required:

- Displayed leadership qualities.
- Knows and uphold the provisions of the Corporate Compliance Plan.
- Intermediate to advanced proficiency level of computer skills, including Microsoft Outlook, Word, Excel, Access, and Power Point.
- Ability to formally present to a wide audience.
- Ability to work independently and in a team environment with a high level of confidence.
- Highest levels of ethics, integrity, and professionalism.
- Knowledge of government program compliance requirements – Medicare, Medicaid, Affordable Care Act (ACA), etc. preferred.
- Knowledge of medical insurance and/or state regulatory requirements.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor of Science/Arts Degree in Criminal Justice, Medical/Health Care Field or related industry or equivalent years of relevant work experience is required.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified Fraud Examiner (CFE), Certifications through America's Health Insurance Plans (AHIP), Healthcare Anti-Fraud Association (HCAFA) and/or Managed Healthcare Professional (MHP), Accredited Health Care Fraud Investigator (AHFI), and/or Certified Professional Coder (CPC) are preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Special Investigations Unit (SIU) Manager
Description of Position: The Manager is responsible for managing SIU requirements to include allegation intake, report analysis, triage, investigation, correction and reporting of fraud, waste, and abuse.
Description of Responsibilities of Position: ▪ Responsible for deposition, testifying in court in support of the business and Attorney General legal actions. ▪ Manage all efforts of your investigative team focusing on thorough but timely investigations, highest impact prioritization, root cause identification, state and federal law enforcement collaboration, evidence development and investigative actions. ▪ Drive and encourage innovative approaches to increase department effectiveness and efficiency. ▪ Ensure quantitative and qualitative measures are used to meet performance objectives. ▪ Develops and maintains key business contacts for investigative and SIU management purposes. ▪ Ensure employees meet all state and federal contract requirements and follow department work processes. ▪ Lead the Investigative team through investigative resolution including corrective action plans, terminations, Fair Hearings, recoveries, negotiations, mediation, and litigation. ▪ Mentor employees on effective and through investigative case presentation. ▪ Mentor direct reports including, coaching, development, performance feedback, disciplinary issues, annual performance evaluations and bonus review. ▪ Lead and promote Employee Engagement. ▪ Drive fraud identification through information sharing efforts ▪ Drive internal process and procedure changes by working with cross departmental teams to resolve identified internal system gaps that may present a FWA or financial risk. ▪ Take a leadership role in state and federal regulatory audits. ▪ Proactively manage investigative team growth to meet new business requirements. ▪ Take a leadership role in state and federal program integrity operations and fraud organizations such as NHCAA, HFPP, and ACFE. ▪ Speak at national conferences on investigative efforts and fraud trends. ▪ Develop and maintain an in-depth knowledge of the company's business and regulatory environments. ▪ Works closely with leadership to establish, communicate, and perpetuate the corporate vision, ensuring appropriate communication to all stakeholders. ▪ Recognize and proactively manage operational dependencies and risks. ▪ Maintains a framework of standards and best practice methodologies that are repeatable and evidence based. ▪ Participate in strategic planning and implement action plans.
Minimum Experience Required: ▪ Bachelor of Science/Arts Degree in Criminal Justice, Medical/Health Care Field or related industry or equivalent years of relevant work experience is required. ▪ Minimum of six to eight (6-8) years of investigative or health care experience is required. ▪ Extensive experience in health care, legal, auditing, claims and/or investigative services is required.

- Leadership/supervisory experience preferred.

Skills Required:

- Demonstrated leadership qualities.
- Support the development of effective working relationships with business partners.
- Solid understanding of claims processing preferred.
- Knows and uphold the provisions of the Corporate Compliance Plan.
- Intermediate to advanced proficiency level of computer skills, including Microsoft Outlook, Word, Excel, Access, and Power Point.
- Advanced troubleshooting and problem-solving capabilities.
- Effective communication and interaction skills.
- Ability to formally present to a wide audience internally and at national conferences.
- Ability to lead a team and achieve performance metrics.
- Highest levels of ethics, integrity, and professionalism.
- Significant knowledge of government program compliance requirements – Medicare, Medicaid, Affordable Care Act (ACA), etc. preferred.
- Significant knowledge of medical insurance and/or state regulatory requirements.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor of Science/Arts Degree in Criminal Justice, Medical/Health Care Field or related industry or equivalent years of relevant work experience is required

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified Fraud Examiner (CFE), Certifications through America's Health Insurance Plans (AHIP), Healthcare Anti-Fraud Association (HCAFA) and/or Managed Healthcare Professional (MHP), Accredited Health Care Fraud Investigator (AHFI), and/or Certified Professional Coder (CPC) are preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description

Title of Position: Senior Director Claims Encounters

Description of Position:
The Senior Director, Claim Encounters is responsible for managing systematic claim processes from claim ingestion to encounters reporting to ensure industry best practice efficiency, accuracy, and adherence to all encounters regulatory requirements.

Description of Responsibilities of Position:

- Oversight of corporate Claims Encounters regulatory reporting.
- Coordinate and direct the activities of business trading partner strategy and relationships and Encounters data management functions, including direct supervision of employees.
- Understanding of how claims payment methodologies, adjudication processing and State Encounters regulations interrelate to maintain compliant Encounters reconciliation processes and SLAs across all lines of business.
- Responsible for Claims Encounters Data process for CMS and State agencies.
- Responsible for other key claims data management and readiness to state and governing entities.
- Ensure department meets claims data submission requirements.
- Responsible for identifying strategy, areas of improvement, and streamlining procedures and policies to ensure effective and efficient workflows from claim ingestion within Facets to reporting of encounters data.
- Understand and coordinate business transactions for all HIPAA standard sets.
- Coordinate required software enhancements for efficient encounters data systems.
- Prepare and monitor departmental budget to control cost effectiveness.
- Manage forecasting and workforce management models to ensure appropriate level of staffing and training.
- Assist in the development and implementation of departmental policies and procedures.
- Provide critical reporting and analysis of functional performance, and make recommendations for enhancements, cost savings initiatives and process improvements.
- Prepare and monitor various management and oversight metrics and reports as required.
- Business owner for oversight of encounters data and trading partner vendors, managing SLA’s, regulatory requirements, and contractual metrics.
- Lead a strategic and tactical internal team focused on delivering operational efficiencies through technology automation and workflow efficiencies.
- Ensure quantitative and qualitative objectives are used to meet department performance objectives.
- Collaborate with other departments to improve quality to members through implementation of quality initiatives and efficiency improvements; ensures that processes are documented and appropriate quality measures are implemented.
- Provide vision and leadership to facilitate the development of cross-functional work teams and participate in the on-going development of new products and technology within areas of responsibility.
- Maintain positive and strategic relationships with internal and external stakeholders.

- Actively participate and partner with vendor management and procurement to secure effective and efficient vendor contracts.
- Participate as a member of the Business Partner Operations (BPO) senior management team to develop strategies and goals for the organization.

Minimum Experience Required:

- Bachelor's Degree or equivalent years of relevant work experience is required.
- Minimum of seven (7) years of experience with a health care claims and/or encounters data department is required.
- Minimum of five (5) years of leadership experience is required.
- Experience managing vendors to contractual requirements is required.

Skills Required:

- Demonstrated understanding of claims operations specifically related to managed care.
- Effective identification of business problems, assessment of proposed solutions to those problems, and understanding of the needs of business partners.
- Knowledge of regulatory reporting and compliance requirements.
- Excellent interpersonal skills and the ability to influence and work with external stakeholders to mutually benefit each organization and 3rd party constituents.
- Ability to support the development of effective working relationships with business partners.
- Demonstrated competencies with direct and indirect management of exempt and non-exempt staff.
- Effective communication and interaction skills.
- Working knowledge and demonstrated proficiency of health care/managed care or similar heavily regulated environment.
- Strong financial acumen preferred.
- Strategic management and leadership skills.
- Demonstrated critical listening and thinking skills.
- Advanced level experience in Microsoft Word, Excel, and PowerPoint.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree or equivalent years of relevant work experience is required

Are any professional licenses or certifications required for this position? [ ] Yes [X] No
If yes, list below:

- Six Sigma certification or similar methodologies is preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Team Lead Claims Encounters
Description of Position: The Team Lead Claims Encounters is responsible for day-to-day activities surrounding the knowledge and insight for Encounter Submissions and critical issues impacting Encounter Submissions.
Description of Responsibilities of Position: ▪ Responsible for day-to-day activities surrounding the knowledge and insight for Encounter Submissions and critical issues impacting Encounter Submissions. ▪ Understand the financial and clinical impact of changes and decisions to the business process to ensure that the Service Level Agreements (SLAs) are achieved. ▪ Guide and direct successful completion of daily tasks. Responsible for onboarding, training, and development of staff. ▪ Prioritize all work, requests, and activities. Escalate any area of significant issues or risk with recommendation for resolution. ▪ Recommend changes or modify solutions as necessary to implement enhancements, resolve issues, or improve operational efficiency. ▪ Track issues and status to ensure proper follow-up, coordination with business area and provide solutions. ▪ Update management on projects/initiatives the Claims Encounters team is involved with and coordinate any needed changes with manager. ▪ Monitor and communicate Corporate & Market management with Encounter oversight metrics and reports as required. ▪ Identify and communicate root cause of issues and appropriate proactive resolution to reduce Encounter issues preventing submissions in the future. ▪ Ensure controls, communication and approvals are followed prior to system implementation. ▪ Provide support of vendors, managing SLA's, regulatory/compliance requirements and contractual metrics conducted by the team. Ensure timely responses and resolution. ▪ Assist in auditing system and process to ensure accuracy and internal controls are in place to minimize any business issues, financial penalties, and sanctions from State and Federal agencies.
Minimum Experience Required: ▪ Associates Degree or equivalent years of relevant work experience is required. ▪ Minimum of three (3) years of health plan business or systems solutions experience is required. ▪ Exposure to Facets or equivalent system is preferred. ▪ Prior supervisory experience is preferred.
Skills Required: ▪ Advanced proficiency in Microsoft Suite to include Word, Excel, and Access. ▪ Edifecs and Encounters knowledge is preferred. ▪ Data trending and data analysis skills. ▪ High level of programming and systems development knowledge. ▪ Effective identification of business problems, assessment of proposed solutions to those problems, and understanding of the needs of business partners. ▪ Demonstrated ability to successfully define a portfolio of initiatives including business requirements gathering, definition/prioritization, project scope definition, project staffing

requirements, application configuration, testing approach, training, documentation, reporting strategy, and change management process.
- Knowledge of regulatory reporting and compliance requirements.
- Excellent listening and critical thinking skills.
- Effective problem-solving skills with attention to detail.
- Excellent written and verbal communication skills.
- Ability to work independently and within a team environment.
- Strong interpersonal skills and high level of professionalism.
- Ability to develop, prioritize and accomplish goals.
- Experience with claims processing skills is preferred.
- Advanced knowledge of coding and billing processes, including CPT, ICD-9, ICD-10 and HCPCS coding.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:
- Associates Degree or equivalent years of relevant work experience is 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: N/A

Key Position: Job Description
Title of Position: Team Lead Enrollment
Description of Position: The Team Lead Enrollment manages the day-to-day operational activities for setup and maintenance of membership records and payment reconciliation activities.
Description of Responsibilities of Position: ▪ Oversees the Enrollment Analysts, ensuring Enrollment Operations meets all service level agreements (SLAs), follows all regulatory guidelines and the that work completed is of the highest quality. ▪ Manage staff for quality review, performance feedback, disciplinary issues, and merit/bonus appraisal review. ▪ Work with Regulatory Compliance Officers and Enrollment Coordinators to ensure that requests are resolved within time lines and tracked for reporting. ▪ Maintain and communicate key performance indicators and other pertinent information to Enrollment leadership and others. ▪ Work with support departments and compliance officers to ensure policies and procedures are current. ▪ Establish and perform an audit process for markets and products that do not have an Enrollment Coordinator. ▪ Identify opportunities for process improvements and initiate efforts using accepted continuous improvement methodologies (DMAIC, Lean, etc.). ▪ Work with Enrollment Process Analyst to ensure internal procedures are documented and reviewed on a regular schedule. ▪ Develop and monitor workflows for Enrollment Operations that ensures maximum level of productivity. ▪ Coordinate incoming information and disseminate to staff to ensure accuracy of communication to internal and external customers. ▪ Proactively keep the management team apprised of the team's performance, projects, and issues. ▪ Develop, deliver, or coordinate the delivery of Enrollment training to other areas as needed.
Minimum Experience Required: ▪ Associates Degree in business, healthcare or related field or equivalent years of relevant work experience is required. ▪ Minimum of three (3) years of healthcare experience to include at least one (1) year of enrollment/eligibility or similar experience is required.
Skills Required: ▪ Proficient in Microsoft Word, Excel, Access, Visio, and PowerPoint. ▪ Expert proficiency in Facets subscriber/member setup and benefits eligibility. ▪ Strong knowledge of database management is preferred. ▪ Advanced computer skills. ▪ Solid verbal and written communication skills. ▪ Ability to work independently and within a team environment. ▪ Attention to detail. ▪ Familiarity with healthcare and knowledge of Medicaid & Medicare. ▪ Critical listening and thinking skills.

- High-level analytical skills.
- Proper grammar usage.
- Time management skills.
- Customer service oriented.
- Decision making/problem solving skills.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Associates Degree in business, healthcare or related field or equivalent years of relevant work experience is required

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Six Sigma Green Belt is preferred

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Triage Investigator
Description of Position: The Triage Investigator manages and monitors all SIU fraud reporting mechanisms (hotline, facets routing, fax, emails) to ensure compliance with regulatory requirements.
Description of Responsibilities of Position: ▪ Monitors SIU issued Corrective Action Plans and Settlement Agreements. ▪ Facilitates provider terminations initiated by SIU investigators. ▪ Handles straightforward and uncomplicated investigations to closure or referral. ▪ Interview members, providers, and provider staff in support of investigative efforts. ▪ Maintains the SIU e-manual. ▪ Generates SIU intake metrics monthly. ▪ Responsible for triaging and managing the fraud reporting mechanisms daily including case input into SIU case tracking software, claim data pulls, grievances information, phone calls, etc. ▪ Responsible for identifying any needed fraud reporting mechanism process improvement. ▪ Maintains fraud allegiants confidentiality and anonymity. ▪ Proactively assists investigators in case development such as records requests/reviews, letter generation, and documentation. ▪ Serves as a liaison to other departments to obtain information needed to support SIU investigative efforts. ▪ Ensure consistency in the execution of actions with providers, members, and other departments.
Minimum Experience Required: ▪ High School Diploma or GED is required. ▪ Associate's Degree in Health-Related Field, Law Enforcement, or Insurance is preferred. ▪ Minimum of three (3) years of SIU experience is required.
Skills Required: ▪ Intermediate computer skills consisting of Microsoft Excel, Access, Outlook, Word, and Power Point. ▪ Ability to navigate multiple software systems at a high proficiency level. ▪ Facets Claim System knowledge a requirement. ▪ Good communication skills. ▪ Ability to work independently and within a team environment. ▪ High attention to detail. ▪ Critical listening and thinking skills. ▪ Proper grammar usage. ▪ Time management skills. ▪ Proper phone etiquette. ▪ Customer service oriented. ▪ Decision making/problem solving skills. ▪ Strong organization skills. ▪ Customer service oriented.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ High School Diploma or GED is required ▪ Associate's Degree in Health-Related Field, Law Enforcement, or Insurance is preferred
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: N/A

Key Position: Job Description
Title of Position: Utilization Management Coordinator
Description of Position: The Utilization Management Coordinator leads and assists with forming strategy related to all functions within medical management and level one case management programs to ensure consistent, efficient delivery of services throughout the healthcare continuum and demonstration of positive outcomes.
Description of Responsibilities of Position: ▪ Provide strategic direction across functional responsibilities in accordance with requirements; regulatory, URAC, HEDIS, NCQA and future business-related standards. ▪ Ensure the incorporation of our Population Health approach into UM design, working with market leaders to ensure alignment. ▪ Identify long-range, competitive strategies for Utilization Management. ▪ Ensure appropriate intake of requests, the setup of cases within Guiding Care along with automation efforts to leverage the portal. ▪ Direct providers to utilization of standard forms for authorization submittals to support automation. ▪ Drive productivity and consistency in compliance with MCG guidelines on case reviews and referrals to MD's. ▪ Continuous review of business workflows to improve productivity and ensure member and provider satisfaction. ▪ Facilitate and promote problem identification, analysis, and resolution. ▪ Expand ability to meet State contract requirements for existing and new populations with proactive processes to ensure success. ▪ Ensure monitoring of regulatory requirements and oversight of all submissions. ▪ Determine benchmarks, goals and outcomes for all programs as well as high cost, volume, and risk conditions. ▪ Determine benchmarks, goals and outcomes for staff and implement an accountability system. ▪ Monitor CQI activities in accordance with regulatory requirements and URAC standards. ▪ Develop and coach employees. ▪ Foster relationships with hospitals, physicians, and community agencies. ▪ Identify "wellness continuum" opportunities and develop successful blending of case, disease, and medical management functions. ▪ Identify and report risk management issues for the department.
Minimum Experience Required: ▪ Minimum of eight (8) years of experience in one of the following: case management, medical management, disease management, quality improvement in a MCO required; quality improvement background preferred. ▪ Minimum of five (5) years management experience required. ▪ Experience in Disease Management preferred.

Skills Required:

- Proficiency in Microsoft Office products including Word, Excel, and PowerPoint.
- Internet research skills preferred.
- Leadership experience and skills.
- Change agent.
- Decision making/problem solving skills.
- Clinical data analysis and trending skills.
- Critical and systems thinker.
- Knowledge of trends in healthcare, managed care, Medicaid, case management, medical management, and quality improvement.
- Excellent communication skills, both verbal and written.
- Management skills including human capital and project management.
- Ability to work independently and within a team environment.
- Attention to detail.
- Understanding of predictive modeling process/tools.
- Training/teaching skills.
- Strategic management skills.
- Negotiation skills/experience.
- Politically astute.
- Program grammar usage, phone etiquette and technical writing skills.
- Time management skills.
- Customer service oriented.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in nursing or related field required or equivalent years of relevant experience required.
- Master's degree preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Current, unrestricted license as a Registered Nurse (RN), Licensed Social Worker (LSW), Psychologist, or Professional Clinical Counselor (PCC) is preferred.
- Managed Care, Utilization management Case Management and/or Quality Improvement certification preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Vice President, Claims
Description of Position: Vice President, Claims is responsible for directing and managing the Claims Operations, Claims Administration, Claims Regulatory Submissions, Claim Compliance, and Recovery functions.
Description of Responsibilities of Position: ▪ Manage strong working relationships with the Market leaders through Operations and Market reviews and other informal channels. ▪ Ensure the integration of the activities between the various internal and matrixed departments as it relates to business processes and data flow. ▪ Create and manage vendor performance metrics for those vendors contracting with Claims in Operations; Negotiate and coordinate contractual, operational, and service requirements for trade vendors serving the Claims department. ▪ Ensure compliance with SSAE-16 standards relative to departmental controls and with Model Audit Rule (MAR) Standards. ▪ Final accountability for Claims business requirements for new product and market implementations. ▪ Foster strong working relationships with the provider community to ensure operational effectiveness. ▪ Interact effectively with internal and external stakeholders to assure the business objectives are well defined and achieved. ▪ Manage internal budgets for the operational departments for on-going operations and new products and markets. ▪ Develop and maintain an in-depth knowledge of the company's business and regulatory environments. ▪ Accountable for strategic and business planning for Operations.
Minimum Experience Required: ▪ Bachelor of Science degree in finance, business, or healthcare field or equivalent work experience is required. ▪ Master's in business administration (MBA), healthcare or related field is preferred. ▪ Minimum of seven (7) years of experience in operations management in a Medicaid and/or Medicare environment is required. ▪ Prior second level management experience is required. ▪ Operational experience in a Medicaid and/or Medicare and commercial environment is a plus. ▪ Operational experience in a service based or marketing environment is a plus. ▪ Operational experience in an information systems environment is a plus.
Skills Required: ▪ Microsoft Office proficient. ▪ Knowledge of health care, insurance and HMO concepts, regulatory reporting, and compliance requirements. ▪ Strong Collaboration skills. ▪ Strategic management skills. ▪ Ability to adapt quickly to changing business needs. ▪ Critical listening and thinking skills. ▪ Strategic management skills. ▪ Negotiation skills/experience.

Are there any educational requirements for this position? [X] Yes [ ] No **If yes, list below:** ▪ Bachelor of Science degree in finance, business, or healthcare field or equivalent work experience is required. ▪ Master's in business administration (MBA), healthcare or related field is preferred.
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: N/A

Key Position: Job Description
Title of Position: Vice President, Clinical Operations
Description of Position: The Vice President, Clinical Operations provides leadership and oversight to the following clinical operations programs and initiatives: Training and Auditing, new business implementation and glidepaths for clinical teams, clinical operational improvements, support of new initiatives, continuous improvement, and review/ analysis of data to inform design and member care.
Description of Responsibilities of Position: ▪ Responsible for build of programmatic design, artifacts, and oversight strategies to support medical affairs, care management and Utilization Management Teams. ▪ Develop, operationalize, and oversee all standardization and clinical content to scale to growth and continued process improvements within all Clinical Operation teams. ▪ Responsible for updating and iterating on staffing model and approach for market variances and standardization across clinical operations with senior leaders. ▪ Support and plan for the communication, implementation, and maintenance of clinical deliverables to meet regulatory and best practice protocols. ▪ Collaborate with the organization's member care leaders in other key operational areas to ensure successful integration of innovation and technology are achieved to fully support clinical needs. ▪ Provide leadership and direction to leaders to ensure tasks, goals and strategies are successfully achieved. ▪ Function as a liaison/consultant for clinical operations/ programs with regulators, market/executive level leaders, and corporate partners. ▪ Serve as interim leadership for new business implementation and acquisitions to proxy for clinical leadership during the support of new market/ new business.
Minimum Experience Required: ▪ Bachelor's degree in business, healthcare or related field or equivalent years of relevant work experience is required. ▪ Master's degree is preferred. ▪ Minimum of ten (10) years of clinical operations leadership experience is required. ▪ Minimum of five (5) years of senior level management experience is required. ▪ Minimum of five (5) years of Managed Care experience in a multi-market organization.
Skills Required: ▪ Considerable knowledge of business theory, business processes, management, budgeting, and business office operations. ▪ Thorough understanding of care management, utilization management programs and operational compliance, governance principles, analytics, and business intelligence. ▪ Excellent understanding of vision and operationalization of clinical program implementation and oversight in an multi-market delivery. ▪ Proficient in Microsoft Office Suite to include Word, Excel, and PowerPoint. ▪ Excellent written and verbal communication skills. ▪ Ability to develop, prioritize and accomplish goals. ▪ Ability to work independently and within a team environment. ▪ Effective listening and critical thinking skills. ▪ Strong interpersonal skills and high level of professionalism.

- Effective problem-solving skills with attention to detail.
- Training/teaching skills.
- Population health, disease management and wellness program knowledge.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's degree in business, healthcare or related field or equivalent years of relevant work experience is required.
- Master's degree is preferred.

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Case Management Certification is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

Key Position: Job Description
Title of Position: Vice President, Information Technology Core Systems
Description of Position: The Vice President, IT Core Systems is responsible for leading strategic and operational planning of the IT Core Systems Landscape, which includes Corporate, Financial and Payer Systems.
Description of Responsibilities of Position: ▪ Develop and execute the IT Roadmap supporting the corporate goals associated with the Core Systems landscape. ▪ Work closely with rest of the application development organization, the CIO Leadership team, and key business stakeholders to develop and execute the IT Strategic Plan. ▪ Oversee the development, design, and implementation of new applications and changes to existing business systems and software packages. ▪ Partner with key business stakeholders to define business and systems requirements for new technology implementations. ▪ Partner with EPMO and business organizations to lead delivery of Enterprise project and program initiatives. ▪ Develop and maintain an appropriate department organizational structure that supports the needs of the business. ▪ Assess and make recommendations on the improvement or re-engineering of the department. ▪ Establish departmental goals, objectives, and operating procedures. ▪ Keep current with trends and issues in the IT industry, including current and emerging technologies as it relates Managed Care and Healthcare IT. ▪ Advocate for the department's vision via regular written and in-person communications with the organization's executives, department heads, and end users. ▪ Oversee the day-to-day operations of a 24/7 production environment, ensuring critical internal and external facing business systems are available to users and business partners. ▪ Optimize ongoing productivity improvement, cost effectiveness and total quality management. ▪ Partner with CIO leadership to ensure system operation adheres to applicable laws and regulations. ▪ Manage external vendor partners to support group initiatives. ▪ Work closely with the Information Security organization to ensure that the business systems environment is secure and follows information security policy and procedures.
Minimum Experience Required: ▪ Bachelor's Degree in the field of computer science, information systems, or business administration or equivalent years of relevant work experience is required. ▪ Master's degree preferred. ▪ A minimum of ten (10) years of experience managing and/or directing an Application Development organization with at least five (5) years in a Senior Leadership role. ▪ Experience in managing partner vendors to contracted SLAs and deliverable expectations is required. ▪ Experience with driving end to end solutions to operational issues from an IT perspective in collaboration with the business is required. ▪ Deep experience and expertise in systems design, development, deployment, and operational support is required.

- Prior experience with Trizetto Product Suite including Facets Claims Processing is strongly preferred.
- Prior experience in SAP is strongly preferred.

Skills Required:

- Knowledge of systems that support enrollment, configuration, claims and encounters.
- Considerable knowledge of business theory, business processes management, budgeting, and business office operations.
- Strong Healthcare Payer business acumen.
- Substantial exposure to enterprise software applications in a Microsoft environment.
- Excellent understanding of project management principles.
- Ability to apply IT in solving business problems.
- In-depth knowledge of applicable laws and regulations as they relate to IT.
- In-depth knowledge of strategic planning and execution.
- Executive and strategic management skills.
- Excellent communication skills both oral and written.
- Excellent interpersonal skills.
- Ability to present ideas in business-friendly language.
- Exceptionally self-motivated and directed.
- Attention to detail.
- Critical listening and thinking skills.
- Ability to set and manage priorities judiciously.
- Customer service oriented.
- Ability to motivate in a team-oriented, collaborative environment.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor's Degree in the field of computer science, information systems, or business administration or equivalent years of relevant work experience is required
- Master's degree preferred

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: N/A

Key Position: Job Description
Title of Position: Vice President, Program Integrity & Retrospective Review
Description of Position: The Vice President, Program Integrity & Retrospective Review is responsible for developing a holistic approach to Program Integrity and Retrospective Review; as a key member of the Operations team, responsible for driving profitable growth of the business through the use of technology, including data and analytics and intelligent automation, to drive transformation of current processes and create opportunities to eliminate manual tasks, allowing employees to focus on strategic initiatives.
Description of Responsibilities of Position: ▪ Oversight of the organization responsible for the overall Program Integrity Program including payment recoveries and inappropriate payment avoidance. ▪ Lead the operations of the retrospective review function and program and ensure the appropriate strategy, tactics, and data capture processes are in place. ▪ Develop key metrics and tracking mechanisms to measure interventions and overall department performance. ▪ Direct operational oversight of claims edits, reimbursement policy, clinical program (complex chart audits, provider education, and prepayment review) and the Special Investigations Unit. ▪ Drive new initiative development, execution, and assessment, working closely with Health Care Analytics to develop best-in-industry predictive analytics, optimize build versus buy strategies, and identify opportunities for fraud, waste, and abuse review. ▪ Accountability to all market, segment, and division leaders as well as state/federal authorities to deliver cost-of-care savings in a compliant and collaborative manner. ▪ Collaboration with external stakeholders including state and federal agencies, law enforcement, trade organizations and others to influence policy, share findings and best practices as required and/or as appropriate. ▪ Works collaboratively with Internal Audit, Compliance, and Enterprise Risk to collectively identify, prevent, address and correct Compliance and Program Integrity risks. ▪ Identify, interpret and/or develop applicable laws, regulations, policies, and procedures to effectively and efficiently manage program operations. ▪ Understand, prepare for, influence and effectively and efficiently implement new and emerging legislative and policy changes.
Minimum Experience Required: ▪ Bachelor of science degree in business administration, healthcare administration or related discipline is or equivalent work experience is required. ▪ Master's in Business Administration, Healthcare Administration and/or other related discipline is preferred. ▪ Ten (10) or more years of program integrity, compliance, SIU, or related experience is required. ▪ Five (5) years Senior Leadership experience with a managed care organization or related industry is required.
Skills Required: ▪ Strong working knowledge of program integrity, including government program compliance, fraud, waste and abuse, laws, regulations, guidelines, and professional standards. ▪ Strong collaborative skills, working with cross-functional stakeholders and external partners.

- Skilled in identifying, understanding, and adapting outstanding practices and processes to help improve performance.
- Has relentlessly high standards and is results-oriented.
- Demonstrates business acumen and strategic thinking, yet able to execute tactically.
- Detail oriented, well organized with strong time and project management skills.
- Solid leadership skills, effectively manage a high performing team, provide coaching and development.
- Demonstrated ability to adjust to shifting priorities, multi-task, work under pressure and meet deadlines.
- Proven ability to recognize opportunity for improvement and lead change.
- Influences others individually and also broadly across the organization.
- Knowledge of full range of organization development interventions and change management frameworks and applications.
- Pursues innovative approaches for implementing strategic solutions.

Are there any educational requirements for this position? [X] Yes [ ] No
If yes, list below:

- Bachelor of science degree in business administration, healthcare administration or related discipline is or equivalent work experience is required
- Master's in Business Administration, Healthcare Administration and/or other related discipline is preferred

Are any professional licenses or certifications required for this position? [X] Yes [ ] No
If yes, list below:

- Certified Professional Coder (CPC) or equivalent certification is required.
- Certified in Health Care Compliance (CHC), Certified Fraud Examiner (CFE), or Accredited Healthcare Fraud Investigator (AHFI) is preferred.

Are there any continuing education requirements for this position? [ ] Yes [X] No
If yes, list below:

Any additional information relevant to this position: N/A

4.3.3.3 ADMINISTRATIVE REQUIREMENTS

4.3.3.3.1. 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.

Yes, we confirm we will have an Administrative Office within 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. The signature of our Chairman of Mississippi True d/b/a TrueCare on *Appendix H: 4.3.3.3 Administrative Requirements Attestation Form*, is proof of our commitment to working collaboratively and being a worry free partner of the Division.

4.3.3.3.2. 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.

TrueCare is committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources. TrueCare acknowledges and will comply with the Division or other State or external review representative informational disclosure requests of transaction involving money, property, facilities, goods, or services between the TrueCare and a Party in Interest in compliance with federal regulations. **TrueCare's ability to deliver operational excellence demonstrates that we respect members and providers and will be a worry-free partner of the Division.**

Storage of Administrative Data and Records

[redacted]

Records Requests Process and Timeframes

We are committed to a worry-free partnership with the Division and one component of that successful collaborative will be our ability to respond to inquiries quickly, efficiently, and effectively working in tandem to resolve member, provider, and systemic issues. In compliance with Appendix A, Section 1.10, TrueCare will acknowledge receipt of the Division's (for the purposes of this section we use Division to include the State of Mississippi entities, including but not limited to the Department of Insurance, the State Auditor, the Attorney General and the Legislative PEER Committee and its external review partners) written, electronic, or oral requests for assistance no later than one business day from receipt of the request from the Division, and we will complete the request to the satisfaction of the Division within five business days from the date of receipt unless the Division specifies another time frame. We acknowledge, should we request an extension of the time frame, the Division may grant the request at its discretion. If the request is urgent, we will acknowledge immediately, without unreasonable delay, the Division's urgent requests for assistance and must give such requests priority. We will complete urgent requests to the satisfaction of the Division within the time frame specified by the Division. If no time frame is specified by the Division, we will complete urgent requests within five business days from the date of receipt.

TrueCare will acknowledge the Division's requests for assistance, including the required date of resolution. If the request we received from the Division was in writing or received electronically, we will acknowledge receipt in the same manner we received the request, either in writing or electronically. For oral requests from the Division, we will acknowledge receipt of the request orally and immediately follow-up with a written or electronic acknowledgement. Upon completion of the request, we will submit to the Division, on or before the required date of completion, a detailed completion summary advising the Division of TrueCare's action and resolution. We will include all information necessary for the Division to adequately determine whether a request is complete in our completion summary and conform to specifications requested by the Division concerning form, format, or content of the summary, if any.

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 392011399, 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.

TrueCare
Name of Offeror

Chuck Reece
Printed name of person attesting for Offeror

Chairman of Mississippi True d/b/a TrueCare
Title of person attesting for Offeror

Signature of person attesting for Offeror

February 11, 2022
Date

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 392011399, 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.

CareSource
Name of Offeror

Sanjoy Musunuri
Printed name of person attesting for Offeror

EVP of Strategy and Business Development
Title of person attesting for Offeror

DocuSigned by:
Sanjoy Musunuri
D01ED035ED8C46D...
Signature of person attesting for Offeror

2/8/2022
Date

4.3.3.4 STAFFING

4.3.3.4.1 Describe the entity's staffing ratios per enrolled Member, including the number of Member services call center employees and nurse advice line employees, as well as supervisor to staff ratios. Describe the job qualifications for Member services call center employees, as well as training and education that the Offeror will provide to these employees.

TrueCare is committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources. TrueCare hires locally, at standardized ratios to ensure all Mississippi Coordinated Access Network (MSCAN) and Children's Health Insurance Program (CHIP) members receive the services they need. Staff qualifications appropriate for each position are vetted through years of experience across multiple Medicaid markets. We hire local staff, knowledgeable about the region and its health care systems, and provide in-depth training and practice to ensure comprehension of and comfort with the MSCAN and CHIP programs. [redacted] **TrueCare's localized approach and fully integrated service delivery leverages the resources of Mississippi providers, our Life Services program, and community partnerships to promote best practices of healthy living and health equity,** while creating a positive economic impact across the state.

Our staffing ratios address requirements for both inbound member inquiries and outbound calls, such as our welcome call activity. Our ratios ensure we have the appropriate levels of staff to achieve and exceed all Division required service levels, while still allowing for ongoing coaching, training, and development of our staff. Using the number of calls per thousand members, our workforce management team calculates the call-in rate to determine staffing needs. In 2021, the average Medicaid call-in rate was eight calls per 1,000 members per day. TrueCare will submit a monthly deliverable report to the Division, in compliance with Appendix A, Section 5.1, including ratios as reflected in Table 4.3.3.4_A, and implement any Division recommendations regarding staffing based on call center sufficiency standards.

Table 4.3.3.4_A: Member Services Staffing Ratios

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Managing Staffing Ratios

TrueCare will use a multidisciplined planning team to ensure optimal performance for MSCAN and CHIP members. To aid in the achievement of operational excellence, our Workforce Management Team analyzes historical call patterns to forecast call volume, build hiring plans, and schedule staff to ensure we are meeting the needs of members and the community with no disruption to service availability. Leveraging our robust suite of workforce management tools, the following teams monitor capacity real-time and project our staffing needs at a 30-minute interval basis, for each day, week, month, and through the year.

- The **Workforce Management team** ensures we achieve operational excellence and are consistently meeting service level goals by performing forecasting, scheduling, hiring logistical support, and real-time management. Business line specific analytics and reporting deliver a transparent view of performance and insights to make the right decisions. We monitor variables influencing staffing requirements including volume, handle time, membership, seasons, time of day, and planned events.

- The **Forecasting team** has the skills and experience to navigate what is known and apply sound judgment to what is unknown to deliver forecasts and staffing recommendations improving customer experience and ensuring we meet performance expectations.
- Our **Staff Scheduling team** uses planned forecasts and known events to schedule using available capacity ensuring the call center is consistently meeting service levels and delivering the same experience for all MSCAN and CHIP members.
- The **Analytics and Reporting** team delivers fast and accurate data, informing the end user to quickly review current call center status and make real-time decisions, changes, and adjustments needed. From high level executive dashboards to daily performance indicators, analytics and reporting is available for all call center leadership to be proactive in meeting member needs.

Call Center Roles and Qualifications

To ensure that Mississippians can easily access their benefits to live healthier lives, TrueCare maintains one distinct, 24-hour toll-free member services number available for inquiries, issues, or referrals. Our automated system and call center staff route calls based on member needs, including appropriately routing to our 24-hour behavioral health (BH)/substance use disorder (SUD) crisis line and nurse advice line.

We will staff our Mississippi member services call center with professionals from the community, bringing local perspective and the ability to relate to current situations and needs. Residing in Mississippi, the member services manager will take the lead in localizing perspectives in hiring and training call center staff, who will meet the following minimum qualifications in Table 4.3.3.4_B.

Table 4.3.3.4_B: TrueCare Call Center Roles and Qualifications

Role	Qualifications
Member Services Manager	▪ Located in Mississippi ▪ Minimum of three years of previous management/leadership experience preferred ▪ Previous experience in a Medicaid environment or related industry preferred ▪ Bachelor’s Degree in business related field or equivalent years of experience required
Call Center Supervisor	▪ Located in Mississippi ▪ High School Diploma or GED is required ▪ Associates Degree or equivalent years of relevant work experience is preferred ▪ Minimum of three years of customer service experience, to include a minimum of one year in a call center environment is required ▪ Previous supervisory/leadership experience in a call center environment is strongly preferred
Member Services Call Center Specialist	▪ Located in Mississippi ▪ High School Diploma or GED required ▪ Associates degree in business or related field or equivalent years of work experience preferred ▪ Minimum of two years of experience in administrative support or customer service preferred
Call Center Trainer	▪ Located in Mississippi ▪ Associate degree in Adult Education, Organizational Development, Instructional Design or related field or equivalent years of relevant work experience is required ▪ Bachelor’s degree is preferred ▪ Minimum of two years related call center or healthcare experience is required ▪ Previous training or curriculum development experience is preferred
Nurse Advice Line Staff	▪ Located nationally and in Mississippi ▪ Minimum of current unrestricted RN licensure in states in which we do business ▪ Minimum of three years of progressive clinical experience is required ▪ Triage, Emergency Nursing or Critical Care experience is preferred ▪ Behavioral Health experience is preferred
BH/SUD Crisis Line Staff	▪ Staff are licensed behavioral health clinicians ▪ Minimum of two years’ experience in their field

Member Services Training and Education

Our dedicated call center staff is hired locally, trained on all our programs, and prepared to address a range of member inquiries and needs. MSCAN and CHIP members will turn to our member services team as the first line of support. Active listening and compassion are woven throughout training to ensure call center staff empathize with member situations, are familiar with the challenges they face, and will consider the member's comprehensive needs, and not just the specific question driving the member's call. Our staff embrace these interactions and work to create the best possible member experience. All call center employees, including the nurse advice and BH/SUD crisis line staff will receive training from our Mississippi call center trainer virtually or in-person.

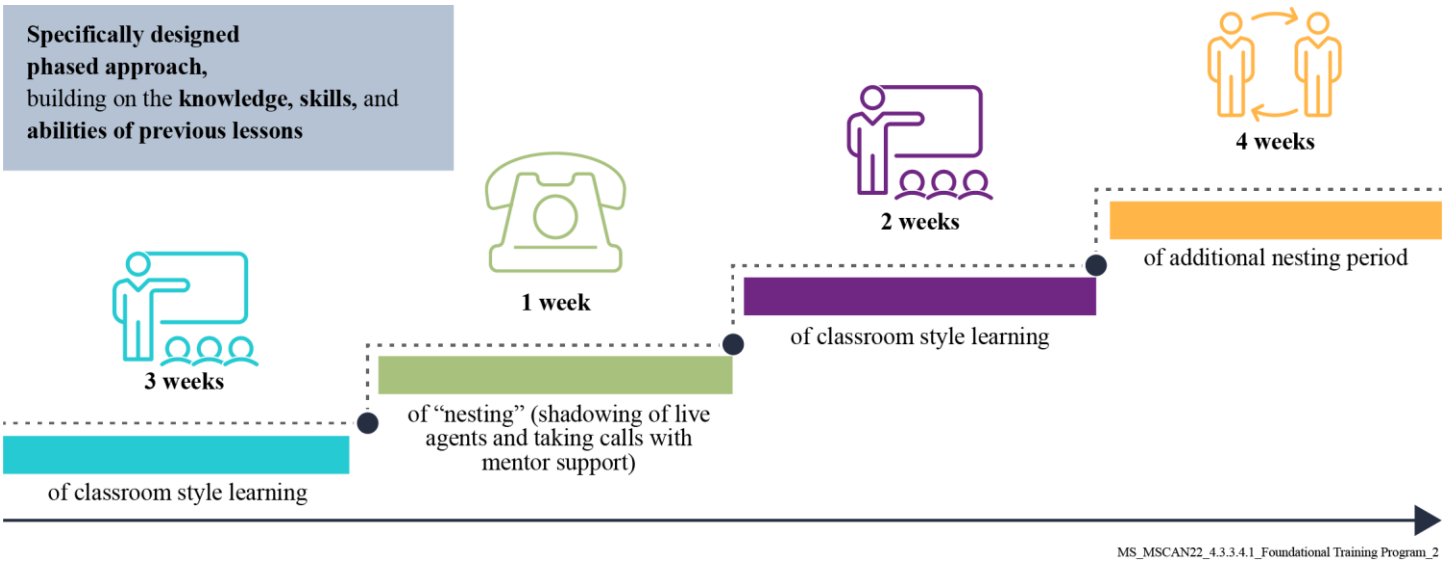
At TrueCare, we train call center staff to:

- **Support and promote** member rights
- **Advance** community health and policy initiatives focused on availability, safety, and quality of care
- **Resolve** member inquiries with a focus on First Call Resolution, supported by engaging and compassionate staff

Our approach to member services and training has created CAHPS scores that are among the nation's highest for all Medicaid plans. Figure 4.3.3.4_A shows our four-phase approach for conducting member services new hire orientation, building on knowledge, skills, and abilities of previous lessons, and adhering to Appendix A, Section 6.9. Our 10-week program provides five weeks of classroom-style learning about TrueCare and the individual needs of our members and community, along with training on MSCAN and CHIP, as required. We incorporate shadowing, structured role-playing, mock calls, and live calls to ensure our new member services call center staff are comfortable before graduating the program. We commit to fully preparing call center employees, and in some cases provide an additional two weeks of training to individuals who may need or request additional support. Post training, we provide staff with a transitional coach for 30 days dedicated to ensuring our new hires succeed.

Figure 4.3.3.4_A: Member Service Staff New Hire Orientation

Allowing for individualization at various junctures, our training approach ensures call center staff are equipped and supported to respond to member needs.



As outlined in Table 4.3.3.4_C, our teams receive initial training on programs, tools, service processes, and technology. We want our staff to focus completely on listening and supporting the member and their needs, and we have invested in a Customer Relationship Management solution providing us with a 360 view of the member, to make the process of navigating information, tracking calls, and details as easy as possible for our staff.

Table 4.3.3.4_C: Member Services Call Center Staff Training Topics

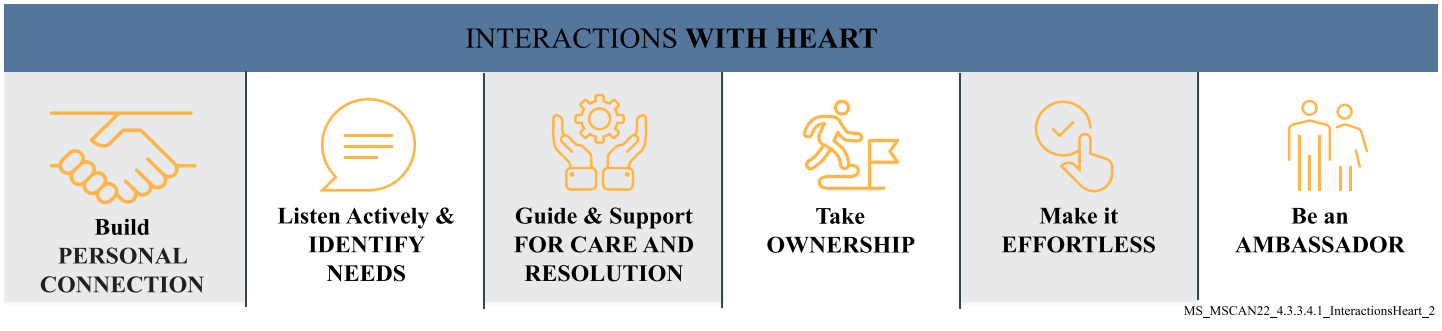
Key Training Areas	Training Components
Programs	▪ Mississippi Programs, Policy, and Benefits ▪ Connecting our members to the appropriate resource to address clinical needs: Features of care management: member assignment to care management acuity levels, our responsibilities for coordinating care, and the role of the member in the care management process, including how MSCAN and CHIP members, caregivers, or authorized representatives may initiate a self-referral into care management
Tools, Technology, and Process	▪ Scenario based training including, but not limited to: – Using Tools – Customer Relationship Management and Interactive Knowledge Base – Verifying eligibility and offering redetermination assistance – Locating a provider, scheduling an appointment – Ordering or replacing ID cards, arranging transportation – Handling grievances and appeals – Identifying care gaps and completion of health risk screening – Making referrals to local or community-based organizations
Routine Updates to Training	▪ Real-time staff alerts ▪ Targeted updates within team meetings and one on one coaching sessions ▪ Micro-video learning and application assessments ▪ Scheduled training, where needed, to ensure adoption of new process and procedures

Member services staff are trained to skillfully triage incoming calls and identify resources to support medical needs. Most importantly, if a member is at immediate risk, specialists connect them to emergency services and 911. As part of new hire and quarterly refreshers, member services staff receive care management, scenario-based modules teaching identification skills for guiding and supporting our MSCAN and CHIP members to the right, immediate resource. We train using simulated member scenarios such as behavioral health diagnoses, limited or no caregiver resource, unemployment, and sudden disabilities. Leveraging our 24-hour nurse advice and BH/SUD crisis lines, our members have direct connections to care managers when they have urgent needs. Our member services call center and nurse advice line can warm transfer to our telehealth service, connecting members immediately to consult with a behavioral health provider. We identify these calls through our call recording system and target them for monitoring to ensure staff follow processes consistently.

We train our Mississippi-based call center teams using our Interactions with Heart Training, behavioral approach to building connections with MSCAN and CHIP members. As illustrated in Figure 4.3.3.4_B, we incorporate soft-skill elements attached to emotional intelligence, effective listening skills, person centered language, and dynamic communication techniques in our training module.

Figure 4.3.3.4_B: Interactions with Heart Training

Interactions with Heart training approach enables building connections with members which are warm, caring, and professional.



Local and Statewide Cultural Competency Training

TrueCare's Mississippi based director of health equity serves as our Cultural Competency Champion and will oversee all dimensions of training and keeping regional awareness in the forefront of presentations. We will leverage the Mississippi ***Alluvial Collective***, to inform customized training curriculum focusing on racial reconciliation. Community based partnerships will inform our thinking and support our shared passion and desire to continually improve productive conversations about race, equity, and our collaborative relationships.

Our leadership participates in an enterprise workgroup on cultural competency committed to advancing National Standards for Culturally & Linguistically Appropriate Services (CLAS). This high-level workgroup includes investing in employee education and training regarding social determinants of health, health disparities, health inequities, and the importance of cultural competency. Our model includes educating and training governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. We address cultural, linguistic, and health literacy barriers by requiring staff to attend cultural sensitivity training programs at hire, annually, quarterly events, and as part of continued education and reinforcement programs. Curriculum includes:

- Health literacy, CLAS, Commitment to Health Equity, Culture, and Diversity Awareness
- Member Health, Safety, Mental Health First Aid, and Welfare Programs
- Experiential poverty simulation called the poverty simulation which focuses on the challenges of living in poverty to provide employees with perspective on the social and economic barriers faced by our MSCAN and CHIP members
- Religion and culture and their influence on health care

Upon hire, all staff must take and complete Implicit Bias and Mitigating Bias training within their first 30 days of employment. Employees must complete training on Diversity, Equity, and Inclusion (DE&I) and cultural competency annually. We require staff, upon hire, to take our Complex Population course series which informs staff on the changing needs of our members and their providers. We refresh courses quarterly as change for our members occurs. Other DE&I courses are available in our learning management system including Understand and Embrace Diversity, How to Create a Respectful Workplace, Fostering Inclusion in the Workplace, and Unconscious Bias. Ongoing and annual competency requirements ensure current and localized training increase cultural awareness and sensitivity to foster an environment open to diverse thinking and understanding cultural norms in health and illness.

Behavioral Health/ Substance Use Disorder Line Training

Our BH/SUD staff receive additional, role specific training in crisis intervention, including the National Suicide Prevention Lifeline guidelines regarding suicide risk assessment and engagement. To best serve the MSCAN and CHIP members in their community, BH/SUD line staff are educated in the local crisis resources available, including mobile crisis providers, crisis stabilization units at local community mental health centers (CMHCs) that operate 24 hours per day, and the role of and how to coordinate with regional Mississippi Mobile Crisis Response Teams and Crisis Stabilization Units. We use technology tools to identify immediate treatment options meeting the member's needs and preferences, and partner with local first responders to dispatch crisis intervention teams or trained law enforcement officers where community-based crisis services are not readily available. We regularly inventory state, regional, and local crisis resources, and update training for our staff ensuring current resources are available for our behavioral health crisis line clinicians.

Nurse Advice Line Training

All nurse advice line staff participate in a comprehensive four-to-six-week training program comprised of our telephone-triage process, decision support software, telephony, and other software applications. We place special emphasis on member-specific or regulatory requirements and cover all applicable HIPAA, URAC, and

NCQA standards. Training incorporates mental and physical health education, classroom time, hands-on practice, self-study, and review of a comprehensive training manual.

Continuing Education and Training Requirements

TrueCare, in compliance with Appendix A, Section 5.1, will provide ongoing education at least quarterly to include education about Medicaid, MSCAN, and CHIP; appropriate instances for transferring a member to a care manager, the behavioral health crisis or nurse advice line; and customer service, including but not limited to how to interact with MSCAN and CHIP members in a culturally appropriate manner, keeping in mind health equity and possible implicit bias. Our training is time sensitive and occurs as necessary to ensure near, real-time updates about Medicaid changes and requirements. TrueCare will submit quarterly reports to the Division detailing the trainings conducted, topics covered, and the number and job title for staff completing the trainings.

We offer continuing education opportunities available on an ongoing basis through internal/external conferences and lectures, self-study, refresher training, and on the job training. Our Training and Professional Development Committee identifies and develops staff enrichment and training programs. The committee recommends program specific training based on information from health data analytics, current epidemiology updates, and evidence-based research and practice guidelines from nationally recognized sources such as the American Diabetic Association and other health related organizations. All staff members complete an annual core competency to ensure proficiency in cultural competency, corporate compliance, and position related clinical and non-clinical skills.

4.3.3.4.2 Describe the entity's staffing ratios per enrolled Provider, including the number of Provider services call center employees, as well as supervisor to staff ratios. Describe the job qualifications for Provider services call center employees, as well as training and education that the Offeror will provide to these employees.

TrueCare's provider services call center team brings a new era of provider collaboration to Mississippi and focuses on understanding the unique needs of providers from a personal, professional, and administrative perspective. Our dedicated provider services call center maintains the appropriate number of qualified staff, ensuring monthly sufficiency ratios, and providing exceptional support to the provider community. Residing in Mississippi, the provider services manager leads our Mississippi team. **TrueCare's ability to deliver operational excellence demonstrates that we respect members and providers and will be a worry-free partner of the Division,** while creating a positive economic impact across the state.

TrueCare will submit a monthly deliverable report to the Mississippi Division of Medicaid (the Division), in compliance with Appendix A, Section 6.9, including the call center staffing ratios in **Table 4.3.3.4_D Provider Services Staffing Ratio**, and any recommendations to the Division regarding staffing based on call center sufficiency standards.

Table 4.3.3.4_D: Provider Services Staffing Ratios

[redacted]	[redacted]
[redacted]	[redacted]

Provider Services Staff Qualifications

Our Mississippi-based employees fulfilling call center roles will meet the following minimum qualifications in Table 4.3.3.4_E: TrueCare Provider Services Roles and Qualifications. For precise detail regarding job descriptions, in compliance with Appendix A, Section 1.13, refer to Appendix H 4.3.3.2, for a comprehensive description of all positions.

Table 4.3.3.4_E: TrueCare Provider Services Roles and Qualifications

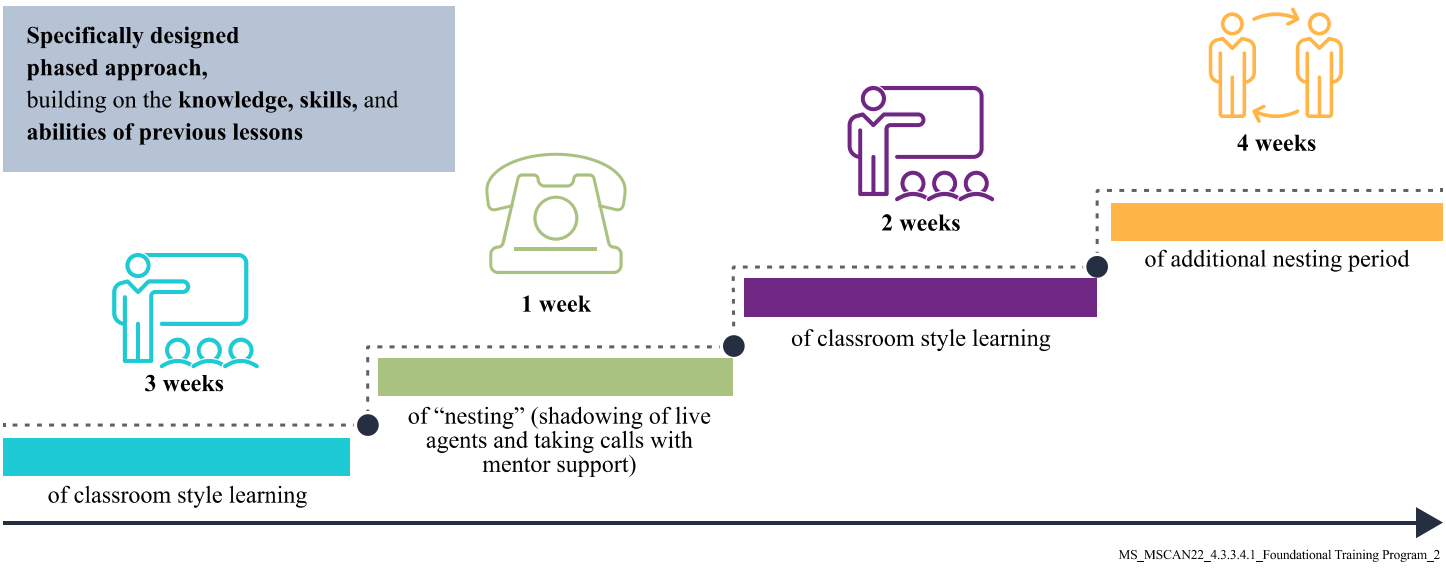
Role	Qualifications
Provider Services Manager	▪ Located in Mississippi ▪ Minimum of three (3) years of previous management/leadership experience preferred ▪ Previous experience in a Medicaid environment or related industry preferred ▪ Bachelor's degree in business related field or equivalent years of experience required
Call Center Supervisor	▪ Located in Mississippi ▪ High School Diploma or GED is required ▪ Associates Degree or equivalent years of relevant work experience is preferred ▪ Minimum of three years of customer service experience, to include a minimum of one year in a call center environment is required ▪ Previous supervisory/leadership experience in a call center environment is strongly preferred
Provider Services Call Center Specialist	▪ Located in Mississippi ▪ High School Diploma or GED required ▪ Associates degree in business or related field or equivalent years of work experience preferred ▪ Minimum of two (2) years of experience in administrative support or customer service preferred
Call Center Trainer	▪ Located in Mississippi ▪ Associate degree in Adult Education, Organizational Development, Instructional Design or related field or equivalent years of relevant work experience is required ▪ Bachelor's degree is preferred ▪ Minimum of two (2) years related call center or healthcare experience is required ▪ Previous training or curriculum development experience is preferred

Provider Services Training and Education

We recognize provider services call center staff require comprehensive, quality training from the onset, and recurring training to reinforce learning. Our new hire training program Figure 4.3.3.4_C: Provider Services Call Center New Hire Training Program offers a specific four phase approach building upon knowledge, skills, and abilities of previous lessons, and adheres to Appendix A, Section 6.9. Our 10-week program provides five weeks of classroom-style learning about TrueCare and the individual needs of our provider community, along with training on MSCAN and CHIP, as required. We incorporate shadowing, structured role-playing, mock calls, and live calls to ensure our new provider services call center staff are comfortable before graduating the program. We commit to fully preparing call center employees, and in some cases an additional two weeks of training is provided to individual employees who may need or request additional support.

Figure 4.3.3.4_C: Provider Services Call Center New Hire Training Program

Using a phased approach to training, we drive superior service to our providers.



Ongoing staff training and updates include "Late Breaking News" articles; Administrative Code Filings, and Provider Billing Handbook along with how these formats impact the Mississippi programs and administration of benefits for our members. We provide quarterly reports detailing training, topics covered, and the number of staff by position completing training to the Division.

As illustrated in Table 4.3.3.4_F Training and Skills Development, provider services staff receive training from the Mississippi provider call services trainer on the individual needs of providers, including how to best support, facilitate resolution, and provide education to providers. Our providers have individual needs whether they are a large hospital system, community and behavioral service providers, or an individual primary care provider. We train our provider services staff how to support these varying individual business needs. Provider services staff use their training to educate providers, respond to questions, and assist providers to use our online tools. Using a tailored behavioral approach to building connections, we promote provider services staff interacting with each provider in a respectful and professional manner.

Table 4.3.3.4_F: Training and Skills Development

Key Training Areas	Training Components
Competences & Skills	▪ Diversity, Equity, and Inclusion – annual training, with quarterly events and reinforcement programs ▪ Complex Populations courses designed to inform staff on the changing needs of our members, and how to think critically about the providers serving them. Our three-course series includes: Complex Populations – Foundations, Complex Populations - Serious Mental Illness, and Complex Populations - Substance Use Disorders ▪ Mental Health First Aid training – annual training with quarterly reinforcement ▪ Interactions with Heart Training – Training focused on our quality program which blends elements of effective listening, person-centered language, accuracy importance, first call resolution, chronic and acute conditions, and health equity training. Annual training with quarterly reinforcement
Programs	MSCAN, CHIP, and Mississippi programs and benefits. This course enables staff to answer provider questions regarding credentialing status; member benefits; pharmacy information; utilization management; claims history; grievance and appeals status; and our provider portal.
Process	Proper procedures needed for all aspects of a provider's experience. We focus on accuracy, the ability to resolve inquiries within in a single interaction and ensuring 100% closure and follow up with the provider. Topics include: ▪ Eligibility questions and redetermination assistance ▪ Benefits and services ▪ Contracting and credentialing ▪ Provider maintenance and support ▪ Dental and Vision programs and benefits ▪ Utilization management ▪ Claims submission, review, and adjustment ▪ Grievances, disputes, and appeals (claims and authorizations) ▪ Coordination of benefits ▪ Provider portal education and support
Communication & Reinforcement	Training on communication methods and how staff receive updates to successfully service providers and members, including: ▪ Real-time updates of procedures with automated alert notifications to staff ▪ Targeted updates within team meetings and individual coaching sessions ▪ Quarterly reinforcement training on enhanced processes ▪ Monthly and quarterly video-based, micro learnings, work process reviews, and automated staff acknowledgement of information application ▪ Scheduled classroom training, where needed, to ensure adoption of new process and procedures

Local and Statewide Cultural Competency Training

TrueCare's Mississippi based director of health equity serves as our Cultural Competency champion and will oversee all dimensions of training and keeping regional awareness in the forefront of all presentations. We will leverage the Mississippi ***Alluvial Collective***, to inform customized training curriculum focusing on racial reconciliation. Community based partnerships

will inform our thinking and support our shared passion and desire to continually improve productive conversations about race, equity, and our collaborative relationships.

Our leadership participates in an enterprise workgroup on cultural competency committed to advancing National Standards for Culturally & Linguistically Appropriate Services (CLAS). This high-level workgroup includes investing in employee education and training regarding social determinants of health, health disparities, health inequities, and the importance of cultural competency. Our model includes educating and training governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. We address cultural, linguistic, and health literacy barriers by requiring staff to attend cultural sensitivity training programs at hire and annually, hosting quarterly events, and through our continued education and reinforcement programs. Some of the classes include:

- Health literacy, CLAS, Commitment to Health Equity, Culture, and Diversity Awareness
- Member Health, Safety, and Welfare Program
- Experiential poverty simulation, the poverty simulation focusing on the challenges of living in poverty to provide employees with perspective on the social and economic barriers faced by our members
- Religion and Culture and their influence on health care

Upon hire, all staff must take and complete Implicit Bias and Mitigating Bias training within their first 30 days of employment. Employees must complete training on Diversity, Equity, and Inclusion (DE&I) and cultural competency annually. We require staff upon hire to take our Complex Population course series which informs staff on the changing needs of our members and their providers. We refresh courses quarterly as change for our members occurs. Other DE&I courses are available in our learning management system including Understand and Embrace Diversity, How to Create a Respectful Workplace, and Fostering Inclusion in the Workplace, and Unconscious Bias. Ongoing and annual competency requirements ensure current and localized training increase cultural awareness and sensitivity to foster an environment open to diverse thinking and an understanding of cultural norms in health and illness.

Continuing Education and Training Requirements

TrueCare, in compliance with Appendix A, Section 5.1, will provide ongoing education at least quarterly to include education about Medicaid, MSCAN, and CHIP. Our training is time sensitive and occurs as necessary to ensure near real-time updates about Medicaid changes and requirements. TrueCare will submit quarterly reports to the Division detailing the trainings conducted, topics covered, and the number and job title for staff completing the trainings.

We offer continuing education opportunities, available on an ongoing basis, through internal/external conferences and lectures, self-study, refresher training, and on the job training. Our Training and Professional Development Committee identifies and develops staff enrichment and training programs. Using current and localized training for ongoing and annual competency requirements, we increase cultural awareness and sensitivity to foster an environment open to diverse thinking and understanding cultural norms in health and illness. All staff complete annual training to ensure proficiency in cultural competency, corporate compliance, and all position related skills.

4.3.3.4.3 Describe staff who will be assigned to the quality management program and their qualifications.

Our commitment to quality extends from the TrueCare Mississippi Board of Directors to our multi-disciplinary Quality Management Committee (QMC) and will be supported by our Mississippi based team of medical director, population health director, and quality management director. Our medical director chairs the TrueCare QMC providing leadership, oversight, and evaluation of the Quality Management Program and Annual Quality Management Work Plan to ensure adherence to state and federal standards. The QMC meets quarterly and includes interdisciplinary representation with provider and beneficiary input. The primary responsibilities of the

QMC are strategic direction, development, monitoring, and evaluation of annual program activities and quality and performance improvement projects. Additionally, our corporate chief medical officer is a Mississippi-licensed physician who will ensure that all corporate initiatives work well for Mississippi.

Chaired by our Mississippi medical director, TrueCare is implementing a Health Services Utilization Committee for our Mississippi programs, which includes the following Mississippi based team members:

- Quality Management Director
- Quality Improvement Manager
- Quality Improvement Specialist
- Regulatory Compliance Representative
- Women's and Children's Health Outcomes Manager
- Vice President of Care Management
- Transitions Coordination Manager
- Care Management Manager
- Utilization Management Coordinator
- Director of Utilization Quality Management Program

TrueCare's ability to deliver operational excellence demonstrates we respect members, providers, and will be a worry-free partner of the Division.

Quality Management Department

Our Quality Management staff, listed in Table 4.3.3.4_G: Quality Management Roles and Qualifications, performs all daily operations and functions**.** For precise detail regarding job descriptions, in compliance with Appendix A, Section 1.13, refer to Appendix H 4.3.3.2 Job Descriptions for a comprehensive description of all positions.

Table 4.3.3.4_G: Quality Management Roles and Qualifications

Role	Qualifications
Quality Management Director	▪ Located in Mississippi ▪ QM Director must be a health care practitioner with a Masters in Nursing (MSN), Business Management or related field ▪ Minimum of five (5) years of leadership/management experience is required ▪ Minimum of three (3) years experience Medicaid, or coordinated care organization required ▪ Minimum of five (5) years of experience developing, implementing or evaluating quality improvement programs is required ▪ Previous experience in quality is required ▪ Possess, or obtain within six (6)months of hire, training in one (1) or more of the following areas: strategic planning, Six Sigma Certification, Lean Six Sigma Certification, Plan-Do-Study-Act (PDSA) Cycle, or Rapid Cycle Improvement
Quality Improvement Manager	▪ Current, unrestricted Registered Nurse (RN) licensure in the state of Mississippi is preferred ▪ Bachelor's Degree or equivalent years of relevant work experience is required, (MSN) or healthcare related field is preferred ▪ Completion of an accredited RN degree program or Bachelors of Science in Nursing (BSN) is preferred ▪ Minimum of three (3) years of experience in a healthcare or CCO, is required ▪ Previous management experience is required ▪ Medicaid or Medicare experience preferred ▪ Experience in quality metrics preferred
Quality Improvement Specialist	▪ Associate of Science in Nursing (RN) is required, BSN is preferred ▪ One (1) to three (3) years of experience in quality improvement, project management, case management or utilization review is required ▪ Three (3) to five (5) years years managed care experience is required ▪ Two (2) years of accreditation experience is required ▪ Minimum of three (3) years of diverse clinical experience as an RN is preferred ▪ National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), or Healthcare Effectiveness Data and Information Set (HEDIS) experience is preferred
Quality Improvement Coordinator	▪ Bachelor's degree or equivalent years of relevant work experience is required ▪ Minimum of two (2) years of healthcare, managed care, or administrative experience is required ▪ Knowledge of the Model of Improvement (PDSA) is preferred

Role	Qualifications
Enterprise Quality Improvement Advisor	▪ Bachelor's degree or equivalent years of relevant work experience is required ▪ Certified Professional in Healthcare Quality or American Society for Quality certification preferred
HEDIS Data Analyst	▪ Bachelor's degree or equivalent experience in computer science/data analytics ▪ One (1) year HEDIS experience required
Population Health Director	▪ Master of Public Health required ▪ Minimum of five (5) years experience administering population health analyses, workgroups, and program interventions ▪ Experience in population health data analytics required ▪ NCQA, URAC, or HEDIS experience preferred
Population Health Program Evaluator	▪ Master of Public Health or Doctor of Public Health degree required ▪ Three (3) to five (5)years experience in population health program development and evaluaiton required ▪ Demonstrated knowledge applying social determinants of health and health equity solutions
Medical Director	▪ Mississippi-licensed physician ▪ Successful completion of a residency training program with population health focus ▪ Minimum of ten (10) years of clinical practice experience is required ▪ Minimum of three (3) years managed care medical director and population health experience is required
Perinatal Health Director	▪ Mississippi-licensed physician ▪ Successful completion of a residency training program, preferably in primary care is required ▪ Active practicing physician with specialty in obstetrics and gynecology in Mississippi or actively practicing physician in Mississippi with a specialty in obstetrics and gynecology in the past five (5) years ▪ Managed care medical review/medical director experience is preferred
Behavioral Health Director	▪ Mississippi-licensed physician ▪ Successful completion of a residency training program, preferably in primary care is required ▪ Active practicing physician with specialty in behavioral health in Mississippi or actively practicing physician in Mississippi with a specialty in behavioral health in the past five (5) years ▪ Managed care medical review/medical director experience is preferred

4.3.3.4.4 Describe the role of the Care Manager and Care Management Team. Describe the minimum level of education, training, and experience required for care managers. Describe the entity's approach to ensure that care managers are culturally competent and understand the unique needs of Members, including how a member's initial risk level and needs may factor into care manager assignment. A ratio of care managers to Members is described in Appendix A: Draft Contract: Section 7: Care Management. Describe the Offeror's ability to reach this ratio. Also provide an overview of the training and education the Offeror will provide to Care Managers.

TrueCare is committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi. Our care management staff members are a culturally competent, multi-disciplinary team comprised of social workers, registered nurses (RNs), clinical pharmacists, registered dieticians, licensed practical nurses (LPNs), licensed behavioral health (BH) professionals, community health workers (CHWs), care management coordinators, perinatal, population health, and other allied health professionals. Additionally, our corporate chief medical officer is from Mississippi and will have oversight responsibilities. Our teams also include certified diabetes educators, certified asthma educators, and certified managed care nurses to round out all aspects of person-centered health care. Table 4.3.3.4_H provides an overview of these positions. For precise detail regarding job descriptions, in compliance with Appendix A, Section1.13, refer to Appendix H 4.3.3.2 Job Descriptions. All care management positions are in Mississippi, which is a testament to **TrueCare's innovative programs and services, proven to consistently improve health outcomes for the Divisions priority areas including maternal health, behavioral health, and special populations.**

Table 4.3.3.4_H: Care Management Position, Roles, and Qualifications

Position	Role	Minimum Education, Training, and Experience Requirements
Vice President Clinical Operations	Located in Mississippi. Oversee and Manage program design, implementation, and ongoing monitoring of key performance indicators. Handles and ensures adequate staffing and staff maintenance of role core competencies. Ensures adherence to all regulatory, compliance, and appropriately report out on program effectiveness to respective internal TrueCare committees. Maintains continued analysis of data to refine program workflows to improve ongoing intervention strategies.	▪ Located in Mississippi ▪ Bachelor's degree in business administration, nursing or related field, or equivalent years of relevant work experience is required ▪ Graduate degree in business administration, nursing, or public administration preferred ▪ Minimum of ten (10) years of current progressive, operational experience in a managed care setting with a focus on utilization management, medical/reimbursement policy, and population health is required ▪ Minimum of five (5) years of strong senior level leadership/ management experience is required ▪ Experience in a coordinated care organization, Medicaid, Medicare, and long-term care is preferred
Care Management Director	Located in Mississippi. Oversees all care management functions by developing and maintaining the Mississippi care management system.	▪ Located in Mississippi ▪ Bachelor's degree or equivalent years of relevant work experience is required; Master's degree is preferred ▪ A minimum of five (5) years of managed healthcare experience with line management responsibility including clinical operations is required ▪ A minimum of two (2) years of experience developing programs/processes to support care management and member wellness is required ▪ Experience working within applicable state, federal, and third-party regulations is required ▪ Operational and process improvement experience is preferred
Maternal Risk Specialty Care Managers	Located in Mississippi. Screens for high-risk needs and support services at levels appropriate to identified needs of pregnant members. Collaborates with the Perinatal High-Risk Management/Infant Services System (PHRM/ISS) identifying members meeting program criteria. Provides care management services coordinated with the Mississippi Division of Medicaid (the Division) care managers to create care plans.	▪ Located in Mississippi ▪ Nursing degree from an accredited nursing program is required ▪ Bachelor of Science in Nursing is preferred ▪ Licensure as a RN is required ▪ Minimum of three (3) years of experience in nursing focused in maternity (e.g., discharge planning, case management, care coordination, or home/community health management experience) is required ▪ Three years or more Medicaid/Medicare managed care experience preferred ▪ Current unrestricted clinical license in state of practice as a RN is required ▪ Case Management Certification is highly preferred
Neonatal Intensive Care Unit (NICU) Specialty Care Manager	Located in Mississippi. Engages families and provides support for coordination of care and transitions of members into the NICU. Coordinates with PHRM/ISS program and provides care management in coordination with Division care managers when members choose to participate in the program.	▪ Located in Mississippi ▪ Nursing degree from an accredited nursing program is required ▪ Bachelor of Science in Nursing is preferred ▪ Licensure as a RN is required ▪ A minimum of three (3) years of experience in nursing focused with NICU experience (i.e., discharge planning, case management, care coordination, or home/community health management experience) is required ▪ Three years or more Medicaid/Medicare managed care experience is preferred ▪ Current unrestricted clinical license in state of practice as a RN is required ▪ Case Management Certification is highly preferred
Behavioral Health Specialty Care Manager	Located in Mississippi. Supports members with complex BH and substance use disorder (SUD) needs and collaborates with Community Mental Health Centers and other BH providers.	▪ Located in Mississippi ▪ Master's degree in a human service field and two (2) years of post-degree professional experience is required ▪ Valid licensure as a counselor or social worker is required ▪ Valid licensure or certification as a SUD expert is preferred

Position	Role	Minimum Education, Training, and Experience Requirements
		▪ Minimum of two (2) years of supervisory experience is required ▪ Managed care experience is preferred ▪ Current unrestricted clinical license in state of practice as a social worker or counselor is required
Transitions of Care Manager	Located in Mississippi. Promotes timely coordination and safe transitions for members experiencing inpatient hospitalization. Facilitates coordination of care through direct support to members and communication and collaboration with primary care providers, primary care medical homes, and community health providers (e.g., hospitals, home health care providers).	▪ Located in Mississippi ▪ Bachelor of Science degree or equivalent years of relevant work experience is required ▪ Minimum of three (3) years of healthcare or managed care experience is required ▪ Medicaid, Medicare, and Marketplace experience is preferred
Care Manager	Located in Mississippi. Collaborates with members of the interdisciplinary care team (ICT) to meet the needs of the individual and the population. Identifies problems or opportunities which would benefit from care coordination.	▪ Bachelor's degree in a health care field or equivalent years of relevant work experience is required ▪ Master's degree is preferred ▪ Licensure as a social worker or counselor is required ▪ Minimum of three (3) years of experience in social work or counseling (e.g., discharge planning, case management, care coordination, or home/community health management experience) is required ▪ LPNs, paramedics, and allied health professionals preferred ▪ Three years or more Medicaid/Medicare managed care experience is preferred ▪ Certified diabetes or asthma educator preferred
Community Health Worker	Located in Mississippi. Provides extended care management services by identifying community resources and providers. Conducts face-to-face visits with members in their homes or communities to address health disparities and other barriers to care.	▪ Located in Mississippi ▪ High School Diploma or General Education Diploma (GED), is required ▪ Minimum two (2) years of experience in community settings with at risk populations providing coordination of services is preferred ▪ Experience with infants, pediatrics, and adolescents is preferred
Peer Support Specialists	Located in Mississippi. Assists members by using their own lived experiences of SUD or BH to support members in their recovery journey.	▪ Located in Mississippi ▪ High School Diploma/GED or higher ▪ Lived experience with complex and difficult issues which may include homelessness, criminal justice system, BH or SUD, severe mental illness, and foster care programs. ▪ Experience using the principles of recovery and resiliency (e.g., concept of recovery plans, the 12-step model, family reunification, re-entry, and community reintegration)
School-Based Health Administrator	Located in Mississippi. Develops relationships with school-based health centers to ensure availability of quality preventive and primary care services to school-aged members.	▪ Located in Mississippi ▪ Bachelor's Degree in Health and Human Services, nursing, public health, or related field or equivalent years of relevant work experience is required ▪ Minimum of three (3) years of experience in nursing, social work, public health, or related healthcare field is preferred ▪ Minimum of three (3) years of experience in school health, community health, Medicaid managed care, or similar setting is preferred ▪ Experience working with data and data analytics is preferred ▪ Experience working directly with providers is preferred ▪ Current unrestricted license in field of practice including (if applicable): Licensed Social Worker (LSW), RN, or LPN in the State of Service is preferred

Position	Role	Minimum Education, Training, and Experience Requirements
Community Justice Liaison	Located in Mississippi. Engages with juvenile and adult members before release from incarceration and during transition back to the community. Coordinates with Mississippi Department of Corrections to help members experiencing incarceration transition to their communities and engage in any necessary medical and behavioral health treatment.	▪ Located in Mississippi ▪ Bachelor's degree in health care, business, or related field or equivalent years of relevant work experience is required ▪ Minimum of two (2) years of care coordination or related experience is required ▪ Experience working with community justice population preferred ▪ Harold P. Freeman Patient Navigation Institute Certification, or equivalent approved training program is preferred
Life Coach	Located in Mississippi. Provides coaching for members in the life services program as defined by member needs (e.g., urgent, immediate, and long term) to prepare members for employment or education programs. Identifies and assists members with referrals related to social obstacles or enhanced member services.	▪ Located in Mississippi ▪ Associate degree or equivalent years of relevant work experience is required ▪ Bachelor's degree in social work, human services administration, or nonprofit management is preferred ▪ Minimum of two (2) years of social service delivery experience is required ▪ Experience working with populations in poverty is preferred ▪ Understanding of or experience with Motivational Interviewing and Change Readiness is preferred
Dietician	Located in Mississippi. Assesses and identifies risk, needs, and challenges related to health, eating, and nutrition. Facilitates behavioral change to prevent or restore health for individuals and groups through educational counseling, skill development, and promoting attitudes conducive to weight management and eating health. Provides assessment of nutritional and health needs and diagnoses nutritional impact to medical conditions and treatment through medical nutritional therapy. Designs diets to treat medical conditions and counsels members on nutrition, develops and implements plan to address health eating habits, meal planning, nutrition plan and promotes health eating habits with balanced lifestyle.	▪ Bachelor's degree [up to one (1) year of post degree work approved by ADA or internship] ▪ Current license issued by the Mississippi State Department of Health and current registered dietitian or registry eligible from American Dietetic Association ▪ One (1) year of experience ▪ Experience with community designed program for population health ▪ Experience with diabetic and obesity program design
Clinical Pharmacist	Collaborates with the clinical team to review member medication profiles and make recommendations to the overall care plan to drive quality and cost-effective pharmaceutical care and promote medication adherence.	▪ Bachelor of Science in Pharmacy is required, PharmD is preferred ▪ Minimum of three (3) years of experience working in a clinical environment or residency is required ▪ Minimum of three (3) years of experience in product or clinical program development or residency is required ▪ Three (3) or more years of government program experience (Medicaid, Medicare, or Marketplace) is preferred
Foster Care Program Manager	Located in Mississippi. Coordinates with MS Dept. of Child Protection Services, county child welfare agencies, and treatment facilities to support the needs of children and families in foster care or at risk of out-of-home placement. Oversees team of foster care specific care managers, ensuring high quality care conferences occur when children require services and supports to meet their needs. Facilitates transitions of care for placement changes, permanency, or residential services.	▪ Bachelor's degree in a relevant human services field such as nursing, social work, psychology, counseling, or related discipline or equivalent year of relevant work experience is required ▪ Master's Degree is preferred ▪ Minimum of five (5) years of experience in Child Welfare System field is required ▪ Program/policy development and implementation experience is preferred ▪ Current, unrestricted license in the state of practice as a RN, Licensed Independent Social Worker (LISW), Psychologist, or Licensed Professional Clinical Counselor (LPCC) is preferred

Care Manager to Member Ratio

Our weighting system monitors each care manager's caseload based on programmatic leveling, with higher risk levels contributing a heavier weight to their overall caseload. Using our national experience with similar populations and NCQA guidelines, we develop caseload ratios to ensure each Mississippi Coordinated Access Network (MSCAN) and Children's Health Insurance Program (CHIP) member receives member-centric level of care coordination and intervention to meet their needs. Our staffing algorithm accounts for acuity and caseload distribution to meet the cadence of contact required by risk level to address MSCAN and CHIP member needs and appropriately assign care managers, nurses, CHWs, and other supports. This process ensures caseloads are balanced with the correct care manager role, manageable, and in compliance with Appendix A, Section 7.4. Within our integrated care management system, the leadership team continuously monitors staffing levels and active caseloads to ensure we do not overburden a care manager. Table 4.3.3.4_I displays our maximum care manager-to-member staffing ratios. Our TrueCare alliance provides a pipeline of workforce for us to draw from within the market. Life services programs develop and curate our CHW positions and our status as a nonprofit, mission driven company attracts candidates. Our fill times are less than 45 days for open positions, which helps ensure that Mississippians can easily access their benefits.

Table 4.3.3.4_I: Care Manager to Member Ratios

Care Management Case Load Ratio	
[redacted]	[redacted]
Medium Risk member Ratio	1 Care Manager: up to 40 members
High Risk member Ratio	1 Care Manager: up to 40 members

Care Manager Cultural Competency

TrueCare's Mississippi based director of health equity serves as our Cultural Competency champion and will oversee all dimensions of training and keeping regional awareness in the forefront of presentations. While supporting the various medical and psychosocial needs of the populations we serve, TrueCare is committed to ensuring the provision of culturally competent and linguistically appropriate services. Our training focuses on core competencies to address the cultural, linguistic, literacy, socioeconomic, health/wellness needs, and preferences of our MSCAN and CHIP members. We are committed to a member-centric model which includes educating and training governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. This training and foundational learning in cultural and other needs is paramount when assigning MSCAN and CHIP members initial and subsequent risk levels.

Health equity, along with cultural, linguistic, and health literacy is a priority. We remove barriers by requiring staff to participate in cultural competency training programs. Our curriculum includes in-person, online, and self-study courses related to social determinants of health, culture, impact of member health beliefs on access and receipt of health care, CLAS standards, health equity, cultural competence and member health, safety, and welfare. Further, we offer an experiential poverty simulation called the poverty simulation in a classroom and online. The simulation focuses on challenges of living in poverty and how it affects member health care decisions. The goal of the simulation is to provide employees insight and perspective on social and economic barriers faced by our members fostering empathy and understanding.

We require employees to prove expertise as a new employee and repeat annually.

Poverty simulation proves impactful

Poverty simulations are specific to the reentry population, simulating their first 90 days after release from incarceration to develop sensitivity about the issues faced by this population. Participants describe the poverty simulation as "impactful", and feedback has been overwhelmingly positive.

- **100%** of participants reported poverty simulation will **influence empathy** in interactions with low-income individuals
- **87%** reported it would **influence understanding** of the complexities of poverty
- **90%** said they will increase their effort to **build relationships** with individuals affected by poverty

Upon hire, all staff must take and complete Implicit Bias and Mitigating Bias training within their first 30 days of employment. Employees must complete training on Diversity, Equity, and Inclusion (DE&I) and cultural competency annually. We require staff upon hire to take our Complex Population course series which informs staff on the changing needs of our members and their providers. We refresh courses quarterly as change for our members occurs. Other DE&I courses are available in our learning management system including Understand and Embrace Diversity, How to Create a Respectful Workplace, Fostering Inclusion in the Workplace, and Unconscious Bias. Ongoing and annual competency requirements ensure current and localized training increase cultural awareness and sensitivity to foster an environment open to diverse thinking and understanding cultural norms in health and illness.

We continually seek and support training opportunities from nationally recognized resources. Our High-Risk Obstetrics (OB), NICU, and other teams completed the March of Dimes "Breaking Through Bias in Maternity Care," training. Available as an in-person or virtual learning experience, the training provides authentic, compelling content for health care providers caring for women before, during and after pregnancy. This training lays a foundation for improvements in racial and ethnic disparities and provides attendees with important insights to recognize and remedy implicit bias. These actions can result in improved communication, overall patient experience and quality of care, and a culture shift across committed organizations towards the goal of achieving equity for all moms and babies.

TrueCare CHWs are foundational to our efforts to ensure culturally competent services. Our field CHWs live and are trusted resources in the communities they serve. They are familiar with local cultural nuances and trained to provide individual guidance, support, education, referrals, care coordination, and other culturally appropriate assistance to MSCAN and CHIP members. TrueCare's CHWs are a testament to our commitment to provide public service at the highest level.

TrueCare knows we make the greatest impact when our employees represent the communities we serve. We recruit and train local employees, including executive leadership, who understand our MSCAN and CHIP members, including several bilingual resources.

Other courses available to improve cultural competency and health equity include:

- **Health Equity, the TrueCare Commitment.** This course provides an overview of health equity, including factors contributing to health inequities; how health inequity affects populations; ways to address health inequities; and the importance of health equity in achieving our mission and vision.
- **Dialogue.** This training focuses on effective communication, identifying different levels of communication and the appropriate deployment at each level. The training also focuses problem solving techniques attendees use to address member perceptions and help a member move from decision to action.
- **"You Gotta have Heart."** This training focuses on increasing cultural awareness and sensitivity with internal staff and external members and partners; fosters an open and accepting environment; and supports open dialogue about change. We focus training on many different departments supporting members and how they interact to ensure we provide a consistent, positive, and memorable experience to all members.
- **Other training**. Other training offers information about the multiple dimensions of health equity's political, social, and economic aspects. We address how power dynamics and implicit biases can get in the way of forming working partnerships and how to enhance effectiveness in designing and implementing actionable, co-creative strategies to develop person centered plans.

Care Manager Training and Education

We design care management training curriculum to ensure TrueCare care managers are afforded a comprehensive understanding of the MSCAN and CHIP clinical and care coordination requirements for all three levels of service, integrated care management processes and principles, person-centered planning, empowerment, relational care tenants' model to foster self-management skills, motivational interviewing, federal rules, and regulations, and

NCQA accreditation standards. The comprehensive care management staff training curriculum encompasses more than 150 courses, covering topics specifically aimed at serving our membership.

Staff must complete the care management training and demonstrate competency before the initiation of Integrated Care Management Program work. To promote continuous education and professional development, we audit staff initially and annually against programmatic and quality standards to ensure quality of program and delivery of member care.

TrueCare addresses MSCAN and CHIP member needs, preferences, and barriers through training of staff and providers. Staff members participate in an all-inclusive care management orientation program to ensure skills and expertise necessary to successfully manage member care. We provide motivational interviewing training to all care managers, including the stages of change and members' readiness to change. Motivational interviewing is a member-centered interviewing style for eliciting behavior change by helping members explore and resolve barriers.

We provide an annual mandatory training to care management staff addressing the needs of children, including the effect of trauma, cultural awareness, safety, and security. This module, coupled with continuous trauma-informed care training, enables TrueCare to support at-risk children and adult members in the MSCAN and CHIP populations who have suffered traumatic experiences. The trauma-informed approach to care ensures we have a complete picture of a member's life situation necessary to provide care coordination services with a healing orientation. Adopting trauma-informed practices can improve member engagement, treatment adherence, health outcomes, and potentially reduce avoidable care and excess costs for health care and social services.

The Care Manager Clinical Training and Auditing team requires all staff to sign off on their required training, with a demonstration of skills and expertise, indicated in Table 4.3.3.4_J before release from orientation. TrueCare provides modularized training with follow up testing to ensure staff members understand the following clinical operational activities:

Table 4.3.3.4_J: Care Manager Clinical Training

Training Topics Requiring Sign Off	
Contact requirements including contact, cadence, and content. Engagement strategies, education, motivational interviewing, and member-centric interventions for all populations. ICT education including provider contact and engagement for ICT meetings	Mandated reporting for abuse, neglect, and exploitation
Quality Measures, NCQA HEIDS, best practices and clinical practice guidelines	Spiritual and cultural sensitivity, specific to Mississippi populations including Indian Tribes, Tribal Organizations, or Urban Indian Organizations, and CLAS standards appropriate care
Health risk screening and comprehensive assessment completion, including evidence-based assessments such as PHQ9, PRAPARE, Edinburgh Postnatal Depression Scale, Child and Adolescent Needs, and others based on branching logic of screening	Identification of fraud, waste, and abuse
Risk stratification and clinical leveling criteria	Health Insurance Portability and Accountability Act requirements
Individualized, person-centered care plans including SMART goals and outcomes measurements	Clinical software platform and capabilities
Documentation protocols including those relevant to NCQA	Covered benefits and enhanced services training, including transportation, MSCAN and CHIP member incentives and programs, community-based organization resources and offerings, and extended continuity of care timeframe for new MSCAN and CHIP members.
BH training including trauma informed care and mental health first aid	Prior authorization process and internal hand-offs, including continuity of care, Coleman Model Transitions of Care
Social determinants of health	Specialty programs such as BH maternal child, high risk OB, NICU, emergency department diversion, transitions of care, and discharge planning

Training Topics Requiring Sign Off	
Potential quality of care issues and incident management training	Advance directives
Person centered framework, process competency, and relational care	Center for Disease Control Health Equity training
Disease management focusing on diabetes, hypertension, sickle cell disease, asthma, and other regionally concentrated acute conditions	Closed-loop referrals and warm hand-offs to internal, community, and faith-based organizations
Core competency on infant health conditions, including developmental delays, EPSDT	Core competency training on pediatrics and pediatrics conditions, including psychosocial issues and developmental delays, EPSDT
Core competency training on adolescence conditions, including psychosocial issues and behavioral health	

4.3.3.4.5 Managed Care Organization (MCO) Accreditation

We have a successful history of achieving full MCO Accreditation with no unsuccessful attempts. Our full time, Mississippi based compliance officer, with oversight from the vice president of quality and performance outcomes, oversees all steps in the National Committee for Quality Assurance's (NCQA) process for achieving interim accreditation and expanding to full NCQA accreditation for MSCAN and CHIP.

We hold NCQA accreditation across five states and eight product lines for Medicaid and exchange lines of business as outlined in Table 4.3.3.4_K: CareSource NCQA Status. In 2021, we successfully completed five renewal surveys across multiple markets resulting in full accreditation. In the current quality outcomes driven environment, we are increasingly called upon to demonstrate the impact of our services. Accreditation offers an objective, independent, and reliable validation of performance. The accreditation process involves a detailed review of administrative, management, and service delivery functions against accepted standards of best practice.

NCQA History of Excellence

100% of our 2021 NCQA surveys scored 100% in quality and care management.

Table 4.3.3.4_K: NCQA Status

Line of Business	Survey Type	Initial Survey Date	Future Survey Date	Status	Timeframe
Ohio Medicaid	Renewal	2012	2024	Accredited	3-Year Accreditation
Ohio Marketplace	First	2013	2022	Accredited	3-Year Accreditation
Indiana Medicaid	First	2017	2024	Accredited	3-Year Accreditation
Indiana Marketplace	Renewal	2015	2022	Accredited	3-Year Accreditation
Kentucky Marketplace	Renewal	2015	2022	Accredited	3-Year Accreditation
Georgia Marketplace	Renewal	2018	2024	Accredited	3-Year Accreditation
Georgia Medicaid	Renewal	2020	2024	Accredited	3-Year Accreditation
West Virginia Marketplace	Renewal	2017	2022	Accredited	3-Year Accreditation

**No unsuccessful attempts.*

NCQA recognized CareSource for a wide range of strengths during the 2021 surveys including:

- Engaged leadership and staff
- Comprehensive Complex Care Management program with effective contact rates and program assessments
- Very supportive member materials and website
- Evidence of good collaboration with both members and practitioners for continuity and coordination of care
- Comprehensive quality improvement program
- Application of telehealth during COVID for members with behavioral health needs
- Inclusion of telehealth services to obtain care after business hours

We successfully achieved all accreditation submissions within the original timelines. Our dedicated accreditation team supports the process with experience managing multiple state, federal, and accrediting bodies' standards, and regulations. TrueCare is committed to challenging the status quo in managed care by partnering with NCQA for new ideas in health care. We collaborate with NCQA to participate in national NCQA initiatives.

HEDIS Learning Collaborative

NCQA selected CareSource as one of 13 plans to participate in the NCQA Healthcare Effectiveness Data and Information Set (HEDIS) Learning Collaborative to develop an inventive method to report on HEDIS measures using data from electronic health records. NCQA initiated this method with a set of measures for depression care. NCQA also selected CareSource as one of two health plans to participate in a virtual event with NCQA to share findings from the collaborative.

In 2017, NCQA nominated and selected CareSource's director of performance outcomes to serve on the adult immunizations measurement advisory panel. Advisory panels provide the clinical and technical knowledge required to develop the measures. In 2021, the advisory panel decided adult immunization status measures would be the first NCQA HEDIS measures using electronic health records to be publicly reportable. CareSource has participated in an NCQA initiative to field test potential changes to HEDIS antibiotic use measures.

In one market, we received recognition from an NCQA surveyor during the 2020 accreditation survey for our dedicated accreditation team supporting the process with their experience managing state, federal, and accrediting bodies' standards, and regulations. NCQA recognized CareSource for strengths during the survey and had the following positive comments about our plan:

- Dedicated and knowledgeable staff
- Utilization management behavioral health denial files include partial approval and approved options
- UM pharmacy denial files clearly state what criteria must be satisfied to approve
- Documentation and appeal and credentialing files well prepared and presented
- Detailed, comprehensive quality documents.

In Mississippi, we use our experience to innovate and improve our ability to meet national standards. TrueCare's innovative programs and services are proven to consistently improve health outcomes in priority areas.

CareSource plans to achieve the NCQA multicultural excellence distinction award in June 2022, for current markets. This distinction validates health plan care processes and interventions that are sensitive to racial, cultural, and linguistic differences of populations. This is the evolution toward full health equity accreditation, which focuses on the CCO's capacity to reduce health care disparities among the populations we serve.

Upon achieving interim accreditation and expanding to full NCQA accreditation for MSCAN and CHIP the TrueCare Mississippi compliance officer provides to the Division, on an annual basis, all documents related to accreditation. In compliance with Appendix A, Section 8.2, we authorize NCQA to provide the Division with

all survey related information at their request. We maintain all NCQA accreditation status on our CareSource website and maintain our status on NCQA's website.

4.3.3.4.6 Describe staff who will be responsible for the entity's Fraud, Waste and Abuse program and their qualifications.

In Mississippi, our compliance officer who handles developing and implementing policies, procedures, and practices designed to ensure compliance, reports directly to the chief executive officer and the board of directors. Our compliance officer oversees our Fraud, Waste and Abuse (FWA), program integrity team, and Special Investigations Unit (SIU). The SIU is responsible for three fundamental activities: intake, triage, and investigations. The program integrity team delivers decades of experience and education in investigations, compliance, and clinical expertise. This highly credentialed and knowledgeable team routinely leads investigations resulting in millions of dollars in savings to taxpayers. We continue to build custom solutions including a significantly enhanced pre-payment claim review program, to expand our proactive prevention and detection capabilities. **TrueCare's ability to deliver operational excellence demonstrates we respect members and providers and are a worry-free partner of the Division.**

The SIU manager is responsible for all FWA activities, including the Fraud and Abuse Compliance Plan, as set forth in Appendix A, Section 10.3. At a minimum, one SIU investigator resides in Mississippi, wholly designated to Mississippi with full knowledge of provider investigations related to MSCAN and CHIP respectively, and is the key staff handling day-to-day provider investigation-related inquiries from the Division's Office of Program Integrity. Our Mississippi team receives additional support from resources including fraud analysts and a data analytics team in our corporate office in Dayton, Ohio. [redacted] The staff indicated in Table 4.3.3.4_L: Fraud, Waste, and Abuse Roles and Qualifications are comprised of experienced professionals with investigative experience. We hire beyond minimum qualifications, including but not limited to Registered Nurse (RN)/Bachelor of Science in Nursing (BSN), Certified Professional Coder (CPC), Health Care Anti-Fraud Associate (HCAFA), Accredited Health Care Fraud Investigator® (AHFI), Certified Public Accountant (CPA), and Certified Fraud Examiners (CFE). For precise detail regarding job descriptions, in compliance with Appendix A, Section 1.13, refer to Appendix H 4.3.3.2 Job Descriptions for a comprehensive description of all positions.

Table 4.3.3.4_L: Fraud, Waste, and Abuse Roles and Qualifications

Role	Qualifications
Compliance Officer	▪ Located in Mississippi ▪ Bachelor's Degree in Business/Healthcare Administration or a related discipline, or equivalent years of relevant work experience are required, Master of Business Administration (MBA), Juris Doctorate, or another advanced degree, is preferred ▪ Minimum of five years of relevant work experience within coordinated care organization operations is required, with at least three years directly involved in government programs or managed care compliance activities preferred ▪ Established relationships with the Department of Health & Human Services, Centers for Medicare & Medicaid Services, state Departments of Insurance or Medicaid Department, preferred
Vice President, Program Integrity and Retrospective Reviews	▪ Bachelor's degree in Business Administration, Healthcare Administration or related discipline or equivalent work experience required; Master's degree preferred ▪ 10 or more years of program integrity, compliance, SIU, or related required experience ▪ Five years of senior leadership experience with a managed care organization required
Program Integrity Director	▪ Bachelor's degree or equivalent work experience in law enforcement, accounting, or a medical discipline required. Significant experience in investigations, medical record audits, health care compliance, or data analytics (as appropriate for position) required ▪ Minimum seven years healthcare experience ▪ Minimum of five years management experience
SIU Manager	▪ Bachelor's degree in Criminal Justice, medical/health care field, or related relevant work experience

Role	Qualifications
	▪ Minimum of six to eight years of investigative or health care experience required ▪ Leadership/supervisory experience preferred
SIU Investigator	▪ Located in Mississippi ▪ Bachelor's degree or equivalent work experience in a health-related field or law enforcement ▪ Minimum of three years of experience in healthcare fraud investigations, medical coding, pharmacy, auditing, or data analytics
SIU Team Lead	▪ Bachelor's degree in Criminal Justice, medical/health care field, or related industry; or equivalent work experience required ▪ Minimum of five years of investigative or health care experience required ▪ Leadership training and experience preferred
Intake Coordinator	▪ High school diploma or General Education Development (GED) required, Associate degree in a health-related field, law enforcement, or insurance preferred ▪ Minimum of three years' experience in a health care related field or customer service
Triage Investigator	▪ Associate degree or equivalent years of relevant work experience in a health-related field or insurance ▪ Experience in medical coding, pharmacy, auditing, data analytics required
Clinical Review Specialist	▪ BSN required ▪ Minimum of five years clinical practice experience required ▪ Significant experience auditing medical records against claims required, prior Fraud, Waste, Abuse (FWA) investigation and auditing experience preferred ▪ Medical research experience preferred
Medical Coder	▪ Bachelor's degree in Business Administration or related field or equivalent years of relevant work experience required ▪ Minimum of five years of experience in medical coding, to include experience in program integrity coding audits required ▪ Experience with reimbursement methodology e.g., ambulatory payment classifications (APC), diagnosis-related group (DRG), outpatient prospective payment system (OPPS) required ▪ CPC or equivalent billing/coding designation required
Program Integrity Internal Controls Analyst	▪ Bachelor's Degree in compliance, healthcare, or legal field or equivalent years of relevant work experience required ▪ Minimum of four years of experience in a compliance or legal field required ▪ Previous experience in internal and external auditing, risk management and performance improvement required, experience with Medicaid, Medicare, and Marketplace product preferred
Medical Director	▪ Located in Mississippi ▪ Doctor of Medicine (MD) or Doctor of Osteopathic (DO) required ▪ Successful completion of a residency training program required, preferably in primary care ▪ Minimum of five years clinical practice experience required; managed care medical review/medical director experience preferred ▪ Bachelor's or Master's in Business Administration, Operational Excellence, Healthcare Administration, or Medical Management preferred
SIU Data Reporting Analyst	▪ Bachelor's degree in management information systems, Computer Science, Business or related field or equivalent years of relevant work experience required ▪ Minimum of five years of experience in data analytics and reporting required ▪ Minimum of two years of experience in CPT coding knowledge and medical terminology required ▪ Previous healthcare billing experience preferred ▪ Experience in data mapping preferred ▪ Training in statistical process control methodology preferred

TrueCare is committed to guarding against FWA of Medicaid program benefits and resources. Our SIU in partnership with Claims & Customer Service Operations, Quality, Delegation Oversight, Clinical, Finance, Information Technology, Human Resources, Compliance, and Legal departments all work collaboratively to improve stewardship of state funding. Ongoing training and communication among these teams and members ensure appropriate and timely reporting of suspected FWA.

4.3.3.4.7 Describe how staff will respond to requests from the Division regarding complaints, ad hoc reports, etc., as required in Section 1.10, Responsiveness to the Division, of Appendix A, Draft Contract.

Responsiveness to Mississippi Division of Medicaid

TrueCare compliance officer, located in Mississippi and supported by the compliance department, serves as the single point of contact for all requests from the Mississippi Division of Medicaid (the Division) in compliance with Appendix A, Section 1.10. Regardless of which department or interaction with the Division receives the request, the compliance officer responds while compiling and collaborating with the appropriate departments for resolution. In the event the compliance officer is unavailable, the chief executive officer or other qualified designee notifies the Division and performs these duties in their absence.

The Mississippi data compliance manager logs and tracks each request from the Division in the compliance tracking database, assessing priority as urgent or non-urgent, unless the Division specifies within the request. TrueCare acknowledges receipt of the Division's written, electronic, or oral requests for assistance no later than one business day from receipt of the request from the Division, and we complete the request to the satisfaction of the Division within five business days from the date of receipt, unless the Division specifies another time frame. We acknowledge, should we request an extension of the time frame, the Division may grant the request at its discretion. If the request is urgent, the compliance officer immediately, without unreasonable delay, acknowledges the Division's urgent requests for assistance and gives such requests priority. We complete urgent requests to the satisfaction of the Division within the time frame specified by the Division. When the Division does not specify a timeframe, we complete urgent requests within five business days from the date of receipt. **TrueCare's ability to deliver operational excellence demonstrates we respect members and providers and is a worry-free partner of the Division.**

TrueCare's acknowledgment of Division requests for assistance includes the required date of resolution, and we acknowledge receipt in the manner we received the request. For oral requests from the Division, we acknowledge receipt of the request orally and immediately follow up with a written or electronic acknowledgment.

- **Urgent Requests:** In addition to tracking and reporting urgent requests, TrueCare's compliance officer remains open to constant contact with the Division to provide status updates.
- **Complaints:** TrueCare's compliance department is guided by the National Committee for Quality Assurance (NCQA), State, and Federal requirements related to the acknowledgment, resolution, tracking, trending, timeframes, written notification, elements, and reporting of member and provider complaints we receive through the Division. Our compliance officer assumes responsibility and oversees the investigation, processing, and collaborates with the data compliance manager and other appropriate staff thru resolution.
- **Ad Hoc Reports:** The data compliance manager collaborates with the appropriate business owner(s), subcontractor(s), and the data analysts on Division ad hoc report requests. The data analyst team ensures each data element in a report and computations in a report, are accurate and reflect the business purpose of the report. TrueCare collaborates and identifies opportunities for improving the ease of data capture, aggregation, and reporting to further ensure prompt, accurate, and reliable reporting to the Division.

Upon completion of the request, the compliance officer submits to the Division, on or before the required date of completion, a detailed completion summary advising the Division of TrueCare's action and resolution. Our completion summary contains all information necessary for the Division to determine whether a request is complete and conforms to specifications requested by the Division concerning form, format, or content of the summary, if any.

4.3.3.4.8 Describe staff who will be responsible for subrogation and Third-Party Liability activities, including staffing levels and qualifications.

Our coordination of benefits (COB) team, with many years of experience working with coordinated care organizations (COO), handles all activities regarding validation to determine primacy regarding subrogation and third-party liability (TPL). Data analysts supporting the enrollment COB team have an average of 10 years of

experience in healthcare. Our analysts review TPL data for accuracy to eliminate any member impact. We staff the COB team based on workforce analysis using membership numbers to determine staffing needs. Staffing is determined by inventory. Enrollment specialists can work 70 records a day on average. As an example, eight full time specialists can process 2,800 records a week. **TrueCare's ability to deliver operational excellence and next generation community based coordinated care demonstrates we respect members and providers and are a worry-free partner of the Division.**

Our experience in multiple states provides us with the expertise and processes in place to work directly with providers while maintaining member privacy. We share information for our members, especially those with special health care needs, with other payers as specified by the Mississippi Division of Medicaid and in accordance with 42 CFR 438.208(b). We ensure member privacy of identifiable health information using established and proven security processes, as documented in 45 CFR 160 and 164.

Table 4.3.3.4_M: Subrogation and TPL Roles and Qualifications provides an overview of these positions. For precise detail regarding job descriptions, in compliance with Appendix A, Section 1.13, refer to Appendix H 4.3.3.2 for a comprehensive description of all positions.

Staff Responsible

Table 4.3.3.4_M: Subrogation and TPL Roles and Qualifications

Role	Qualifications
Director of Enrollment	▪ Bachelor's degree in accounting, finance, healthcare management or related field or equivalent years of work experience is required ▪ Master of Business Administration or other related post-graduate degrees, preferred ▪ Minimum of seven or more years of leadership and management experience required ▪ Minimum of five years of business operations or similar experience required, preferably in a health care environment ▪ Medicaid managed care, Medicare Advantage, or other healthcare experience preferred
Sr Manager, Enrollment Operations	▪ Bachelor's Degree or equivalent work experience is required ▪ Minimum of five years of leadership/management experience is required ▪ Minimum of five years of business operations or similar experience is required, preferably in a health care environment ▪ Medicaid managed care, Medicare Advantage, or other healthcare experience is preferred
Enrollment Production System Analyst/Subject (SME) COB Data Review	▪ Bachelor of Science degree in Management Information Systems or Business Analysis or equivalent work experience is required ▪ Minimum of three years of health care operations experience in insurance, managed care, or related industry is preferred ▪ Experience working with mailing databases and print fulfillment vendors preferred
Operations Business Analyst /SME CMS Medicare data	▪ Bachelor's degree in Computer Science, Information Systems, Business Administration or related field or equivalent years of relevant experience is required ▪ A minimum of five years of experience in requirements management is required ▪ Familiarity of the healthcare payer industry and knowledge of Medicaid and Medicare preferred
Team Lead, Enrollment	▪ Associates Degree in business, healthcare or related field or equivalent years of relevant work experience is required ▪ Minimum of three years of healthcare experience to include at least one year of enrollment/eligibility or similar experience is required
Enrollment Specialist	▪ High School Diploma or equivalent required ▪ Associate degree in accounting, finance or business-related field or equivalent work experience is preferred ▪ Minimum of two years of healthcare, insurance, or related industry experience to include at least one year of enrollment/eligibility or like experience is required

4.3.3.4.9 Staffing Describe staff who will be responsible for the entity's encounter reconciliation policies and process, including staffing levels and qualifications.

Across all markets our 99.95% overall encounter completeness rate and 99.84% first pass accuracy rate establishes us as an industry leader. Overseen by the chief information officer, TrueCare will maintain the policies, procedures,

and mechanisms to support and report all encounter data and regulatory data requirements. As requested, our team will meet monthly with the Mississippi Division of Medicaid (the Division) and fiscal agent representatives to support data exchange and report any challenges in the reporting process. We are committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model which will bring a new era of provider collaboration to Mississippi. We will work with the State's fiscal agent to create file structures and content to support the State's ongoing needs relative to encounter information.

To meet the State's encounter data requirements, the TrueCare encounter team will collect and submit physician, facility, and other provider encounter data to ensure compliance with the appropriate Data Companion Guide(s). We have established, rigorous processes for regular submission of encounter data to State agencies and the Centers for Medicare and Medicaid Services. **TrueCare's ability to deliver operational excellence demonstrates we respect members and providers and will be a worry-free partner of the Division**.

To ensure timeliness, accuracy, completeness of encounters submission and prudent management of state resources, TrueCare has dedicated Encounters Information Technology (IT) and Encounters Operations teams. Table 4.3.3.4_N Encounter Reconciliation Roles and Qualifications reflects the staff responsible for encounters operations activities. For precise detail regarding job descriptions, in compliance with Appendix A, Section 1.13, refer to Appendix H 4.3.3.2 Job Descriptions for a comprehensive description of all positions. Reinforcing the activities of our dedicated teams, we maintain policies, procedures, and processes encouraging providers to submit clean claims ensuring we meet all contractual requirements for prompt, accurate, and complete encounters including fully compliant encounter data elements.

Table 4.3.3.4_N: Encounter Reconciliation Roles and Qualifications

Role	Qualifications
Chief Information Officer	▪ Bachelor's degree in Computer Science, Business, or equivalent experience ▪ Ten (10) years of experience in an IT related field ▪ One year of experience in managed care, preferably in systems management ▪ Experience with coordinating hardware and software agreements with vendors ▪ Eight (8) years of managing technical and non-technical staff
Vice President, Claims	▪ Bachelor of Science degree in finance, business, or healthcare field, or equivalent work experience is required ▪ Master's in Business Administration, healthcare, or related field is preferred ▪ Minimum of seven (7) years of experience in operations management in a Medicaid or Medicare environment is required ▪ Prior second level management experience is required ▪ Operational experience in a Medicaid or Medicare, commercial environment is preferred ▪ Operational experience in a service based or marketing environment is preferred ▪ Operational experience in an information systems environment is preferred
Senior Director, Claims Encounter	▪ Bachelor's degree or equivalent years of relevant work experience is required ▪ Minimum of seven (7) years of experience with a health care claims or encounter data department is required ▪ Minimum of five (5) years of leadership experience is required ▪ Experience managing vendors to contractual requirements is required
Manager, Claims Encounter Data	▪ Bachelor's degree or equivalent years of relevant work experience is required ▪ Minimum of five (5) years of managed healthcare, claims, or managed care regulated environment experience is required ▪ Minimum of three (3) years of previous leadership experience is required
Team Lead, Claims Encounter	▪ Associates degree or equivalent years of relevant work experience is required ▪ Minimum of three (3) years of health plan business or systems solutions experience is required ▪ Exposure to Facets or equivalent system is preferred ▪ Prior supervisory experience is preferred
Encounters Systems Analyst	▪ Bachelor's degree or equivalent years of relevant work experience is required ▪ Minimum of three (3) years of managed healthcare, claims, or managed care regulated environment experience is required

Edifecs Configuration	▪ Four (4) years of experience developing and deploying Java or Middleware based applications using at least one technology such as International Business Machines WebSphere, The Information Bus Company Business works, Oracle web logic, Oracle Glassfish, Oracle JCaps, or related technologies ▪ Four (4) years of experience using software life-cycle methodologies such as waterfall, agile-scrum in developing products and IT applications ▪ Four (4) years of experience using software engineering tools for configuration management, defect tracking, unit testing, build and deployment; and ▪ Three (3) years of experience with Electronic Data Interchange (EDI) mapping, and EDI analysis
Vice President, IT Core Systems	▪ Bachelor's degree in the field of computer science, information systems, or business administration or equivalent years of relevant work experience is required; Master's degree preferred ▪ Minimum of ten (10) years of experience managing or directing an application development organization with at least five (5) years in a senior leadership role ▪ Experience in managing partner vendors to contracted service level agreements and deliverable expectations is required ▪ Experience with driving end to end solutions to operational issues from an IT perspective in collaboration with the business is required ▪ Experience and expertise in systems design, development, deployment, and operational support is required ▪ Prior experience with Trizetto Product Suite including Facets Claims Processing is strongly preferred ▪ Prior experience in Systems Applications and Products(SAP) is strongly preferred
Associate Director, IT - Encounters	▪ Bachelor's degree in Business, Computer Science, or related field or equivalent years of relevant work experience is required ▪ Minimum of five (5) years of experience in management of encounters teams is required ▪ Minimum of ten (10) years of relevant IT experience is required ▪ Experience translating business requirements into technical specifications is preferred ▪ Project planning and project management experience is preferred
Application Developer	▪ Bachelor of Science in the field of computer science or software engineering or equivalent years of relevant work experience required ▪ Minimum of five (5) years of advanced Object-Oriented Programming principles and design experience required ▪ Experience leading a development team is preferred ▪ Experience developing and designing n-tier applications with multi-tier architectures is preferred ▪ Unified Modeling Language experience is preferred
Data Analyst	▪ Bachelor's degree or equivalent years of relevant work experience required ▪ Minimum of three (3) years of experience in data analysis or equivalent analytic experience ▪ Experience in data mapping preferred ▪ Healthcare experience preferred

Staff Levels

The encounter team staffing includes no less than two (2) dedicated encounter systems analysts, located in Mississippi, to manage member encounter data processing, timeliness, accuracy, and completeness of encounters submissions to the Division per the encounter submission requirements under 42 CFR § 438.242 and Appendix A, Section 16.7. In addition, TrueCare's Mississippi dedicated staffing includes a senior director who leads the Encounters Operations team, two managers, a lead analyst, an encounters systems analyst, and an Edifecs configuration analyst who oversees encounters operations and subcontractors in partnership with the associate director of IT.

4.3.3.4.10 Staffing Describe staff who will be wholly dedicated to the associated Contract and those staff members that are shared.

TrueCare is committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi. **TrueCare's localized approach will rely on Mississippi people and resources, with**

support from our national team. [redacted] The Table 4.3.3.4_O reflects all staff who will be supporting Mississippi including the phase in which they will be hired and identifies if they are wholly dedicated or shared services.

Table 4.3.3.4_O: Dedicated and Shared Staffing by Phase

Phase	Job Title	Dedicated
Implementation	Behavioral Health (BH) Director, Chief Executive Officer (CEO)/Project Manager, Chief Operating Officer, Chief Financial Officer, Project Manager, Medical Director, Compliance Officer, and Perinatal Health Director	Wholly
Implementation	Chief Information Officer, and Director of Compliance	Shared
Transition to Operations	Care Management Director, Claims Administrator, Data and Analytics Manager, Grievance and Appeals Coordinator, Member Services Manager, Population Health Director, Provider Services Manager, Quality Management Director, and Utilization Management Coordinator	Wholly
Transition to Operations	Clinical Pharmacist	Shared
Operations	Administrative Specialist, Associate Vice President, Health Partnership, Behavioral Health Specialty Care Manager, Call Center Supervisor, Call Center Trainer, Care Manager, Community Health Worker, Community Marketing Representative, Community Justice Liaison, Community Partner Strategy Lead, Dietician, Director, Health Equity, Director of SDOH and Community Partnerships, Encounter Systems Analyst, Employer Specialist, EPSDT Coordinator, Foster Care Program Manager, Health Literacy Campaign Coordinator, Health Plan Operations Analyst, Health Partner Network Manager, Housing Strategy Lead, Life Coach, Manager Creative Marketing, Care Management Manager, Maternal High Risk Specialty Care Manager, Member Health Assessor, Member Services Call Center Specialist, Network/Contracting Manager, NICU Specialty Care Manager, Nurse Advice Line, Peer Support Specialist, Performance Improvement Evaluator, Provider Enrollment Coordinator, Provider Services Call Center Specialist, Provider Issue Resolution Specialist, Provider Services Representative, Quality Improvement (QI) Coordinator, Quality Improvement Manager, Quality Improvement Specialist, School Based Health Administrator, Special Investigations Unit (SIU) Investigator, Special Investigations Unit (SIU) Manager, Care Management Team Lead, Transitions of Care Manager and Vice President, Clinical Operations	Wholly
Operations	Application Developer, Associate Director Information Technology Encounters, Clinical Care Reviewer, Clinical Review Specialist, Data Analyst, Data Compliance Manager, Data Liaison, Director of Enrollment, EDIFECS Configuration, Encounter Team Lead, Enrollment Production System Analyst, Enrollment Specialist, HEDIS Data Analyst, Intake Coordinator, Intake Specialist, Manager of Claims Encounter, Medical Coder, Operations Business Analyst, Program Integrity Director, Program Integrity Internal Controls Analyst, Senior Manager of Enrollment Operations, Special Investigations (SIU) Data Reporting Analyst, Special Investigations Unit (SIU) Team Lead, Senior Director Claims Encounter, Team Lead Claims Encounter, Team Lead Enrollment, Triage Investigator, Vice President, Claims, Vice President, Program Integrity and Retrospective Reviews, and Vice President, Information Technology (IT) Core Systems	Shared

[END OF RESPONSE]

[redacted]

4.3.3.5 SUBCONTRACTORS

Use the forms provided in Appendix H to describe Subcontractors the Offeror expects to utilize for this Contract. If a subcontractor has provided services for the Offeror for a managed care contract in the past three (3) years, use the appropriate form in Appendix H to detail those services.

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.

TrueCare intends to use the subcontractors listed in Table 4.3.3.5_A. The corresponding Subcontractor and Prior Experience with Subcontractor forms are in Appendix H 4.3.3.5 Subcontractors.

Table 4.3.3.5_A: TrueCare Mississippi Subcontractors

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

2. 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.

As a CCO committed to change the trajectory of Mississippi's healthcare via a fully integrated, transparent service delivery model, TrueCare chooses and manages its subcontractors based on a philosophy that encompasses three primary criteria:

1. **Best in Class:** Our operational philosophy embraces the expectation that all phases of our service be best in class. This includes selective subcontracting utilizing proprietary, data driven selection processes to ensure the highest levels of implementation execution, service excellence, quality measures/results, and principles of inclusion.
2. **Improved Health Outcomes:** We have a commitment and passion to make a lasting difference in our members' lives by delivering services through real-time bidirectional data exchanges with most providers as well as providing next generation member engagement, education, and community-based coordinated care. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources.
3. **Delivering Exceptional Member Experience:** Our subcontracting process allows us to select partners with proven ability to build total member satisfaction focused on achieving a positive member experience and enhancing health outcomes.

Achieving Best in Class

We expect all phases of our service to be excellent. In pursuit of this goal, we continuously benchmark internal vs external capabilities and selectively subcontract where our analytics confirm meaningful opportunity. Subcontracting may be short term while we develop internal capability, or longer term based on our partner's commitment to continuous improvement as driven by member experience and outcomes.

Finding the Right Partner

Our subcontractor selection process is exhaustive, inclusive, and data driven. We issue Request for Proposals (RFPs) to industry leading companies based on carefully defined requirements and Service Level Agreements (SLAs) which emphasize both Division and TrueCare goals. The RFP process for subcontractor selection ensures that all subcontractors are selected to bring the most value to our members. After onsite presentations and pre-delegation assessments, we shortlist based on cross-functional review of weighted scoring criteria. Our proprietary scoring criteria cover more than 25 dimensions of business performance, which in turn breaks down into over 100 scoring sub-categories. Credentialed subject matter experts complete scoring for each category after they have attended all subcontractor bid presentations and reviewed all RFP responses.

Selection of a front-runner emerges from a rigorous Term Sheet process, which entails reducing salient contract terms and extensive SLAs to writing and securing best and final offers from each of our top candidates. This requires adherence to our best practices contract terms and expectations, and it allows us to eliminate partners who cannot meet our rigorous commitments. Using this process allows us to select high-performing subcontractors who have proven ability to achieve our demanding expectations.

Closing and Implementation

We begin contracting negotiations with the shortlisted candidates and reject those that cannot meet our high standards. While retaining the other candidates on warm standby, we move our front-runner to the contracting stage by translating the mutually agreed upon Term Sheet into a formal Agreement. Our Vendor Management team coordinates cross-functional review and approval of the Agreement, and ensures our vendor risk, delegation oversight, information security, medical economics, compliance, legal, and clinical teams review and address their respective areas to ensure we meet and exceed utilization requirements by membership type. At our option, we use a Letter of Intent (LOI) to initiate negotiations in parallel with final contracting process. We submit these contracts for approval by the Division in compliance with the model contract prior to execution.

A jointly developed, mutually agreed upon Project Plan, inclusive of milestone-based deliverables subject to our acceptance, drives our implementation plan. Timely results are ensured not only using weekly checkpoints, corrective actions, escalation points, and Steering Committee oversight, but also by withholding implementation fees (and the potential incurrence of penalties) based on timely delivery and acceptance of milestones. The net result of our standardized and rigorous process is a clearly defined, highly enforceable partnering Agreement that ensures achievement of desired results for all stakeholders, most importantly including the MSCAN and CHIP members. Notably, we share our subcontractor agreements with our state Medicaid partners (pre- or post-execution at their discretion) and we have a perfect record of acceptance.

Improving Health Outcomes

A unique and differentiating factor we bring to all our managed care engagements is our innovative approach to driving appropriate utilization of care through our subcontractor agreements. We use sophisticated fee models, customized to each service category, which drive appropriateness of care and related efficiency gains. These innovations will include detailed reporting and reconciliation processes. Our innovative contractual approaches generate quantifiable improvement in health outcomes while raising the score on NCQA Quality performance.

Proven Implementation Excellence

Using its proven subcontracting philosophy, we have successfully implemented similar programs in Ohio, Georgia, Indiana, and Arkansas with 100% readiness review success.

We hold our subcontractors to strict, contractual SLAs across every aspect of their solution. We require our partners to have effective and timely training, policy, and enforcement procedures covering all aspects of the Agreement including ensuring the optimal delivery of services, addressing member and provider issues, combating fraud, waste, and abuse, and certifying comprehensive payment integrity. Claims adjudication must be precise, accurate, and timely to ensure optimal results. The SLAs in our contracts also contain material penalties (i.e., fees at risk), which escalate in the event of recurrence. Our partners accept such SLAs because they have confidence in their services, as do we. We monitor performance through our Vendor Risk and Oversight team, in collaboration with business owner subject matter experts, to audit performance and host standing internal reviews to discuss key performance indicators (KPIs), accuracy compliance, timeliness, and reporting benchmarks.

Delivering Exceptional Member Experience

Subcontractors earn our trust through a combination of demonstrated operational excellence and recognized local knowledge of the health care environment. We require our subcontractors to know our communities and to collaborate with us to address the needs of our members. Where appropriate, they must leverage their knowledge of the local community to connect members to local resources, understand local needs and disparities, and be familiar with local cultural nuances. Our subcontractors must be committed to diversity, equity, and inclusion. They should understand and mirror the populations we serve to help build racial, ethnic, and geographic bridges and be equipped to link members to culturally and linguistically appropriate services. Finally, they must be committed to quality across all levels of the organization.

While our chosen subcontractors are independent entities, they are an extension of TrueCare, and we hold them to the same standards and performance expectations to which we hold ourselves. In addition to a top ranking, we selectively seek subcontractors who are committed to both assisting our members in the successful navigation of their health care needs and partnering with the Division to achieve strategic aims, goals, and objectives. We require our subcontractors to maintain the highest standards of systems and data security, thereby ensuring uncompromised integrity as it relates to data-sharing, authorized access, integrations and flexible dashboarding and reporting services. Finally, we require our subcontractors to meet the quality standards and NCQA accreditation standards for all programs we administer.

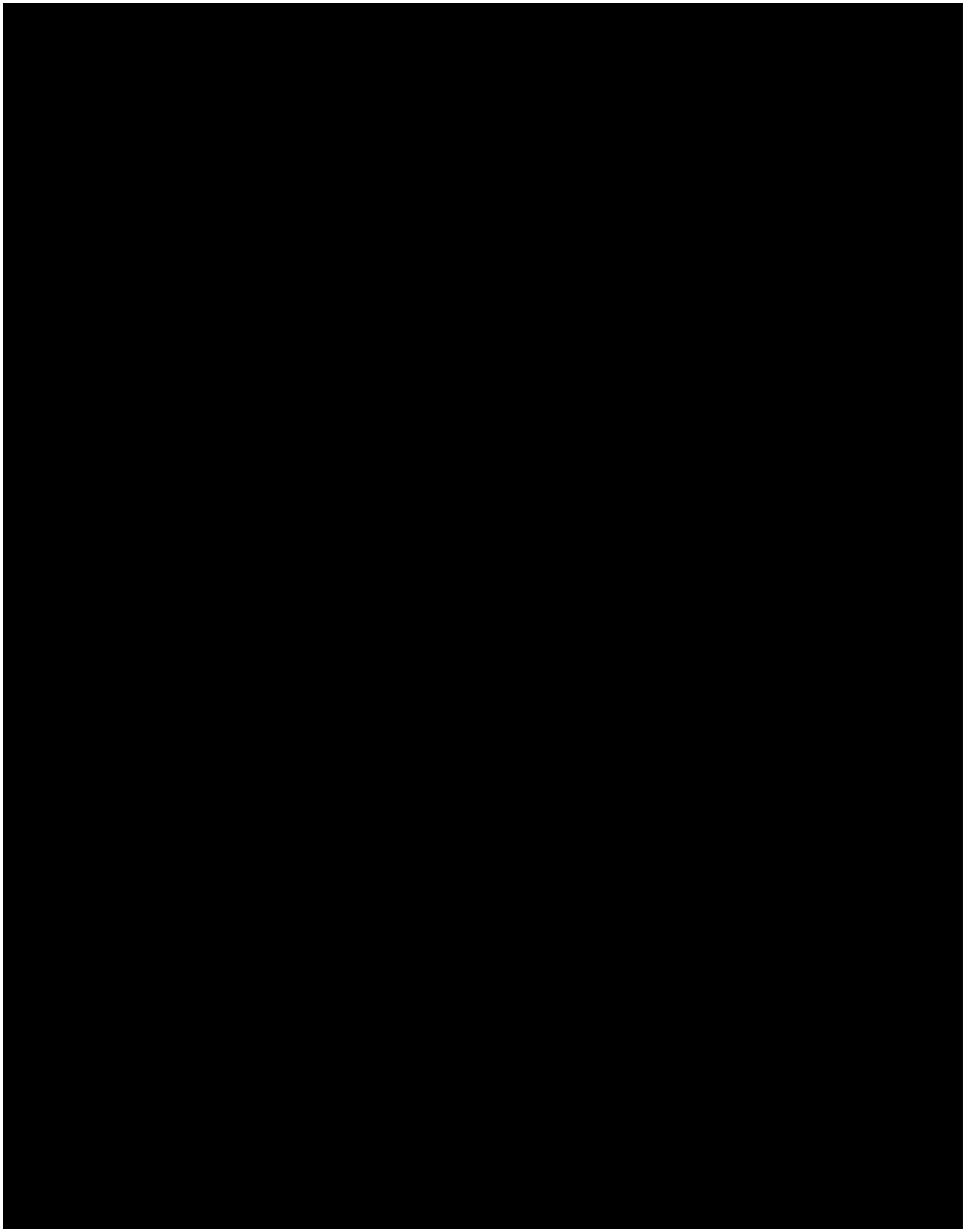
In another Medicaid managed care market we administer, we achieved a score of 100% on the NCQA quality standards and population health management standard. This underscores our adeptness in working with our subcontractors to develop and implement processes and procedures that support positive health outcomes, enhance the member experience, and ensure appropriate utilization of services and cost-effective care.

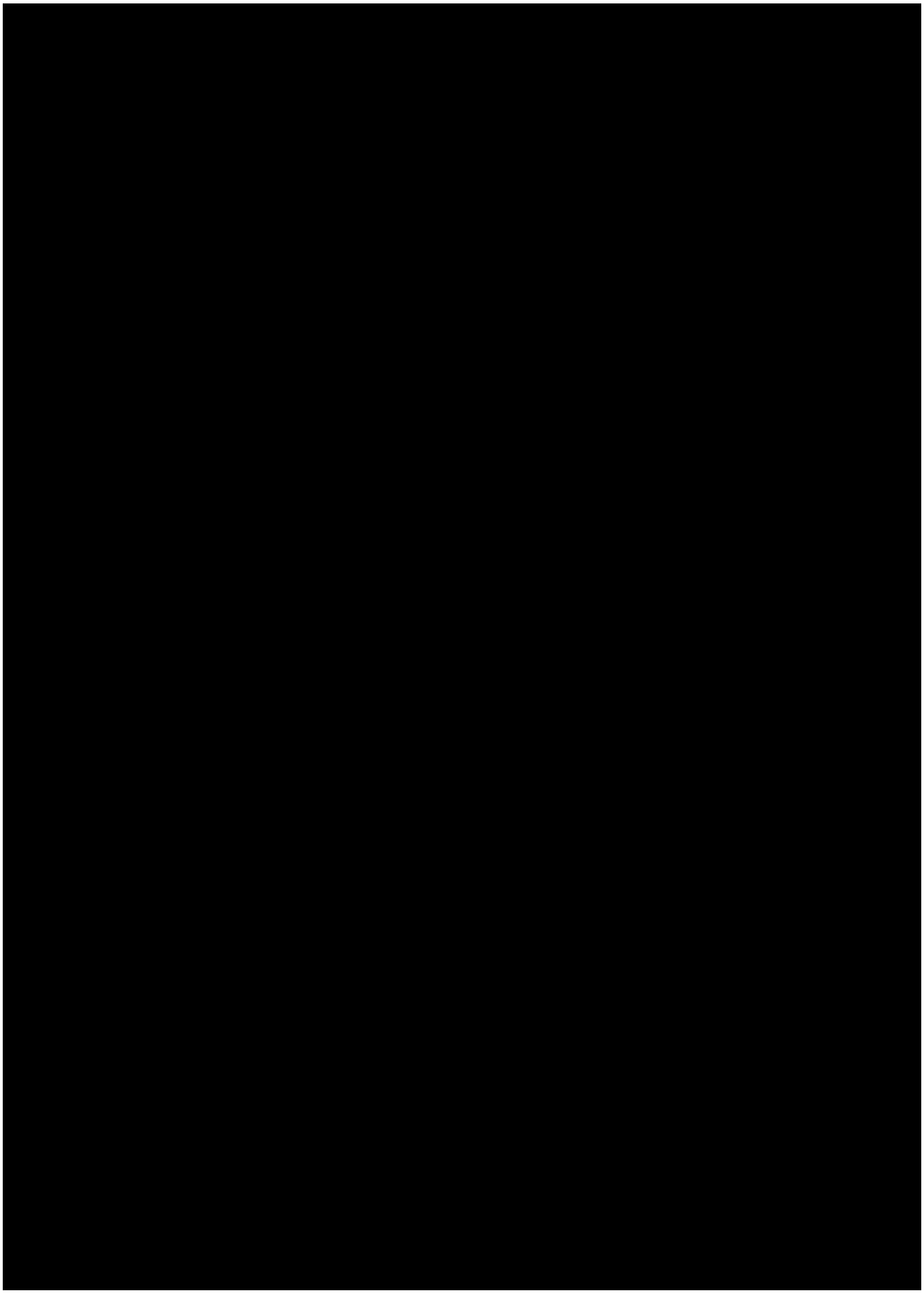
Partnering for Creative Local Solutions
We partner with proven entities for creative local solutions as the following examples demonstrate.

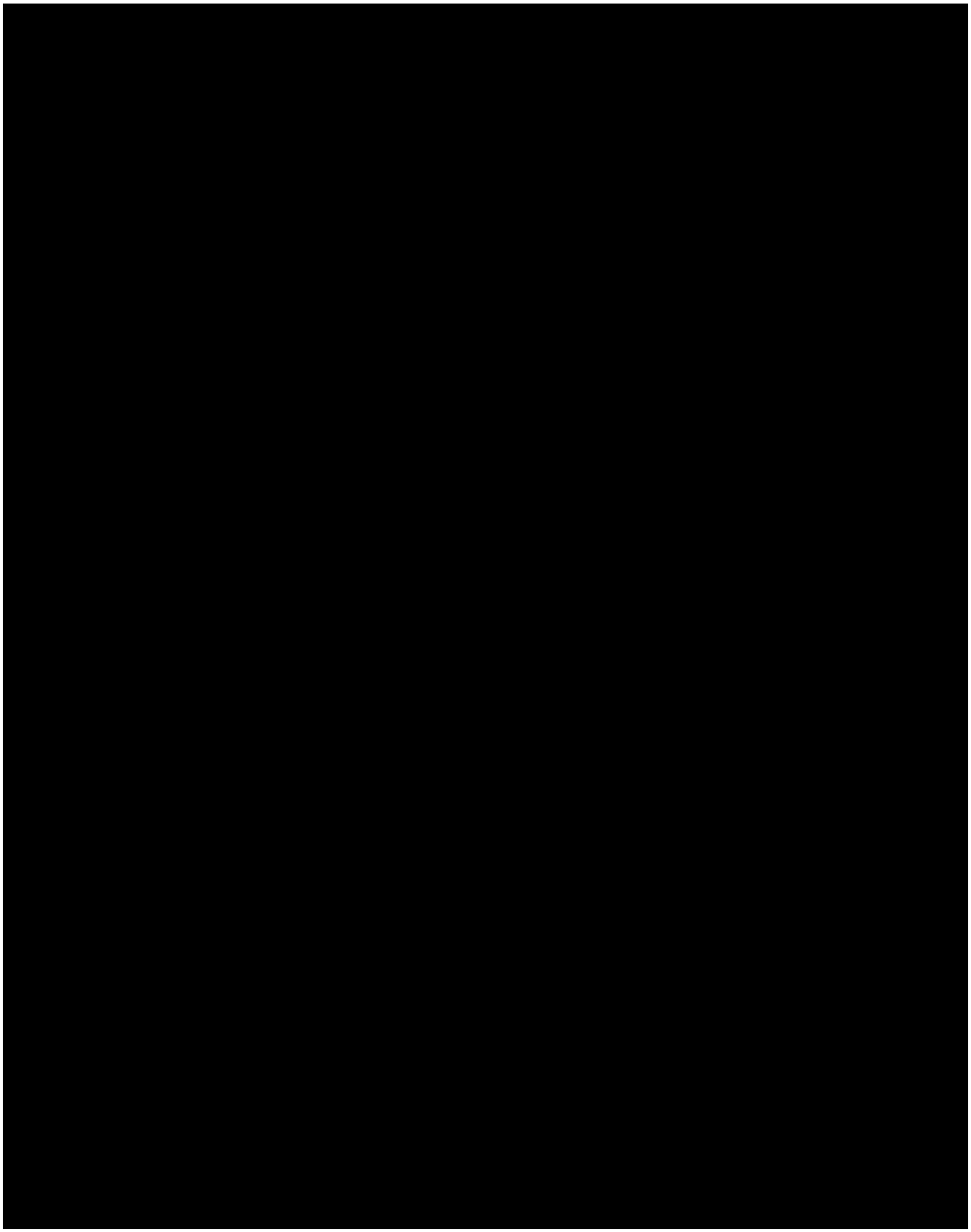
Vision: Our goals for our Mississippi vision subcontractor center on operational excellence that exceeds contractual and NCQA standards to promote appropriate care, cost efficiency, timely provider payments, while offering Mississippi experience. In another market, **we achieved a rate of 100% prompt payment for vision service claims, 100% accuracy for encounter submission, and 100% compliance rate on all processed grievances and appeals** using this vendor**.**

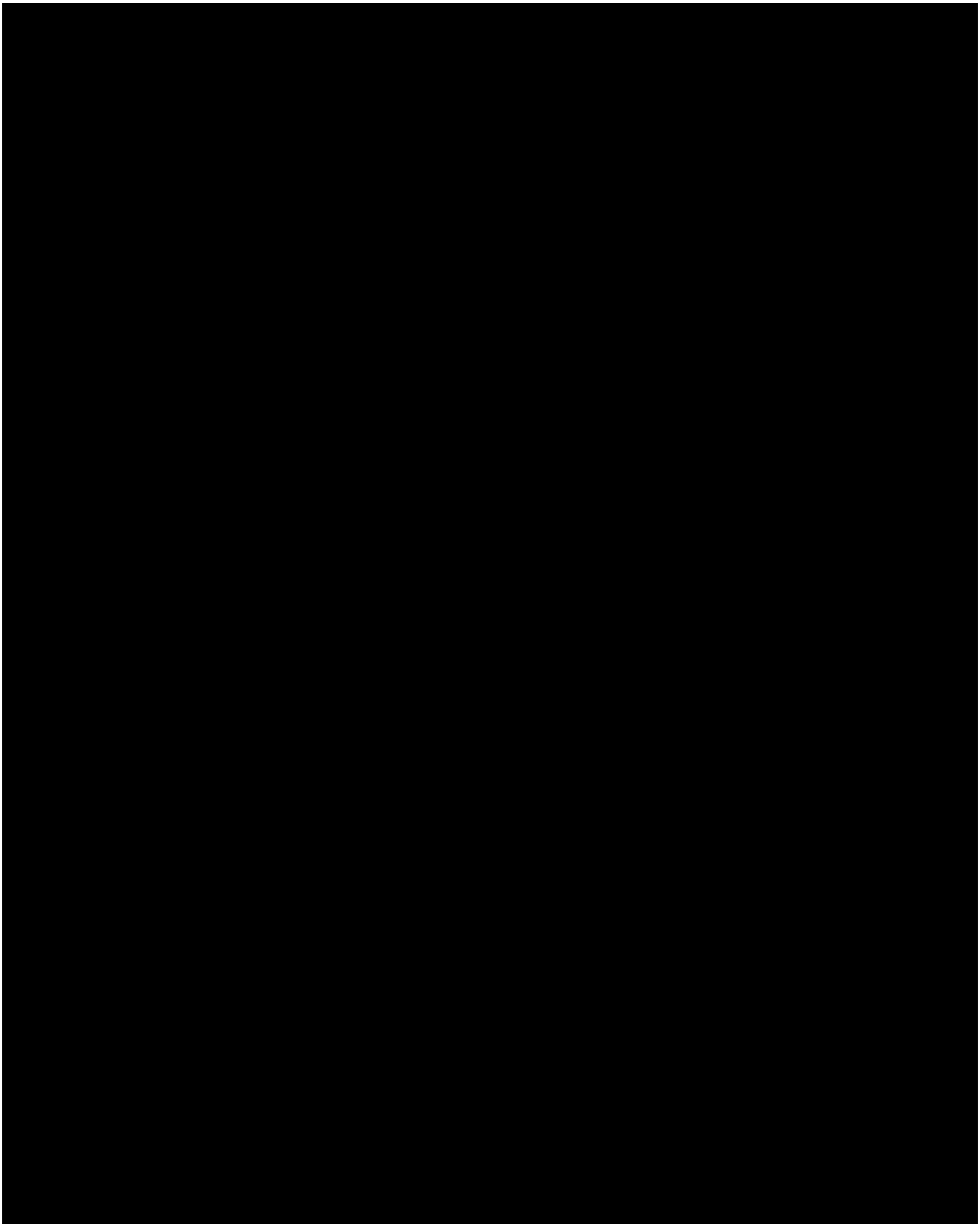
Dental: We facilitate effective integration that affords a seamless experience for our members and providers and optimizes our dental services. Our goals center on performance management that exceed National Committee for Quality Assurance (NCQA) standards. **In another market, we have historically achieved a rate of 100% prompt payment, claims accuracy, and high-performance rates.** Our dedication to the procedures outlined in our subcontractor philosophy ensures operations flow seamlessly to promote appropriate care, cost efficiency, and timely provider payments.

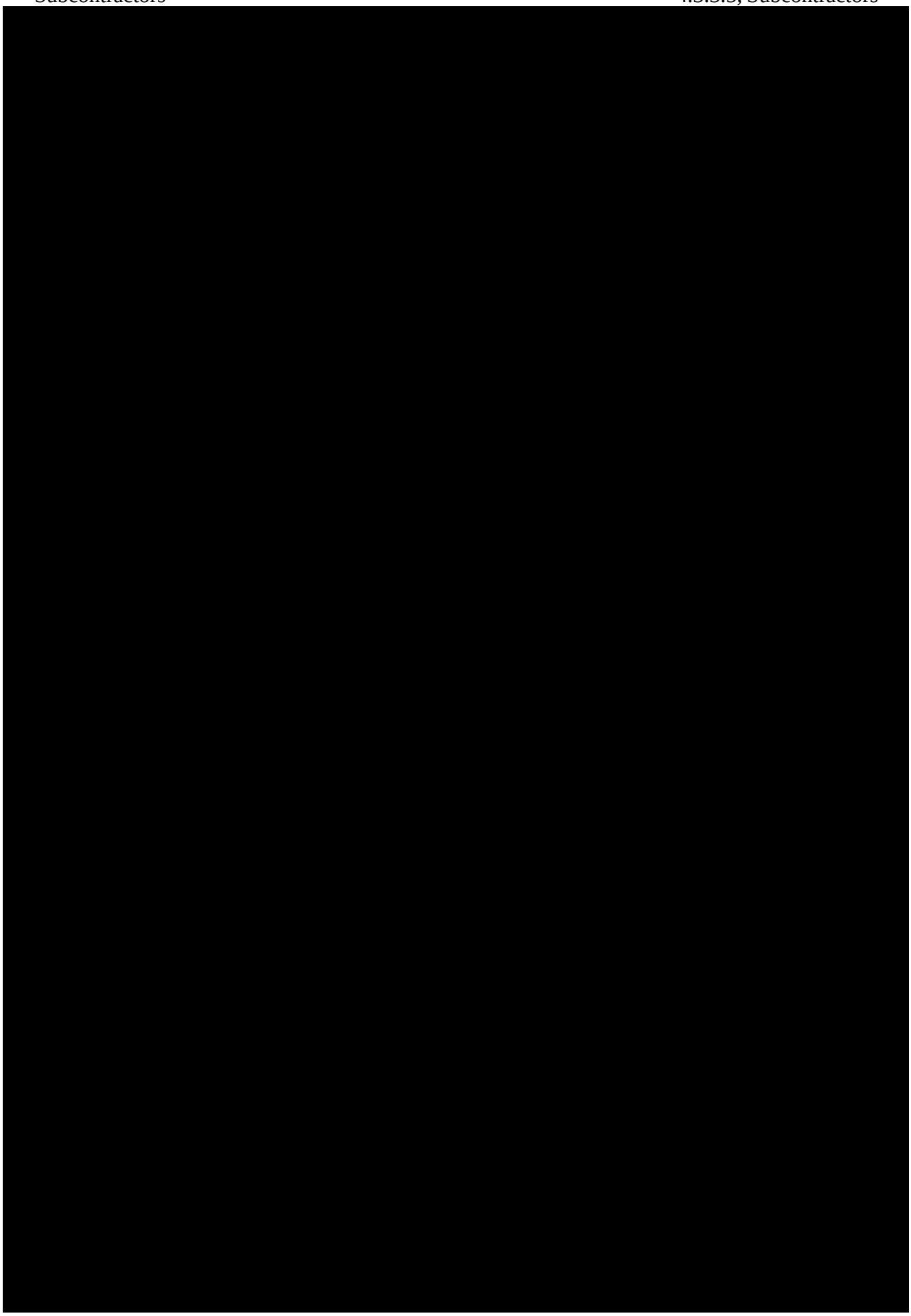
Summary
To achieve our goal of best-in-class services, we selectively subcontract where our analytics confirm meaningful opportunity. We evaluate potential subcontractors via a combination of RFP tools, weighted scoring comparisons, data driven analytics, innovative fee models, uncompromising quality standards, and proven performance results. We combine this with strong State Medicaid partnerships to drive clearly defined, highly enforceable subcontractor agreements with partners who have a proven ability to achieve our demanding expectations. Using these practices, we intend to not only meet but also exceed the requirements in Appendix A, Section 13.

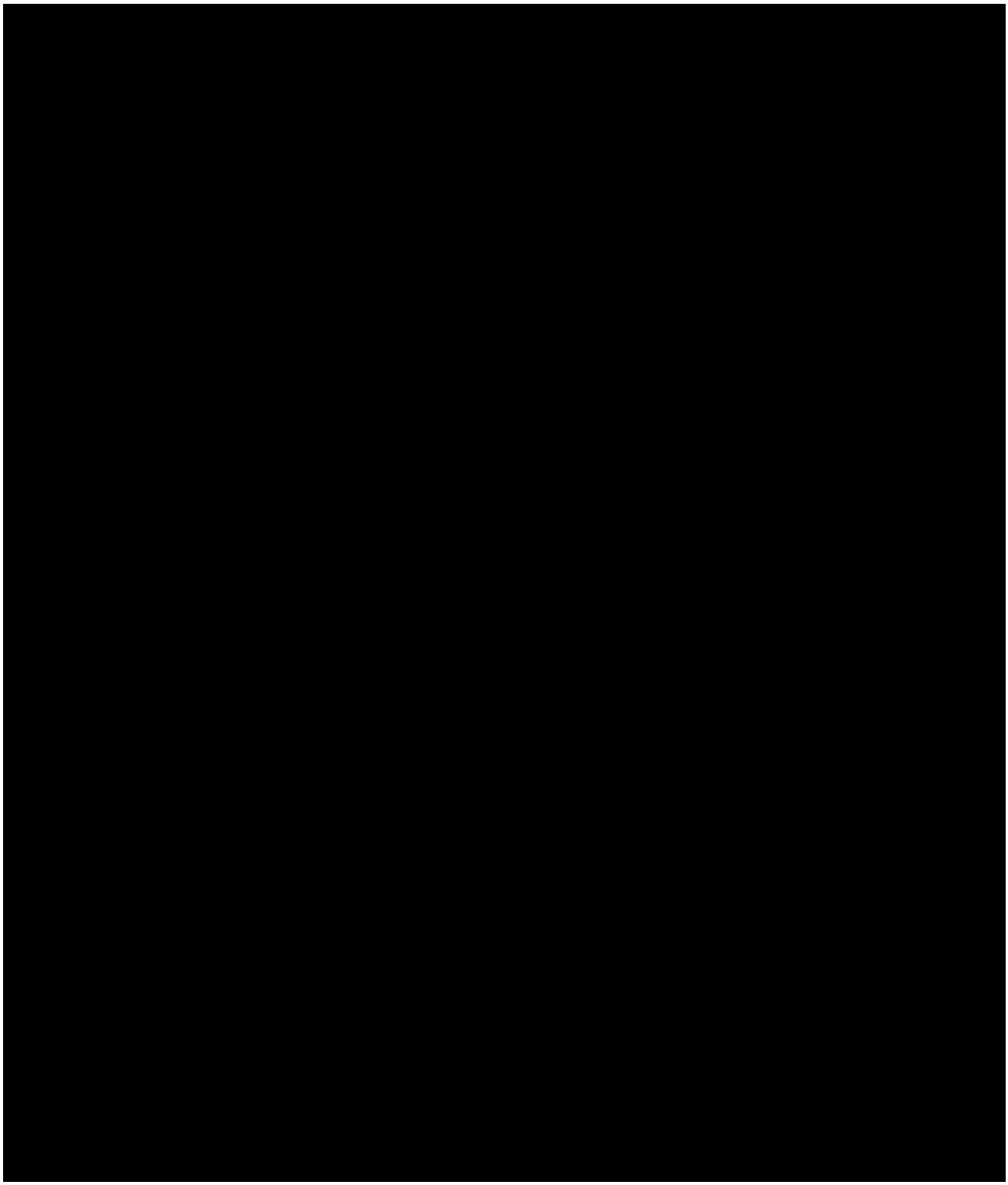


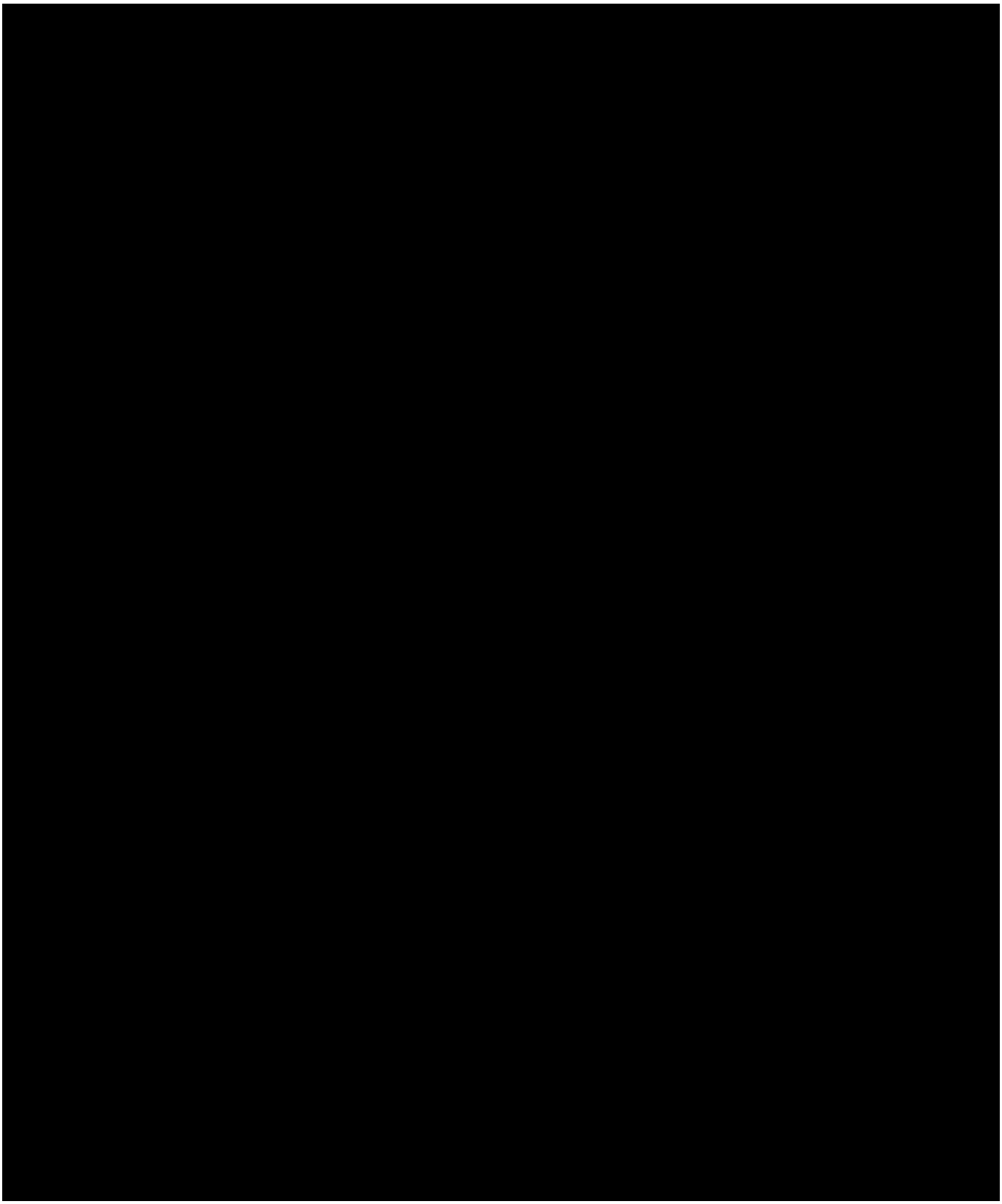


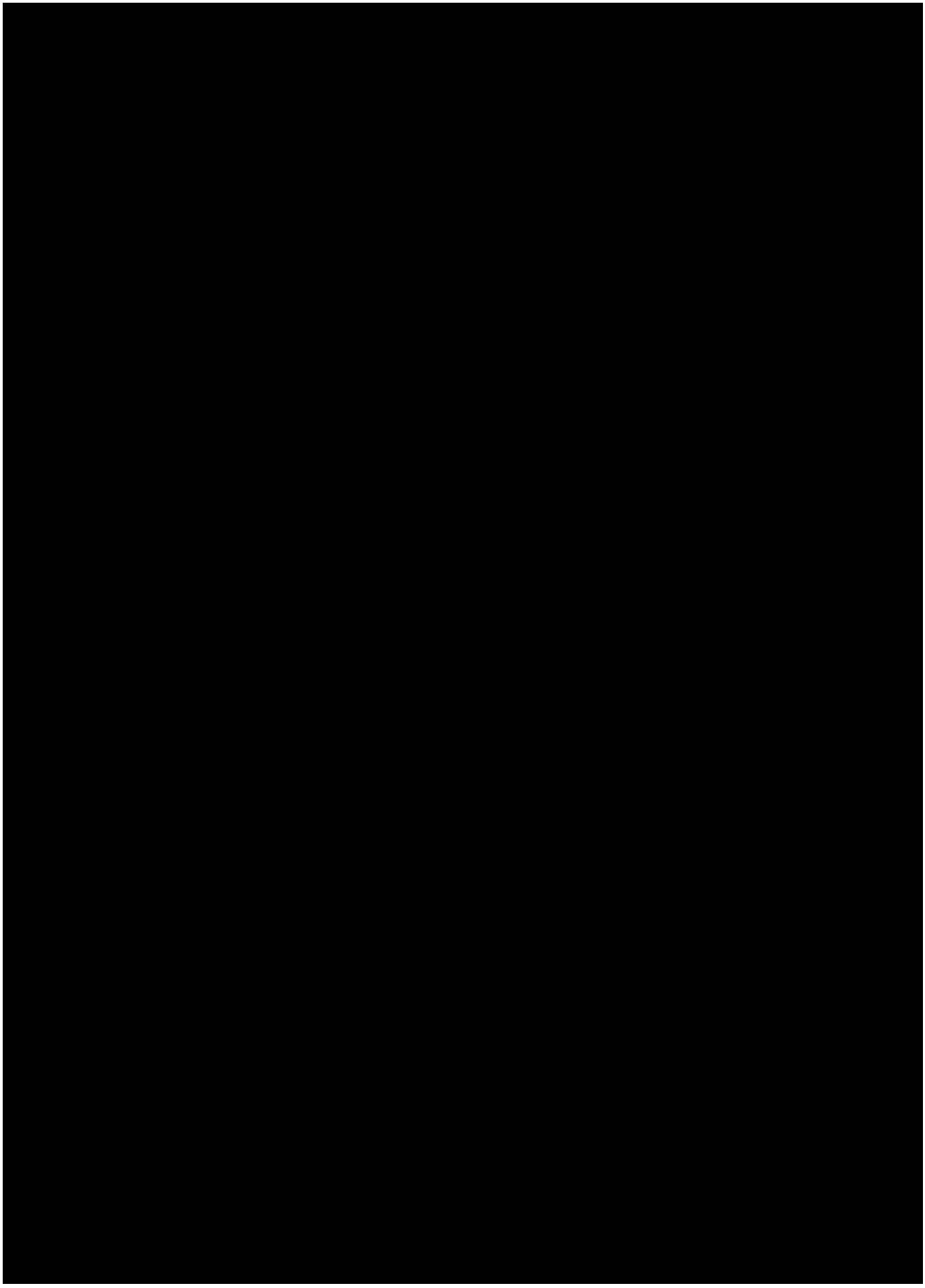


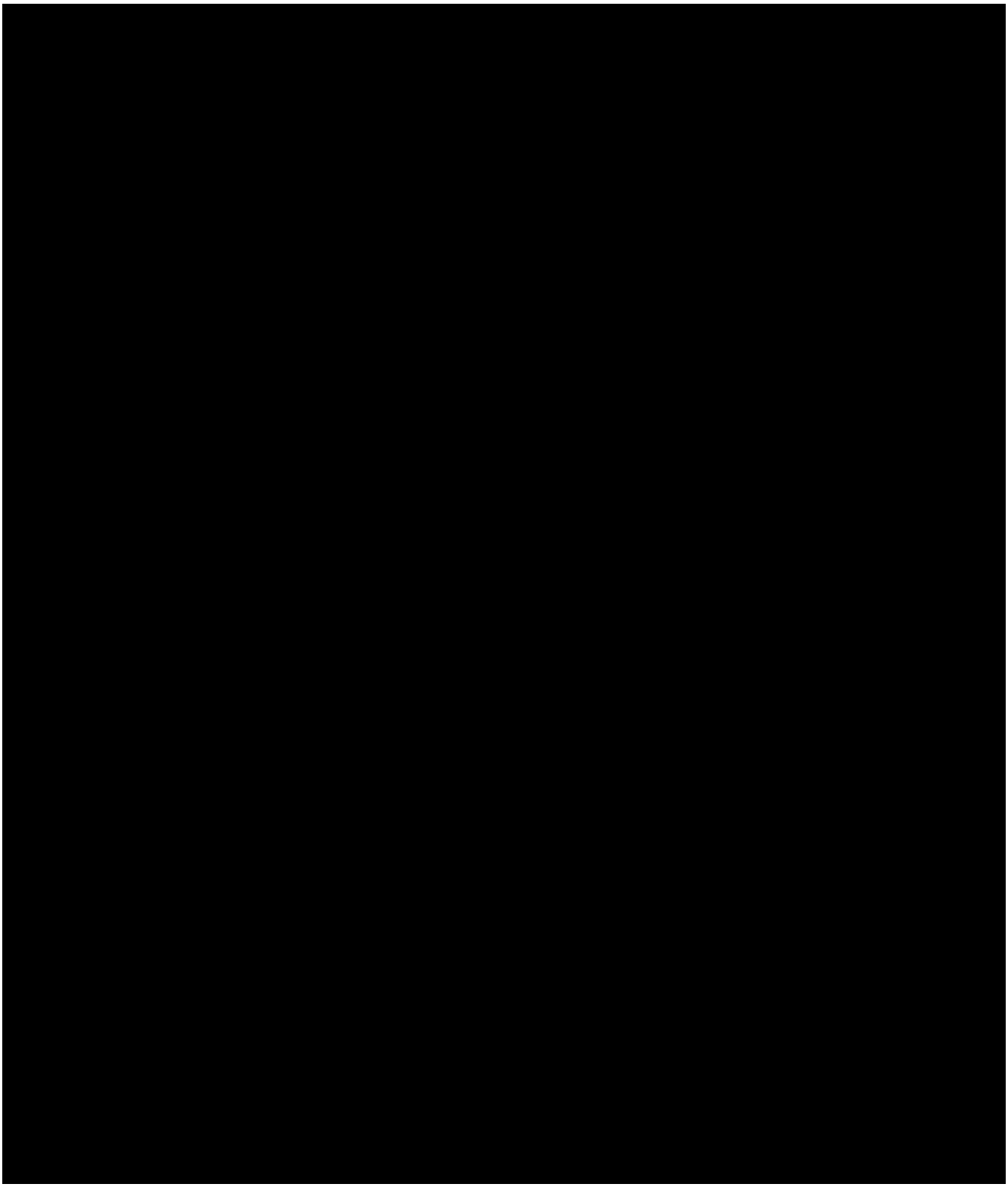


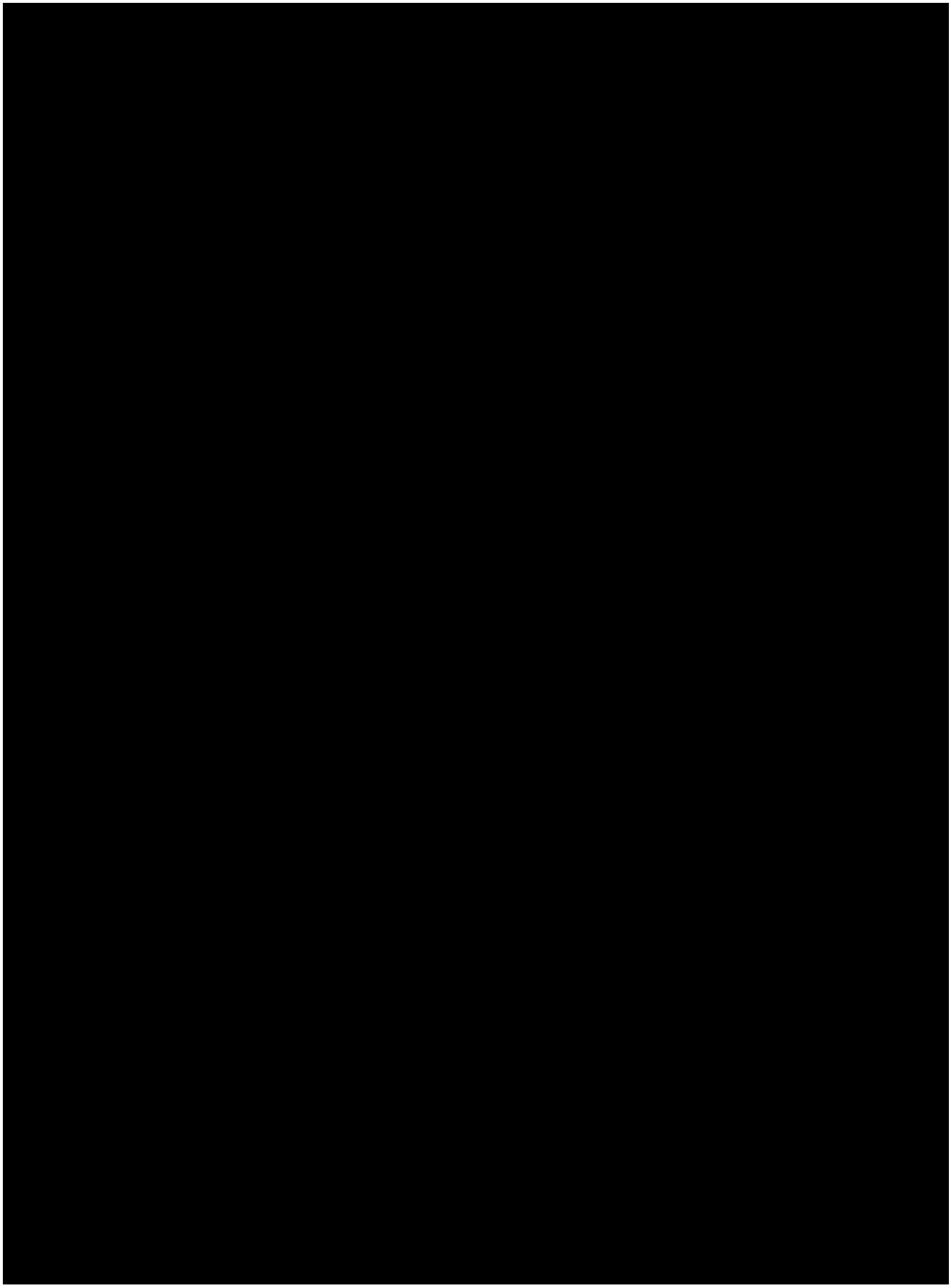


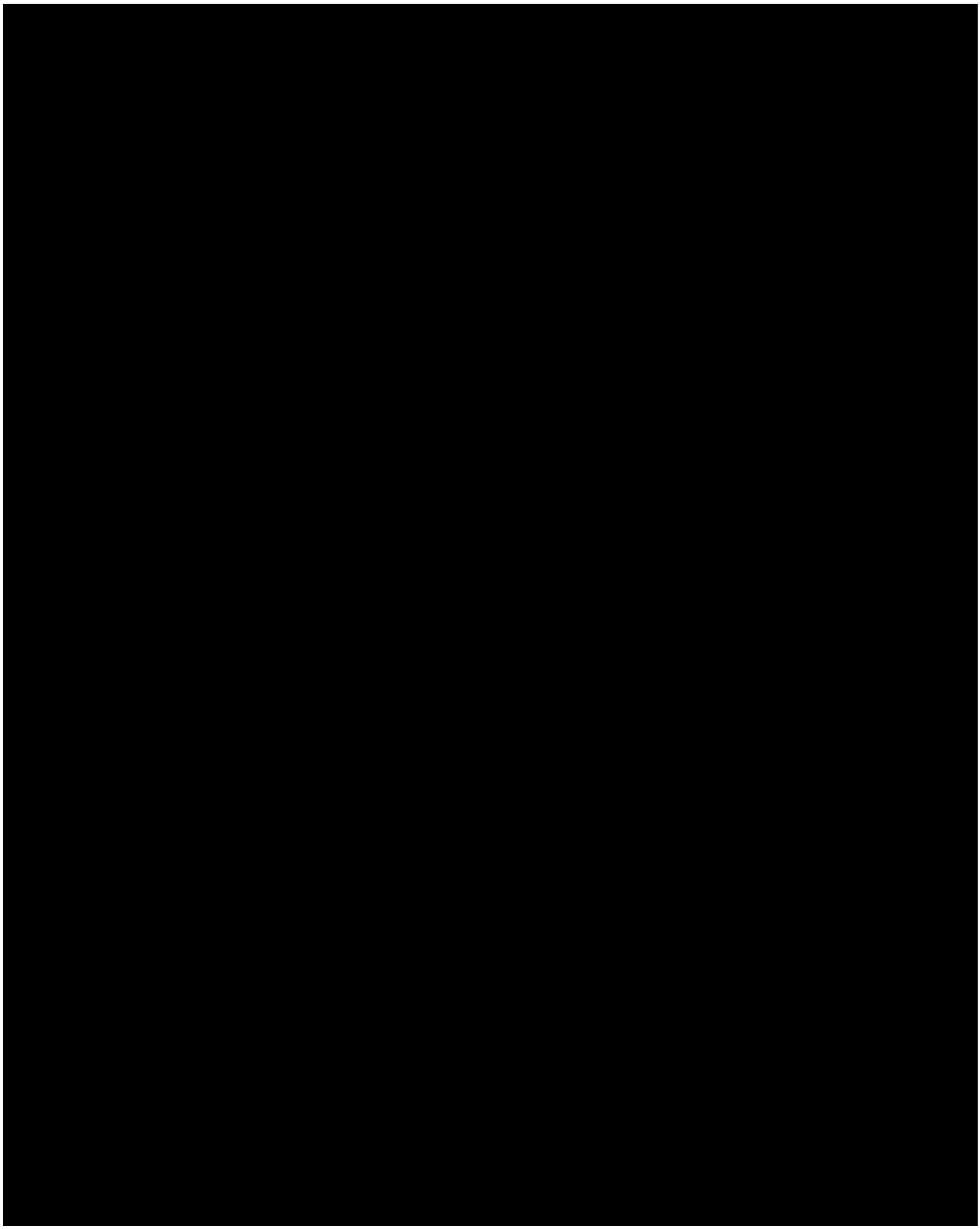


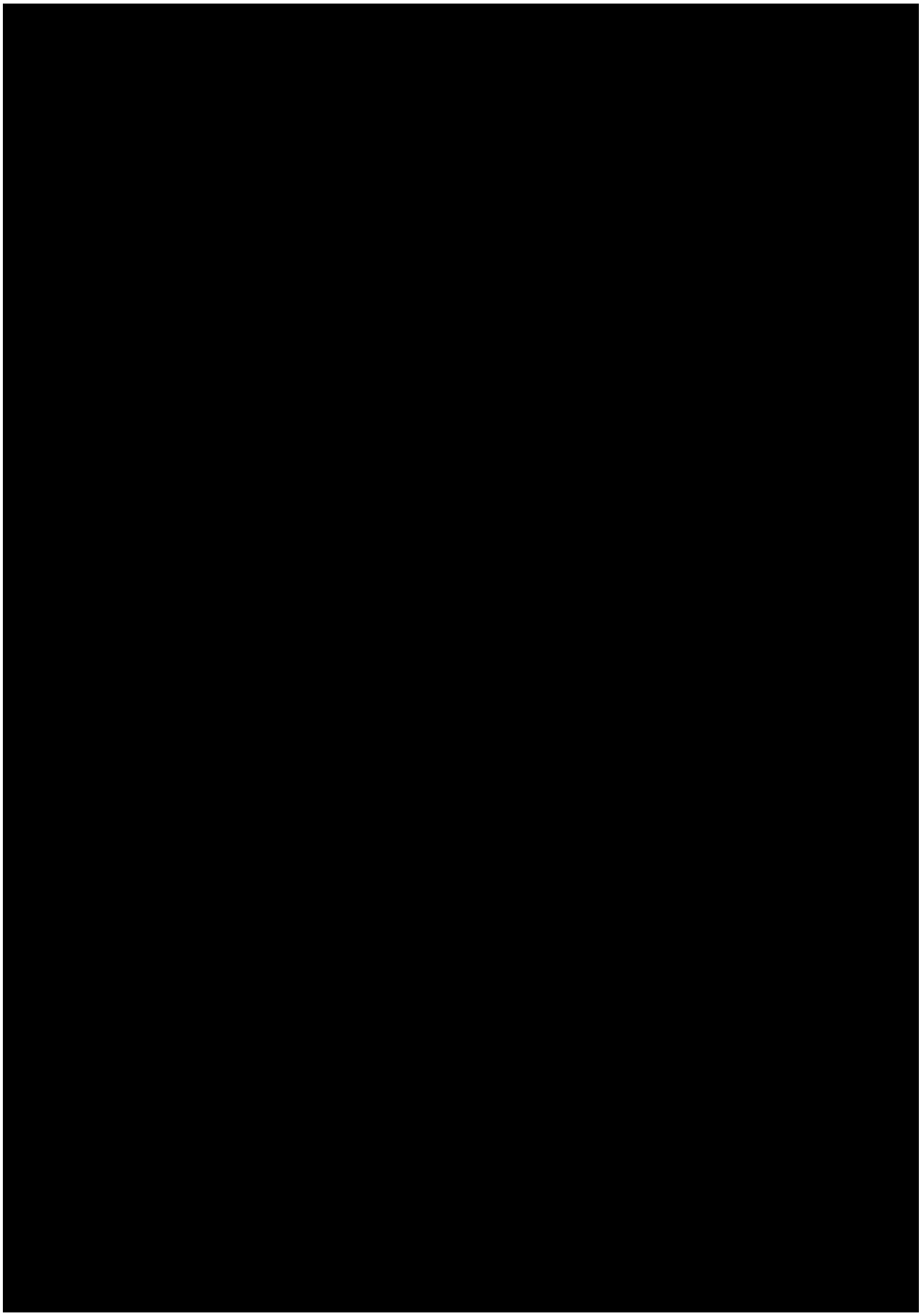


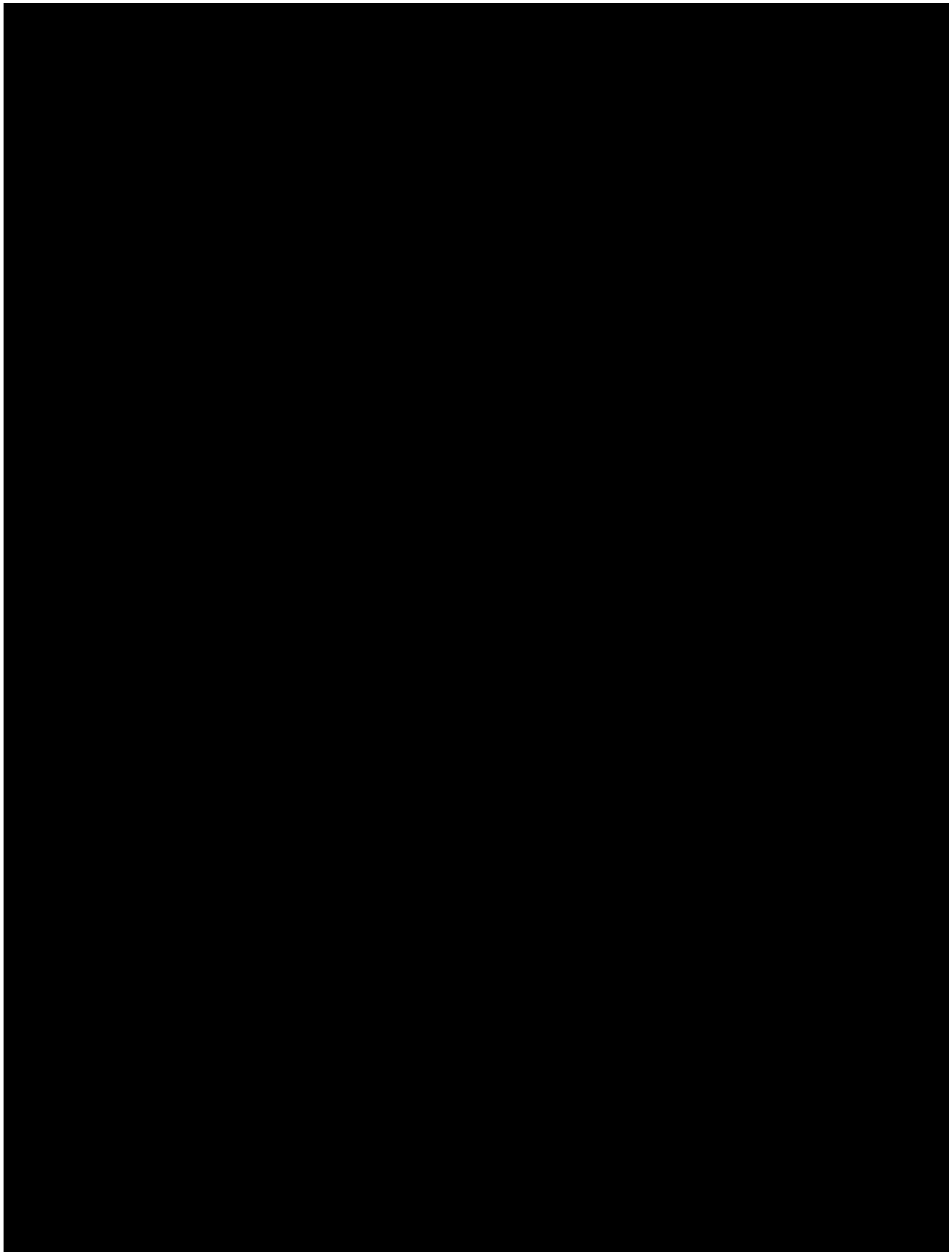


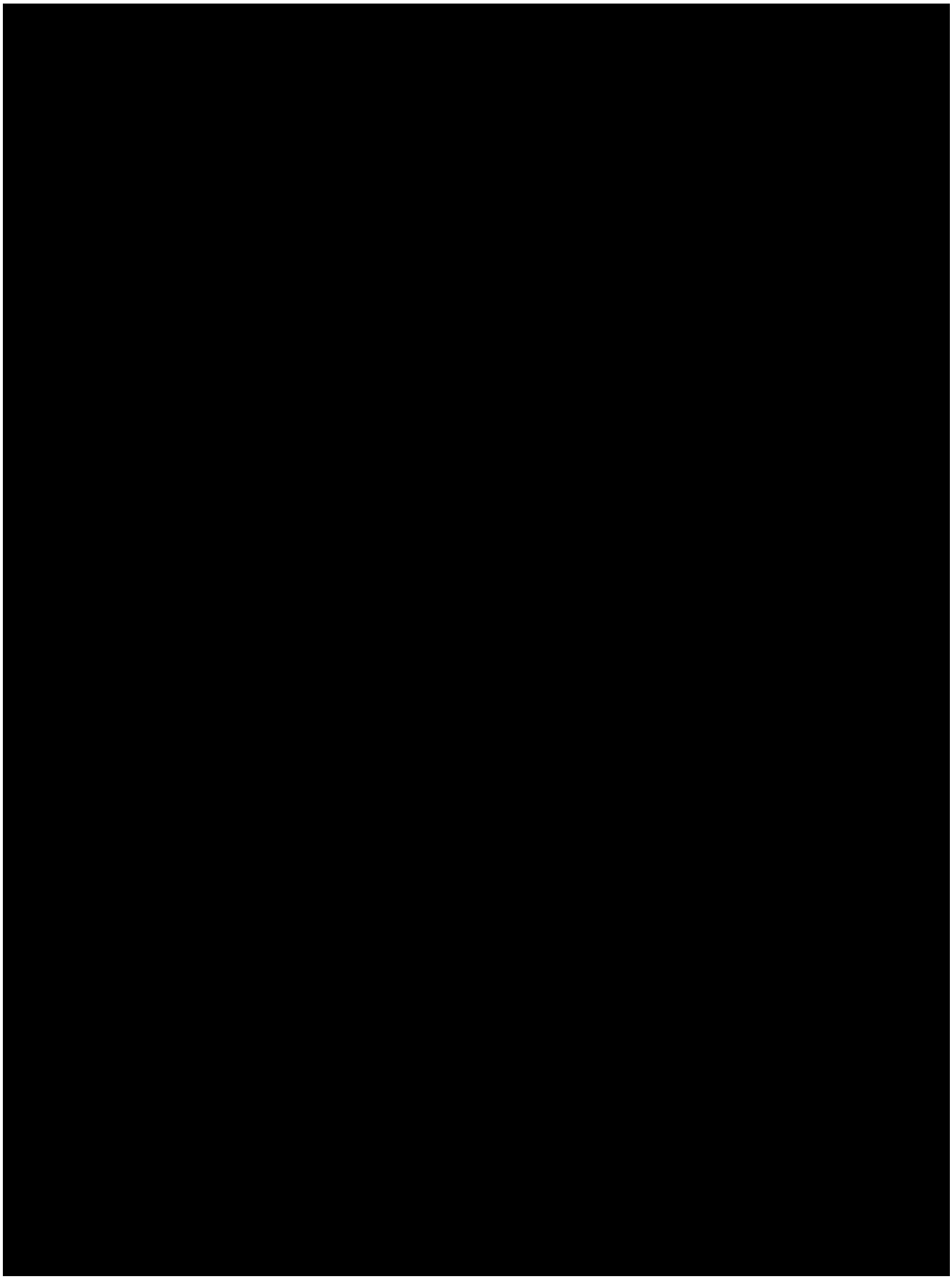


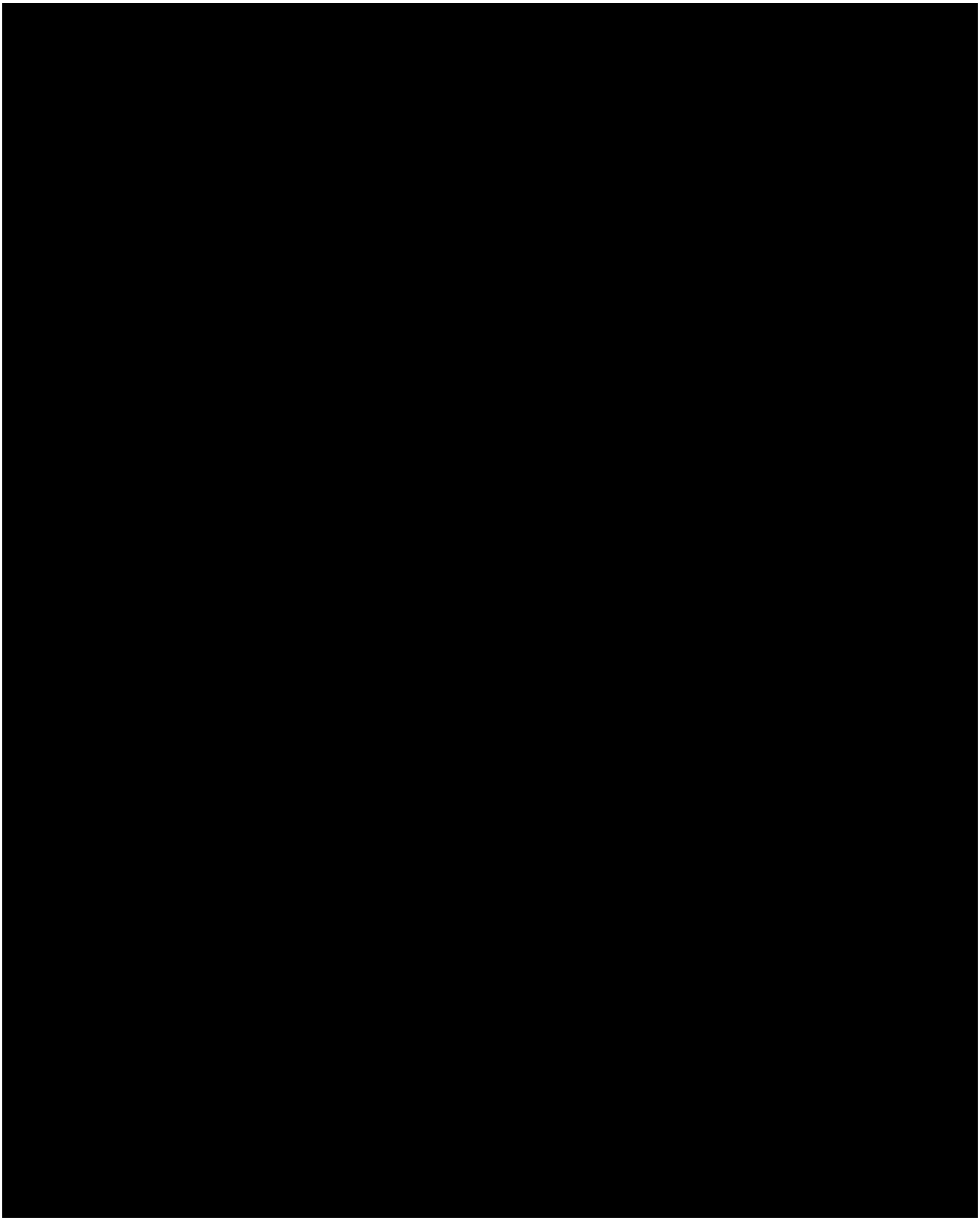


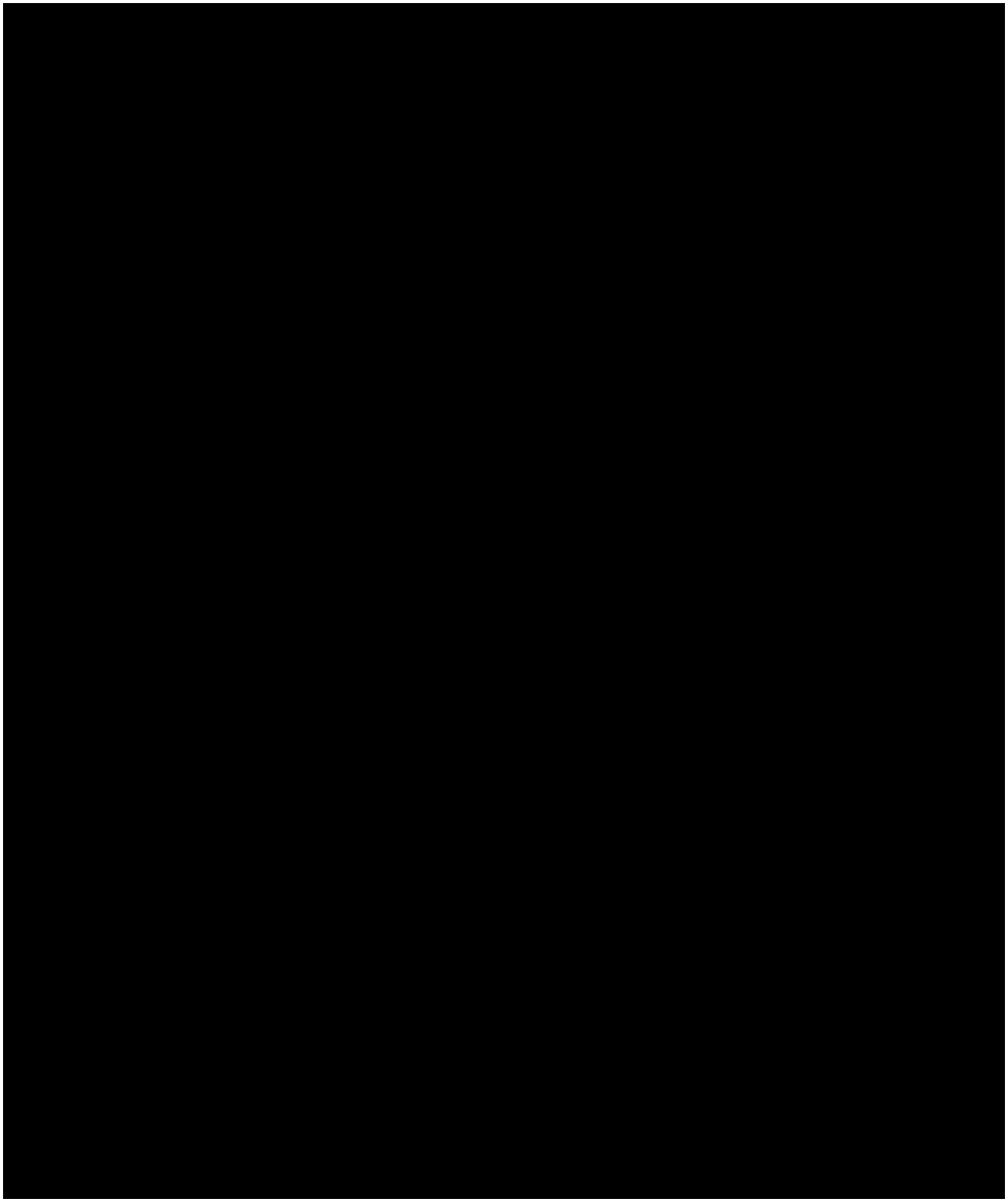


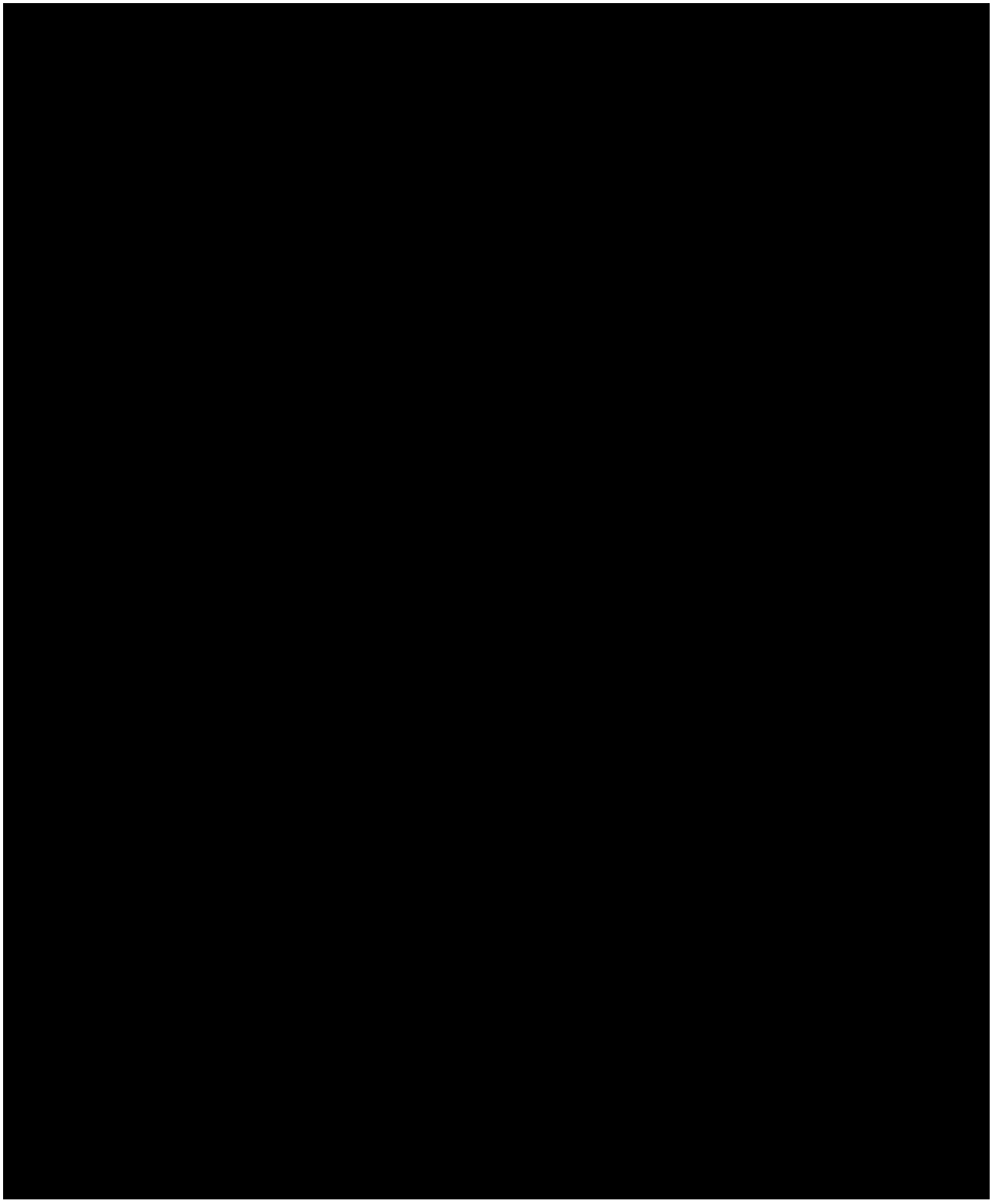


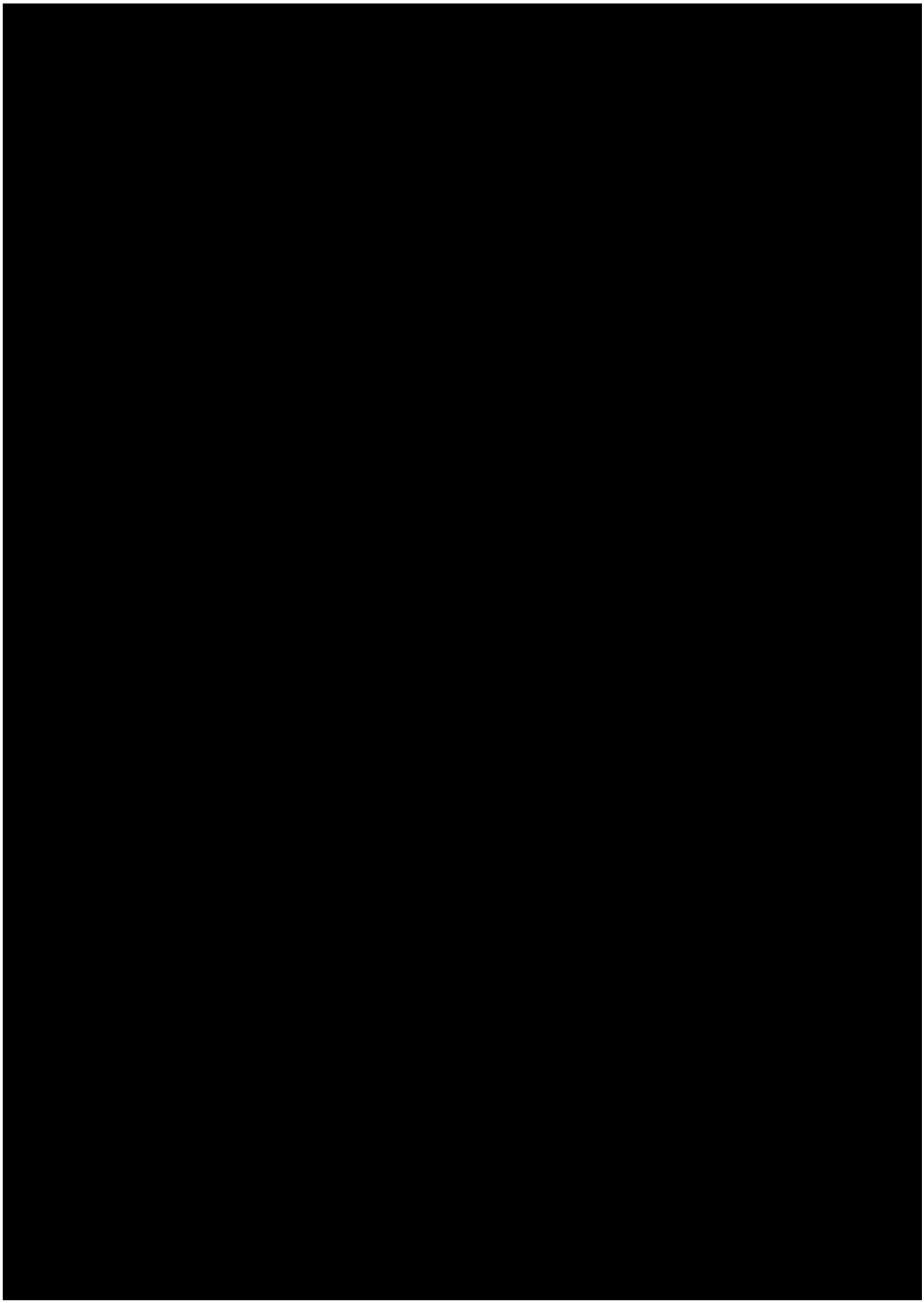


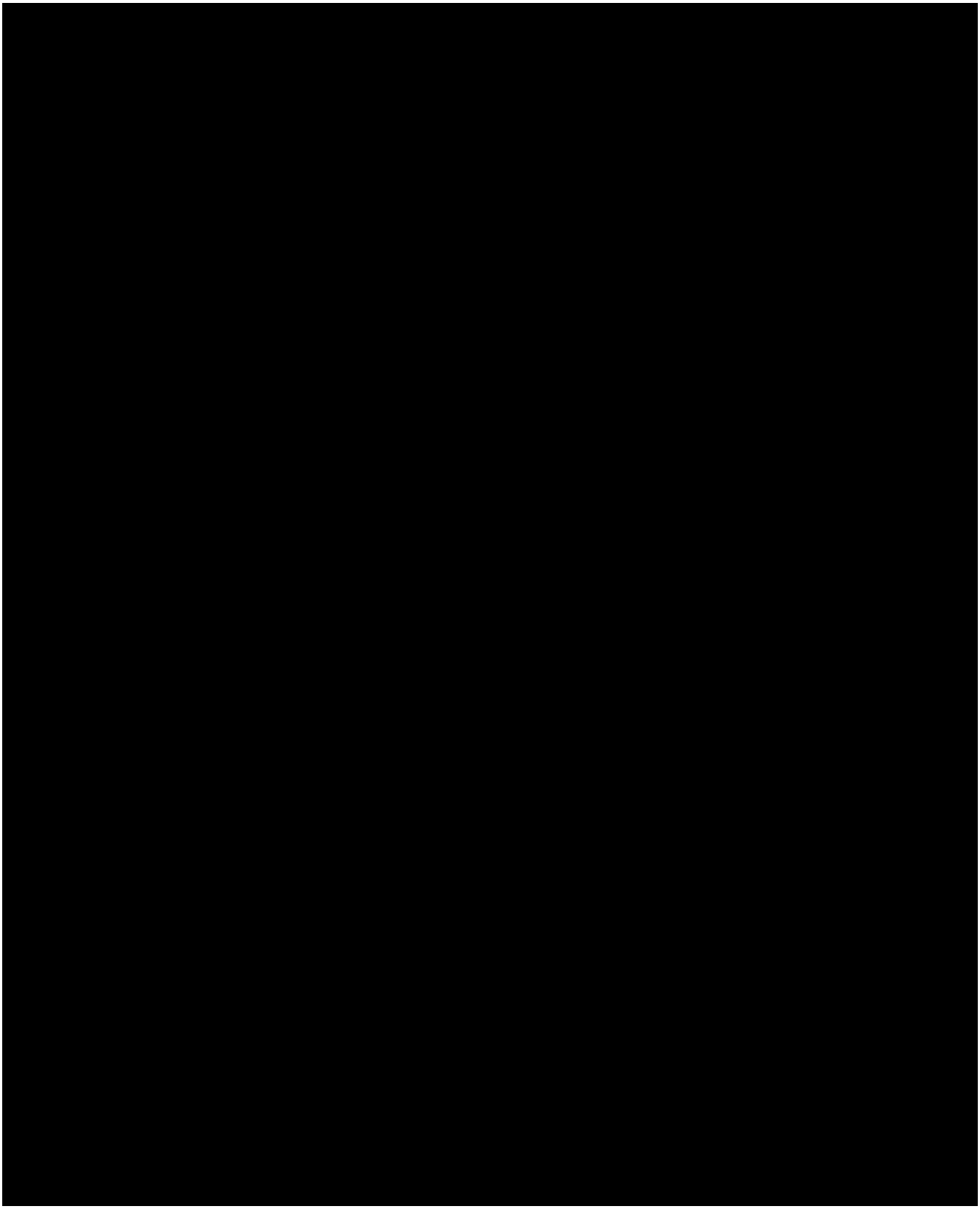


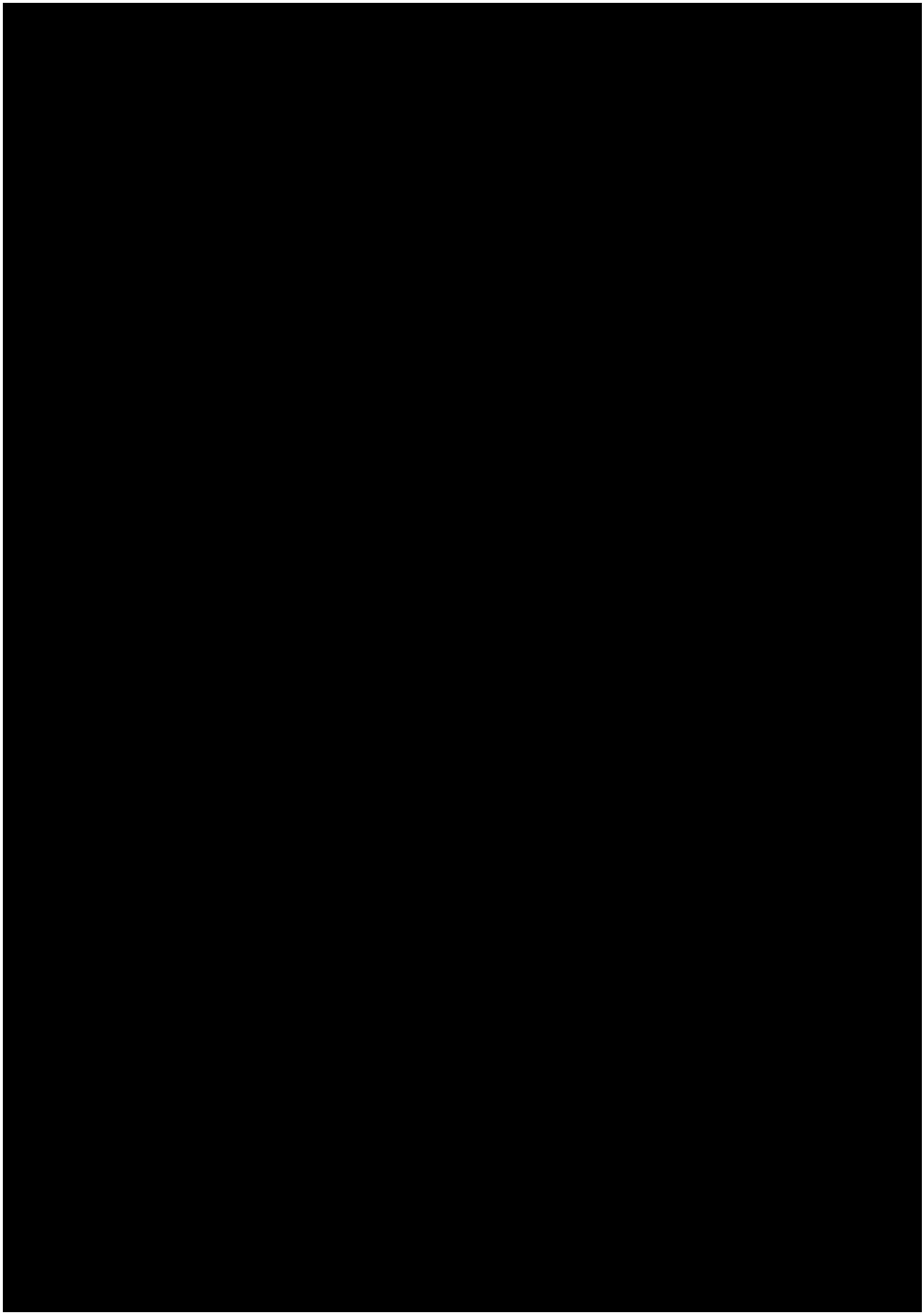


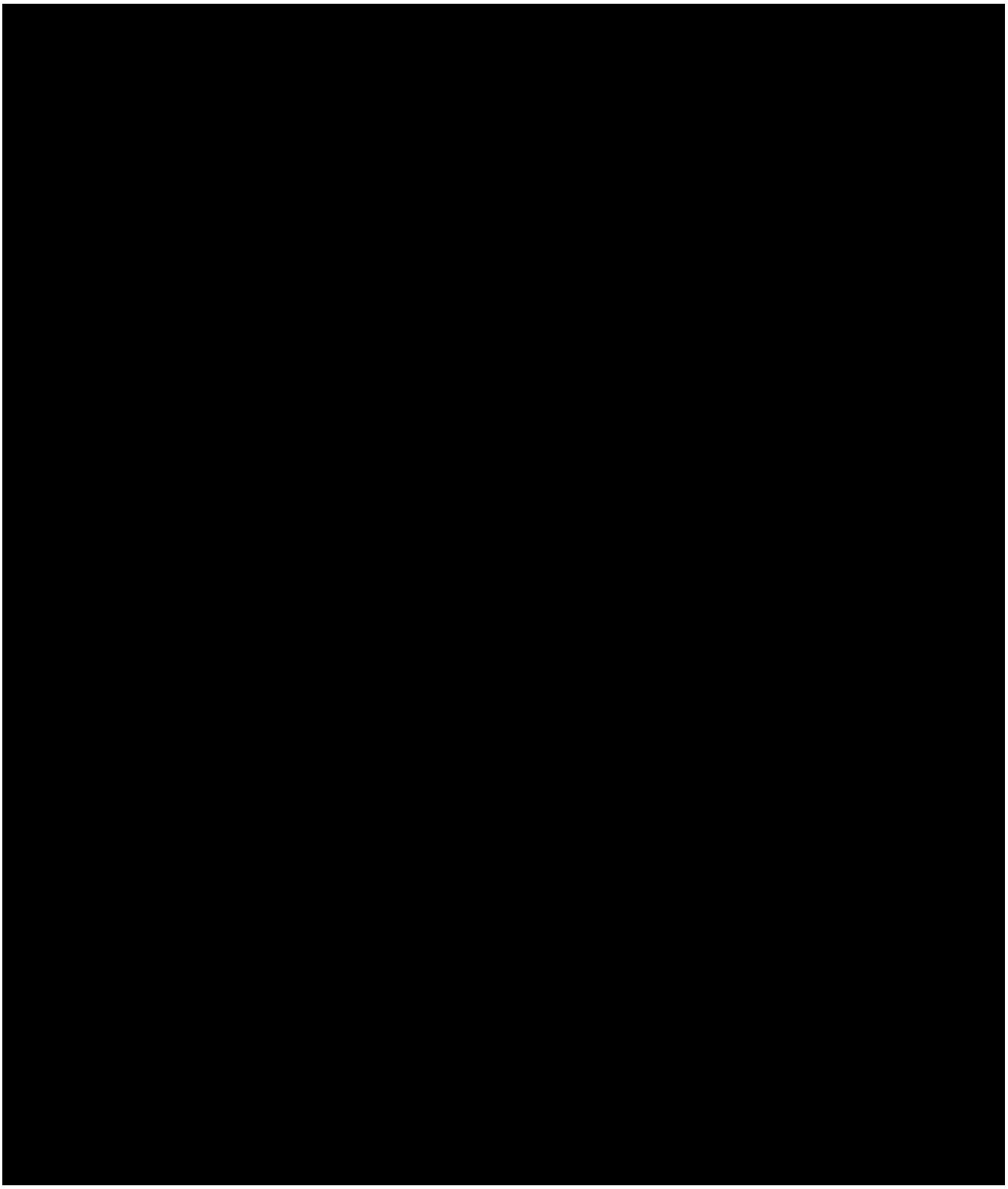












[END OF RESPONSE]

4.3.3.6 ECONOMIC IMPACT

There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be located in Mississippi. Use the form provided in Appendix H to detail expected wages for those positions as well as any other positions the Offeror will locate in Mississippi. Additionally, include a narrative explanation no longer than two (2) pages of other investments, if any, that the Offeror plans to make in Mississippi.

[redacted]

Table 4.3.3.6_B: Mississippi Investments

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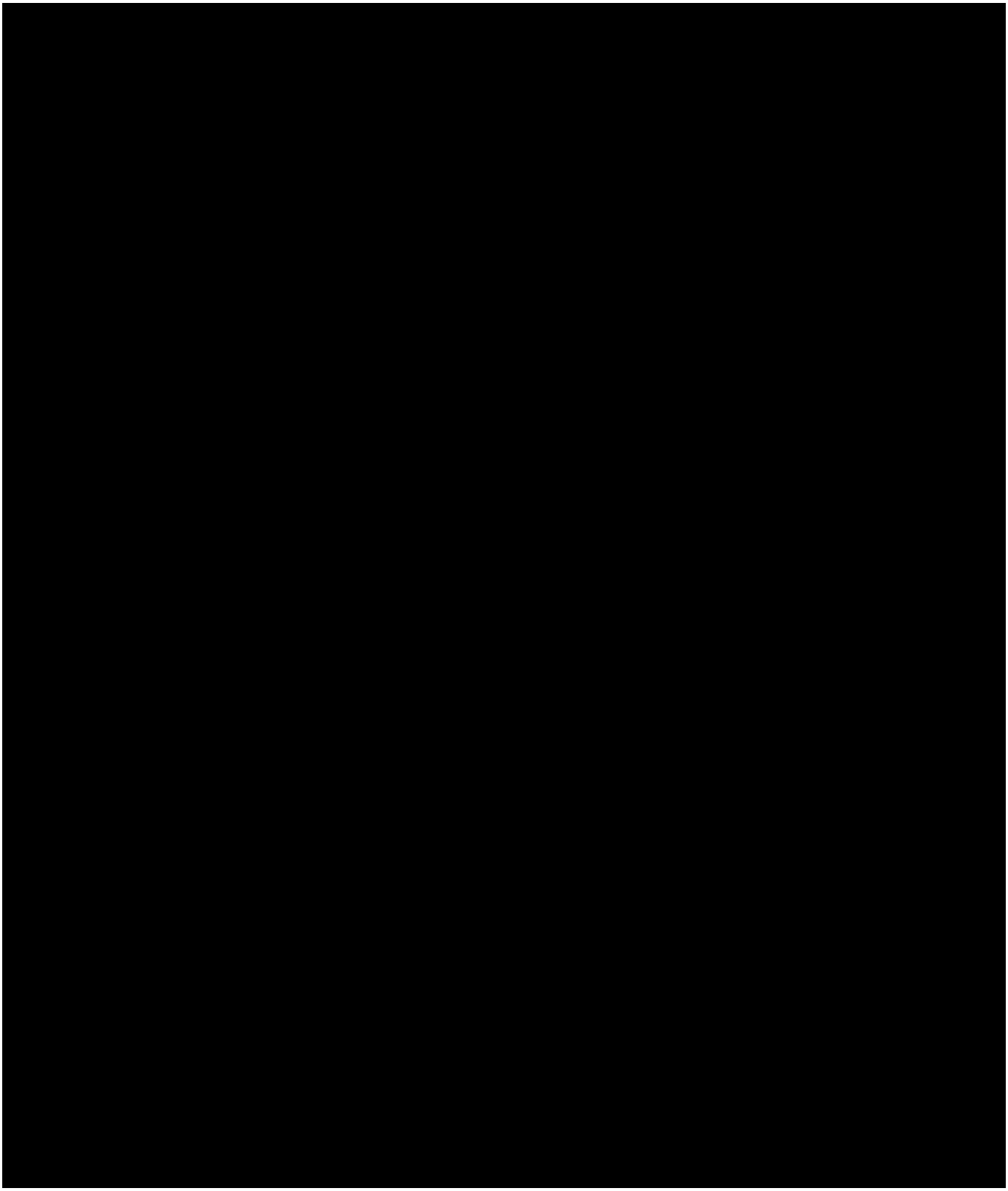

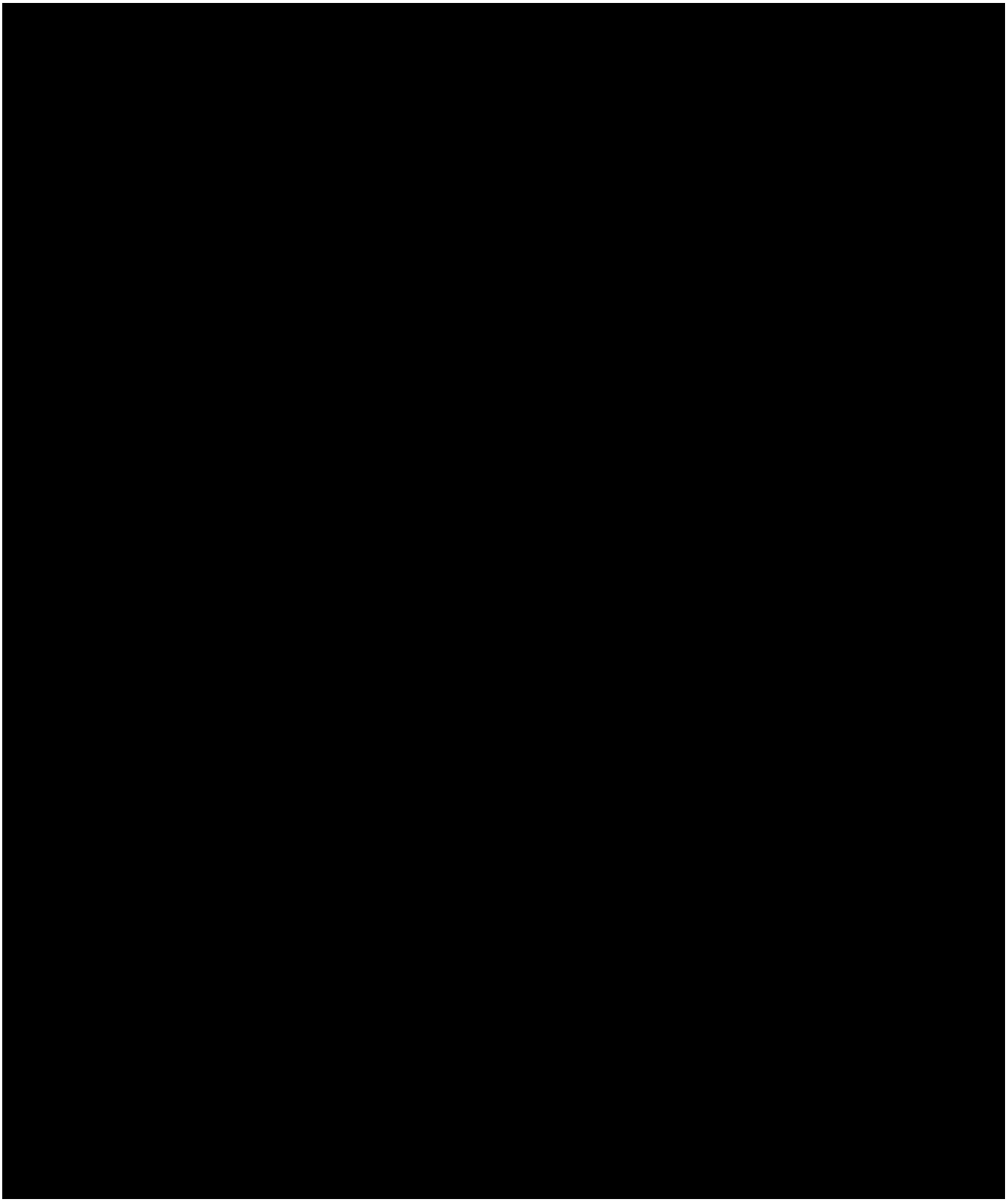

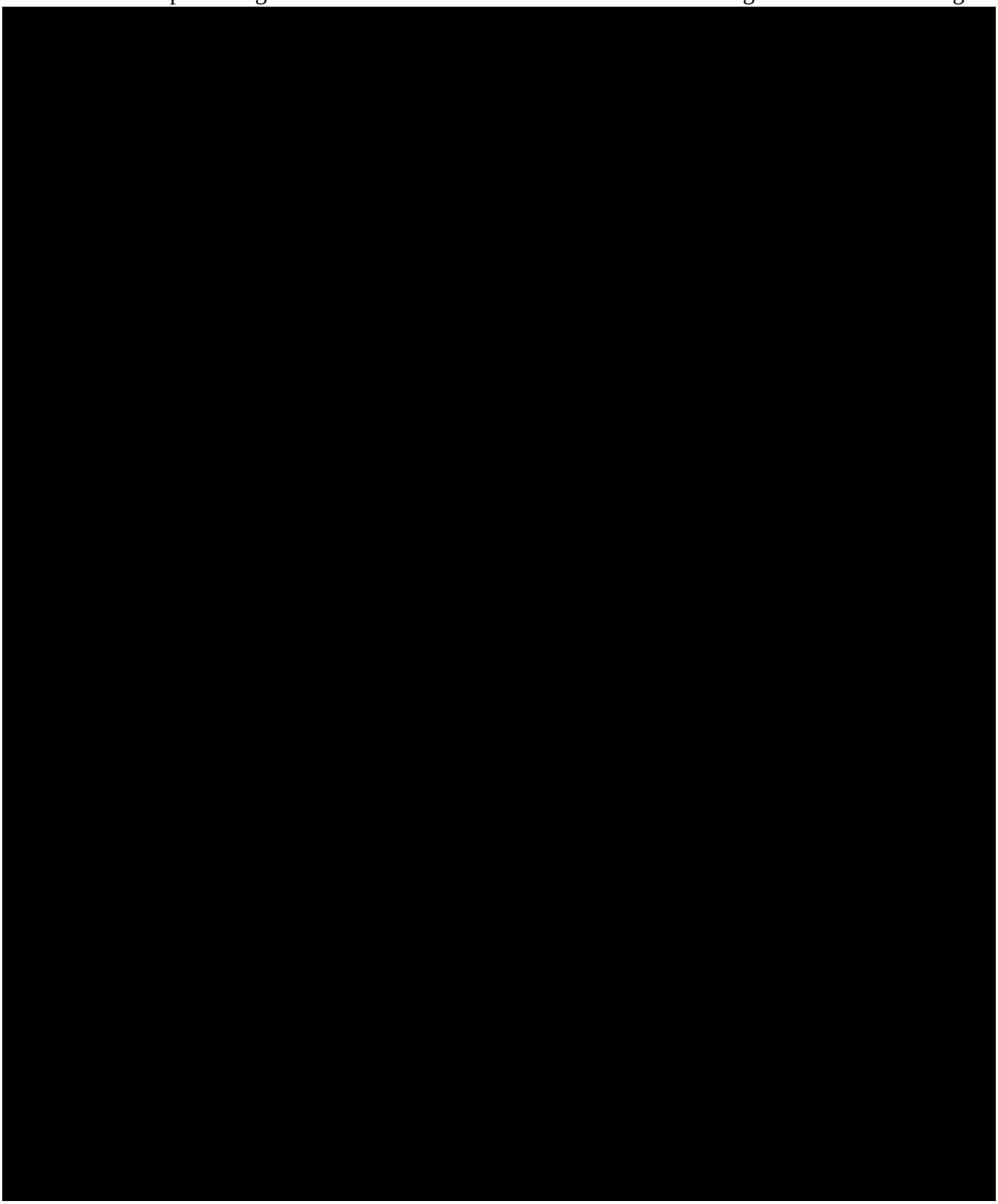

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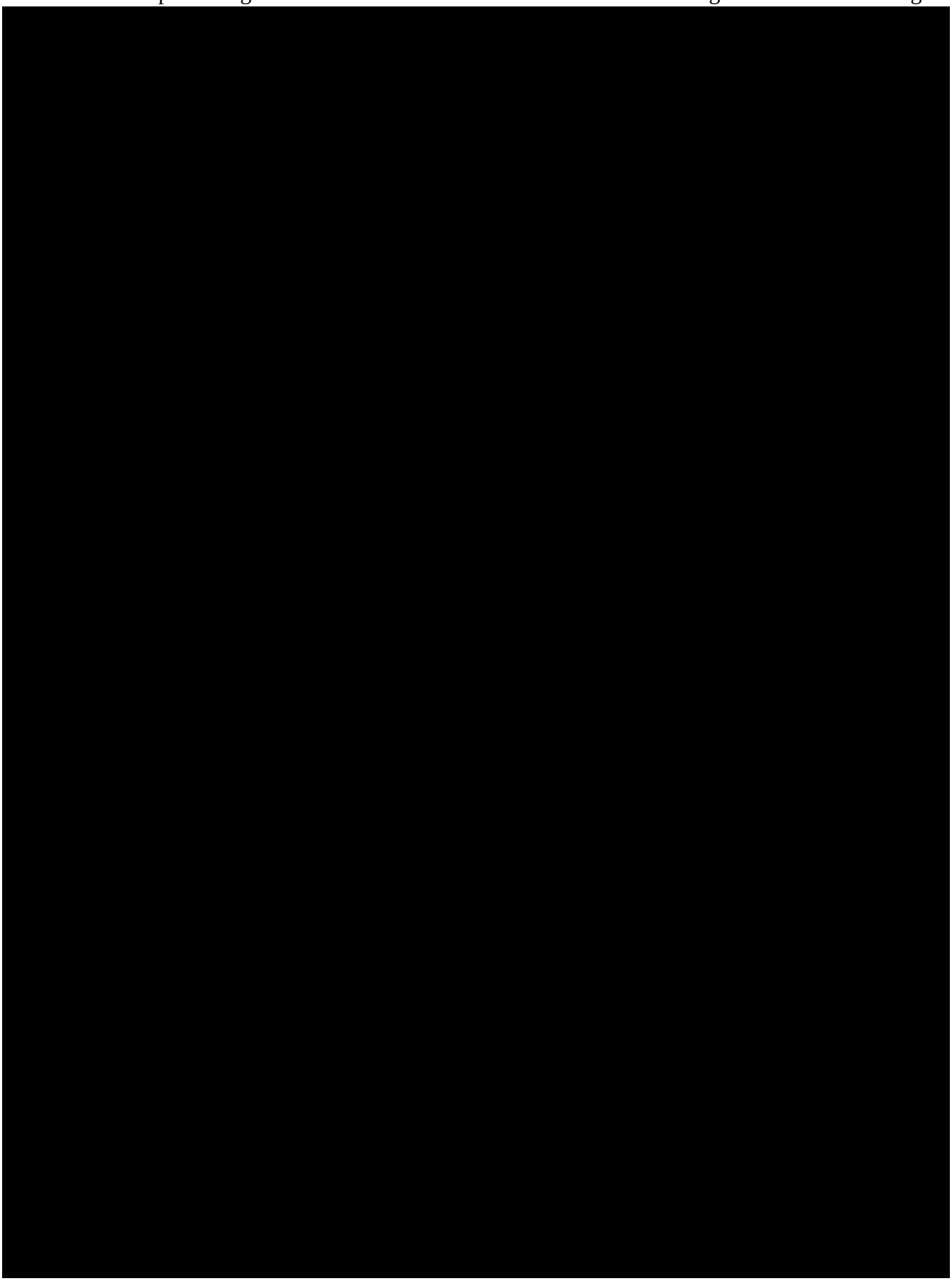
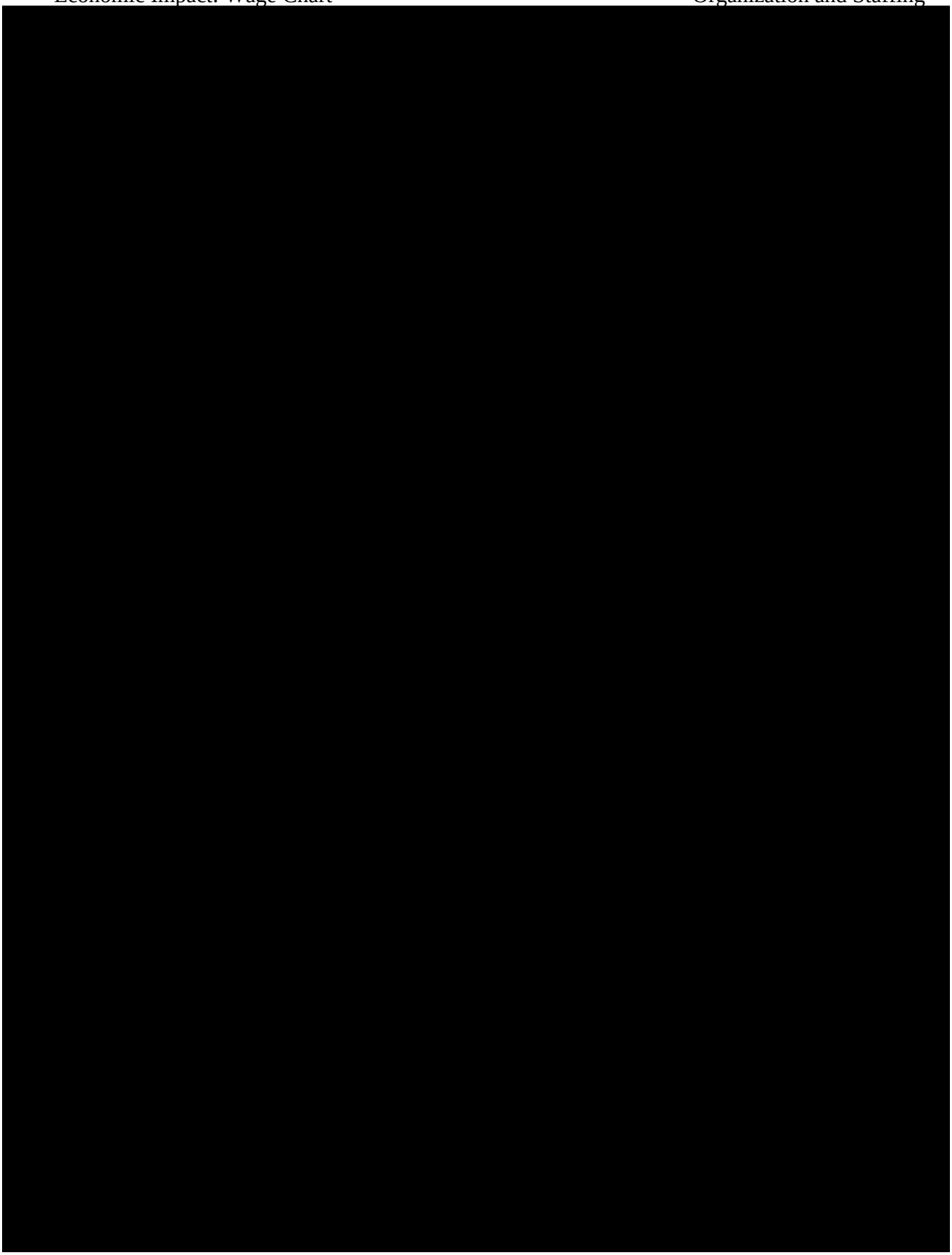
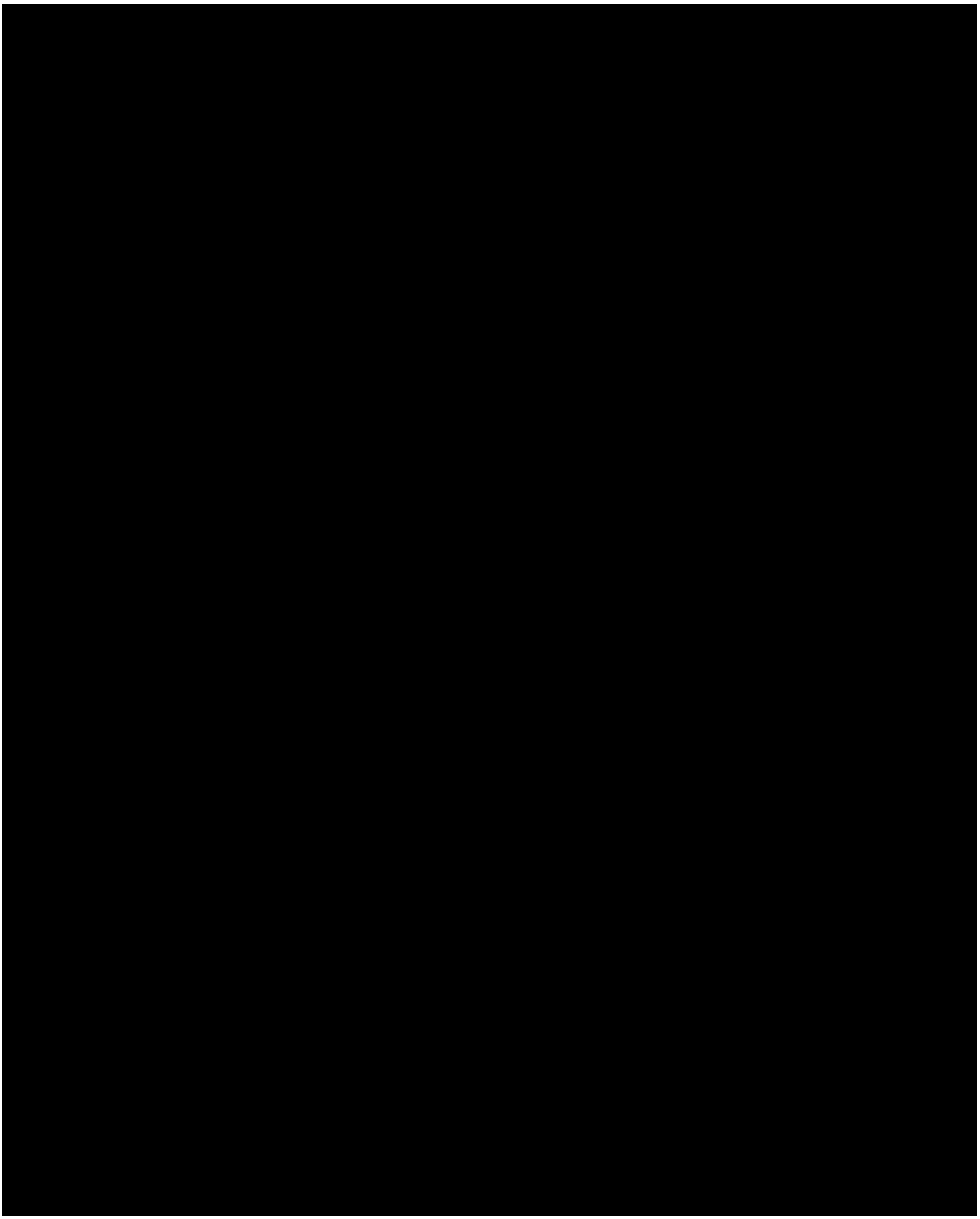
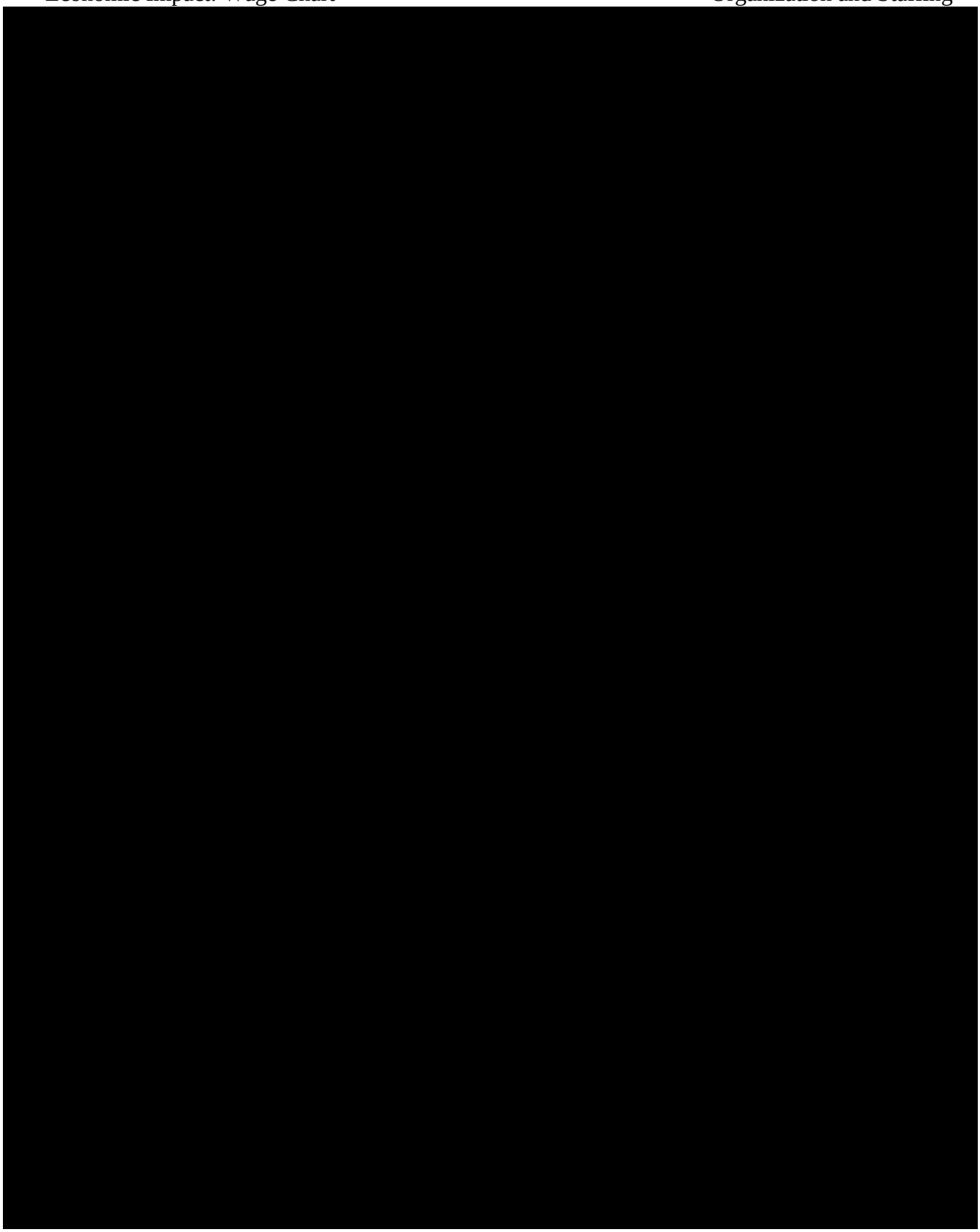
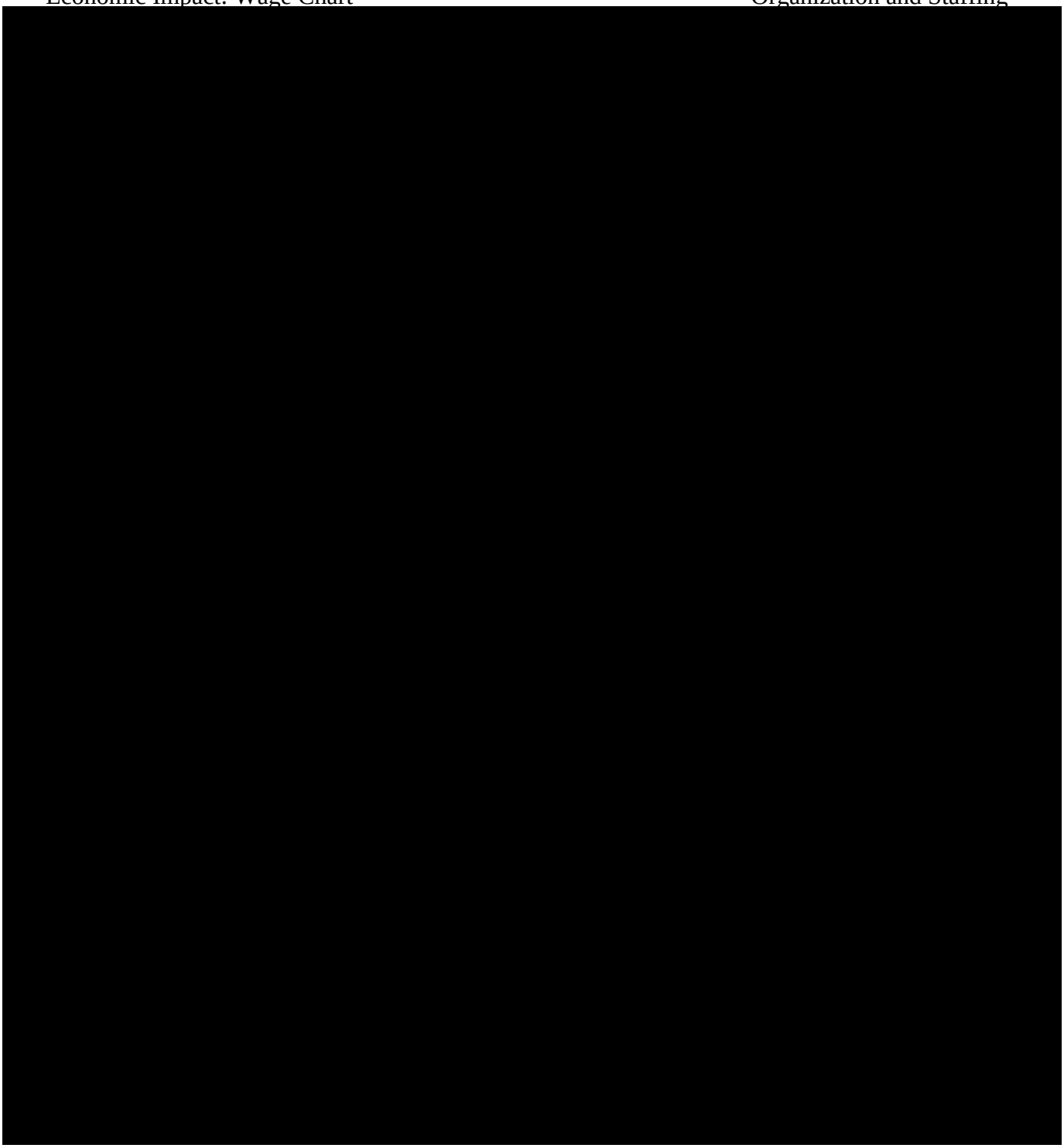
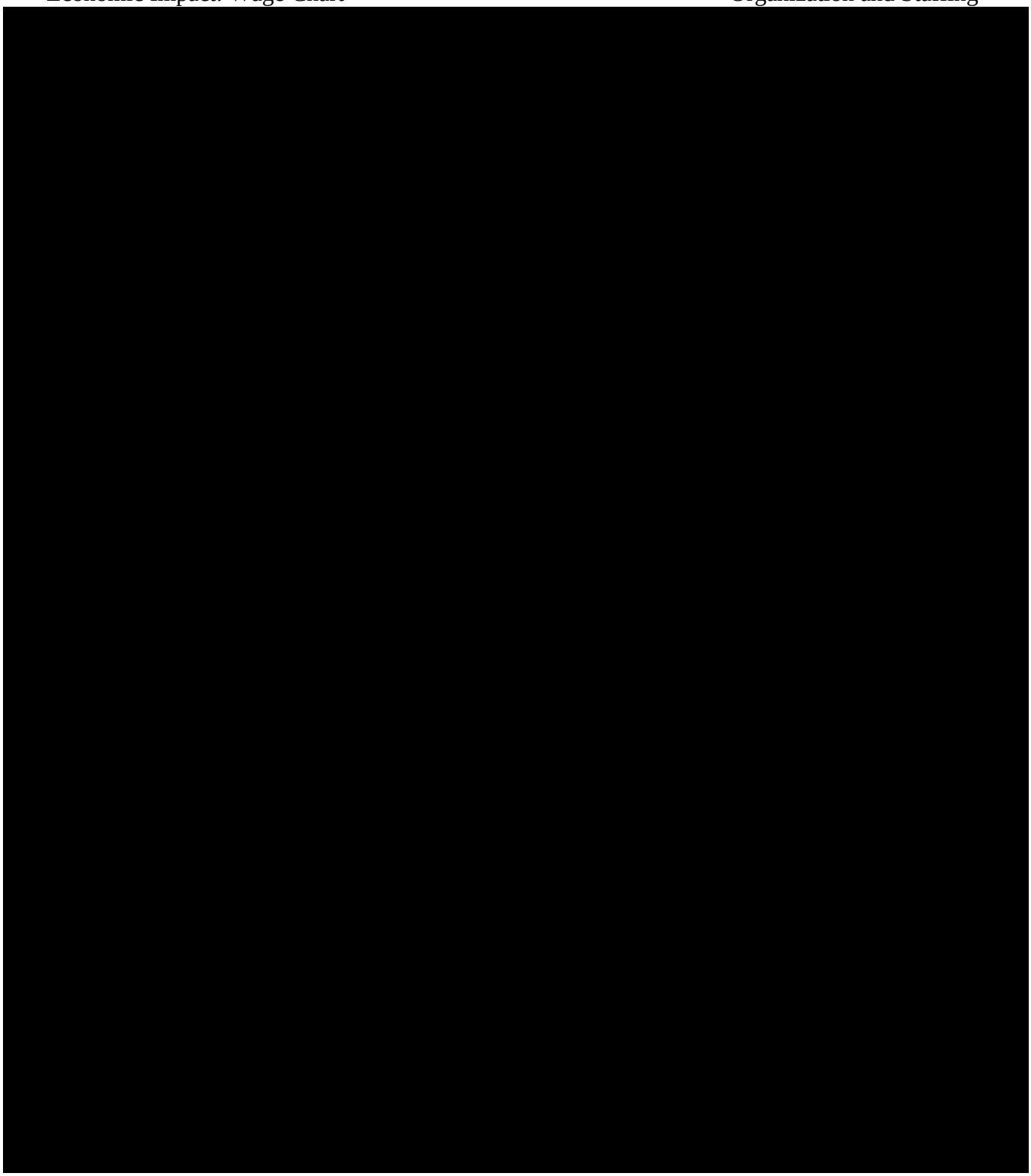


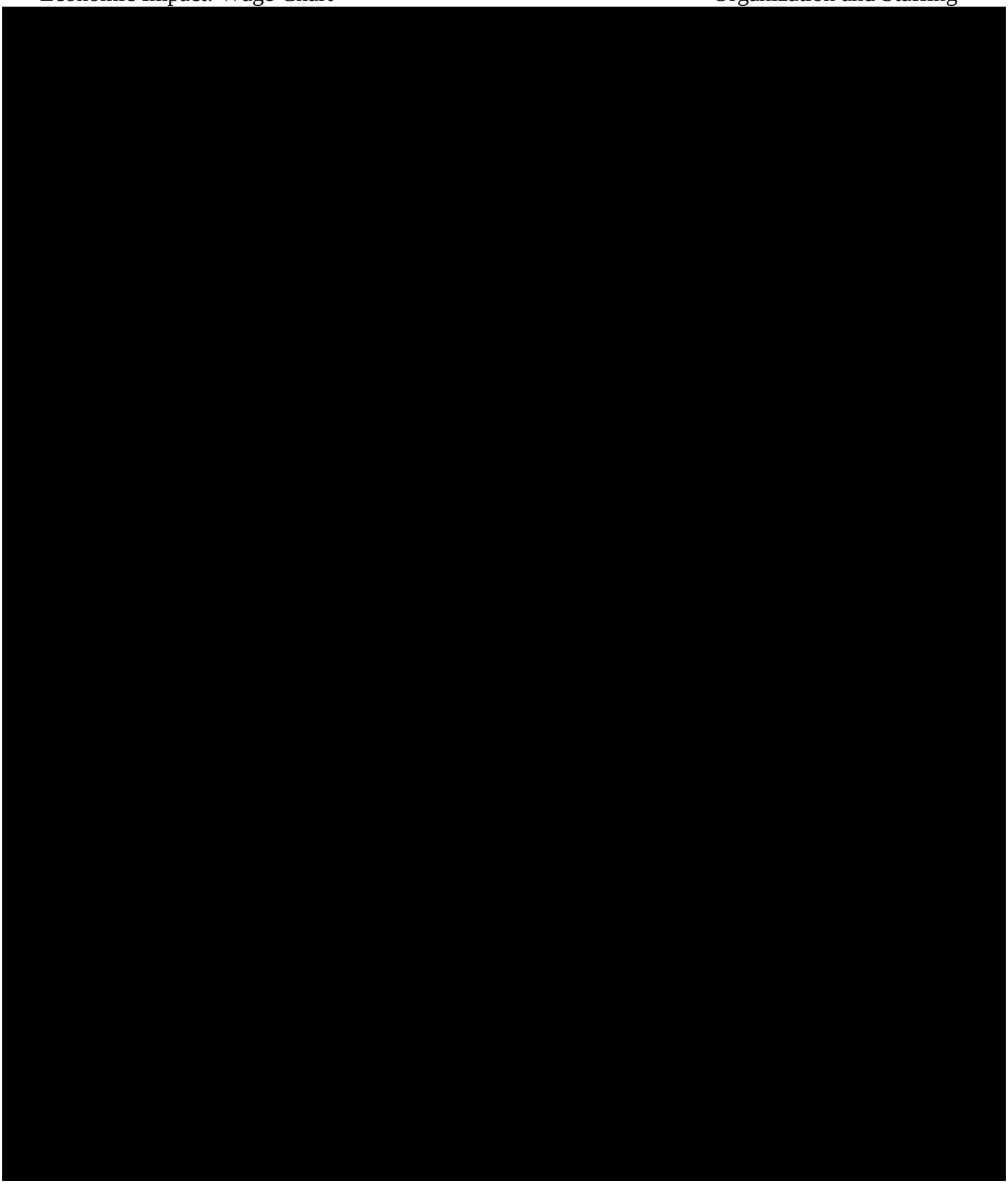


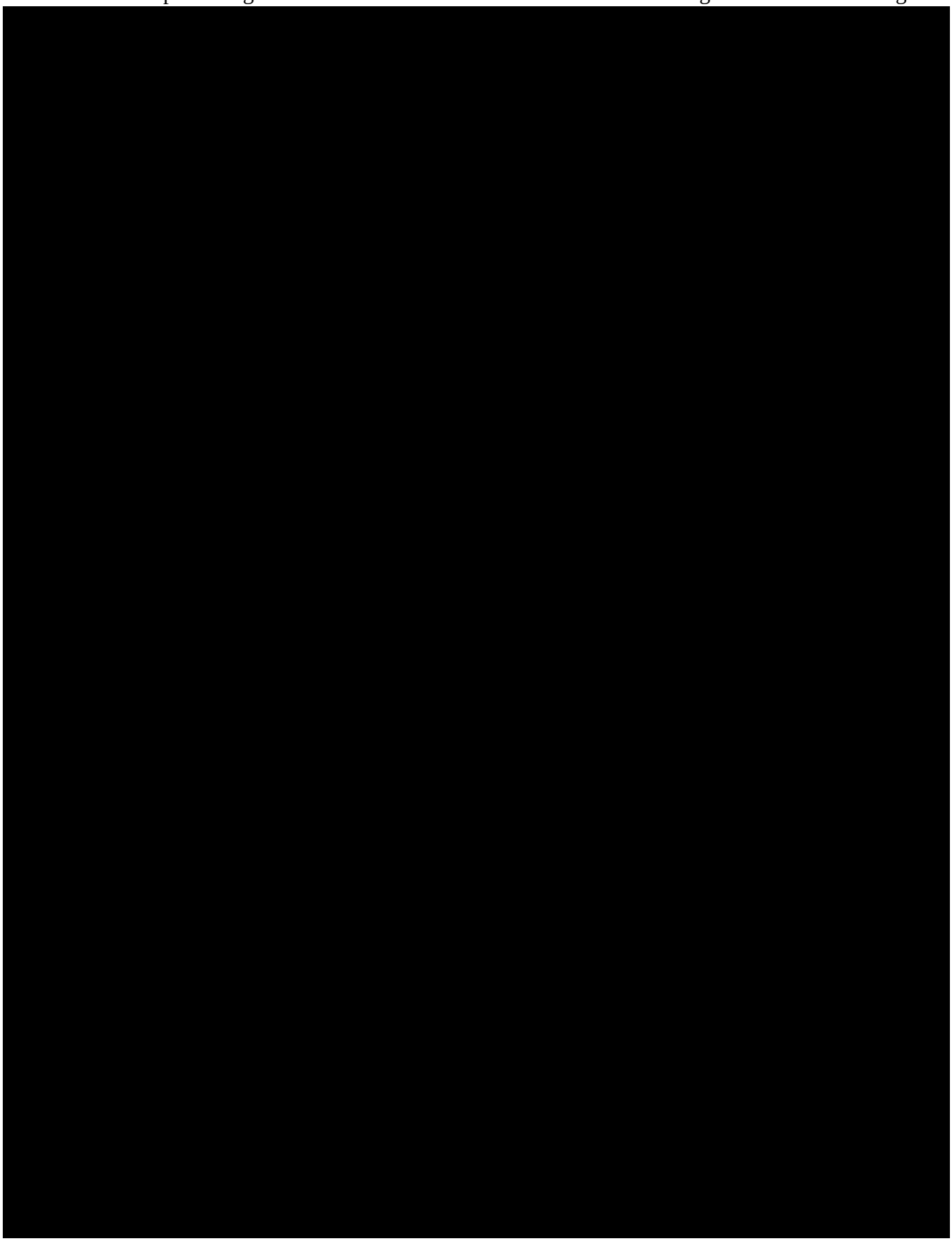


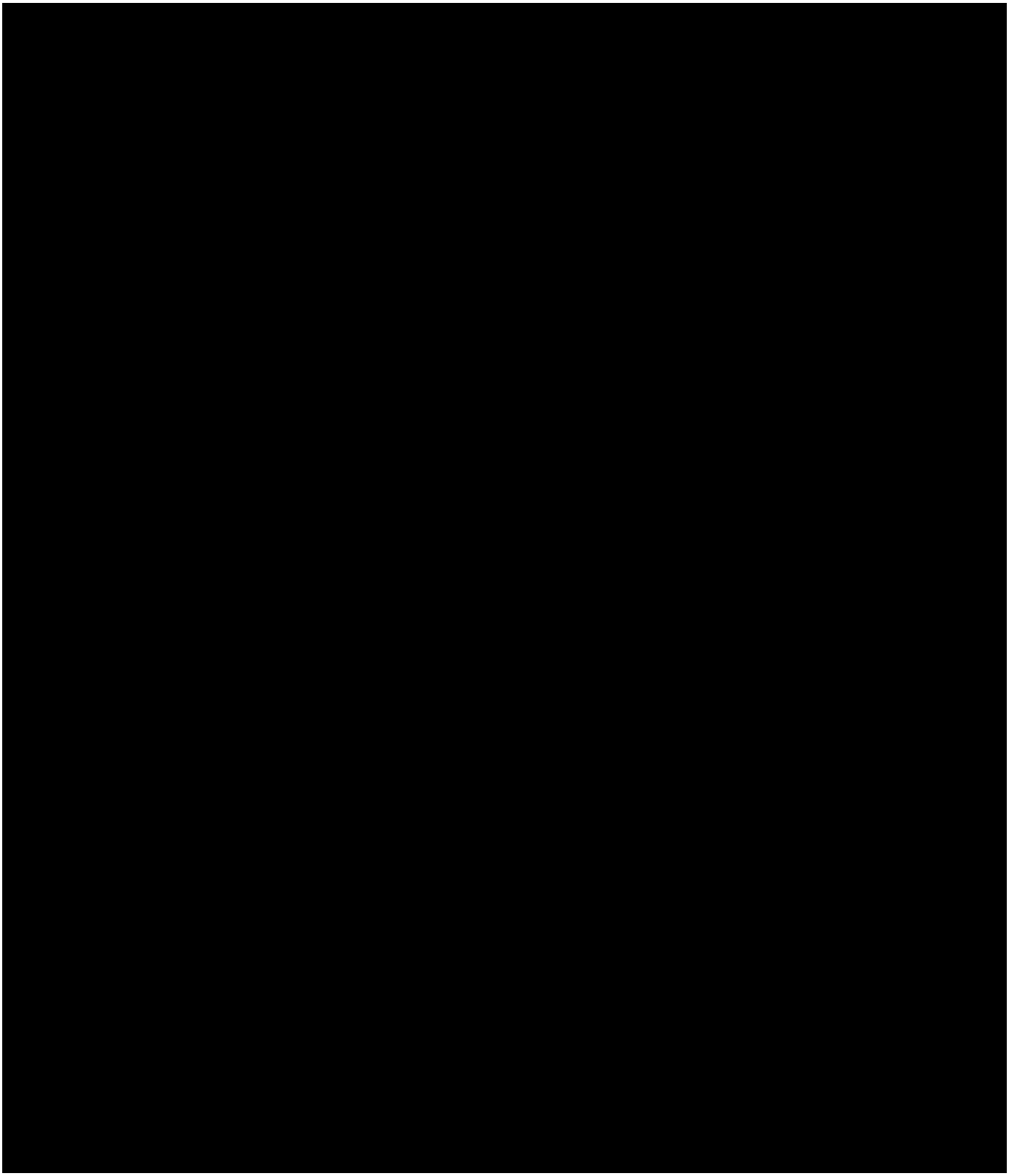


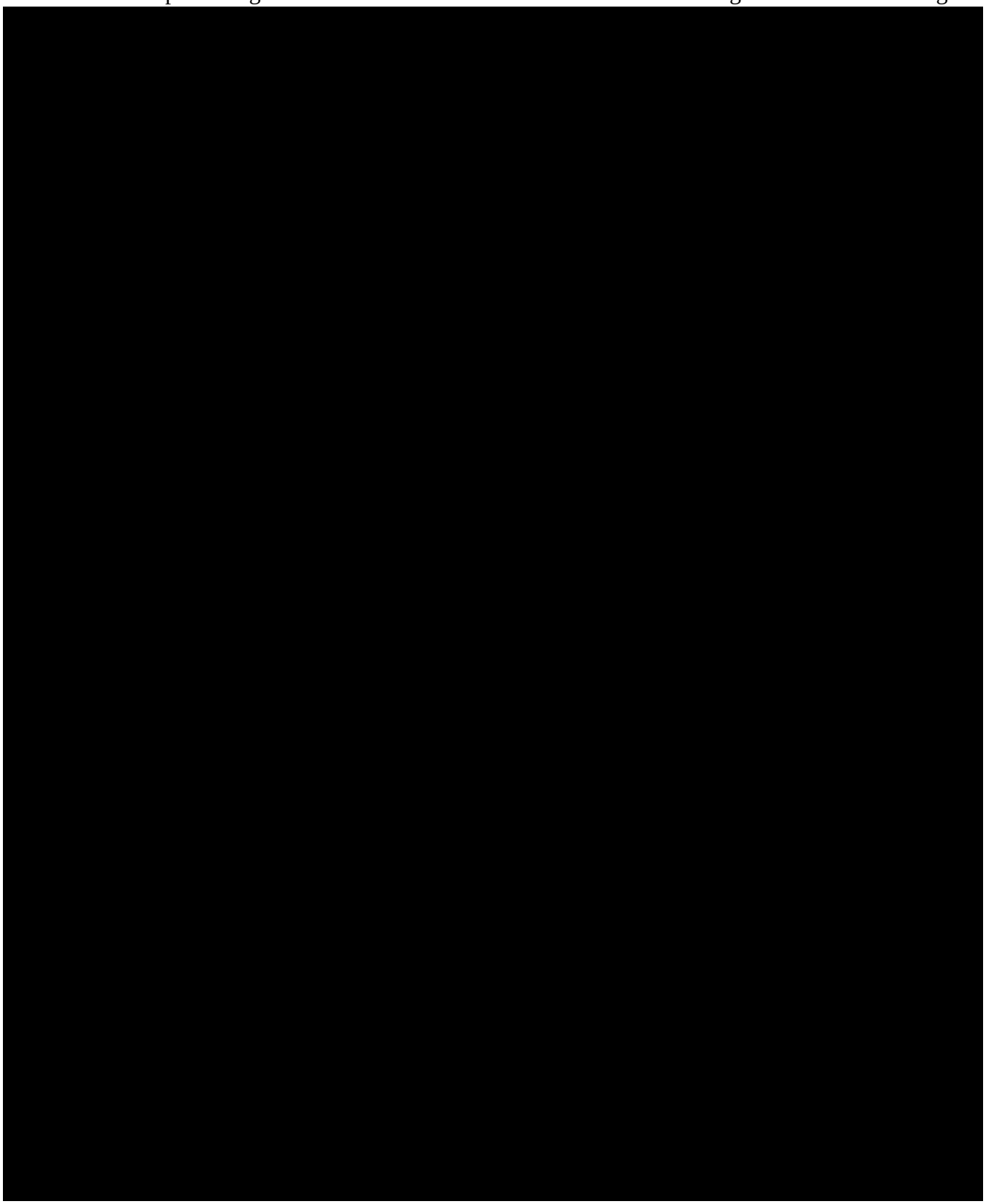


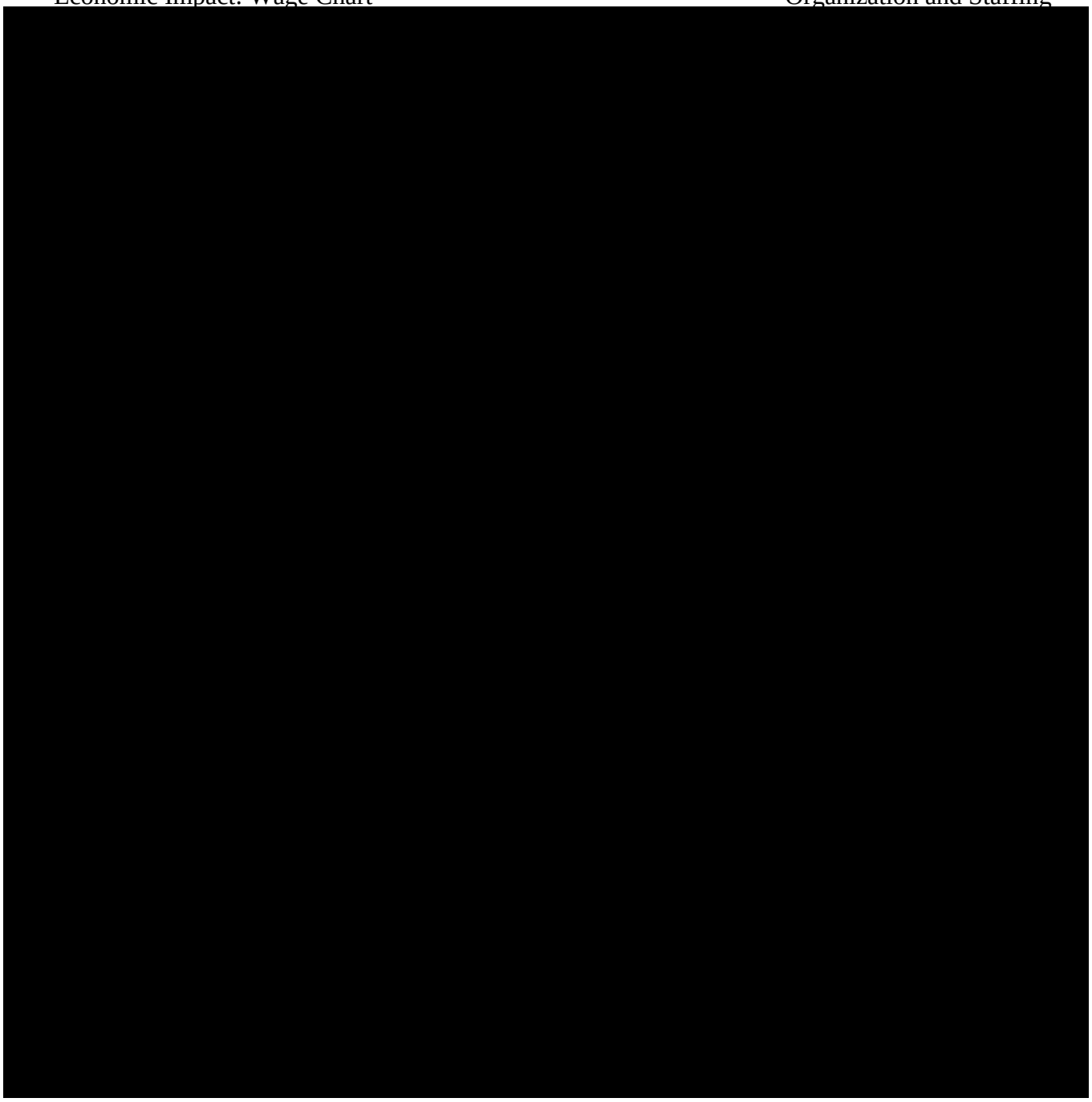












[END OF RESPONSE]

4.3.4 MANAGEMENT AND CONTROL

The Management and Control Section shall include details of the methodology to be used in management and control of the program, program activities, and progress reports. This Section will also provide processes for identification and correction of problems. Specific explanation must be provided if solutions vary from one phase to another.

Introducing TrueCare, a New Mississippi Medicaid Plan with the Power to Improve the Health of Mississippians and Transform the Delivery of Healthcare in Mississippi TrueCare represents the Mississippi-focused collaboration between two industry-leading healthcare organizations: Mississippi True and CareSource. Mississippi True is a not-for-profit Mississippi health maintenance organization that was formed by a coalition of Mississippi's most well-established hospitals and health systems to serve as Mississippi's one and only provider-sponsored health plan. CareSource Management Services, LLC (CareSource) is a nationally recognized managed care organization with more than 30 years of Medicaid managed-care experience, a not-for-profit mission, a unique member-centric focus, and an established reputation as a leader in quality and operational excellence. As a result, this allows TrueCare to be a worry-free partner to the Division. TrueCare will harness the synergy between CareSource's unique strengths and Mississippi True's capacity as Mississippi's only provider-sponsored health plan with responsibility as the license holder; however, **CareSource will serve as the plan's managed-care program administrator running the day-to-day operations and ensuring fiscal responsibility.** By combining CareSource's extensive experience in Medicaid health-plan operations with Mississippi True's deep and longstanding relationship to the Mississippi provider community, TrueCare offers significant advantages over the typical Medicaid CCO plan and has the power to improve the health of Mississippians to transform the delivery of healthcare in Mississippi.

4.3.4.1 DAY-TO-DAY MANAGEMENT

1. Program management approach;

TrueCare is organized and staffed to "facilitate collaboration between Mississippi Medicaid providers and managed care entities to align incentives in support of integrated and coordinated health care delivery, and to encourage the development of appropriate population or community health strategies to better serve Medicaid beneficiaries and the state's health care delivery system as a whole." Miss. Code Ann. § 83-5-601. As a coordinated care organization (CCO), we are committed to changing the trajectory of Mississippi's healthcare system by providing a fully integrated, transparent service delivery model with the majority of its providers in a real-time bidirectional data exchange. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources. TrueCare is led by an exemplary Board of Directors comprised of respected leaders from the Mississippi healthcare industry, including a dedicated seat for a non-hospital employed physician representative. Our Board of Directors takes an active role in the operations of our health plan and provides operational oversight to ensure cost effective, high-quality care for MSCAN and CHIP members. The TrueCare Chief Executive Officer (CEO)/Project Manager reports directly to the Board of Directors.

The TrueCare executive team area is all Mississippi based, full-time, dedicated employees. Executive positions serving the Mississippi functions (in addition to other Key Staff) of the Draft Contract are listed in Table 4.3.4.1_A.

Table 4.3.4.1_A: TrueCare Executive Roles

Executive Title	Executive Role
Chief Executive Officer/Project Manager (CEO)	The full-time in-state CEO has "decision-making authority" and "administers the day-to-day business activities" of TrueCare and serves as the Contract Officer for TrueCare. The CEO is "authorized and empowered to make operational and financial decisions, including rate negotiations for Mississippi business, claims payment, and Provider relations/contracting" and is "able to make decisions about coordinated care activities and must represent [TrueCare] at meetings required by the Division." The TrueCare COO, CFO, MD, and CCO report to the CEO. The CEO also serves as the liaison between the TrueCare Board of Directors and the TrueCare committees. The CEO also serves as the "Project Manager" during the implementation phase of the Contract where they are "responsible for overseeing the implementation of the contract requirements."

Executive Title	Executive Role
Chief Compliance Officer (CCO)	The full-time in state CCO serves as the primary point of contact for the Division and approves all contract deliverables prior to submission to the Division. The CCO oversees TrueCare's compliance program and CareSource's Mississippi Director of Compliance.
Chief Operating Officer (COO)	A full-time, in-state COO that is responsible to "oversee day-to-day business activities" of TrueCare.
Chief Financial Officer (CFO)	The full time, in state CFO oversees all financial activities including all financial reports submitted to the Division.
Medical Director (MD)	The MD is a Mississippi-licensed physician who actively practiced in Mississippi within the past five years and is responsible for the proper provision of covered services to members. The MD "serves as a liaison between [TrueCare] and providers; be available to [TrueCare]'s staff for consultation on referrals, denials, Grievances, and Appeals; review potential quality of care problems; participate in the development and implementation of corrective action plans; [and] serve on Quality Workgroups as required by the [Medicaid] Division." The CareSource Perinatal Health Director and Behavioral Health Director report to the MD and the MD oversees any clinical and quality activities delegated to CareSource. This role serves on any required State Quality Committees.

The TrueCare executive team is reinforced by various TrueCare Committees aligned to the State's Medicaid program goals and a third-party auditor to assist in ensuring operational excellence.

- TrueCare Operations and Information Committee – To satisfy Section 13's delegate oversight requirements, this committee oversees TrueCare's operational performance, the performance of TrueCare's information technology systems, and the accuracy and timing of encounter data. To that end, the committee oversees operations and information technology and report any findings or suggestions to the TrueCare CEO, COO, and CCO. This committee meets at least monthly and the COO and/or CareSource CIO must attend as requested. Three members shall serve on the committee and must have at least the following qualifications: (1) located in Mississippi; (2) have managed care experience; and (3) have experience in operations and healthcare claims payment.
- TrueCare Finance Committee – To satisfy Section 13's delegate oversight requirements, this committee oversees and is accountable for TrueCare's financial-related functions. The committee oversees the financial performance and reports any findings or suggestions to the TrueCare CEO and CFO. The Committee meets at least monthly and the CFO must attend as requested. Three members shall serve on the Committee and must have at least the following qualifications: (1) located in Mississippi; (2) have managed care experience; and (3) have a healthcare finance background.
- TrueCare Clinical Committee – To satisfy Section 13's delegate oversight requirements, this committee oversees CareSource's clinical decision-making, provision of covered services, and other clinical issues, and reports any findings or suggestions to the TrueCare CEO, MD, and CCO. The Committee meets at least monthly and the CareSource MD and the CareSource Perinatal Health Director and Behavioral Health Director must attend as requested. Three members shall serve on the Committee and must have at least the following qualifications: (1) located in Mississippi; (2) have managed care experience; and (3) served as a Mississippi-licensed physician.
- Third-Party Auditing Consultant – In addition to the audits required by the State contract, TrueCare is engaged with a third-party auditing consultant on a retainer to perform performance oversight audits of CareSource. At least biannually, the Third-Party Auditing Consultant shall perform comprehensive audits of CareSource's operations, compliance, finances, clinical performance, information and technology, and accuracy and quality of the submissions to the State of Mississippi to include, but not be limited to, encounters. These reports are produced for the CEO, CCO, and applicable CareSource Committees. The CEO, CCO, or Committees may also request other ad hoc audits.

Together, the TrueCare Board of Directors, Executive Team, and its committees manage and oversee the implementation of the Draft Contract and subsequent operations. The remaining Key Employee, the Chief Information Officer, is a CareSource enterprise employee who oversees information technology and systems. The Perinatal Health Director and Behavioral Health Director are full-time, Mississippi-based CareSource employees who are actively practicing or have been actively practicing physicians in the past five years. They report to TrueCare's Medical Director. The remaining positions required in Draft Contract 1.13.1.2 and 1.13.2 are CareSource employees that are dedicated fiduciaries to TrueCare and Mississippi and report

through the application TrueCare executive. TrueCare's leadership and employees bring extensive experience and expertise to the programs and their recipients, including experience shaping healthcare trends and Medicaid best practices.

Lastly, to bolster the already strong communication and collaboration, an Alliance Joint Development Committee was formed consisting of 3 members of the TrueCare executive team and 3 CareSource executives to provide further oversight of the TrueCare operations, discuss strategies, and ensure the Division's goals are satisfied.

Program Management Approach

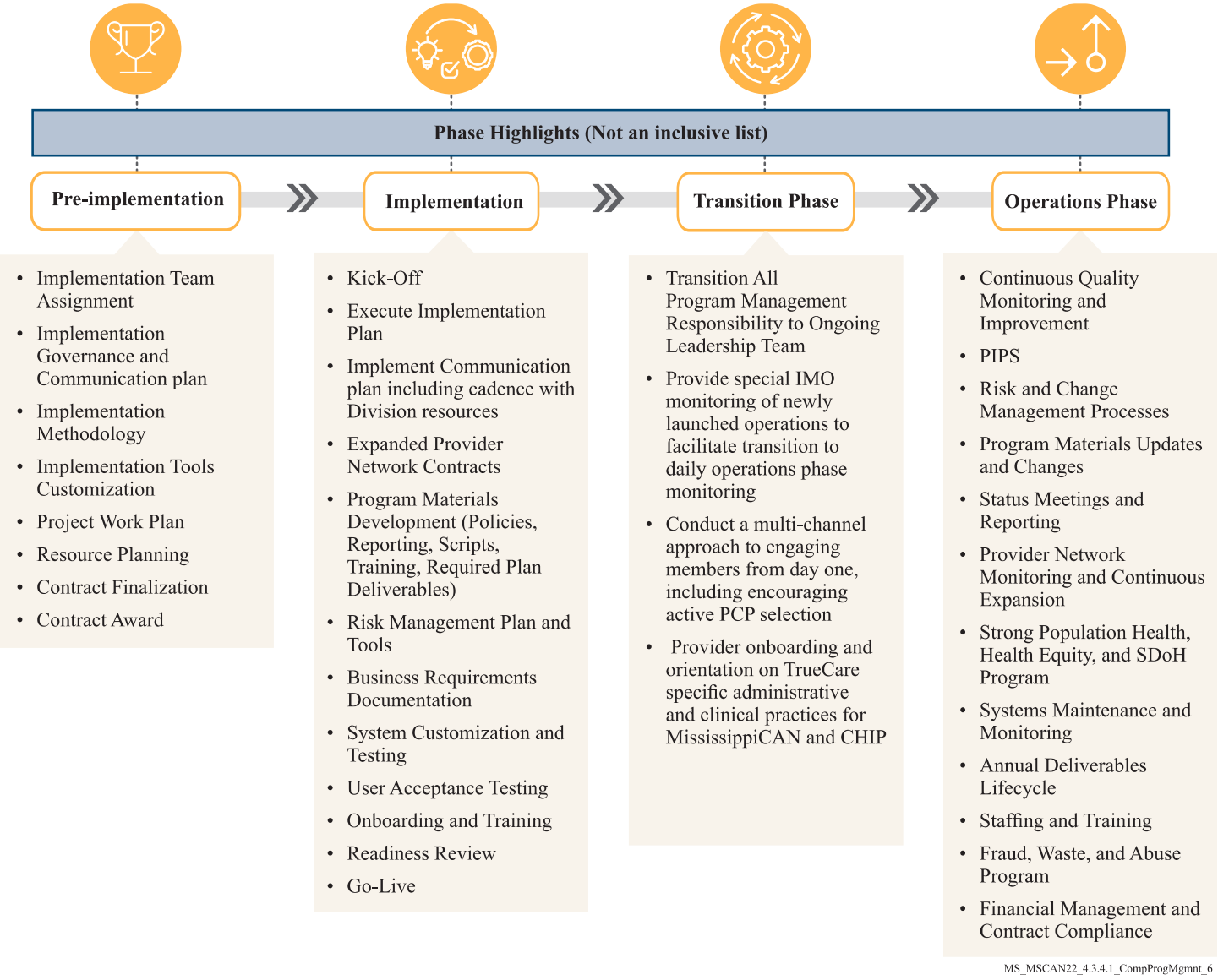
TrueCare follows a disciplined, experience-based approach to the management of all phases of the program and contract. Our delivery approach is rooted in industry-standard methodologies, including the Project Management Institute's (PMI) Project Management Body of Knowledge (PMBOK) standards and guidelines, the International Institute of Business Analysis's (IIBA) Business Analysis Body of Knowledge (BABOK) guide, and Scaled Agile Framework (SAFe) methodology. Most importantly, we practice transparency, accountability, and consistency to provide a low-risk solution while meeting the Division's objectives for quality managed care.

The day-to-day management of Mississippi TrueCare operations encompasses all major contract phases from pre-implementation preparation to the end of the contract. We plan and track all activity using a comprehensive Implementation Work Plan and Project Work Plan, which includes a detailed schedule, tasks and subtasks in a work breakdown structure, predecessors and dependencies, and responsible parties. This detailed program management approach applies to all phases of the operation.

We provide additional program management approach detail by program phase in Figure 4.3.4.1_A.

Figure 4.3.4.1_A: TrueCare Provides Comprehensive Program Management Through all Contract Phases

Our program management approach covers best practices and requirements for each phase of operations.



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Implementation Phase

The CareSource Implementation PM is responsible for implementation work under the direction of the CEO/Project Manager and is an executive leader familiar with the Mississippi Medicaid and Children's Health Insurance Program (CHIP) landscape. Our team of Medicaid implementation specialists with more than 30 years of experience support the Implementation Project Manager. We bring our best practices to Mississippi by assigning an Implementation Management Organization (IMO) to support the Implementation PM.

Our partnership with CareSource brings experience and best practices from Medicaid implementations in states such as Ohio, Georgia, Indiana, and Arkansas in the form of a New Market Implementation Playbook (Playbook). This Playbook allows us to leverage a library of repeatable tools; processes and procedures; roadmaps; templates; and other artifacts to drive efficiency across the

Proven Readiness Review Success

Our IMO has successfully met all readiness review requirements on schedule for previous implementations in Ohio, Georgia, Indiana, and Arkansas.

implementation phases from initiation to deployment. The most important of these is our new Medicaid market toolkit, consisting of pre-configured and fully tested system components, including but not limited to benefits administration, clinical care management, utilization management, and standardized interfaces as shown in Figure 4.3.4.1_B. This prepares us to quickly and easily apply Mississippi-specific needs, requirements, and desires for a faster and lower risk technology implementation.

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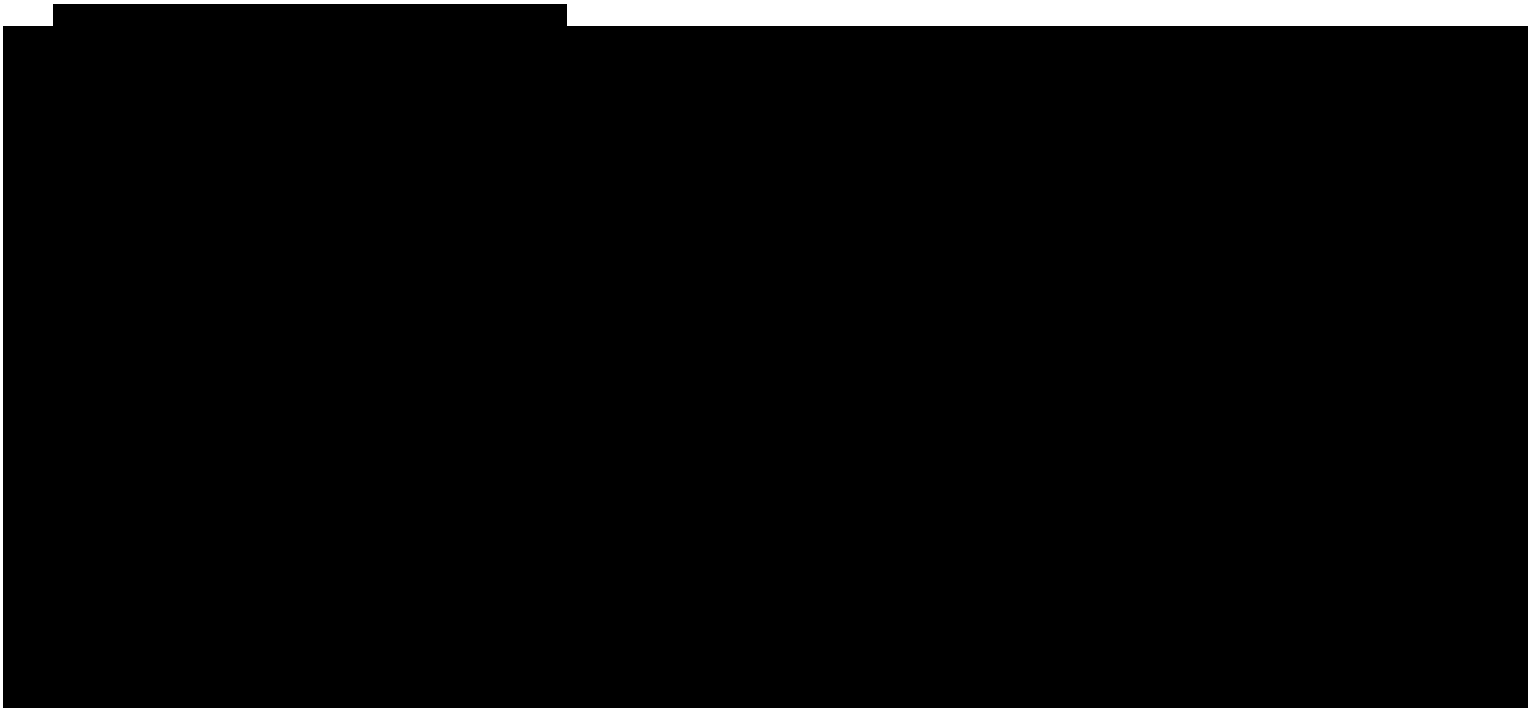


The ready-to-customize for Mississippi concept is rooted in the premise that at the core of all Medicaid programs there are commonalities that can be operationalized and leveraged for subsequent implementations. The outcome of the approach is a base configuration for each of the components that have been tested and available for fast and efficient state-specific configuration. This allows us to jumpstart the implementation efforts, minimize time to build, improve time to market, and achieve high-quality deployments. The benefits of this approach can be seen beginning with integration testing with state and other partners carrying through into operations improving timeliness and accuracy.

Implementation Phase. The TrueCare IMO provides a consistent approach to implementation execution through proven strategies and tools. The most important of these tools are the Implementation Plan (part of the Project Work Plan), the RTM, the Risk Management Plan, and the Communication Plan. Our Implementation Plan includes all the tasks, subtasks, predecessors, dependencies, successors, responsible parties, and milestones outlining the critical path to the Mississippi operational start date. The Communication Plan guides the meetings, reports, and critical points of contact necessary for a transparent, seamless implementation process.

During the implementation phase, our IMO works across operational areas to support these additional implementation tasks:

- **Initiation.** Prior to the official start of the implementation phase, we finalize the IMO Team, prepare the Implementation Work Plan and kick-off presentation, create the Requirements Traceability Matrix (RTM), and customize Mississippi-specific templates for key implementation tools.
- **Confirm Contractual Compliance.** As part of our implementation process, business analysts review the contract and supplemental guidance provided to ensure requirements are identified, documented, and tracked through our RTM. Our

compliance team, under the leadership of the TrueCare Chief Compliance Officer, reviews and approves the RTM prior to the implementation of all requirements.

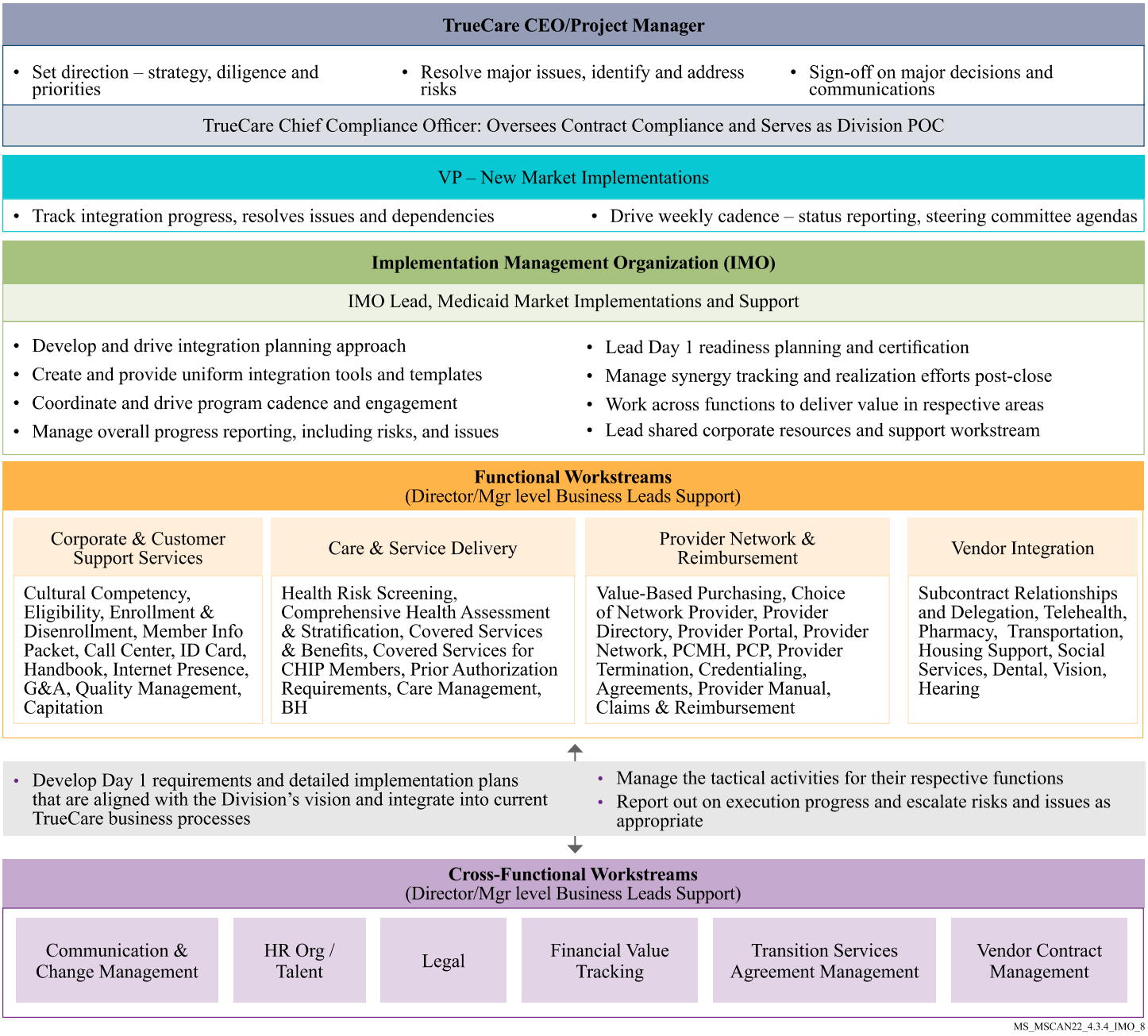
- **Conduct Product Benefit Design, Definition, and Configuration.** Our product design process begins with assessing the goals of the state in conjunction with the needs of the population. Based on these priorities, our TrueCare leaders develop a framework for supporting our care and service outcome goals. We then develop Mississippi-specific requirements and codify the changes on top of the base product already deployed into our systems and conduct all necessary testing according to our established testing plan.
- **Confirm Completion of the Physical Infrastructure and Staffing Plans**. Leveraging CareSource executives such as our Vice President of Customer Care, Vice President of Human Resources Business Partnerships, and Vice President of Talent Strategy, TrueCare leans on CareSource's best practices to establish TrueCare's facilities, staffing, and provider support functions. We focus our facilities planning on accessibility and support for underserved communities throughout the state and our recruiting functions on local community networks.
- **Augment New Hire Training with Mississippi-Specific Cultural Competency Content**. Different populations have different needs, and we are committed to ensuring that assessments and conversations held are in a manner that is both respectful and understanding of the enrollee's cultural preferences, conditions, and/or disabilities.
- **Monitor and Document Information System Implementation and Integration**. The IMO confirms all tasks and subtasks specific to core application and system requirements implementation including requirements development, testing, quality assurance, and information security. We have identified a Vice President of Application Development and Support to lead the Mississippi information system implementation.

Throughout the process, we adopt an agile approach that allows for iterative business and system requirements, so we can adjust to state-specific needs or special circumstances while avoiding and mitigating risk. Not only does this flexible approach minimize disruption, it also significantly improves our ability to meet key deadlines and improves our preparation for onsite readiness review.

Figure 4.3.4.1_C provides the structure and functional description of our proposed Mississippi IMO.

Figure 4.3.4.1_C: TrueCare Implementation Management Organization

Our IMO includes clear lines of authority and accountability for a seamless implementation.



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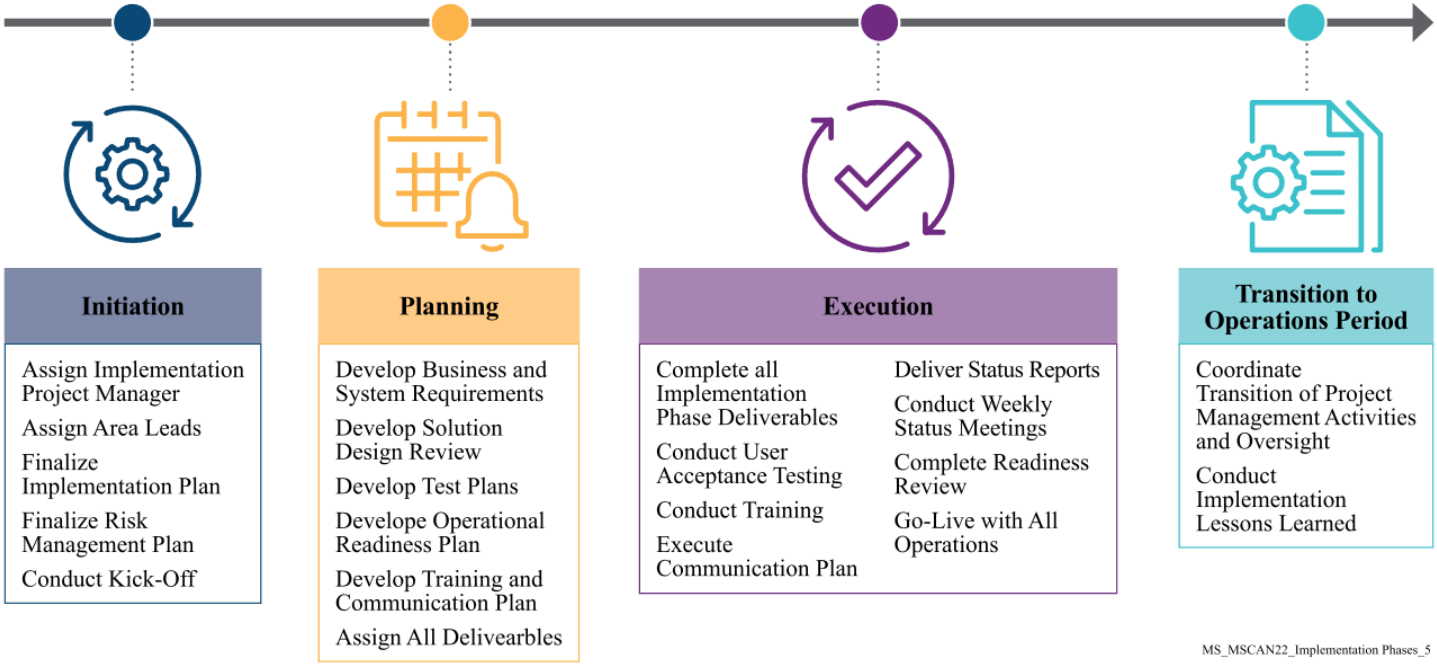
Implementation Sub-Phases. Our implementation contains discrete sub-phases as summarized in Figure 4.3.4.1_D. Throughout the implementation, we offer open collaboration and transparency with the Division and involve Mississippi operations staff for a smooth transition to the ongoing operations period. At the end of implementation, we document lessons learned and update our Playbook to improve future implementations, including any significant program changes that require project management oversight. Through CareSource's role in TrueCare, the Division benefits through documented experience from similar implementations—significantly mitigating risk and offering MSCAN and CHIP members a seamless experience as they start their journey with TrueCare.

Figure 4.3.4.1_D: Detailed Implementation Sub-Phases

The TrueCare IMO provides comprehensive oversight and support from program initiation, to transition, to ongoing operations management.



Transition to Operations Phase

During the first 120 days of full operations, the IMO supports the ongoing operations leadership for each department area and facilitates timely resolution of any issues reported by members, providers, partners, or regulators as necessary to confirm a strong start. The IMO provides an extra layer of monitoring to ensure a successful transition as well as additional support to new operations including member services, claims monitoring, utilization monitoring, and transitions of care. For example, during our Ohio Medicaid implementation, we monitored the special populations team daily for 120 days to confirm our staff, email and phone lines, and processes tied to population type were operating as intended. During the transition to operations phase, we also conduct multi-channel member outreach and comprehensive provider onboarding and training.

Operations Phase

Our program management approach continues the established methodology, controls, and best practices put in place during implementation to set up our operations for continuing success. After implementation is completed, the IMO transitions all project management functions, tools, and plans to the TrueCare executive team and supports the operations management team.

Our management team, based in Mississippi and staffed with experienced operations management professionals, assume control of the Work Plan, Risk Management Plan and tools, Change Management Process, Communication Plan, and other operational controls. The operations management team works closely with the leads of all functional areas to continue the PMBOK-aligned, disciplined project management and control necessary to not only meet, but exceed, the Division’s contractor expectations.

The day-to-day management of our operations focuses on fulfilling the requirements included in the executed contract, as currently listed in Appendix A, Draft Contract, in line with all performance standards, metrics, and Division objectives. Within our strict adherence to the RTM and Division-approved Project Work Plan, we infuse our operations with Division spirit and goals through our health equity initiatives, program improvement plans, and focus on quality. We enforce quality and

accountability in all day-to-day operations while never losing sight of the overall goals such as improving maternal, child, and adolescent health. With TrueCare, Mississippi receives True Excellence.

2. Program control approach;

TrueCare provides well-defined and established program controls for all components of program operations. Here we describe our controls under two categories: operational tools and contract governance controls. We provide oversight of all processes through the executives and committees listed in the response to question 1. Program management approach.

Our program operational controls and tools include the following:

- **Adherence to Project Work Plan (including implementation schedule).** We confirm compliance with the Work Plan and schedule through our weekly Work Plan and scheduled status reports and meetings. During the implementation, this includes both internal IMO meetings and meeting with the Division to collaboratively address any potential schedule risks, dependencies, and resource allocation adjustments.
- **Management Document Control.** TrueCare stores all contract deliverable documentation, narrative plans, and communication artifacts within SharePoint for strict version and access control, revision history, and facilitated approval workflow. This includes specific Mississippi work products as well as reusable proprietary tools such as our Implementation Playbook, Root Cause Analysis Template, and Communication Plan.
- **ServiceNow.** We use ServiceNow's Project Management Information System (PMIS) for our IMO work plans, risk tracking, and monitoring processes. This software facilitates dynamic tracking of dependencies, tasks, and resources with a Gantt chart and dashboard features for easy monitoring.
- **Business and System Requirements Documentation.** We create and implement a full set of Mississippi-specific business and system requirements documentation in alignment with industry best practices.
- **Deliverable Acceptance Criteria/Quality.** Prior to deliverable creation, TrueCare confirms the format, general content, and quality acceptance criteria to support an easy, and low stress Division approval process.
- **Readiness Review.** Our IMO prepares and practices all readiness review desktop exercises and on-site walkthroughs in advance of the formal Division review for a simple and clean review process.
- **Internal Meetings and Monitoring.** TrueCare conducts regular internal program management status meetings including steering committee oversight meetings and cross functional meetings to facilitate collaboration and accountability.
- **Management Reporting.** We complete management and project status reporting to offer transparency throughout the contract and facilitate collaborative risk management and problem solving.
- **Data Analytics.** TrueCare provides access to robust, on-demand project activity and member activity analysis through Power BI business intelligence tools. This monitoring provides early identification of risks and problems for mitigation.
- **Communication Plan.** Our plan names all stakeholders and guides the meetings, reports, and critical points of contact.
- **Stakeholder Tracking**. We maintain a project specific stakeholder register and periodically review it with the project team to ensure completeness. This stakeholder register ensures that all users, process owners, business stakeholders, and IT stakeholders are engaged and included in the design of processes and solutions that impact their span of control.
- **Organizational Change Management.** We practice integrated program and organizational change processes for implementing change across TrueCare, synchronizing changes due to new initiatives or problem resolution, and preparing leaders for handling changes within their teams.

We also provide the following contract governance controls:

- **Compliance Department.** TrueCare brings a complete compliance team for oversight of all contract activities and achievement of performance standards, including a full-time Mississippi-based TrueCare Chief Compliance Officer supported to fully dedicated fiduciary CareSource Mississippi Director of Compliance.

- **Contract Change Management.** All changes to contract scope must follow our mutually approved Change Management Plan and contract amendment process.
- **Data Security Controls.** Our HIPAA-compliant data management practices align with the National Institute of Standards and Technology (NIST) Cybersecurity Framework (CSF) NIST 800-53 R4 and all related CFR 45 provisions and security provisions listed in the RFQ.
- **Subcontractor Monitoring.** We confirm our subcontracts include all flow-down requirements. Our monitoring activities include the review of ownership and financial records, analysis of key performance indicators, and performing periodic scheduled and surprise audits. We conduct a comprehensive annual audit for all delegated subcontractors.
- **Financial Controls and Audits.** TrueCare complies with all RFQ and Appendix A, Draft Contract financial, auditing, insurance, and invoicing requirements.
- **Provider Governance**. We also provide a financial structure, which places providers with financial risk as CCO leaders. This brings **True Accountability** to providing cost effective and safe care for Mississippians.

Financial Controls and Audits

As previously described, TrueCare provides a three-member Finance Committee, CFO, and a Third-Party Audit Consultant for financial oversight. We practice accepted accounting principles (GAAP) and conduct all required independent audits under Sarbanes-Oxley. We comply with all financial RFQ requirements and State and federal regulations. We support implementation and ongoing project accountability through financial dashboards that provide visibility into budgets, planned costs, actual costs, variances, and change requests.

TrueCare is subject to the self-reporting requirements of the Model Audit Rule (MAR), which requires a "Management Report of Internal Controls over Financial Reporting" annually from non-public insurance companies, similar in concept to Section 404 of the Sarbanes-Oxley legislation. The National Association of Insurance Commissioners (NAIC), a non-profit organization that organizes U.S. state insurance commissioners established the MAR reporting requirements. TrueCare leverages the CareSource experience in this area, as CareSource has complied with the MAR reporting requirements since 2010 and has since continually grown and matured its internal controls in the areas of Finance, Operations, and Information Technology.

TrueCare is a Financially Strong Nonprofit

At TrueCare, we take seriously our responsibility to act as a fiduciary agent of the state, and we recognize that we have a fiscal responsibility to state taxpayers. Without shareholders to satisfy, we can optimize the use of the state’s funds and ensure value.

TrueCare Office of Organizational Change Management

Medicaid programs are a continuously developing landscape, and Mississippi’s commitment to innovation accelerates this rate of change. TrueCare is prepared to evolve as an organization to meet the changing demands of the State through the next managed care contract period. To support our approach to program control, we provide a well-developed organizational change management approach to guide the TrueCare staff and culture through any necessary change including significant program growth. Figure 4.3.4.1_E illustrates our four pillars of organization change support and the tools we use to maintain a stable and supportive program in Mississippi.

Figure 4.3.4.1_E: Pillars of the TrueCare Organizational Change Management Approach

Organizational Landscape	Leadership and Stakeholder Commitment	Learning	Communication
• Assesses the current organizational environment • Develops the appropriate Change Management approach • Builds the infrastructure for sustainable change	• Coaches leadership to actively lead the transition • Arms leaders with the resources that they need to guide their teams through individual and organizational transitions	• Educates the organization on new processes & technologies • Develops the knowledge, skills, and behaviors	• Delivers the right message to the right person at the right time • Aligns organizational and project strategies • Provides a compelling message to lead the organization through the change
Tools for Managing Change			
Change Effort Assessment: Defines the complexity of the change and how much effort will be required to manage the people aspect of the change. **OCM Work Plan:** List of the change management activities, assigned responsibilities, due dates, status, and other critical information to ensure the OCM work is done on time and is aligned with the project plan. **Change Readiness Audit:** Survey template that evaluates the level of organizational readiness for change.	**Leadership Alignment:** Determine the degree of leadership agreement about the change related to the vision, priority, and gaps. **End-User Stakeholder Analysis:** Defines end-user groups critical to a successful change and assesses the impact of change on each group. **Commitment Assessment:** Self-assessment that allows stakeholders to plot their level of commitment & develop a stronger commitment.	**Training Plan:** Plans that outline what training is needed, by which end-user group, and how that training will be provided; should be completed in the design/ transition work phase as training needs become clear. **Work Transition Plan:** Detailed actions to address changes in roles, responsibilities, and organization structure.	**Communication Plan:** List of audiences, messages, and specific communications vehicles to build individual and organizational commitment to change. Defines key communications events, target audiences, methods of delivery, timing, and responsible parties.

MS_MSCAN22_4.3.4.1_PillarsofTC_2

3. Manpower and time estimating methods;

Mississippi requires partners who offer accountable, cost-effective support designed to provide the optimum benefit to MSCAN and CHIP members and the community with every position hired. TrueCare provides the right staffing balance to confirm MSCAN and CHIP members receive the best quality service possible. This is not a single deliverable, but a continuous process of adjustment throughout the life of the contract. TrueCare works closely with the Division and our subcontractors to define specific, documented staffing ratios for each function or role and trigger points for onboarding additional resources. We look forward to providing stable, secure jobs for skilled Mississippians.

Implementation Workforce Management

During the Implementation Phase, we tie our implementation project work plan to the resource management and capacity function within our advanced workflow system, ServiceNow. This allows the TrueCare implementation team to continuously track resource availability, allocations, and utilization. Within ServiceNow, team members can request resources, update plans, and even perform what-if analysis to mitigate the risk of resource scarcity.

We use this functionality to continuously monitor resource utilization during the implementation period and make all necessary adjustments for schedule adherence.

Ongoing Workforce Management

During ongoing operations, we will use a combination of expert forecasting bolstered by the predictive power invested in our Neptune Intelligence Computer Engineering (NICE) workforce management system to plan for standard attrition, program changes, and seasonal fluxes in front line staffing needs. NICE is the Gartner Magic Quadrant leader for workforce management and includes built-in forecasting and optimization features. We use historical volume data provided by the Division if available, or data from our similar operations in other states, to complete initial forecasting. Once Mississippi operations begin, we can quickly and dynamically anticipate and react to staffing needs on a day-to-day

basis through data-driven workforce management. We use our fully integrated, transparent service delivery model with the majority of its providers being in a real-time bidirectional data exchange to bring a new era of provider collaboration to Mississippi.

NICE inContact CX Excellence award

In 2018, the CareSource workforce management team received the NICE inContact CX Excellence award for driving measurable improvements in Key Performance Indicators across multiple business areas, including operational efficiency, customer satisfaction, and service transformation. This proves our ability to expertly use the NICE tools to predict manpower needs and provide a ready, complete workforce in line with changing program requirements.

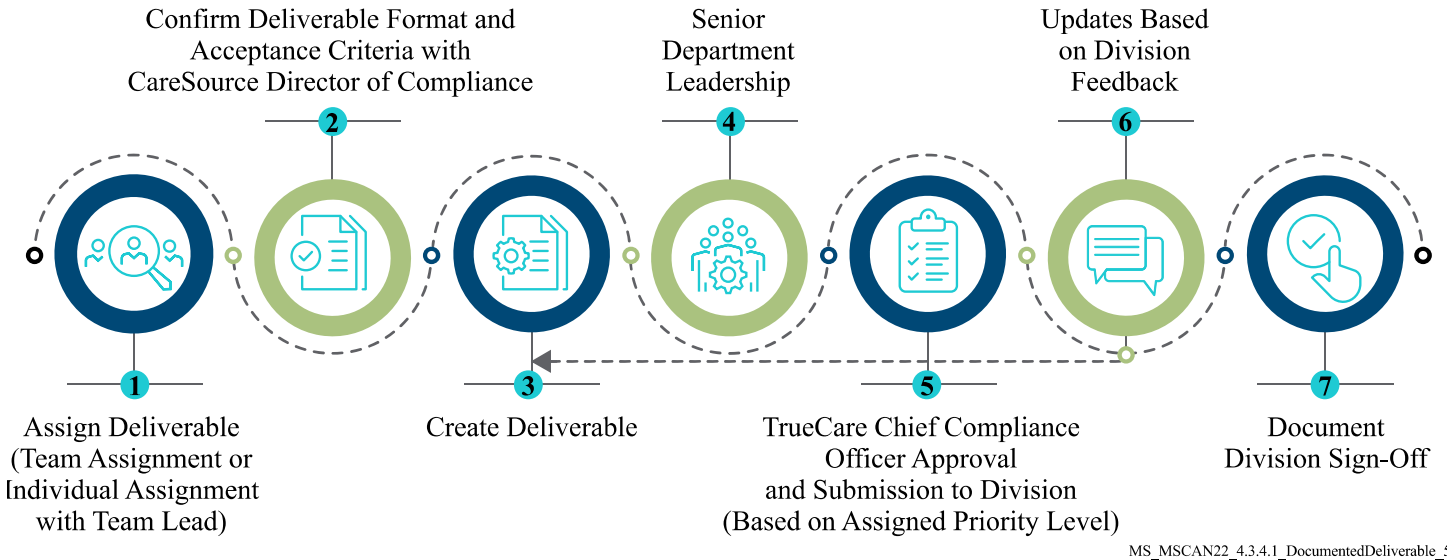
Our forecasting and workforce management teams work closely with our human resources and talent acquisition staff to control the rate of recruitment and onboarding for the optimal staffing ratios proven to provide a superior member experience and meet all contract performance standards.

4. Sign-off procedures for completion of all deliverables and major activities (Note: The level of final sign-off on deliverables at the Division level will depend on the specific Deliverable).

TrueCare follows a standard, documented, step-by-step approach to deliverable sign-off. Prior to creating any contractually required deliverable, TrueCare works with the Division Contract Officer to confirm assumptions, acceptance criteria, and preferred format. This saves both Division and TrueCare resource time allowing us to provide the deliverable as expected during the first submission. Before any required or TrueCare proposed deliverable reaches the Division, TrueCare thoroughly reviews each element to confirm compliance, completeness, and accuracy. Figure 4.3.4.1_F represents the deliverable process from the requirement initiation to sign-off by the Division. We work with the Division to assign priority levels and respective Division approvers for all deliverables. Our TrueCare Chief Compliance Officer (CCO) submits each deliverable to the appropriate reviewer or the assigned Division administrator responsible for routing the review request.

Figure 4.3.4.1_F: Complete Contract Deliverable Process and Sign-Off

Our deliverable creation, compliance, and sign-off processes confirm the Division receives high-quality, ready to sign-off deliverables which meet all contract requirements.



MS_MSCAN22_4.3.4.1_DocumentedDeliverable_

TrueCare obtains and documents the Division's written approval for all Deliverables 60 calendar days prior to the operational date and based on the Division's required timelines throughout the term. We document the Division sign-off within our compliance records, and within the document itself as part of the complete revision and approval history. For any changes, we repeat this process, document the change specifically by line number or paragraph, and document the

new approver and date. The Division must actively approve all deliverables; this approval will not be recorded by default or failure to respond.

Internally, we follow the same process to document approval from Senior Department Leadership followed by TrueCare CCO approval prior to submission to the Division. Senior leadership may include additional committees, such as the Quality Committee or Implementation Steering Committee, depending on the subject area. In every instance, our TrueCare CCO confirms the deliverable meets all acceptance criteria prior to submission. This confirmation ensures the Division only receives deliverables ready for sign-off.

5. Management of performance standards, milestones, and/or deliverables;

TrueCare brings established processes, experienced people, and proven tools to the management of performance standards, achievement of schedule milestones, and submission of quality deliverables. Table 4.3.4.1_B demonstrates our high-level approach to managing a sample of the performance standard categories as provided in Appendix A, Draft Contract, Exhibit G. Liquidated Damages. Our comprehensive project management tools and operational structure designed to monitor milestones and track and approve deliverables supports our performance management activities. This list is not inclusive of all performance management activities or standards but represents a sample of our approach across select categories.

Table 4.3.4.1_B: TrueCare Approach to Performance Standard Success

Contract Performance Standard Category	TrueCare Approach to Success
1. General Requirements: Access to Records, Accuracy, Subcontractor Management	The Legal and Compliance Department actively confirms adherence to all contract requirements, maintains subcontracts, and reviews every deliverable and public-facing statement. Our Compliance Department works to prevent, detection and correct issues found within internal Departments to ensure regulatory adherence and confirm Division access to record.
2. Readiness Review: Go-Live Date and Named Deliverables	The IMO manages all readiness review requirements including those listed in Category 2 of the performance standards listed in Appendix A. The IMO: ▪ Lists all deliverables, including 90-Day required plans and the Provider Directory, within the ServiceNow Project Work Plan for continuous updates ▪ Provides Weekly Progress Reports and Status Meetings ▪ Conducts Formal Readiness Review Walk Throughs and Sign-Off Prior to Go-Live
3. Performance Standards: Service Authorizations	TrueCare tracks all metrics associated with service authorizations and emergency transportation, including volume and turnaround timeliness for oversight by our Utilization and Care Management Committee and Quality Committee. We also complete quality reviews, monthly audits on a randomly selected sample of these processes and score the audits using the NCQA File Review Workbooks. We provide immediate feedback to supervisors and contributors for performance management coaching and education.
3. Performance Standards (continued): Provider Incentives	We provide complete compliance and legal review of all provider contracts to confirm compliance to contract standards including standards for provider incentives. TrueCare practices True Accountability, ensuring providers share in the risk associated with member outcomes. We provide a fully integrated, transparent service delivery model with the majority of its providers through real-time bidirectional data exchanges to bring a new era of provider collaboration to Mississippi.
3. Performance Standards (continued): External Quality Review	TrueCare facilitates and cooperates with all External Quality Review requirements while incorporating the review findings into our annual Quality Management Improvement Plan (Also referred to as the Annual Quality Plan in Appendix A) for complete accountability.
4. Administrative Matters: Key Personnel	The Talent Acquisition Team manages all prior approval requests (documenting approval 15 days prior to the employee start date) for the Division regarding Key Personnel while offering a full recruiting program focusing on local Mississippi talent and internal talent development to maintain a continuous back-fill for key roles and robust candidate pipeline.

Contract Performance Standard Category	TrueCare Approach to Success
5. Enrollment: Verification	TrueCare has robust systems and processes in place to receive, process and make available eligibility information to network and out of network providers via call centers, provider portal as well as electronic data interchange protocols.
5. Enrollment (continued): Nondiscrimination	TrueCare emphasizes nondiscrimination from the very first day starting with onboarding and extensive non-discrimination training program and required annual certification. TrueCare has processes in place to ensure complete quality oversight through sampling, internal auditing, and review of call recordings.
6. Covered Services and Benefits and Member Services	We have developed operational quality control processes for each covered services and benefits and member services performance standard. We then verify adherence to these standards through our compliance auditing and monitoring processes and Chief Compliance Officer oversight.
7. Marketing and Member Materials	The TrueCare compliance and legal team reviews all marketing and member materials, policies, and practices for compliance with legal, privacy, and contract standards prior to submission for Division approval. We enforce adherence to approved policies and procedures through multiple levels of operational oversight and comprehensive training and compliance auditing and monitoring.
8/10. Member/Provider Grievances and Appeals: Timeliness and Hearing Attendance	We carefully track all grievances and appeals activities with operational reporting dashboards, monitoring for compliance insights establishing effective oversight. We then verify adherence to these standards through our compliance auditing processes and Chief Compliance Officer oversight. Our system tracks the user involved with all grievance and appeals activity. We use this record to verify that the correct representative attends each fair hearing.
9. Provider Services and Network	TrueCare applies a strict provider screening and contract process using only pre-approved contract language for all agreements and requiring multiple levels of legal and compliance approval. We follow Division-approved procedures and conduct auditing as appropriate to verify compliance.
11. Call Center: Operational Times and Performance	TrueCare uses the Cisco Unified Contact Center Enterprise system combined with NICE IEX workforce management tools to track, actively manage, and confirm performance to call center standards for both the member and provider call centers. This includes the availability of personnel roles and skillsets, such as nursing professionals, and confirmation of operational hours for all lines.
12. Performance Measures: EPSDT and CHIP Well Child Measures	TrueCare promotes EPSDT and immunization services through extensive, customized member outreach and educational campaigns; provider and member incentives; provider gap reports and analytics; and pharmacist outreach. We use the TrueCare EPSDT tracker to document the timing of immunizations, health examinations, lead testing, and utilization of services (including vision, dental, hearing, and all medically necessary services) to identify gaps in care. TrueCare pushes alerts across multiple systems accessed by our member-facing staff and providers to encourage the closure of any gaps in care. This tracker also provides the data necessary for reporting our performance to this standard.
13. Claims	TrueCare maintains documented, electronic policies and procedures that establish transparent guidelines for processing transactions, monitoring, and auditing provider claim submissions and claim adjudication accuracy. We implement these policies and processes using Cognizant TriZetto Facets® for full tracking and reporting of claims activity and payments.
14. Privacy and Security	Our Chief Compliance Officer works closely with our Privacy Officer, Chief Information Officer, and our privacy and information security professionals to enforce all privacy and security policies, facility requirements, training, annual policy acknowledgments, and system controls. TrueCare systems comply with all HIPAA, NIST, and State information security requirements.
15. Encounter Data	We use Edifecs Encounter Management as our integrated encounter data collection and reporting system and run all data through automated validations to confirm adherence to all Federal and Division requirements including HIPAA, SNIP, NCCI, NUBC, NUCC, and the State's encounter companion guides.
16. Program Integrity	The TrueCare Program Integrity program led by our Mississippi Chief Compliance Officer serves as the primary point of contact for the Division. The Compliance Officer uses an existing template based on the Office of Inspector General's Seven Elements of an Effective Compliance Program, and the complies with all federal and state requirements regarding fraud, waste, and abuse (FWA), to provide the FWA Compliance Plan ahead of the required schedule. We offer a complete Conflict of Interest program with Division notifications built into the framework from day one of the contract.

Contract Performance Standard Category	TrueCare Approach to Success
17. Third Party Litigation	We follow the approved contract deliverables process for the required TPL templates and forms, document all approvals, and incorporate the approved templates into our automated notification system with rigorous testing and quality control. We process the State's TPL file automatically each day and monitor all follow-up actions.
18. Remedies: Corrective Action Plans and Termination	If evoked, the corrective action and termination processes for Mississippi is managed by our Chief Compliance Officer with full, daily oversight by the TrueCare executive management team for every step in the process.

Tracking and Achieving Milestones

The TrueCare Work Plan includes implementation schedule milestones and ongoing operational milestones including annual deliverable dates and process improvement plan dates.

We actively manage the schedule through:

- Weekly status meetings for the implementation and all ongoing initiatives regarding the schedule, scope, and budget
- Rapid notification to the Division of any schedule risks due to dependencies, predecessor delays, or unexpected issues
- Monthly or bi-weekly internal management meetings to report on all program updates and status
- Weekly implementation or periodic project progress report submission to the Division and meetings with the Division per an agreed upon schedule based on Division availability
- Bi-weekly Risks, Issues, Decisions, Action Items, and Changes (RIDAC) meetings for team members to follow up on risks, issues, dependencies, action items, and decisions
- Use of tools within ServiceNow to track all tasks and subtasks with self-service and automated reporting and activity dashboards

Using ServiceNow, we can view the project schedule as a Gantt showing all progress and clearly identifying any bottlenecks or risks as shown in Figure 4.3.4.1_G. This excerpt is from the Implementation Phase.

[redacted]

Readiness Review

The accumulation of our structured, highly regulated implementation process, as discussed in our response previously in this section, is a comprehensive readiness review process. The proven successful TrueCare internal readiness review includes an examination of all the elements necessary for a successful go-live, including confirmation of testing results, a complete inventory of deliverables, line-by-line confirmation of the RTM and Implementation Plan tasks, and a walkthrough of all facilities, processes, and system functions. If the Division, at its discretion, elects to conduct a Division-led readiness review, we conduct a mock exercise in preparation for the official Division review and provide all necessary cooperation and resources toward a successful official review. We invite the Division to attend and participate in our readiness review desktop exercises and on-site walkthroughs and participate in any Division requested exercises.

We welcome the Division for on-site visits to any TrueCare facility, including subcontractor facilities, prior to, during, and after the official go-live date. TrueCare provides transparency into all areas of in process implementation and during ongoing operations including, information technology, administrative services, Provider Network management, and medical management. The official go-live date for operations is contingent on Division approval.

Management of Deliverables

The TrueCare contract compliance team, led by the TrueCare CCO and CareSource Director of Compliance, tracks all contract deliverables and requirements throughout the contract period for contract requirement compliance and documents confirmation of delivery and approval.

As discussed previously in response to question 4.3.4.1-4, TrueCare follows a robust internal review process and tracks the creation, submission, and approval of all required deliverables along with the schedule included with the Implementation Work Plan and Operations Period Work Plan. In addition to the deliverables included in Appendix A, Draft Contract, our TrueCare IMO creates additional deliverables that facilitate further collaboration and transparency through the implementation process and then can be adapted to support ongoing operations throughout the contract. This includes our detailed kick-off presentation, documented lessons learned throughout the process, and our Organizational Change Management (OCM) Plan. By adding all the deliverables appropriate to the implementation of services in Mississippi to our continuously reviewed and coordinated Work Plans, TrueCare offers the Division true transparency and the opportunity to confirm we are meeting the State’s needs through every step in the process.

6. Internal quality control monitoring;

TrueCare is committed to quality across all levels of the organization. We practice accountability by actively monitoring and controlling all operational areas and aligning our continuous clinical quality improvement program with Mississippi’s Comprehensive Quality Strategy and the Division’s Strategic Plan. We comply with all applicable policies and procedures of the Division, such as the Mississippi Administrative Code, Title 23, as well as the Mississippi Medicaid State Plan, the Mississippi CHIP State Health Plan, and any other federal or state laws and regulations.

As described in our response to Question 2 of this Section, we use an inclusive set of tools to monitor program contract requirements, performance standards, implementation schedule adherences, reporting and deliverable quality, accuracy, and timeliness. We leverage data analysis tools and systems such as Power BI, ServiceNow, and SAS for active monitoring, analysis, and continuous quality and performance improvement across functions. For example, we confirm our online provider directories are up to date through an automated analytics process that compares our directory attributes to available Health Plan directories, claims data, and multiple publicly available source data to identify potential anomalies to evaluate and outreach for validation. For each phase and area of our operation, TrueCare enforces and documents specific, responsible owners and confirms required actions.

TrueCare provides a robust set of quality control mechanisms across departments including utilization and care management; fraud, waste, and abuse control; call center customer service quality sampling and auditing; grievance and appeals tracking and response; and systems development testing and release management. In our response to question five

of this section, we provide a chart listing specific controls used for quality monitoring and management of select performance standards for select functional areas.

TrueCare provides oversight and guidance through our Quality Management Improvement Committee (QMIC) comprised of knowledgeable executives across the organization, including our Mississippi Medical Director, Behavioral Health Director, and the Quality Management Director. The QMIC works closely with the Division to confirm our program's alignment with Division and State goals for ongoing quality improvement through our internal quality controls and monitoring.

7. Program status reporting, including examples of types of reports; and,

The Division requires detailed, easy-to-read reporting across managed care organizations to ensure the quality of care and fiscal responsibility expected from its managed care partners. TrueCare understands these needs and facilitates complete oversight through timely delivery of all required reports across functional areas. This includes our weekly implementation progress reports, ongoing management, and contract compliance reporting, financial statements and invoices, and robust operational service reporting facilitated through Microsoft Power BI and SQL Server Reporting Services. This variety of reports spans detailed management narratives, annotated schedules, risk and issue management tools, and real-time reporting for clinical and claims data. The data governance organization approves each data source, system of records, defines metadata, and governs reports for enterprise consumption and regulatory submissions.

We also provide a full suite of pre-built, self-service functions for interactive, ad-hoc reporting—allowing our analysts to create reports to satisfy Division needs as they arise. The TrueCare enterprise data warehouse (EDW) consolidates data from multiple systems and external sources to provide a concise, accurate, and complete data repository to meet all Mississippi information needs. Our business intelligence platforms access this data to build reports and dashboards for pro-active internal management and risk monitoring as well as creation of Division required reports and ad-hoc reporting requests.

Report Delivery. TrueCare delivers all the reports listed in Appendix A, Draft Contract Section 16 and the Reporting Manual, on time and with confirmed accuracy. During the implementation phase, we confirm the format of each report meets the needs of the Division, and we test any automated report generation and subscription-based report delivery functions prior to the operational start date.

Report Examples

TrueCare provides a wide variety of reports including all those reports required in Appendix A, Draft Contract, Section 16, and additional management reports designed to promote transparency with the Division. The following section provides a select set of examples of reports used for similar engagements (Figures 4.3.4.1_H, 4.3.4.1_I, and 4.3.4.1_J). During the implementation phase, we work with the Division to confirm the format of all required reports to best meet the Division's needs.

Our full suite of operations progress reports includes data from all relevant TrueCare tracking systems, provides transparency for Division oversight, and provides all necessary federal data requirements. Here we provide several examples of the types of reports we provide for Mississippi. These reports are provided for example purposes only and do not include actual market data.

Figure 4.3.4.1_H: Example Call Center Performance Standards Report

TrueCare provides easy-to-read call center reports including required metrics to show performance to contract standards. These targets (goals) are adjusted to reflect Mississippi standards.

		2020				2021			
	Target	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**
Live Answer (Average Speed of Answer)	**≤ 30 sec**	17 sec	4 sec	9 sec	19 sec	15 sec	15 sec	14 sec	19 sec
Percent of calls answered within 30 seconds	**≥ 85%**	90.15%	97.73%	93.32%	86.68%	89.33%	87.94%	89.34%	87.57%
Incomplete Calls (Abandonment Rate)	**≤ 5%**	1.53%	.30%	.77%	1.83%	1.37%	1.79%	1.28%	1.59%
Average Call Length	**N/A**	7:30	8:04	7:17	8:37	8:38	8:39	8:48	9:34

MS_MSCAN22_4.3.4.1 _CallCenterPerf_1

[redacted]

[redacted]

8. Approach to the Division’s interaction with contract management staff.

TrueCare designates our Mississippi-based Chief Compliance Officer (CCO) as the single point of contact (POC) for the implementation and for overall operations oversight. The CCO represents the TrueCare CEO Project Manager as required by the Division. The Division may always contact our CCO or CEDO to handle an issue or concern in whatever method preferred by the Division. We also provide contact information for finance, compliance, quality, and other functional areas as detailed in our Communication Plan. We support open, two-way communication for a culture of collaboration and transparency between similar roles across organizations. For example, during integration testing, our TrueCare business analysts and system engineers engage in open, collaborative communications with their Division counterparts.

Risk and Problem Communication. TrueCare integrates Division representatives into our risk management process through frequent reporting, collaborative problem solving, and joint risk identification activity. In this way, the Division is always aware of potential risks and emerging problems, and we collaboratively resolve any problems with no impact on MSCAN and CHIP members.

Responsiveness to the Division. As part of our commitment to transparency and collaborative oversight, TrueCare acknowledges all Division requests as soon as possible but always within the required one business day of receipt and dedicates sufficient resources for a response within five business days unless granted an extension. We acknowledge and respond to requests in the same manner and format which received and include a detailed completion summary with every resolution. Our process prioritizes issues impacting MSCAN and CHIP members.

[END OF RESPONSE]

4.3.4.2 PROBLEM MANAGEMENT

1. Assessment of program risks and approach to managing them;

TrueCare is committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model. The risk management process is essential to ensuring operational excellence and bringing a new era of provider collaboration to Mississippi. Risk management is an ongoing process that occurs throughout the contract lifecycle and is a key component of our superior operational performance. The TrueCare[1] risk management process is based on Project Management Body of Knowledge (PMBOK) and facilitated by a set of tools within our ServiceNow application. The risks, issues, decisions, action items, and changes (RIDAC) application within ServiceNow ties to our project plan with individual risks associated with tasks and groups of tasks as well as responsible parties. ServiceNow offers risk dashboards for immediate insight into the status of known risks, schedule adherence, and upcoming milestone deadlines.

The TrueCare implementation management organization (IMO) team has a customized risk management plan for Mississippi. The process is implemented during the initial project implementation phase and is transitioned to the ongoing Mississippi TrueCare operations management team, led by the Vice President for the Mississippi Market working with oversight from the CEO/Project Manager, for diligence throughout the contract term.

Proven Implementation Excellence

Using their proven Implementation Playbook, CareSource has successfully implemented similar programs in Ohio, Georgia, Indiana, and Arkansas with 100% readiness review success.

We have adapted this Playbook to our Mississippi TrueCare implementation to bring best practices and pre-identified and mitigated risks to our initial Risk Management Plan.

Risk Identification and Analysis. Our risk management process involves identifying the full spectrum of risks, for both implementation and ongoing management, using the best practices and lessons learned acquired from similar market implementations conducted by CareSource and TrueCare insight into the Mississippi Medicaid and CHIP environment. We use an industry standard risk log to identify risks by category, likelihood of occurrence, impact if realized, and responsible internal parties. With this information, we assign a risk severity score that represents the severity of the risk and document risk mitigation strategies appropriate to each risk. TrueCare considers the following factors when assessing a risk and assigning a severity score.

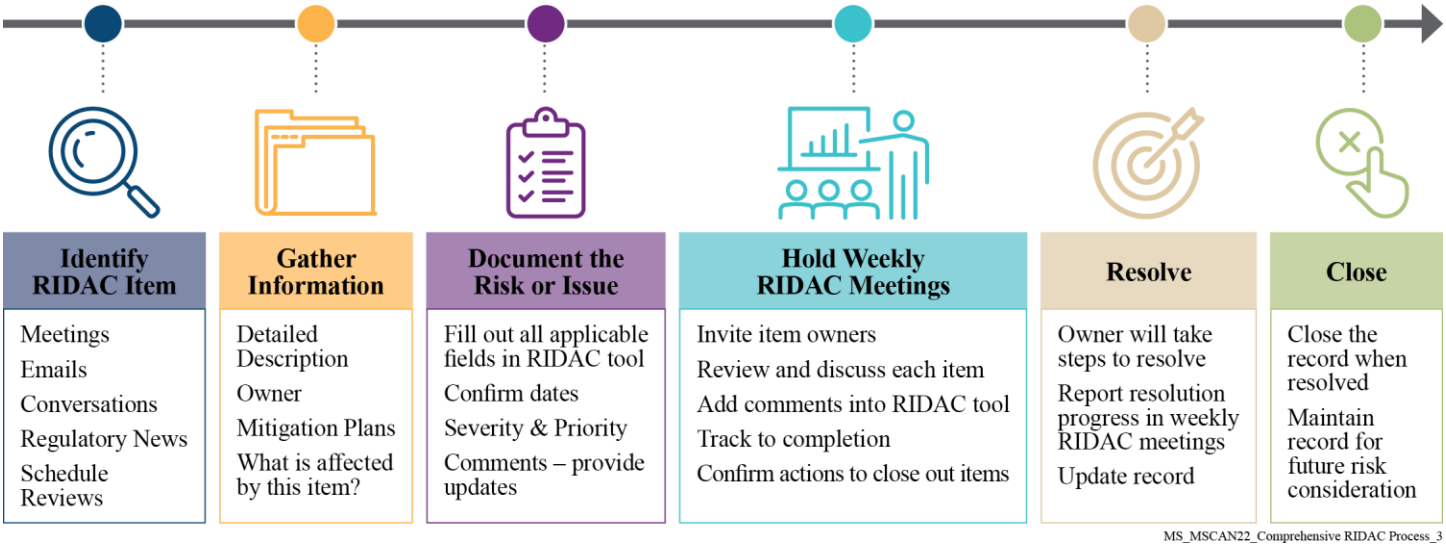
- Business Functional Areas Impact
- Internal/External Partnerships Impact
- Previous Implementation Experience
- Communication Complexity
- Complexity of Training
- Change Complexity
- Data Sensitivity or Privacy Considerations

We align each identified risk to specific strategic areas, order them based on severity score, and determine the best avoidance and mitigation approach from all perspectives. These strategic areas include operational performance activities and standards, care or utilization management, information security, data governance, or business continuity. Once we have assigned severity scores to identified risks and associated them with strategic areas, we have the basis for a customized risk management plan for the **True Excellence** in Mississippi.

[1] Through an alliance between Mississippi True and CareSource (this alliance is collectively referred to in this Qualification as "**TrueCare**"), CareSource will serve as a subcontracted managed care program administrator, and Mississippi True will act in its capacity as Mississippi's only provider-sponsored health plan with oversight of all health plan operations, thereby fulfilling its legislatively ordained mission to "encourage and facilitate collaboration between Mississippi Medicaid providers and managed care entities . . . to align incentives in support of integrated and coordinated health care delivery, and to encourage the development of appropriate population or community health strategies to better serve Medicaid beneficiaries and the state's health care delivery system as a whole." Miss. Code Ann. § 83-5-601(1). As a result, TrueCare combines industry-leading managed care operational excellence with a local, member-centric approach to healthcare.

TrueCare follows the established RIDAC process to actively manage these risks. Figure 4.3.4.2_A demonstrates a high-level view of our RIDAC process.

Figure 4.3.4.2_A: TrueCare Active RIDAC Process.
TrueCare actively identifies, tracks, and mitigates risks through a proven process refined through experience.



Risk Monitoring and Control. As demonstrated in Figure 4.3.4.2_A, we continuously monitor and document risks and issues for all areas of the operation during the entire contract term. We understand that new risks can develop at any time, and we continue to track and mitigate new risks through all phases of the contract. We monitor and track risks using dashboards like the one shown in Figure 4.3.4.2_B. We review each of these risks during our regular weekly RIDAC meetings.

[redacted]

2. Anticipated problem areas and the approach to management of these areas, including loss of key personnel and loss of other personnel; and

[redacted]

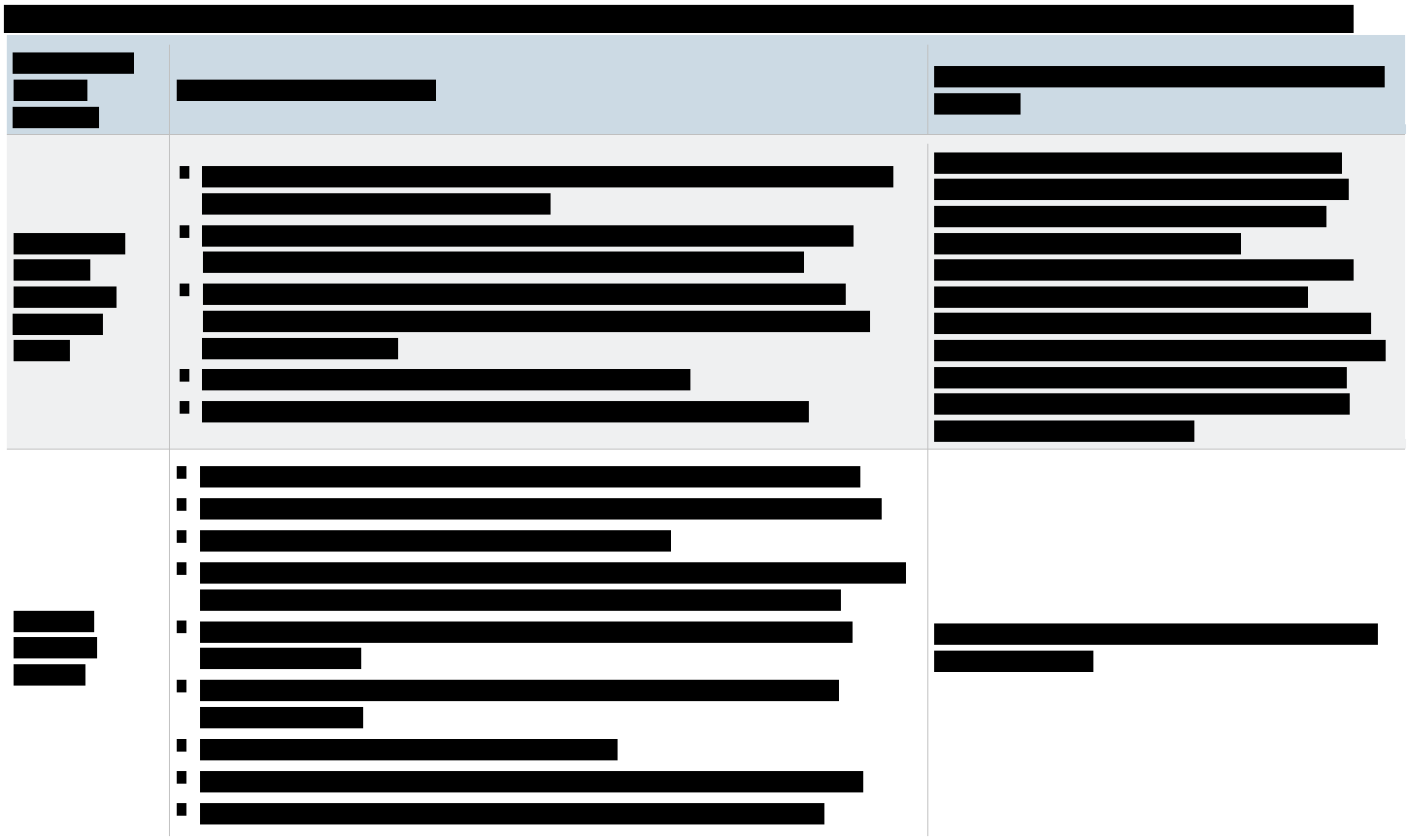
The TrueCare established risk and problem resolution process prepares our team to adapt and quickly resolve any problems. We provide:

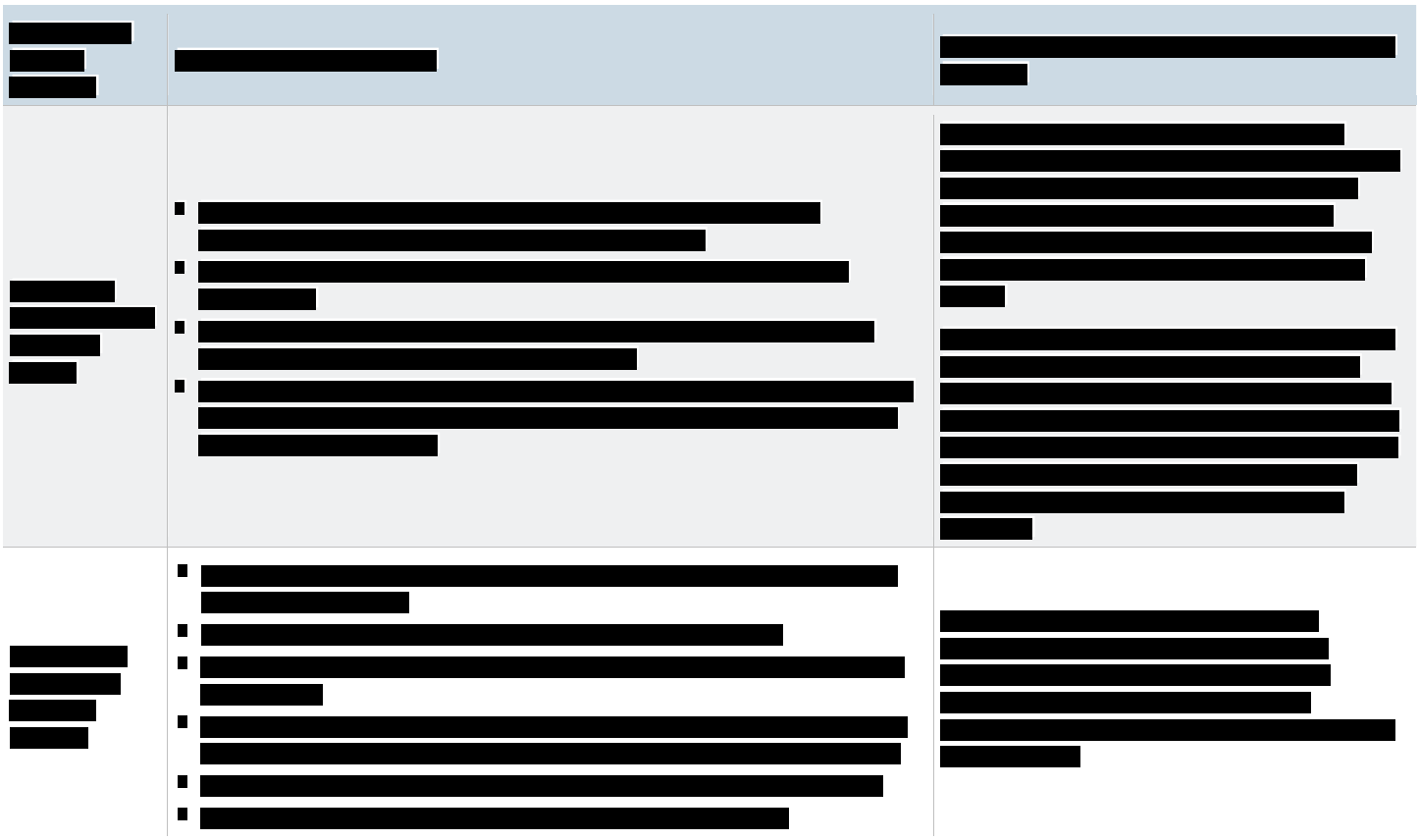
- Early identification of risks and problems.
- Quick and efficient escalation of problems and mitigation of risks.
- Easy-to-review data of all risks and problems impacting the operation at any point in time.
- Root cause analysis and support for assigned problem teams.
- Transparency and alignment across all stakeholders on the risk and problem resolution activities.

Experience Avoids Common Implementation Risks and Issues. TrueCare brings the significant CareSource implementation experience to anticipating and preventing common risks. We know that certain aspects of CCO implementations (benefits, pricing, and contract requirements) are key areas to begin planning for and mitigating risks early. This approach allows us to create a longer runway for the implementation of critical components that may require more resources or longer durations. Table 4.3.4.2_A highlights a few of the common implementation risks that TrueCare plans to mitigate and/or avoid during the Mississippi implementation.

[redacted]

During the operational period, we practice nonstop diligence when it comes to mitigating risks or containing problems under resolution. Table 4.3.4.2_B lists a few select examples of risks and problems common to Medicaid and CHIP operations which TrueCare is prepared to avoid or quickly resolve if avoidance is not possible. Our proven success avoiding and resolving problems offers the Division a worry-free partnership as we continuously improve services to MSCAN and CHIP members. Additionally, our fully integrated, transparent service delivery model enables communication and collaboration with providers through real-time bidirectional data exchanges. Our innovative service delivery model is a key factor in TrueCare's ability to anticipate, avoid, mitigate, and resolve operational problems such as those listed in Table 4.3.4.2_B.





Handling the Loss of Key Personnel

TrueCare is prepared for any sudden loss of key personnel including the executive and administrative roles listed in Appendix A, Draft Contract, and other management roles prioritized internally such as heads of each of our operational areas. We identify and document back-up individuals for all key roles from day one of operations in Mississippi. We continuously refine our succession planning through an established talent review process. The talent review process allows us to gain insights into the representation of diverse talents across the organization used to drive talent planning and development actions that support a culture of inclusion. We use a data-driven succession planning process for proactive collaboration between HR and business leaders and use predictive capabilities to plan for talent acquisition needs, turnover loss expectations, and industry-aligned opportunities for advancement. We use Workday, our Human Resources Information System, to share and analyze key talent data points to confirm business continuity from a workforce planning and talent mobility standpoint. In this way, we mitigate the risk of talent loss.

For the Division, we document a clear assessment of “ready now” and “ready future” talent pools for leadership and succession planning. If a key position does not have an identified “ready now” successor, we appoint an interim resource from our existing talent pool of resources in development. During the interim period, we continue to access the talent and skills across the pool of internal candidates and consider additional talent acquisition before making a permanent decision. TrueCare does not allow any key personnel position to remain vacant for greater than 90 calendar days – our average days to fill is 40 days. In most scenarios, these positions are filled sooner through identified back-up personnel, after waiting the required 15 or more business days for Division approval.

Loss of Other Personnel

The TrueCare Team comes equipped with multiple strategies for both preventing and handling the sudden or sustained loss of front-line personnel. For a sudden loss due to an emergency, we initiate our established business continuity procedures. We temporarily augment our front-line personnel, such as call center staff, by trained, ready-to-perform staff members from similar markets. TrueCare maintains a baseline Mississippi policy training used to prepare back-up personnel in emergency scenarios. These temporary back-up personnel serve to minimize any impact on Mississippi members during periods of emergency.

Lack of access to Mississippi facilities due to a hurricane or mandatory pandemic shutdown is not a significant risk for loss of personnel. We mitigate facility access restrictions or pandemic concerns with proven work-from-home capabilities. During the COVID-19 pandemic, we moved 99% of workers in select markets to at home service.

When using work-from-home alternative operations, TrueCare continues to recruit locally for all positions and require work within Mississippi for those positions which require it. While work-from-home is a solution for emergency access when facilities are unavailable and when pandemic concerns for social distancing make in-facility work challenging, this solution is also preferred by some staff members as a method to reduce attrition due to pandemic fears.

CareSource Rapid Recruitment

When CareSource workforce management analysis determined the need to add to our organization-wide utilization management team, we set a goal to hire 100 new staff members for our Utilization Management area within 60 days. After only 30 days, we had successfully identified 130 candidates after interviews to proceed.

Rapid Recruiting for Unforeseen Staffing Loss or Needs. Although TrueCare continuously recruits toward forecasted staffing needs, if an unforeseen circumstance results in a loss of personnel or sudden recruiting difficulty, we leverage our relationships with staff augmentation partners for temporary short-term staffing and initiate our proven rapid recruiting plan. During rapid recruiting, we pull all available talent acquisition professionals and Human Resources Business Partners together to prioritize Mississippi recruiting, interviewing, and onboarding. Our rapid recruiting, like ongoing recruiting efforts, focuses on local community and school relationships rather than staffing agencies. We leverage our existing relationships through our current Mississippi community presence and our initial implementation staffing efforts to continuously add to our local employee pipeline.

We have proven the efficiency of these strategies when faced with a sudden increase in membership due to an auto-assignment event triggered when an MCO exited the market unexpectedly and we were assigned a portion of this membership. We successfully handled the increased member need. Due to the relationships and pipeline built within the local community in this circumstance, CareSource was able to open and extend offers within two weeks.

3. Approach to problem identification and resolution.

As stated previously, TrueCare follows established risk management and problem resolution processes for both anticipated (documented on our risk log) and unforeseen problems. We comprehensively monitor all identified risks in our risk logs through regular status reporting and risk management meetings. In addition, we continuously review performance data dashboards, quality assurance data, and stakeholder feedback to identify new risks or problems.

When a risk becomes an issue or problem, our approach actively changes from avoidance to mitigation and resolution. For anticipated problems that we were unable to avoid, we will follow the pre-documented mitigation strategy and proceed directly to the problem resolution process, which is step two in the following list. For unforeseen problems, TrueCare performs the following three primary steps for resolution.

1. **Root Cause Analysis.** TrueCare conducts root cause analysis (RCA) using an established template employing various methods, such as the five why's approach, to determine and drive resolution. Our RCA template details the approach taken to identify and document the root cause of a particular problem. The RCA template also includes the follow-up actions necessary to properly address the root cause.
2. **Resolution.** Once the RCA is complete, we prepare a resolution plan for approval. If the resolution requires changes to current operations or processes, the OCM team follows the documented change management process. This includes creating a detailed impact assessment of the suggested change and coordinating sign-off from multiple internal areas to confirm synchronized changes across operations. If the problem requires a contract change, we follow the Division approved contract change management procedure before taking any action.
3. **Transparency and Lessons Learned**. Our commitment to Mississippi extends beyond the delivery of contract obligations and performance standards. As we resolve problems collaboratively, we also share our lessons learned to offer Mississippi insight for use in developing future Division best practices.

We provide specific examples of our problem resolution success in Table 4.3.4.2_A and Table 4.3.4.2_B of the previous subsection.

Summary
MSCAN and CHIP members benefit from a managed care relationship that offers seamless services and equitable access to high quality care. TrueCare puts in place powerful processes and documents responsible parties to proactively avoid and mitigate contract and program management level risks and quickly resolve any problems with zero impact to MSCAN and CHIP members.

[END OF RESPONSE]

4.3.4.3 BACKUP PERSONNEL PLAN

If additional staff is required to perform the functions of the Contract, the Offeror should outline specifically its plans and resources for adapting to these situations. The Offeror should also address plans to ensure the longevity of staff to allow for effective Division support.

TrueCare is committed to changing the trajectory of Mississippi's healthcare system via a fully integrated, transparent service delivery model with the majority of providers through real-time bidirectional data exchanges, next generation member engagement and education, community-based coordinated care, and operational excellence which brings a new era of provider collaboration to Mississippi. Our mission is to ensure Mississippians can easily access their benefits to live healthier lives, while prudently managing the state resources. By maintaining a strong pipeline of candidates and an extremely active talent development operation, TrueCare[1] can quickly transfer responsibilities or hire the necessary staff to perform key functions of the contract. Our TrueCare Talent Acquisition Team will offer a Staffing Plan rooted in best practices and specific Medicaid managed care implementation and operations experience. The plan includes a succession planning process designed to support business continuity as well as employee longevity. TrueCare will demonstrate **True Excellence** and continue the CareSource proven staffing and retention practices. In times where additional staffing is rapidly needed, we have many layers of talent to pull from to ensure that the Division can rely on us to always have sufficient personnel for all contract scope functions, and for meeting MSCAN and CHIP member needs by:

- Starting with accurate needs forecasting based on historical and comparative data
- Building a strong Mississippi talent network
- Providing pro-active workforce management to optimize use of existing personnel
- Fostering staffing resilience by retaining our top talent and diverse pool of member-facing support personnel
- Developing internal talent with role-based succession planning
- Planning for and responding to emergency staffing needs

We address each of these staffing strategy elements in order.

TrueCare Rapid Recruitment

When workforce management analysis determined the need to add to our organization-wide utilization management team, we set a goal to hire 100 new staff members for our Utilization Management area within 60 days.

After only 30 days, we had successfully received more than 600 resumes, conducted 160 interviews, and identified 130 candidates to proceed to hire.

Accurate Forecasting

We will leverage TrueCare expert forecasting specialists and experience, reinforced by the predictive analytics built into our NICE[2] workforce management system, and historical volume data provided by the Division to provide the baseline staffing forecasts for all contract functional areas.

Building a Strong Talent Network

Throughout the contract term, TrueCare will continuously reforecast and recruit toward staffing needs with a focus on leveraging local diverse Mississippi community resources and partnerships. We aim to hire Mississippi-based and Mississippi knowledgeable personnel across all functions and levels of authority. Using the experienced recruiting team rather than relying solely on staffing vendors, we will build a grassroots

[1] Through an alliance between Mississippi True and CareSource (this alliance is collectively referred to in this Qualification as "**TrueCare**"), CareSource will serve as a subcontracted managed care program administrator, and Mississippi True will act in its capacity as Mississippi's only provider-sponsored health plan with oversight of all health plan operations, thereby fulfilling its legislatively ordained mission to "encourage and facilitate collaboration between Mississippi Medicaid providers and managed care entities . . . to align incentives in support of integrated and coordinated health care delivery, and to encourage the development of appropriate population or community health strategies to better serve Medicaid beneficiaries and the state's health care delivery system as a whole." Miss. Code Ann. § 83-5-601(1). As a result, TrueCare combines industry-leading managed care operational excellence with a local, member-centric approach to healthcare.

[2] NICE is the Gartner Magic Quadrant leader for workforce management and includes built-in forecasting and optimization features.

network of community relationships with local schools, community-based organizations, job fair providers, and state-sponsored employee assistance programs. Building upon our Mississippi roots, we aim to keep Mississippi talent in Mississippi for Mississippi.

For Mississippi, we have already begun recruiting interns from Mississippi State University and Mississippi Valley State for our summer internship program. We also plan to partner with Jackson State University's School of Public Health to create internship opportunities and career pathways. We recruit from underrepresented communities, including people of color, women, and people with military backgrounds. TrueCare's localized approach to recruiting presents a **True Commitment.**

We conduct informal information sessions to engage community members interested in learning more about the culture and opportunities available with TrueCare. We always recruit with the future in mind, making significant investments in our staff members to enable them to grow and develop, and ensuring their long-term success. We encourage employee referrals as a recruiting strategy and offer referral bonuses when candidates are successfully hired.

During implementation and continuing through the contract term, we will maintain a pipeline of qualified candidates beyond our immediate needs—ready for further vetting and hiring as the need arises.

If an unforeseen circumstance results in either an undercalculation of staffing needs or sudden loss of personnel, we will leverage our relationships with trusted, key staff augmentation partners for temporary short-term staffing and initiate our proven rapid recruiting plan. During rapid recruiting, we will pull all available national corporate talent acquisition professionals together to prioritize Mississippi recruiting, interviewing, and onboarding. Our rapid recruiting response, like ongoing recruiting efforts, focuses on local community relationships rather than staffing agencies. We leverage our existing relationships through our current Mississippi community presence and our initial implementation staffing efforts to continuously add to our local employee pipeline.

We have proven these strategies when faced with a sudden increase of membership due to an auto-assignment event, and when an MCO exited the market unexpectedly which resulted in the assignment of a portion of the membership to us. In both circumstances, we successfully handled the increased member need to ensure members could easily access their benefits to live healthier lives.

Proactive Workforce Management and Ongoing Forecasting

TrueCare will not only be ready to hire more personnel if the need arises, but we will also optimize the productivity of our onboarded team. We can quickly and dynamically anticipate and react to staffing needs on a day-to-day basis through data-driven workforce management practices, including re-balancing staffing across departments and functions, cross-training personnel, and shift-based adjustments to meet fluctuating demand such as in the dynamic call center environment. The workforce management team will also plan for standard attrition, program changes, and seasonal fluxes in front line staffing needs.

Retaining our Top Talent

TrueCare will provide employees with training and development, career paths for advancement opportunities, and a culture of inclusion and excellence necessary for sustained employment. CareSource’s has a 90% employee-reported satisfaction rate and was named a top place to work in 2020 by IndyStar for employee support and engagement, as demonstrated by this recent quote from our employee engagement survey.

"The culture of CareSource is remarkable. I feel well supported by my colleagues and my superiors. My supervisors allow me the autonomy and authority necessary to be effective in my role."

– Employee Survey Response

TrueCare will adapt the following employee retention methods for Mississippi:

Competitive Wage. TrueCare provides fair and equitable compensation for all positions. In Mississippi, we will provide a minimum rate substantially above the State's minimum wage for all front-line staff positions.

Supporting Professional Development. We invest in our staff through advanced, personalized learning and talent development programs. Our holistic approach to staff learning and development combines both enterprise- and business-function training teams. This all-inclusive approach provides business, leadership, and interpersonal skill development programs as well as job-specific skills training. Our employee learning and development begins upon hire through our new employee assimilation program. This program provides both live virtual and self-paced activities for employees to learn the culture, values, and business of TrueCare. We design the new employee learning activities to cascade into business function job skills training. We provide ongoing enterprise-level learning through business acumen; interpersonal skills; competency-aligned diversity, equity, and inclusion (DEI); and compliance courses (live, virtual, or self-paced). We further support our clinical staff by offering access to free online continuing education for nurse, social worker, and case manager licensure.

Volunteer Time. TrueCare offers up to 12 hours of paid time off each year for employees to dedicate to a nonprofit cause. This benefit reinforces our culture of giving and our **True Commitment** to Mississippi.

Leadership Coaching. Within our Talent Development Team, we provide six months of one-to-one coaching, conducted by an International Coaching Federation (ICF) master certified coach, to new senior leaders transitioning to their respective roles and their teams. New operational managers will receive coaching and assimilation support through the cohort-based new leader experience program. Both programs use a strength-based approach to leadership and team engagement. The Talent Development Team facilitates new leader assimilations for all new leaders. This experience provides both the leader and the team an opportunity to build and foster relationships, and an open forum for the team to share any questions and concerns with their new leader. We also use this coaching method as part of our talent development process to identify leaders for placement within our succession planning process—identifying backup personnel for key personnel positions and similar important roles in Mississippi.

Team Engagement. We support leaders by offering team engagement activities that foster improved communication, collaboration, team-based assessments, and strategic alignment. The Talent Development Team partners with human resources and leaders to develop their teams as a unit, which supports quality work outcomes, impacts employee motivation and retention, and contributes to positive team outcomes.

Engagement Survey and Follow-Up Actions. We not only administer employee engagement surveys, known as Lifecycle Pulse surveys, to inform our talent development activities; we also use these surveys to identify department-specific trends and opportunities. Following the survey, we require every leader to address the concerns of their department or to share and expand on programs with positive feedback.

Stay Interviews. We leverage the stay interview process where managers speak one-to-one, openly with employees at risk of disconnecting, to foster open communication and trust. Through these meetings, we gain insight into how to retain employees while they are still employed.

Staff Mentoring. The Talent Development team offers comprehensive group and individual mentoring programs, where seasoned leaders facilitate mentoring sessions to support employee growth and development. Mentoring is also a key component of our various leadership programs. We support employees in building long-term mentor relationships. We also provide peer-to-peer mentoring programs when appropriate.

Leadership Development. We offer programs for employees identified through the talent review and succession planning process and develop individual competencies necessary for job expansion and leadership responsibilities. This provides an advancement path, as well as a competent, ready pool of employees to fill key leadership positions.

Cross Training. We cross train member and provider representatives so they can fill voids as they arise. Cross training also benefits the employees by allowing them to learn and practice skills across multiple functional areas, access a greater range of promotion opportunities, and stay engaged and challenged each day.

Employee Resource Groups (ERG). We provide a specialized lens for employees to better connect with co-workers and the local community through voluntary and employee-led ERGs. ERG participants benefit from the monthly educational sessions, increased peer-to-peer engagement, and expanded relationships across the business. Examples of our ERGs include the Asian Pacific Islander Community and the Black Employee Network.

Heart2Heart Recognition Program. Integral to our culture is the way we encourage and recognize employees who go above and beyond to help one another and the organization. We understand employees can be motivated by financial rewards, recognition, or the intrinsic value of working in a member services organization. The Heart2Heart points-based program enables leaders and peers to recognize those who demonstrate our mission and who make a difference. Leaders award points, which can be redeemed at an online store for a variety of merchandise. This program recognizes and rewards employee performance based on the following principles:

- We value our employees.
- We live the mission.
- We drive innovation through learning and continuous improvement.
- We demonstrate accountability to deliver results.
- We collaborate to support a matrix environment.

Succession Planning for Management Personnel Backup

We are prepared for any sudden loss of key personnel. We identify and document back-up individuals for all key roles beginning on day one of operations. We continuously refine our succession planning through an established talent review process focused on people, capabilities, and roles. Our data-driven succession planning process uses predictive capabilities to plan for talent acquisition needs, turnover loss expectations, and industry-aligned opportunities for advancement. We use the Workday Human Resource Information System to share and analyze key talent data points to confirm business continuity from a workforce planning and talent mobility standpoint. In this way, we mitigate the risk of talent loss.

For Mississippi, we will document a clear assessment of “ready now” and “ready future” talent pools for leadership and succession planning. If a vacancy for a key position does not have an identified “ready now” successor, we will appoint an interim resource from our development talent pool while continuing to access the talent and skills across the pool of internal candidates and while considering additional talent acquisition. We will notify the Division within five business days of any known vacancy and fill all positions within the required 90 calendar days, but most commonly much sooner. Our Talent Acquisition Team averages 40 days to fill an open position. In most scenarios, we will fill positions substantially sooner through identified backup personnel, waiting only for required Division approval.

Alternate Staffing for Emergency Situations

TrueCare comes equipped with multiple strategies for both preventing and handling the sudden or sustained loss of front-line personnel. For a sudden loss due to an emergency, we initiate our established business continuity procedures as discussed in our response to question *4.3.4.4. Emergency Preparedness*. Many of our front-line personnel, such as call center staff, can be temporarily augmented by trained, ready-to-perform staff members from similar markets. We will maintain a baseline Mississippi policy training used to prepare backup personnel in emergency scenarios. These temporary backup personnel serve to minimize any impact on MSCAN and CHIP members during periods of emergency and ensure Mississippians can easily access their benefits to live healthier lives.

Lack of access to Mississippi facilities due to a hurricane or mandatory pandemic shutdown is not a significant risk for loss of personnel. We mitigate facility access restrictions or pandemic concerns with proven work-from-home capabilities. During the COVID-19 pandemic, we moved 99% of workers in select markets to at home service with no gap in services to members. When using work-from-home alternative operations, we will continue to recruit locally for all positions and require work within Mississippi for those positions which require it.

[END OF RESPONSE]

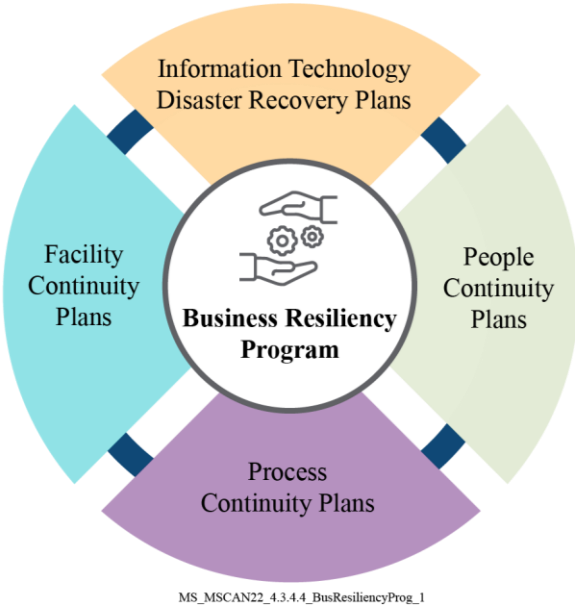
4.3.4.4 EMERGENCY PREPAREDNESS PLAN

The Offeror should discuss its services and staffing continuity plans should an emergency, including but not limited to a natural disaster, pandemic, or act of a public enemy, occur during the life of the Contract.

TrueCare[1] is prepared to respond to the full range of emergencies including, but not limited to, a natural disaster, pandemic, or act of a public enemy, in coordination with Mississippi Division of Medicaid, the Mississippi Emergency Management Agency, and local enforcement as necessary. Our fully integrated, transparent service delivery model with the majority of its providers in a real-time bidirectional data exchange is used as a key piece to our emergency preparedness plan. Our Business Resiliency Program includes Business Continuity plans and Information Technology Disaster Recovery (BC plans and IT DR) as separate but tightly integrated functions within the overall resiliency program as shown in Figure 4.3.4.4_A. As part of this resiliency framework, we provide a structured approach to incident response and ensure the appropriate resources are engaged at the right time mitigating risks through proven, resilient technology.

Figure 4.3.4.4_A: TrueCare Business Resiliency Program

Our Business Resiliency Program components are integrated across the organization to prepare for and effectively handle emergencies with no disruption in service.



We will adapt our proven all hazards business continuity plans and processes for Mississippi operations and submit a combined plan to the Division prior to the operations start date. We will also focus special attention to hurricane procedures with contingency plans should facilities become unavailable and/or in the event the staff members become unavailable due to local evacuations.

We include emergency contact details in all BC plans, listing all responsible business owners and continuity resources, communication processes, and workload relocation strategies to move work to other sites or home offices. We integrate the full business resiliency program into business operations to ensure alignment of the continuity plans with business requirements and address all levels of incidents and disruptions.

2020 COVID-19 Response

During the initial days of the pandemic, CareSource mobilized resources across the company to support our members and communities to address the impact of the pandemic. This included:

- On-going investments in technology such as virtual private network (VPN) and network capacity to maintain daily operations with no impact on productivity.
- Providing the organization with centralized communications and issue management which allowed leadership to stay informed while keeping focused on their business units.
- Invoking our business continuity plans to quickly and efficiently scale operations to address a large increase in regulatory changes and ensure members had access to care.
- Offering members and providers COVID-19 updates and information through the CareSource website, member portal, and provider portals.

[1] Through an alliance between Mississippi True and CareSource (this alliance is collectively referred to in this Qualification as "**TrueCare**"), CareSource will serve as a subcontracted managed care program administrator, and Mississippi True will act in its capacity as Mississippi's only provider-sponsored health plan with oversight of all health plan operations, thereby fulfilling its legislatively ordained mission to "encourage and facilitate collaboration between Mississippi Medicaid providers and managed care entities . . . to align incentives in support of integrated and coordinated health care delivery, and to encourage the development of appropriate population or community health strategies to better serve Medicaid beneficiaries and the state's health care delivery system as a whole." Miss. Code Ann. § 83-5-601(1). As a result, TrueCare combines industry-leading managed care operational excellence with a local, member-centric approach to healthcare.

We integrate resiliency training into our annual compliance training as well as provide quarterly, company-wide messages around winter weather planning, tornado season, travel safety, and hurricane season. We hold quarterly meetings with the BC plan owners to review and prioritize program improvement opportunities. Each department within the enterprise maintains and tests a business continuity plan.

For IT, our technical teams conduct a business impact analysis (BIA) review at least annually. This includes tabletop testing exercises and review of any significant organizational or technology changes. We integrate the results of the BIA and testing into the relevant BC plans and IT DR Plan and conduct a full plan review and approval process internally and with the Division for all changes.

In support of our business resiliency program, our enterprise incident management team (IMT) performs the following critical functions:

- **Incident Identification and Management:** Our IMT receives all escalated reports of incidents across internal teams and collaborates with department leadership to assess the impact, determine risk areas, and notify state and federal agencies, as necessary. The IMT notifies designated leadership within our organization and communicates updates as available. Until restored, IMT continues to monitor and manage all business continuity incidents.
- **Emergency Alternate Procedures:** We develop and maintain emergency alternate procedures (EAPs) for the critical business processes as identified in the BIA. These procedures may include manual workarounds or alternate access methods for key data, and they outline the processes we follow to restore services, facilities, systems, or infrastructure.
- **Emergency Communications:** We include emergency communication guidelines within our BC plans for Mississippi as well as the overall organization. This includes guidelines for internal notifications, meetings, and notifications to the division. We pre-record emergency employee and public messages for common emergency scenarios and document approvals from the Division. We perform regular monitoring of the risk to our locations where we have an existing presence. This includes events ranging from weather emergencies to terrorism and pandemic concerns. Our weather communication plans include processes for advance preparedness for pending storms as well as post event employee health and safety verification.

  For example, when tornados hit near our Ohio and Kentucky locations, our member support team contacted members in the line of the storm to provide them with Red Cross and CareSource support telephone numbers. Similarly, our pandemic response strategy is based on the advice and pandemic preparation plans of the Centers for Disease Control (CDC). We coordinate this through our pandemic governance model.

TrueCare also identifies available resources for member support activities outside of the standard scope of work.

For example, during the pandemic, CareSource mobilized staff members to provide vaccination support at clinics near our offices in all markets.

Alternate Staffing for Emergency Situations

Our team comes equipped with multiple strategies for both preventing and handling the sudden or sustained loss of front-line personnel. For a sudden loss due to an emergency, we initiate our established business continuity procedures. Trained and ready to perform staff members from similar markets temporarily augment our front-line personnel, such as call center staff. We maintain a baseline Mississippi policy training used to prepare backup personnel in emergency scenarios. These temporary backup personnel serve to minimize any impact on MSCAN and CHIP members during any periods of emergency.

We mitigate facility access restrictions or pandemic concerns with proven work-from-home capabilities. During the COVID-19 pandemic, we moved 99 percent of workers in select markets to at home service. While work-from-home is a solution for emergency access when facilities are unavailable and when pandemic concerns for

social distancing make in-facility work challenging, we continue to recruit locally for all positions and require work within Mississippi for those positions which require it. We understand the importance of connecting with our beneficiary population, and the best way to do that is to have a robust Mississippi-based workforce.

Management Personnel Backup

We are prepared for any sudden loss of key personnel. In the event a key position does not have an identified "ready now" successor, we appoint an interim resource from our development talent pool while continuing to access the talent and skills across the pool of internal candidates and considering additional talent acquisition. We do not allow any key personnel position to remain vacant for greater than 90 calendar days – our average days to fill is 40 days. In most scenarios, we fill these positions sooner through identified backup personnel, waiting only the required 15 or more business days for Division approval.

Maintaining Call Center Functionality

TrueCare reviews the continuity backup solution for telephone service each month across the organization to ensure it can keep providing services in the event of a natural disaster, any interruption in service, or power failure. Our system maintains full continuity of operations and data collection at full capacity for more than the required eight hours. While we provide full business continuity and backup procedures through a dual data center configuration, our call center also runs through a virtual desktop and uses voice over IP (VoIP) technology, also referred to as softphones. We empower TrueCare customer service representatives (CSRs) to work from any approved location using this softphone technology and secure access to our customer relationship management (CRM) and member support systems. CareSource used this functionality to maintain services during the most difficult period of the pandemic with 99% of agents working from home with no gaps in service to members.

TrueCare can also set up temporary Mississippi facilities, if necessary, in the event of a natural disaster or terrorist threat using this work-from-anywhere virtual capability.

[redacted]

[redacted]

Examples of Recent Incident Response

The TrueCare Alliance has successfully handled a variety of incidents including natural disasters, the COVID-19 pandemic, and an act of a public enemy. Table 4.3.4.4_A provides examples of our effective emergency handling using the same processes and resources proposed for Mississippi operations.

[redacted]

Summary

We provide a TrueCare Business Resiliency Program that includes processes, system redundancy, and staffing continuity approaches to effectively handle any emergency, including natural disasters, pandemic concerns, or acts of a public enemy, with no disruption to member services or staff availability.

[END OF RESPONSE]